STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675437	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation & Healthcare of Live Oak	8221 Palisades Drive Live Oak, TX 78233

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 1 (Resident #1) resident reviewed for accidents and hazards. The facility failed to provide a two-person mechanical lift transfer for Resident #1 on 2/11/2025. This failure placed residents at risk for falls and injury. The findings included: Record review of Resident #1's face sheet dated 2/11/2025 revealed an [AGE] year-old female with admitted [DATE] and readmission 04/04/2023 with diagnoses which included: Alzheimer's disease, vascular dementia with behavioral disturbance and anxiety disorder. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMs score of 3 which indicated a severe cognitive impairment. The MDS indicated Resident #1 function ability for moving from lying to sitting and sit to stand and for chair transfers was complete dependence on staff where the staff provided all the effort and assistance of 2 or more helpers. Record review of Resident #1's Physical Therapy Evaluation and Plan of Therapy dated 10/08/2024 revealed on page 4 of the assessment for functional ability: the resident was totally dependent on staff without attempts to initiate with bed mobility and total dependence on staff without attempts to initiate via Hoyer lift. Record review of a Nursing Functional scoring assessment completed on 2/06/2025 and signed by LVN B revealed her transfer assessment revealed she was dependent on helpers for all of the effort and the resident does none of the effort to complete the activity. The assessment indicated the assistance of 2 or more helpers was required for the resident to complete the transfer activity. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan last revised on 2/11/2025 (date of surveyor entrance and observation of transfer) revealed Resident #1 had an ADL self-care deficit that listed transfers of 2 person transfers. Prior to the edit on 2/11/2025 a revision history listed transfers as total assistance x 2 mechanical lift. An edit history revealed the care plan edit on 2/11/2025 was made by the Administrator. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMs score of 3 which indicated a severe cognitive impairment. The MDS indicated Resident #1 function ability for moving from lying to sitting and sit to stand and for chair transfers was complete dependence on staff where the staff provided all the effort and assistance of 2 or more helpers. During an observation on 2/11/2025 at 3:07 p.m., CNA D approached CNA A and requested assistance with a transfer of Resident #1. Resident #1 was seated in the hallway in her wheelchair. Resident #1 gave permission for the surveyor to observe. CNA A and CNA D placed a gait belt around Resident #1's waist, positioned her wheelchair near her bed, and locked the wheelchair wheels. CNA A and CNA D had a brief discussion about how to transfer Resident #1 with CNA D suggesting they each take a side. CNA A stated no, he would do the lift and positioned himself directly in front of Resident #1. CNA D did not attempt to stop CNA A. CNA A rocked Resident #1 back and forth a couple of times and then abruptly lifted her to a standing position by grasping her gait belt in the back in a bear-hug position. Upon rising a Hoyer sling was clearly visible under the resident. Resident #1's feet were touching the floor during the lift, but she did not appear to bear any weight. CNA A then immediately placed the resident on the bed. Resident #1 made grunting noises and said ouch when picked up and placed on the bed. CNA D did not assist with the transfer until the resident was already on the bed and then she assisted with positioning on the bed. Resident #1 became emotional after the transfer and CNA D reassured the resident that she was okay, and the transfer was over. Resident #1 denied pain. Upon exiting the room, a third staff member (unidentified) brought a Hoyer lift to the door to use. CNA D stated they had already transferred the resident. During an interview on 2/11/2025 at 3:15 p.m., CNA A stated Resident #1 was normally transferred with the use of a sling and Hoyer lift. He stated the Hoyer's were being worked on and were not available so they had used a gait-belt to transfer Resident #1. CNA A stated acknowledgement that the transfer was done with only one person. During an interview on 2/11/2025 at 3:18 p.m., CNA D stated the facility had two Hoyer lifts on their side of the building and neither of them were in working condition when Resident #1 needed to be transferred from her wheelchair to bed. CNA D stated Resident #1 had been up in her wheelchair since approximately 11:30 a.m. and needed to lay down. She stated the plan of care for Resident #1 indicated a Hoyer lift was needed for transfers. When CNA D was asked if she had notified maintenance or anyone else that the Hoyer's were not functioning, she stated the batteries were dead because staff did not plug them in. She stated both of the batteries were dead and stated staff needed to keep the lifts plugged in. CNA D stated she did not go to the other side of the building to see if a Hoyer was available. CNA D stated CNA A performed a one person transfer instead of providing two-person transfer because if they had attempted a two-person transfer without the Hoyer, Resident #1 would have tried to grab them and hold on. CNA D stated she knew two people were required to transfer Resident #1. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/2025 at 1:11 p.m., LVN B stated Resident #1 had progressive dementia. She stated Resident #1 had lower back pain and arthritis. LVN B stated whenever they moved Resident #1, she would briefly cry out but when they were done, she was fine. She stated whenever staff moved her, she would get scared because she scared easily. She stated when staff was done, she was always thankful and loving. LVN B stated Resident #1 required a Hoyer transfer with two staff. She stated if her care plan said Hoyer transfer was needed then a Hoyer should be used for her safety. She stated the Hoyer batteries should always be charged. LVN B stated CNA A should not have performed a one-person transfer. She stated if LVN D was not able to assist, they should have come and asked for help. She stated the CNAs knew Resident #1 required two people for her safety. During an interview on 2/12/2025 at 2:01 p.m., the DON stated Resident #1's care plan should be accurate to reflect her transfers. She stated Resident #1 should have been a two-person transfer. She stated her expectation was for staff to notify her if the Hoyer's were not working so they could get one from the other side of the building and so they could get the Hoyer looked at and repaired. The DON stated if it was a batter issue, it needed to get charged. The DON stated it was important for staff to utilize what was in the care plan for the safety of the resident. During an interview on 2/12/2025 at 2:49 p.m., the DOR (Director of Rehabilitation) stated an assessment had not been completed on 2/11/2025 prior to her transfer to see if she was safe to downgrade with transfers. She stated her last assessment was approximately two months ago and Resident #1 was total dependent for transfers. The DOR stated Resident #1 was not safe for a one-person transfer. The DOR stated typically a two-person transfer required the resident to be able to bear weight and pivot. She stated the resident did not have to have the ability to stand and pivot, they could squat and pivot where they are hovering but their feet should still touch the floor. The DOR stated it was important to have adequate staff for transfers for resident safety. During an interview on 2/12/2025 at 4:53 p.m., the Administrator stated she edited Resident #1's care plan from transfers with two-person mechanical lift to two-person transfer on 2/11/2025. She stated she made the edit because the Hoyer lift was down, and Resident #1 needed to be transferred. The Administrator stated she met with the IDT team meeting which included herself, LVN B and an ADON. She stated she did not include physical therapy in the decision-making meeting. She stated they discussed it as a team and after discussing it she made the change to the care plan. The Administrator stated she did not know if the plan was to keep Resident #1's care plan at 2-person transfer as opposed to Hoyer lift transfer because it was not discussed. She stated Resident #1 had behaviors that needed to be discussed before a decision was made. She stated those behaviors included touching peoples, a tendency to yell out and behaviors of trying to feed other residents. When asked how those behaviors affected her transfer status, the Administrator stated all behaviors affected all areas of her life. She stated the IDT team discussed how the transfer best met the needs of the resident. She stated she made the decision to change her care plan and transfer status because at the time she did not think about getting another Hoyer from another part of the building. She stated after the transfer was made; a member of management did go get a Hoyer from the other part of the building. She stated the IDT team decided Resident #1 was safe for a two-person transfer. The Administrator stated she was not aware until today (2/12/2025) that the transfer was done with only one staff member. She stated she was able to confirm with staff today that a two-person transfer was not done. She stated she stated she did not have feelings about the staff not doing a two-person transfer, but would have a conversation with the CNA involved. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled Transfer: Bed-Chair/Wheelchair dated 2/05/2015 revealed: One person-Stand-pivot: 8. Instruct /assist resident to push down on arms on bed and into floor with feet 9. Stand first, then pivot feet to reach chair/wheelchair. The policy did not address assessment for transfers. Record review of a facility policy titled Transfers of Residents dated 5/2012 revealed: Transfers are defined as the act of moving a resident from one surface such as a bed to the wheelchair or from the wheelchair to the toilet. The goal is to ensure the safety of the resident when moving from one place to another, to prevent injuries to the resident, to prevent injuries to staff member assisting the resident, and to enable the resident to as independent during the transfer as possible. The policy did not address how a resident was assessed for safe transfer. Record review of a facility policy titled Mechanical Lift dated 4/24/2014 revealed: Purpose: to move immobile or obese patients for whom manual transfer poses potential for a resident injury. The policy did not address any other transfer or assessment for transfers. Record review of a facility policy titled Activities of Daily Living last revised 1/01/2024 revealed the policy discussed dressing of the resident and did not address resident assistance with transfers or assessment of ADL skills.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interview, and record review, the facility failed to ensure food was prepared in a form designed to meet individual needs for 1 of 8 residents (Resident #2) reviewed for dietary services. The facility failed to ensure Resident #2 received their prescribed diet (mechanical soft with pureed meat texture) for evening meal service on 2/11/2025. This deficient practice could place residents, who were provided a mechanically altered diet, at risk of choking, aspiration (inhaling food,) and diminished quality of life. The findings included: Record review of Resident #2's face sheet dated 2/11/2025 revealed a [AGE] year-old female with an admitted [DATE] with diagnoses which included: cerebral infarction due to thrombosis of left cerebellar artery (stroke caused by a blockage of an artery leading to the brain), dementia with anxiety, dysphagia oropharyngeal phase (impairment in the ability to swallow which included difficulty with the mouth and throat). Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMs score of 4 (scale of 0-15) which indicated a severe cognitive impairment. The MDS indicated Resident #2 required supervision or touching assistance with eating. Record review of Resident #2's care plan last revised on 1/06/2025 revealed a diet of mechanical soft with puree meat due to dysphagia with interventions which included: provide, serve diet as ordered. Record review of Resident #2's physician orders revealed a diet order with a start date of 10/28/2024 for mechanical soft with pureed meat texture. Record review of Resident #2's meal tray ticket for evening meal service on 2/11/2025 revealed: ticket printed on: 2/10/2025 .mechanical altered/ground nectar with pureed meats and a handwritten note at the bottom of the ticket which read: pureed meats. The individual food items that were on the tray were not listed, just the diet orders. During an observation on 2/11/2025 at 6:13 p.m., Resident #2 was observed in her room seated on the edge of her bed with her evening meal. The meal tray consisted of a grilled ham and cheese sandwich which had been cut in half along with onion rings and diced beets. The ham on the sandwich was a whole piece and was not pureed. During an interview on 2/11/2025 at 6:13 p.m., CNA A stated Resident #1's meal did not contain pureed meat as noted on the resident meal ticket. CNA stated the whomever passed out the tray was responsible for checking for accuracy. She stated she did not know who passed out the tray but would tell the nurse. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 2/11/2025 at 6:16 p.m., LVN B entered Resident #2's room and looked at the meal tray. LVN B stated confirmation that Resident #2's meal did not contain pureed meat. She stated she needed to clarify with the kitchen because Resident #2 had difficulty swallowing. LVN B stated whoever passed the trays was responsible for ensuring the accuracy of the diet. She stated that fell mostly on the CNA staff. LVN B stated the nursing staff did not check the meals for accuracy unless they were the ones assisting with passing out the trays. She stated she was assigned to Resident #2 and had not checked the trays. LVN B stated the CNA staff knew the halls and knew their residents and if there was an error, the CNA should take the tray back to dietary to correct. LVN B removed the tray from the room. During an observation and interview on 2/11/2025 at 6:22 p.m., the DM (Dietary Manager) entered Resident #2's room with a meal tray for Resident #2. The DM placed the tray in from of Resident #2 which contained pureed sandwich, pureed beets, and pureed onion rings. The DM stated she ran out of the other diet and only had pureed items left. She stated that was why she delivered the meal tray herself to see if Resident #2 was okay with eating a pureed meal (as opposed to just pureed meats). Resident #2 was not able to answer interview questions due to cognitive status and did not seem to understand the questions about her diet. Resident #2 stated it was okay and began to eat the meal. The DM stated she had two DA's (dietary aides) and the cook working and preparing meals in the kitchen. She stated the first aide places the meal ticket on the tray and into the hall cart. She stated the cook does not check meal tickets and only fulfills request such as how many chopped, pureed, etc. to prepare. She stated the second DA ensured the meal accuracy before the trays left the kitchen. The DM stated every resident meal and diet was audited every Monday in PCC for accuracy. The DM stated none of the meal tickets contained a list of meal items that should be on the tray such as beets, onion rings, ham and cheese sandwich. She stated the tray tickets only included diet orders to avoid confusion if she had to substitute meal items. During an interview on 2/12/2025 at 2:01 p.m., the DON stated Resident #2's ham/meat should have been separated from the sandwich, pureed, and served separately and she should have received a diet as ordered by her physician. She stated the nurses were responsible for checking the meal trays for accuracy before the trays go the CNAs to pass out. The DON stated the nurses should be looking at the ticket and looking at the meal before handing off the trays to the CNAs. The DON stated it was important, so the residents were getting diet as ordered by a physician. Record review of a facility policy titled Diets, Nutrition and Hydration last revised 8/2023 revealed: Each meal will be provided according to physician orders, Facility Diet Manual, and menu spread sheet. Diet Order: A diet order is a prescription written by the attending physician, practitioner or registered dietitian to change a resident's diet or establish a diet for a new admission.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interview, and record review, the facility failed to provide drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration for 6 of 8 residents (Resident #1, #2, #5, #6, #7 and #8) reviewed for hydration, in that: The facility failed to ensure Residents #1, #2, #5, #6, #7 and #8 had access to water and/or beverages in their rooms between meals and failed to ensure 16 ounces of fluid was offered with meals. These deficient practices could affect resident's hydration and lead to discomfort, dehydration, and/or a diminished quality of life. The findings included: 1. Record review of Resident #1's face sheet dated 2/11/2025 revealed an [AGE] year-old with an admitted [DATE] and readmission 04/04/2023 with diagnoses which included: Alzheimer's disease, vascular dementia with behavioral disturbance and anxiety disorder. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMs score of 3 which indicated a severe cognitive impairment The MDS indicated Resident #1 required total assistance for bed movement and transfers and supervision or touch assistance for eating. Record review of Resident #1's care plan last revised on 1/06/2025 revealed she was at risk for dehydration related to impaired cognition and history of weight loss with interventions which included: nursing to offer hydration cart in between meals, as well as beverage served with meals. During an observation on 2/11/2025 at 11:18 a.m., Resident #1's room did not have any water, beverages, or water pitcher at bedside. During an observation on 2/11/2025 at 2:45 p.m., a staff member (unidentified) was observed with a cart containing multiple empty water pitchers going room to room on the 100 hallways. The cart was not observed on the 200/300 or 400 hallways with residents. During an observation and interview on 2/11/2025 at 3:07 p.m., Resident #1 was observed in bed, awake and alert. There was no water or beverages in the room. There was an empty disposable water cup on a bedside table not in reach of the resident pushed away from the bed. An empty water pitcher was observed in the bathroom. Resident #1 was not able to answer interview questions due to her cognitive status. During an interview on 2/11/2025 at 3:18 p.m., CNA D stated Resident #1 was impaired and did not ask for water. During an interview on 2/12/2025 at 1:11 p.m., LVN B described Resident #1 as exhibiting symptoms of progressive dementia and stated she was reliant on staff. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #2's face sheet dated 2/11/2025 revealed a [AGE] year-old with an admitted [DATE] with diagnoses which included: cerebral infarction due to thrombosis of left cerebellar artery (stroke caused by a blockage of an artery leading to the brain), dementia with anxiety, dysphagia oropharyngeal phase (impairment in the ability to swallow which included difficulty with the mouth and throat). Record review of Resident #2's physician orders revealed a diet order with a start date of 10/28/2024 for nectar thick fluids. Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMs score of 4 (scale of 0-15) which indicated severe cognitive impairment. The MDS revealed Resident #2 required supervision or touch assistance for for bed mobility and transfers and supervision or touch assistance for eating. Record review of Resident #2's care plan last revised on 1/06/2025 revealed the resident had impaired communication related to cognitive communication deficit with interventions which included anticipate and meet needs. During an observation and interview on 2/11/2025 at 11:56 a.m., Resident #2 was observed lying in bed awake. There was no water, drinks, or water pitcher in the room. Resident #2 answered yes when asked if she had enough to drink but was unable to answer any of the other interview questions and appeared confused. During an observation on 2/11/2025 at 4:48 p.m., Resident #2 did not have water or beverages in her room. During an observation on 2/11/2025 at 6:13 p.m., of Resident #2's evening meal served in her room revealed she received one 6-ounce cup of tea and one 6-ounce cup of water that was thickened. During an interview on 2/12/2025 at 1:11 p.m., LVN B described Resident #2 as having symptoms of progressive dementia. She stated Resident #2 was confused. She stated her dementia prevented her from knowing what was going on around her. LVN B stated Resident #2 would forget she had eaten and was overall very forgetful. 3. Record review of Resident #5's face sheet dated 2/11/2025 revealed a [AGE] year-old admitted on [DATE] with diagnoses which included: profound intellectual disabilities, cognitive communication deficit (consequence of brain injury that affects a person's ability to communicate effectively) and Down Syndrome (genetic disorder caused by the presence of a third copy of chromosome 21 with associated developmental delays, intellectual disability and characteristic physical features). Record review of Resident #5's quarterly MDS dated [DATE] revealed a BIMs score of 9 which indicated moderate cognitive impairment. The MDS revealed Resident #5 required substantial/maximal assistance with bed mobility and transfers and set up assistance with eating. Record review of Resident #5's care plan last revised on 1/06/2025 revealed the resident was PASRR positive due to Down syndrome and profound intellectual disabilities. The care plan indicated Resident #5 had profound communication deficit with interventions which included anticipate and meet needs. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 2/11/2025 at 3:23 p.m., Resident #5 was observed in her room, awake and sitting in bed holding a stuffed toy. There was no water, beverages, or water pitcher in the room. Resident #5 was unable to answer interview questions due to her cognitive status. CNA D stated confirmation that there was no access to water in Resident #5's room. CNA D stated Resident #5 mostly gets water with her meal trays. CNA D stated Resident #5 was unable to ask for water due to her mental condition. CNA D stated Resident #5 had the ability to ask but did not. She stated Resident #5 mostly asked for sweets. CNA D stated they did not leave water for Resident #5. During an observation on 2/11/2025 at 4:48 p.m., Resident #5 did not have water or beverages in her room. During an observation on 2/12/2025 at 10:54 a.m., Resident #5 was not in her room. There was no water pitcher, water, or beverages in the room. During an interview on 2/12/2025 at 1:11 p.m., LVN B described Resident #5 was able to tell staff when she needed something but was intellectually impaired. 4. Record review of Resident #6's face sheet dated 2/11/2025 revealed a [AGE] year-old admitted on [DATE] with diagnoses which included: dementia with anxiety, dementia with behavior disturbance and neurofibromatosis type 1 (genetic disease affecting the nervous system resulting in tumor growth of the nervous system and affecting the brain). Record review of Resident #6's quarterly MDS dated [DATE] revealed a BIMs score of 5 which indicated a severe cognitive impairment. Record review of Resident #6's care plan last revised on 1/06/2025 revealed she was a hydration risk related to malnutrition with interventions which included monitor intake. The MDS for Resident #6 revealed substantial/maximal assistance with bed mobility and transfers and partial/moderate assistance with eating. During an observation and interview on 2/11/2025 at 2:59 p.m., Resident #6's room was observed with CNA C. Resident #6 was in her bed which was a low bed mattress on the floor and a floor mat beside the mattress. There was an empty plastic disposable cup and a second disposable cup with approx. 1 cm of water in the bottom of the cup on a bedside table on the other side of the room and not within reach of the resident. CNA C stated he kept the water out of the reach of the resident because she would spill it and if she wanted water, she would have to ask for it. During an interview on 2/11/2025 at 3:00 p.m., Resident #6 stated she had enough to drink for now. She stated staff did not bring her water unless she asked for it but if she did ask, they would bring it. Resident #6 stated she was able to lift the cup and the water pitcher on her own. She stated she was able to drink water by herself as long as she had a straw. Resident #6 stated she would like to have access to water with a straw without having to ask for it. During an interview on 2/12/2025 at 1:11 p.m., LVN B described Resident #6 as having symptoms of sundowners (a person with dementia who becomes increasingly irritable or difficult as the day progresses) with cussing behaviors and was also on hospice but was improving. She stated Resident #6 was able to advocate for herself and did not want to be at the facility. She stated Resident #6 could request water if she wanted it and often left her room. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Record review of Resident #7's face sheet dated 2/12/2025 revealed a [AGE] year-old admitted on [DATE] and readmitted on [DATE] with diagnoses which included: cerebral infarction, type 2 diabetes mellitus with hyperglycemia (elevated blood glucose levels) and circulatory complications, and hepatic encephalopathy (a neurologic disorder that occurs with liver disease). Record review of Resident #7's care plan last revised on 1/06/2025 revealed he had a cognitive impairment related to Parkinson's disease and dementia. The care plan revealed Resident #7 had impaired communication as evidenced by not always understanding which placed him at risk for not having his needs met. The care plan also indicated Resident #7 was a dehydration risk. Record review of Resident #7's significant change MDS dated [DATE] revealed a BIMs of 10 which indicated a moderate cognitive impairment. The MDS for Resident #7 revealed supervision or touch assistance required for bed mobility and transfers and set up assistance with eating. During an observation and interview on 2/11/2025 at 2:54 p.m., Resident #7's room was observed with CNA C. Resident #7 was not in the room. There was no water or beverages in the room. There was an empty water pitcher on the bedside table. CNA C stated confirmation that Resident #7's room did not have any water or beverages. CNA C stated Resident #7 came and went in and out of the room all day and wandered around the facility. CNA C stated Resident #7 could ask for water if he wanted it. During an observation on 2/11/2025 at 4:50 p.m., Resident #7 did not have water or beverages in his room. An observation of Resident #7's personal refrigerator in the room revealed it contained only condiments and there were no drinks. During an interview on 2/12/2025 at 1:11 p.m., LVN B described Resident #7 as having dementia which had increased. She stated he also had Parkinson's disease and the symptoms from that had also increased. She stated he was able to advocate for himself but was forgetful. She stated Resident #7 had a personal refrigerator in his room and was always in and out of his room. She stated he was capable getting what he needed. During an interview on 2/12/2025 at 12:55 p.m., Resident #7 stated he gets enough to drink but he had to ask for it. He stated they would not give him water unless he asked. He stated the facility used to provide water pitchers with water in his room. He stated they were not doing that anymore and he did not know why. He stated he wished they would provide the water in the pitchers again. 6. Record review of Resident #8's face sheet dated 2/11/2025 revealed a [AGE] year-old admitted on [DATE] and readmitted on [DATE] with diagnoses which included: cerebral palsy (permanent neurologic disorder that affects movement and posture resulting from damage to the brain), chronic kidney disease stage 3, dementia with behavioral disturbance. Record review of Resident #8's annual MDS dated [DATE] revealed a BIMs score could not be obtained because the resident was rarely or never understood and had both long- and short-term memory problems. The MDS revealed Resident #8 was dependent on staff for bed moviligy, required substantial/maximal assistance with transfers and required partial/moderate assistance with eating. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675437	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehabilitation & Healthcare of Live Oak	8221 Palisades Drive Live Oak, TX 78233

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's care plan last revised 1/06/2025 revealed the resident was PASRR positive for intellectual disability. The care plan also revealed Resident #8 was non-verbal with interventions which included anticipate and meet needs. The care plan revealed Resident #8 was a hydration risk and at risk for hydration with interventions to encourage the resident to drink fluids of choice. During an observation/interview on 2/11/2025 at 11:27 a.m., Resident #8 was observed in her room lying in bed. The resident was awake and alert but unable to answer any interview questions due to cognitive status. Resident #8 did not have any water, drinks, or water pitcher in the room. During an observation and interview on 2/11/2025 at 3:21 p.m., Resident #8 was in bed awake. Upon entering the room along with CNA D, Resident #8 said water Momma. CNA D acknowledged Resident #8 said water and stated she called everyone Momma, although it was unclear if she was repeating the word or if she was asking for water. CNA D stated she did not leave water in the room for Resident #8 because she would drink it constantly. She stated Resident #8 liked water and was a really good drinker. When asked if it would cause harm to the resident for her to have access to water during the day, CNA D said no. During an interview on 2/11/2025 at 3:18 p.m., CNA D stated Resident #8 was mentally impaired and staff had to provide water to her. During an observation on 2/11/2025 at 4:48 p.m., Resident #8 did not have water or beverages in her room. During an observation of lunch meal service in the dining room on 2/11/2025 at 12:20 p.m., revealed staff provided residents with a beverage of choice (lemonade or tea), served in a variety of cups including personal cups and mugs. Water was not served unless a resident requested it. During an observation of lunch meal service on 2/11/2025 on the 200/300/400 hallway revealed residents were served tea in a small juice size cup (6-ounce cup) and water in a small juice sized cup (6-ounce cup). During an observation of evening meal service in the dining room on 2/11/2025 from 5:30 pm to 6:10 pm revealed staff served approximately 14 residents. Residents in the dining room were served a beverage of choice. Water was not routinely serviced and only 1 of 14 residents in the dining room were observed with water. During an observation on 2/11/2024 at 6:13 p.m., a test tray was requested. The tray contained one 6-ounce cup of water and one 6-ounce cup of unsweetened tea and along with the meal. During an interview on 2/12/2025 at 1:11 p.m., LVN B described Resident #8 as having a syndrome. She stated Resident #8 was unable to tell staff what was wrong, and the staff had to pay attention to her. LVN B stated Resident #8 was always drinking and if they left water for her, she would pour it on herself. She stated she also worried that Resident #8 would choke and had instructed staff not to leave water for her. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/11/2025 at 3:03 p.m. CNA C acknowledged many residents did not have water, water pitcher or drinks in their rooms. He stated in the mornings all residents receive coffee with their breakfast. He stated for both lunch and dinner the residents received a beverage of choice. He listed punch, lemonade, tea, and water as choices. He stated they provided residents the beverage they asked for at meals. He stated if residents required thickened liquids, those drinks had to come from the kitchen. CNA A stated for residents who could not ask for water, they were provided water with their meals. He stated he did not provide water to residents between meals unless they asked because the residents were provided water or beverages with each meal. He stated he did not utilize the water pitchers that some of the other resident's had in their rooms because most of the residents did not have the strength to pick them up. During an interview on 2/11/2025 at 3:18 p.m., CNA D acknowledged there was not water or beverages available in the resident rooms. She stated none of the residents on the hallway had water, but she would bring it if they asked. She stated staff had to provide it. She stated on a typical day Hospitality Services would pass out water, but she had not seen them today. She stated without Hospitality Services the CNAs would have to provide water at the beside. CNA D stated water was provided on the meal trays. She stated Resident #1 was impaired and did not ask for water. CNA D stated Resident #8 was mentally impaired, and staff had to provide water to her. During an interview on 2/11/2025 at 4:57 p.m., the DM (Dietary Manager) stated residents who were served in the dining room for meal service received one 8 once glass of water with their meal and once 6 once glasses of the beverage of their choice. She stated the residents who had trays delivered to their hallways had one 6 ounce glass of water and one 6 once glass of water. She stated only residents in the dining room were served soup with their meals as an appetizer. She stated the residents who had meal trays did not receive soup unless they had specifically requested it. She stated the facility had a dietitian who came to the facility two times a month to review. During an interview on 2/12/2025 at 12:25 p.m., ADON F stated he was new to the facility and still on orientation. He stated, that's a good question when asked about the facilities policy on water at the bedside. He stated he was still learning how the facility worked and did not have the answer to the question. He stated in other facilities he had worked with, they had water at the bedside at all times. He stated he was big on pushing fluids for the geriatric community because they don't remember. During an interview on 2/12/2025 at 1:11 p.m., LVN B stated the facility had a hospitality aide that passed water to the residents. She stated the hospitality aide should be making rounds in the morning after breakfast and after lunch and should be leaving water in the resident rooms. She stated the water should be left in water pitchers or plastic or foam cups of water. She stated on 2/11/2025 HA (hospitality aide) E had been at the facility. She stated if the hospitality aide was unavailable the CNAs should have done it. She stated most of the residents could ask for water, but a few could not. LVN B She stated she had communicated the importance of drinking with the staff. During an interview on 2/12/2025 at 1:47 p.m., HA E stated he was a hospitality aide and his duties included passing out water on all hallways. He stated he also passed out juices. He stated he leaves a water pitcher in the rooms if the resident does not have one or he fills their personal thermos/cups. He stated on 2/11/2025 he provided water to all rooms. When asked why the residents on the 300/400 hallway did not have water or water pitchers on 2/11/2025 or today 2/12/2025, he stated it was possible he got distracted and never got to some of the residents. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/2025 at 2:01 p.m., the DON stated the facility ensured residents were hydrated by having a hospitality aide go room-to-room at 10 a.m. and again at 2 p.m., to ensure residents had water and snacks. The DON stated the hospitality aide had a cart with water and juice on them. She stated they provided thermos (pitchers) and cups and some of the residents had their own cups. She stated if a resident did not have a thermos for whatever reason, it should be replaced. The DON stated the nurses and ADON should monitor the staff to ensure this was done. The DON stated all residents should have access to hydration because every cell in the body needed water. She stated water should be in every resident room. During an interview on 2/12/2025 at 2:20 p.m., the RD (Registered Dietitian) stated the nursing staff was responsible for ensuring adequate water intake. She stated each resident should receive one beverage and one water with each meal for a total of 16 ounces of fluid per meal or at least that was what should be offered. She stated the nursing staff made sure the resident get ice with water and water and beverage of choice at meals and she felt like they did a fairly good job of it. She stated the residents should also have a water jug at bedside. The RD stated beverages were available on the hallways and from the kitchen. The RD stated nursing staff should encourage dementia residents to drink. She stated those jugs (thermos/pitchers) the residents get should be filled because dementia causes brain deterioration, and they might not feel as hungry or thirsty. She stated staff should also encourage fluids with meals. The RD stated staff should go by every hour for fluids and nursing staff should be encouraging large drinking cups. The RD stated hydration was important to maintain hydration. She stated water works with everything: blood, brain, and electrolyte health. The RD stated she was last at the facility last week. She stated she sees residents on a quarterly basis for hydration needs, not necessarily the entire resident population. She stated she had not seen or discussed any hydration deficits with the facility. During an observation/interview on 2/12/2025 at 4:25 p.m., HA G was observed in the main dining room near the kitchen talking with other staff. He stated he did not work on 2/11/2025. He stated he just arrived to work for the evening shift. He stated when he passed fluids in the evenings, he used disposable cups and showed a small 6-ounce Styrofoam cup. He stated he also used the thermos which held 9 ounces of fluid for water or juice depending on resident preference. He stated he was trained to provide beverages to all residents except those with NPO status and those with feeding tubes. He stated the facility beverage station was in the main hallway immediately outside the dining area and showed surveyor the set up. HA G showed surveyor a water fountain and water bottle re-fill dispenser in the hallway. HA G stated that was the only hydration station except for the carts that he pushed around the halls. Record review of a facility policy, titled Diets, Nutrition and Hydration last revised on 8/2023 revealed: Each resident should receive at least two to three 8 oz to 12 oz beverages with each meal, including residents who have orders for thickened liquids, unless contraindicated by diet or fluid orders. Each resident will be offered and have access to beverages between meals. Hydration: 1. Fluid should be available for residents between meals for additional hydration. Fluids will be delivered and/or refreshed a. prior to each meal b. between meals during snack/hydration times (e.g. 10 am, 2 pm and 8 pm) c. hydration cart d. hydration or beverage station (s) .2. Facility hydration should include more than one beverage and should be offered to each resident unless contraindicated by fluid intake orders. 4. Residents on thicken liquids will have at least 1 8 oz thickened beverage sent out with nourishment .Hydration stations will be: attractive and inviting, use of clear glass or plastic beverage dispensers, use of cut fruit or other water infusions such as cucumbers, lemons, limes, and table clothes to dress up old carts or tables.