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	07/01/2026

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

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #1) out of 4 residents reviewed for medical records. CNA-A documented inaccurately Resident #1's functional ability regarding the resident was able to walk 150 Feet on 05/06/2026 and 05/09/2026, but the resident could not walk 150 Feet. This failure could place residents at risk for missed treatments which could result in decline in healing and well-being. Findings included:Record review of Resident #1's face sheet, dated 07/01/2026, revealed the resident was a 62-years-old female and admitted to the facility on [DATE] with diagnosis of aftercare following surgery, abnormality of gait and mobility (feeling of balance when walking), and muscle weakness. The resident was discharged to the home on [DATE]. Record review of Resident #1's discharge MDS, dated [DATE], revealed the resident's BIMS score was 15 out of 15, which indicated the resident cognitive was intact, and in the Section GG (Functional Abilities), Walk 10 Feet was coded as 09 indicated Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Record review of Resident #1's comprehensive care plan, dated 02/09/2026, revealed [Resident #1] has an Activities of Daily Living Self Care Performance Deficit and is at risk for not having their needs met in a timely manner. For intervention - Walking - not attempted due to safety. Record review of Resident #1's Documentation Survey Report (Functional Abilities), dated May 2026, revealed CNA-A documented 05 - indicated Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity on 05/06/2026 and 05/09/2026. Interview on 07/01/2026 at 12:36 p.m., the DOR said Resident #1 was unable to walk, and the resident could stand up, turned, and sit down on the chair with a walker with assists but could not walk. Interview on 07/01/2026 at 2:45 p.m., CNA-A said she remembered Resident #1, and the resident was unable to walk. CNA-A stated she documented the resident completed walk 150 feet on 05/06/2026 and 05/09/2026, and it was her mistake because the resident could not walk, and inaccurate documentation might provide incorrect care to the resident. Interview on 07/01/2026 at 1:50 p.m., the DON said CNA-A documented Resident #1's ability for walking 150 feet as 05 - Helper sets up or cleans up; resident completes activity, and it was inaccurate because the resident was unable to walk. The DON said the medical records should be accurate. She said in this case the inaccurate documentation did not affect the resident because the resident could not walk, regardless of the inaccurate documentation. She said the medical record should have reflected the resident's status correctly. Record review of the facility policy, titled Maintenance of Clinical Records, dated 02/20/2021, revealed This facility will maintain clinical records for each resident in accordance with acceptable standards of practice that reflects the current plan of care and services provided as well as in a manageable size for use by the care providers.2. In accordance with accepted professional standards of practices, the facility must maintain medical records on each resident that are: a. Complete b. Accurately documented c. Readily accessible d. Systematically organized e. Maintained in folders or chart holders sufficient in size for the volume of the record f. Filed in an easily retrievable manner.

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