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	05/15/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide clean bed and bath linens that are in good condition for 5 of 8 residents (Resident #1, #2, #3, #4 and #5) reviewed for a safe, clean and comfortable environment The facility failed to ensure Residents #1, #2, #3, #4 and #5 had a fitted and top sheet on their bed for a dignified and comfortable experience in their own beds. This failure could place residents at risk for a decline in quality of life and feelings of frustration. The findings were:Record review of Resident #1 face sheet dated 5/14/2026 revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses which included: cerebral infarction (stroke), memory deficit following cerebral infarction (memory problems after stroke), and generalized muscle weakness. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated he was cognitively intact, without symptoms of behaviors or rejections of care . Resident #1's functional abilities were listed as set-up/clean-up assistance for self-care and mobility. The assessment indicated Resident #1 was occasionally incontinent of bowel and bladder. Record review of Resident #1's Care Plan (undated) revealed he had a communication problem with interventions which included anticipate and meet needs. The Care Plan indicated Resident #1 had an ADL self-care performance deficit and required setup assistance for all ADLs and mobility. The Care Plan revealed Resident #1 had a behavior problem where he would strip his bed and then lay on the mattress with interventions to assess and anticipate resident needs. During an observation and interview on 5/14/2024 at 8:47 a.m., Resident #1 was observed fully clothed, including shoes, lying on his side on the bed with his face away from the door. There were no sheets on the bed. Resident #1 was lying directly on the mattress. A pile of sheets used sheets were observed on a chair in the room. Resident #1 stated he took the sheets off his bed but was unable to remember when this occurred or why he took the sheets off. He stated he would like sheets on his bed and would not want to lay on the bed all day without sheets. During an interview on 5/14/2026 at 10:25 a.m., CNA F stated Resident #1 had an accident every morning and took the sheets and blankets off his bed because he was embarrassed. CNA F stated when she arrived for her shift today at 6:00 a.m., Resident #1 had sheets on his bed. She stated she cleaned him up from the accident; he went to breakfast and then would come back and lay down in his bed after breakfast. She stated he had a little routine. CNA F stated she was unable to make his bed with clean linens until just now (at time of interview) because she had to wait for clean linens to come out from laundry. She stated this typically occurred around 9:30 a.m. CNA F stated there were somedays when she made her morning rounds with the residents at 6:00 a.m. that not everyone had sheets on their beds because there are not enough linens. CNA F stated the early morning time was a very active time in the building. She stated residents liked to get up early and shower and shave or had appointments or had therapy and needed to get ready early. She stated they had all just learned to work around the laundry, knowing the morning laundry would be out around 9:30 a.m. 2. Record review of Resident #2's face sheet dated 5/14/2026 revealed an [AGE] year-old female admitted on [DATE] with diagnoses which included: moderate dementia without behavioral disturbance, psychotic disturbance, mood disturbance and (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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