

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Advanced Rehabilitation & Healthcare of Live Oak		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure sufficient nursing staff with appropriate competencies and skills set to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plan of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for 1 of 12 nursing staff (RN K) reviewed for nursing services. RN K did not demonstrate competency when she failed to identify and document a left heel DTI upon readmission from the hospital on [DATE] for Resident #1. This failure could place residents at risk of staff not providing nursing or related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being. Findings include: Record review of Resident #1's undated face sheet revealed Resident #1 was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included cerebral infarction (a disruption in the brain's blood flow), type 2 diabetes (a condition where the body has difficulty regulating blood sugar levels), congestive heart failure (a condition in which the heart doesn't pump blood as well as it should) and anemia (a low number of blood cells). Record review of Resident #1's admission MDS assessment, dated [DATE], revealed Resident #1 had a BIMS score of 15, indicating intact cognition. Section GG - Function Abilities revealed Resident #1 had impairments on both sides of Resident #1's upper and lower extremities and required substantial to maximum assistance with bed mobility and transfers. Section M - Skin Conditions revealed Resident #1 was at risk for developing pressure ulcers and revealed that Resident #1 did not have any pressure ulcers or any other ulcers, wounds, or skin problems. Record review of Resident #1's undated comprehensive care plan revealed Resident #1 has a care plan that stated Resident #1 was at risk for the potential development of a pressure ulcer, dated [DATE] and revised [DATE]. Record review of Resident #1's weekly skin assessment, dated [DATE], revealed a head-to-toe assessment was completed and Resident #1 did not have an impairment in skin integrity. Record review of Resident #1's SBAR Communication Form, dated [DATE], revealed Resident #1 was transferred to the hospital on [DATE] for an evaluation related to a change in condition. Record review of Resident #1's hospital discharge documentation, dated [DATE] revealed, Extremities: well healed incision of R BKA, L heal pressure ulcer-skin intact. Record review of Resident #1's Clinical admission Assessment, dated [DATE] by RN K, revealed Resident #1 readmitted to the facility from the hospital. The document revealed a skin assessment that stated Resident #1 had no skin issues. Record review of Resident #1's progress notes by the Wound Treatment Nurse, [DATE], revealed, Skin observation performed. DTI present to left heel, non-blanchable (a condition where skin redness persists even when pressure is applied) persistent maroon area. Edema (swelling) present to left upper extremity. Discoloration present to bilateral hip area. Friction/shear markings present to left hip. Healing shear marks present to bilateral breast folds. Record review of Resident #1's [DATE] medication administration record revealed and order, Clean left heel with wound cleanser, pat dry. Skin prep. Offload. Every day shift for PI, start date, [DATE]. The administration record revealed Resident #1 received the treatment on [DATE], [DATE] and [DATE]. Record review of Resident #1's progress note, dated [DATE] at 1:42 p.m., revealed Resident #1 was transferred to the hospital related to hypoglycemia. During an interview with Resident #1's responsible party, [DATE] at 12:53 p.m., the responsible party stated Resident #1 was deceased and passed away on [DATE] at the hospital on hospice services. During an interview with the Wound Treatment Nurse, [DATE] at 11:09 a.m., the Wound Treatment Nurse stated when a resident admits/readmits to the facility, the admitting nurse would complete an assessment of the resident and part of the assessment included a head-to-toe skin assessment. The Wound Treatment Nurse stated she would be notified by the admitting nurse if a resident admitted with any skin concerns, reviewed the admitting clinical assessment, and then completed a skin assessment of each new admission/readmission within 24 hours of the admission. The Wound treatment Nurse stated the admitting nurses should document any skin concerns on the clinical admission assessment. The Wound Treatment Nurse stated Resident #1 did not have any skin concerns prior to Resident #1's hospitalization from [DATE] to [DATE], and Resident #1 returned from the hospital with a left heel DTI. The Wound Treatment Nurse stated the DTI should have been identified on the Clinical admission Assessment completed by RN K and when the Wound Treatment Nurse identified the left heel DTI the Wound</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 8 residents (Resident #2) reviewed for infection control in that: CNA D did not wear a gown when providing direct care to Resident #2 who had a foley catheter and was on enhanced barrier precautions (EBP). This deficient practice could affect residents on enhanced barrier precautions and place them at risk for infection. The findings were: Record review of Resident #2's undated face sheet revealed Resident #2 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes (a condition where the body has difficulty regulating blood sugar levels), Hemiplegia (paralysis of one side of the body) and chronic kidney disease (gradual loss of kidney function). Record review of Resident #2's quarterly MDS assessment, dated 10/30/2025, revealed a BIMS score of 14, indicating intact cognition. Section GG - Functional Abilities revealed Resident #1 was dependent on facility staff for toileting hygiene. Section H - Bladder and Bowel revealed Resident #2 had an indwelling foley catheter and was always incontinent of bowel. Record review of Resident #2's undated comprehensive care plan revealed a care plan that read, Resident #1 required enhanced barrier precautions due to a foley, date initiated 09/04/2025. Record review of Resident #2's November 2025 medication administration record revealed enhanced barrier precautions related to Resident #2's foley, start date 08/20/2025. Record review of Resident #2's November physician orders revealed Resident #2 had a physician order for enhanced barrier precautions, start date 08/20/2025. During an observation, 11/14/2025 at 11:40 a.m., Resident #2 had a sign on his door that said Enhanced Barrier Precautions. CNA D was observed walking out of Resident #2's room with a small clear bag that contained a brief and gloves. During an interview with Resident #2, 11/14/2025 at 11:50 a.m., Resident #2 stated CNA D had been in Resident #2's room changing his brief from an incontinent episode and emptied his foley catheter bag. Resident #2 stated CNA D wore gloves during the direct care but did not wear a gown. Resident #2 stated staff did not usually wear gowns when providing care to him. During an interview with CNA D, 11/14/2025 at 12:10 p.m., CNA D stated she had just changed Resident #2's brief and provided foley catheter care to Resident #2. CNA D stated she did not wear a gown while providing care. CNA D stated she had recently received training on infection control and EBP in a recent skills fair at the facility. CNA D stated she could identify which residents required EBP because they had a sign on their room door, and residents with wounds or foleys were on EBP and staff had to wear a gown and gloves when providing direct care. CNA D stated it was important to wear the appropriate PPE for EBP because, it was for the resident's safety and to not contaminate anything. CNA D walked over to Resident #2's dresser and opened the top drawer and revealed PPE gowns and stated PPE was located in resident rooms and accessible when providing direct care. During an interview with the DON, 11/18/2025 at 11:30 a.m., the DON stated staff had received training on EBP and the expectation was for staff to wear a gown and gloves when providing direct care to residents on EBP. The DON stated residents on EBP had a sign on their room door indicating the need for a gown and gloves when providing direct care, and a resident with a foley or a wound required the use of EBP. The DON stated it was important for staff to use the appropriate EBP when providing direct care, to help protect the patient from the transference of germs into open areas. The DON stated a resident could get an infection from the transference of germs. Record review of the facility's policy titled, Infection Prevention and Control Program, date implemented 10/24/2022 and revised 04/12/2025, revealed, this facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections as per accepted national standards and guidelines. Record review of a document provided by the facility Administrator as part of the facility EBP program revealed the document was a CMS Memorandum directed to State Survey Agency Directors, dated 03/20/2024, with the subject identified as Enhanced Barrier Precautions in Nursing Homes. The document revealed, Guidance - 'Enhanced Barrier Precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning gown and gloves during high-contact resident care activities that provide opportunities for transfer</p>		