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	04/05/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45307 Based on interview and record review, the facility failed to treat each resident with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, for five of nine anonymous residents reviewed for resident rights. Facility residents were not offered the right to vote in the March 5th election and did not have a plan in place to enable residents to vote in the May 28th or November 5th election. This deficient practice could place residents needing assistance at risk for diminished quality of life, loss of dignity, and self-worth. The findings included: Group interview on 04/03/2024 at 1:20 PM, five residents in a confidential resident group interview stated they have made concerns to the facility Social Worker and Administrator related to the ability to vote either by being transported to a polling site or by receiving mail-in ballots during the last election on March 5th. The resident group stated historically, the elections were coordinated by the Activity Director however as there had been a transition from a former Activity Director to a new one in the last few weeks, no one reached out to them about voting in the March 5th election. The resident group stated they made verbal and written concerns to the Social Worker and Administrator related to the elections but did not receive a resolution back. The resident group stated the paper grievance process included completing a paper grievance form and dropping it into one of the grievances boxed located by the Administrators and Social Worker's offices. The resident group stated they have observed administrative staff such as the Administrator remove the paper grievances from the grievance box and dispose of them in the garbage before reviewing them. The resident group stated they had made complaints to the state regarding this alleged grievance disposal, but no resolution or correction occurred. (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

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/04/2024 at 11:52 AM, the Social Worker stated she had been at the facility since February of 2022 as the facility Social Worker. The Social Worker stated since she had been at the facility, she never had the responsibility of coordinating resident voting during local, state, or federal elections. The Social Worker stated the elections coordination was completed by the Activity Director in the past elections by providing transportation to the closest polling site. The Social Worker stated she completed resident wellness rounds daily of which each resident was observed and interviewed at least on a biweekly basis. The Social Worker stated during the instances or within the paper grievance process there was not a concern for resident voting in elections and denied receiving any verbal grievances by residents within the resident council. The Social Worker stated she had never observed a paper grievance be disposed of before it was reviewed. Phone interview on 04/04/2024 at 6:01 PM, the former Activity Director stated she left the facility voluntarily out of concern for the residents not receiving sufficient care planning or advocacy due to her not being permitted to attend the care plan meetings while at the facility. The former Activity Director stated she expressed these concerns to her administration, but no corrective action came about, even after submitting complaints to the state. The former Activity Director stated while she was at the facility, the elections were a part of her role responsibility, however when she left the position in March of 2024, she only remained at the facility to brief her replacement for a single day and could not describe the elections component as she was having her replacement shadow her for a day. Interview on 04/04/2024 at 6:22 PM, the current Activity Director stated she began working at the facility on 03/13/2024 where her first days included completing onboarding and shadowing the former Activity Director. The current Activity Director stated she was never informed or described when she was hired or by the former Activity Director that she would be responsible for coordinating transportation to election polling sites or procuring mail-in ballots to the residents. The current Activity Director stated her hiring and onboarding was very fast paced as the former Activity Director was only present for a single day as she was leaving to a different facility. The Activity Director stated she had no plans to coordinate elections for the facility as she was not instructed to, but stated based on investigation she would begin acting immediately to coordinate the next election for the residents. Interview on 04/05/2024 at 6:05 PM, the Administrator stated she was not aware of resident not having been assisted in voting for the March 5th, 2024 election and stated the responsibility of coordinating transport to and from polling sites was a role for the Activity Director and not the Social Worker. The Administrator stated she is not certain why the last election was not coordinated and stated it was her understanding the next election would be planned by the Activity Director. The Administrator stated she did not see any risk associated with not assisting residents of the facility to exercise their constitutional right to vote and left no further comment. The Administrator stated all paper grievances submitted in the grievance box were reviewed and followed-up for resolution and denied any allegation of grievances being disposed of prior to review. Record review of resident council grievances, dated October of 2023 through March of 2024, provided by the Administrator on 04/02/2024, reflected a total of eighteen grievances recorded of which none reflected concerns for voting coordination or eligibility. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy titled Resident Rights, dated review 02/20/2021, reflected 1. Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. a. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 45307 Based on interview and record review, the facility failed to consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility for 7 of 9 anonymouse resident council residents. The facility failed to return resident's clothes after laundry service for at least six months after receiving individual and resident council grievances. This deficient practice could place residents needing assistance at risk for diminished quality of life, loss of dignity, and self-worth. The findings included: Record review of resident council minutes, dated October 18, 2023, reflected four council members experiencing lost clothes from the previous month (September 2023). Record review of resident council minutes, dated December 12, 2023, reflected four council members having a current concern of lost clothes. Record review of resident council minutes, dated January 9, 2024, reflecting a single council member having a current concern of lost clothes. Record review of resident council minutes, dated February 13, 2024, reflected a single council member having a current concern of lost clothes. Record review of resident council minutes, dated March 12, 2024, reflected two council members having a current concern of lost clothes. Record review of resident grievances, dated 12/12/2023, reflected a concern by Resident #115 that [she was] missing dark green stretch pants with yellow corgi dog/present on them with the resolution that the EVS Manager would investigate their whereabouts. Record review of resident grievances, dated 12/12/2023, reflected a concern by Resident #35 that [he was] missing 1 pair plaid red/black/white pajama pants with the resolution and outcome that the EVS manager would investigate their whereabouts but found them on 12/19/2023. Record review of resident grievances, dated 03/26/2024, reflected a concern by Resident #114 that [family member] wishes to have driver take [Resident #114's] clothing to him since [family member] is out of the country. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Phone interview on 04/01/2024 at 12:00 PM, Resident #114's family member stated Resident #114 was at the facility for a total of two weeks from 02/28/2024 through 03/15/2024 and during that time, clothes were purchased for Resident #114 by Resident #114's family member. Notification to the facility of the new clothes was made on 03/13/2024, two days before discharge (on 03/15/2024), with the request that the clothes be cleaned and provided with Resident #114 upon discharge as they were new clothes. Resident #114's family member stated she never received the clothes back and neither did Resident #114 and was told by the Administrator that the clothes take 2-3 full days to clean and process and that they were lost in the laundry prior to admission. Resident #114's family member stated as of 04/01/2024 Resident #114 still had not received the clothing and the response by the facility was that they could not coordinate with Resident #114's new facility to drop off the recently found clothing. Group interview on 04/03/2024 at 1:20 PM, seven residents in a confidential resident group interview stated they have made concerns related to missing clothes after the clothes were taken to the laundry. The resident group stated they made verbal and written concerns to the Social Worker and Administrator related to the missing clothes but did not receive a resolution back apart from one instance. The resident group stated the paper grievance process included completing a paper grievance form and dropping it into one of the grievances boxed located by the Administrators and Social Worker's offices. The resident group stated they have observed administrative staff such as the Administrator remove the paper grievances from the grievance box and dispose of them in the garbage before reviewing them. The resident group stated they had made complaints to the state regarding this alleged grievance disposal, but no resolution or correction occurred. Interview on 04/04/2024 at 11:52 AM, the Social Worker stated she had been at the facility since February of 2022 as the facility Social Worker. The Social Worker stated she had been present for the most recent resident council meeting in March of 2024 but did not recall concerns for missing clothes and had personally not received any concerns of missing clothes. The Social Worker stated she reviewed the grievances and stated she had not identified a systemic concern for lost resident's clothes and confirmed receiving grievances related to lost clothes prior to March. The Social Worker stated she had never observed a paper grievance be disposed of before it was reviewed. Interview on 04/05/2024 at 11:18 AM, the EVS Manager stated he was the contracted manager for the housekeeping department and the laundry department and his direct manager was within his company and not to the facility Administrator. The EVS Manager stated he had been at the facility for the last 7-8 months in his current role and stated the process for completing laundry would be that the CNAs would bring the dirty linens after either the resident or the aides would write the room number and last name on the collar or pant waist in order to identify the article of clothing afterwards. The EVS Manager stated he directly assisted his laundry aides often and would often observe resident clothing without sufficient identification in order to return the clothing to the appropriate resident. The EVS Manager stated the primary reason the clothes were not arriving with sufficient identification were that nursing staff were not adding the room number or last name and only placing initials or at times nothing at all resulting in unidentifiable clothing items. The EVS Manager stated when he arrived at the conclusion of nursing department being chiefly responsible for dependent residents not receiving their clothing back, he consulted with the facility Administrator, of which The Administrator responded they would investigate. The EVS Manager stated this problem has occurred for the last few months. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/05/2024 at 6:05 PM, the Administrator stated she was aware of residents not receiving their clothing back and stated the primary reason was that individual residents would not appropriately mark their clothes with their names to have them returned but denied staff not supporting dependent residents in marking clothing. The Administrator stated she did not see any risk associated or affect on residents not receiving their clothing returned to them after laundry service. The Administrator stated all paper grievances submitted in the grievance box were reviewed and followed-up for resolution and denied any allegation of grievances being disposed of prior to review. Record review of facility policy titled Resident Rights, dated review 02/20/2021, reflected 4. Respect and dignity. The resident has a right to be treated with respect and dignity, including: . b. The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. 45307 Based on interview and record review the facility failed to ensure that the residents had the right to have reasonable access to mail for four of nine anonymous residents reviewed for forms of communication. The facility did not provide residents with their Saturday mail, and instead it was provided on Monday. This deficient practice could affect any resident and result in access to communication being denied. The findings included: Group interview on 04/03/2024 at 1:20 PM, four residents in a confidential resident group interview stated they have made concerns in the last several months related to receiving their mail on Saturdays. The resident group stated they made verbal and written concerns to the Social Worker and Administrator related to the undelivered mail on Saturday but did not receive a resolution back. The resident group stated the paper grievance process included completing a paper grievance form and dropping it into one of the grievances boxed located by the Administrators and Social Worker's offices. The resident group stated they have observed administrative staff such as the Administrator remove the paper grievances from the grievance box and dispose of them in the garbage before reviewing them. The resident group stated they had made complaints to the state regarding this alleged grievance disposal, but no resolution or correction occurred. Interview on 04/04/2024 at 4:11 PM, the BOM stated she had been at the facility for six years as the BOM. The BOM stated the typical process for receiving mail at the facility included the mail being delivered Monday through Friday by the USPS and hand delivered to the receptionist. The BOM stated the receptionist would provide the mail to the BOM to be sorted. The BOM stated after receiving the mail, the BOM would provide all of the mail addressed to resident's directly to the Activity Director who would then distribute it during her daily rounds. The BOM stated mail has not been delivered by the USPS on Saturday for the last several months since at least last Summer (August of 2023) and stated the facility was informed by the USPS they could not deliver on Saturday due to there not being a safe location for mail to be delivered to. The BOM stated at the time the USPS stopped delivering on Saturday, there was not a weekend receptionist to receive the mail and no one was in the front of the building to receive the mail from the postal worker. The BOM stated since the USPS stopped delivering, a weekend receptionist has started but no one has reached out to the local post office to resume Saturday delivery. The BOM stated she is uncertain who would have that role responsibility to contact the local post office but that she herself had not been tasked with doing so and had not done so on her own. Interview on 04/04/2024 at 6:22 PM, the current Activity Director stated she began working at the facility on 03/13/2024 where her first days included completing onboarding and shadowing the former Activity Director. The current Activity Director stated she does not work on Saturday and stated she was not certain who received the mail or distributed it on the weekend but stated she did receive mail on Monday that was received before the mail carrier delivered on Monday. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/05/2024 at 6:05 PM, the Administrator stated she was aware of residents not receiving mail on Saturday and stated that was due to the local post office not delivering on Saturday since there was no receptionist on the weekend until recently but denied receiving concerns about residents not receiving their mail until Monday. The Administrator stated no one had reached out to the local post office to resume delivery on Saturday. The Administrator stated she did not see any risk associated with residents not receiving their mail on Saturday. The Administrator stated all paper grievances submitted in the grievance box were reviewed and followed-up for resolution and denied any allegation of grievances being disposed of prior to review. Record review of facility policy titled Resident Rights, dated review 02/20/2021, reflected Information and communication. The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility . The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: i. Privacy of such communications consistent with this section; and ii. Access to stationary, postage, and writing implements at the resident's own expense.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview, and record review, the facility failed to inform each resident periodically during the resident's stay, where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible for 1 of (Resident #70) of 8 residents reviewed for coverage notice. The facility failed to develop, implement, and practice appropriate billing practices, subsequently Resident #70's resident liability changed from $0 to $1,395.90 for 11/01/2023-12/31/2023, $1,427.70 for 01/01/2024-02/29/2024, and to $1,262.80 03/01/2024-Ongoing. The facility failed to notify Resident #70 in a timely manner about the change in Resident liability when they received a notice, dated 02/02/2024, from Texas Health and Human Service Commission about the new liability amount Resident #70 would be responsible for and resulted in a $8,502.60 bill on 04/01/2024. These failures could place residents at risk of being unaware to changes to financial charges during their facility stay. Findings Included: Record review of Resident #70's Admission Record revealed a [AGE] year-old male with an initial admitted [DATE] and a readmitted [DATE]. The payer information revealed primary payer was Medicaid, secondary was Resident Liability, third Managed Care therapies and fourth Medicare B coins from Medicaid. The Resident had diagnosis that included other sequelae following unspecified cerebrovascular disease (lingering effects or complications that arise as a direct result of a cerebrovascular condition-stroke). Record review of Resident #70's MDS, dated [DATE], indicated resident had a moderate impairment for cognition. During an interview on 04/02/24 at 11:03 a.m. Resident #70 stated the day before the Business Office Manager (BOM) came and the business office manager came to bring him a bill and stated he owed the facility $8,000. The Resident stated he was in contact with another facility to transfer to but felt he could not leave at this time. The Resident stated he was told if he cannot pay he cannot leave. The Resident stated he received money monthly which he used to eat. The Resident stated he refused to eat the facility food and he was worried how he would have money to eat now. The Resident stated he made a payment when they gave him the bill. The Resident stated he was stressed about the bill. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 04/04/24 at 2:02 p.m. the BOM stated she helped Resident #70 reapply for Medicaid a few months back. The BOM stated they did not notify the resident of the letter they received from Texas Health and Human Services in February because it was not official. The BOM stated she was waiting for everything to update with Medicaid and for it to show up in a program the facility used to become official. The BOM stated it updated and became official in Mid-March and she went to notify Resident #70 then. The BOM manager stated she did not have a copy of the bill and notification she provided the Resident in March. The BOM manager stated the bill she gave him is a manual one she made, and it did not save. The BOM provided another original letter from a box in her office from Texas Health and Human Services, dated 03/20/24, addressed to Resident #70 and C/O to the BOM. The BOM said she gave Resident #70 a copy of this notice that came in the mail for Resident #70. During a follow up interview on 04/04/24 at 3:46 p.m. Resident #70 stated he was never given any mail from Texas Health and Human Services dated 03/20/24 addressed to Resident #70 and to the BOM. Resident #70 stated the first bill he received from the BOM was on April 1st, 2024. The resident stated he had received no mail from Texas HHSC since the summer of 2023. During an interview on 04/05/24 at 5:55 p.m. the Administrator stated they wait for a program to update before they will bill residents. The Administrator stated she does not know of why Medicaid notices would have the BOM name on them and they should not be addressed to the BOM. The Administrator stated if a letter was addressed to a Resident, and they did not receive the letter they would lack the information that came to them, and it could be a dignity issue and lack of knowledge of what is going on. Record review of a statement, dated 04/01/24, stated the bill was due upon receipt. The amount due was $8,502.60. Resident #70 was listed, and a statement of charges were: 01/01/2024 $1.427.70 Resident Liability Due [DATE]-31 2024 02/01/2024 $1,427.70 Resident Liability Due [DATE]-29 2024 03/01/2024 $1,427.70 Resident Liability Due [DATE]-31 2024 04/01/2024 $1,427.70 Resident Liability Due April 01-30 2024 11/01/2023 $1,395.90 Resident Liability Due [DATE]-[DATE] 12/01/2023 $1,395.90 Resident Liability Due [DATE]-31 2023 Balance Due: $8,502.60 Record review of a letter from HHSC, dated 02/02/2024, revealed it was addressed to the facility. It stated Resident #70, Medicaid for Nursing Facility Resident, would need to pay $1,395.90 for 11/01/2023-12/31/2023, $1,427.70 for 01/01/2024-02/29/2024, and $1,262.80 03/01/2024-Ongoing. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a letter from HHSC, dated 03/20/2024, revealed it was addressed to Resident #70 and C/O [BOM]. It stated Resident #70, Medicaid for Nursing Facility Resident, would need to pay $1,427.70 for 05/01/2024-Ongoing. It stated his unearned income was RSDI (Retirement, Survivors, Disability Insurance) in the amount of $1,502.70. Record review of the facility's policy titled Billing, dated 04/07, stated Policy, The methods presented in this chapter are the most commonly used billing controls, payment controls, and Medicaid pending controls. The company policy requires each facility to have this system in place to control billing, payment, and pending Medicaid. For each resident, the facility staff must: Determine the correct RESIDENT TYPE Enter the necessary accounts receivable information into the automated system to insure the prompt and timely billing of all charges. Submit billing to the proper agent or agency for payment .WHO DOES WHAT Administrator, DNS/Facility Controller: Determines Resident Type based on medical and financial information. Facility Controller, Or Designee: Enters information into the Accounts Receivable system: Resident Data/Billing, Ancillary, Cash, Facility Controller Generates and mails:, Private statements, Medicare A/B billing, Medicaid billing, Ins-HMO, Hospice, Veterans. Facility Controller, Administrator Follows up on unpaid or incorrectly paid charges .Medicaid/Medicaid CO-A: Medicaid is a state-funded program for residents requiring nursing home care who do not have the financial means to pay privately for these services. In order to be approved for Medicaid, an application must be filed with the state ' s social services or welfare department. When the application is approved, Medicaid: Determines the resident ' s monthly income, Requires that the resident pay this monthly income, less allowable deductions. NOTE: The amount the resident must pay to the nursing home is referred to as the resident liability or applied income. Medicaid Pays the nursing home for the remaining cost of the resident ' s care. Payment: Medicaid pays an all-inclusive daily rate. This means that both room and board and ancillary services are included in the rate. However, Certain ancillaries may be approved for additional payment, Preferred Personal need items may be charged to the resident in addition to the Private Portion. Levels of Care: The daily rate that is paid to the Nursing Facility is based on the residents ' level of care. The level of care is based on the resident ' s medical condition. The following briefly outlines the procedure for billing Medicaid and documenting payments. A. Enter information daily into the A/R system to generate room and board and ancillary charges. B. Complete Medicaid billing according to state instructions, insuring that billed days, agree with census days. C. Weekly [NAME] are submitted every Friday as a template in the state Medicaid [NAME] software. Individual Claims are submitted daily as needed. D. Every Monday (or 1st business day of the week) from the Medicaid [NAME] system, retrieve Medicaid Remittance Advice, and post the payments into the Accounts (continued on next page)

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	675437	A. Building B. Wing	04/05/2024

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Receivable System. E. Follow up immediately on rejected or incorrectly paid claims. F. Use date on remittance advice for deposit date. G. File remittance advices in date order in a 3 ringbinder .Documentation All claim forms; as well as all payments received must be retained in the appropriate binder or financial file.

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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** 45857 Based on observations, interview, and record review, the facility failed to ensure the residents' right to a safe, clean, comfortable, and homelike environment for 21 (room [ROOM NUMBER], #314, #315, #316, #401, #403, #404, #405, #406, #407, #408, #409, #410, #411, #412, #413, #414, #415, #416, #417, #418) of 23 rooms reviewed for homelike environment: The facility failed to ensure resident bathrooms had hot water maintained at a comfortable temperature which was at least 100 degrees F. These failures could place residents at risk for living in an uncomfortable, and unhomelike environment which could cause a diminished quality of life. The findings included: Observations on 04/02/24 beginning at 10:12 a.m. revealed the following hand sinks had one handle. To turn the sink on you would raise the handle up and turn it to the left or right. The following temperatures were taken in both positions and read the same temperature by this surveyor. The bathroom sinks in the following resident rooms had temperatures of: Room # 314 (Resident #94) 71.2 degrees F room [ROOM NUMBER] (Resident #33) 70.0 degrees F room [ROOM NUMBER] (Resident #55) 71.6 degrees F Room # 407 (Resident #92) 71.1 degrees F Room # 408 (Resident #39) 70.6 degrees F room [ROOM NUMBER] (Resident #87 and #95) 72.0 degrees F Room # 410 (Resident #71 and #77) 70.3 degrees F Room # 416 (Resident #82) 71.0 degrees F room [ROOM NUMBER] (Resident #70) 71.6 degrees F room [ROOM NUMBER] (Resident #22) 70.2 degrees F During an interview on 04/02/2024 at 9:13 a.m. Resident #94 stated the water in her room was ice cold. Resident #94 stated she used the shower in her room to shower and it had been cold every time she used it for the past couple of weeks. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 04/02/2024 at 9:35 a.m. Resident #55 was laying in bed. Resident #55 hair appeared greasy. Resident #55 stated she wanted to take a real bath. Resident #55 stated the staff would only give her a bed bath and she kept asking them to give her a bath in a shower. Resident #55 stated staff just did not want to let her shower and did not know if the water in her bathroom was hot or not because she could not get to the bathroom without staff helping her. Resident #55 stated staff told her she could only have a bed bath. During an interview on 04/02/2024 at 9:38 a.m. Resident #92 stated the facility had not had hot water for 3 weeks. Resident #92 stated staff only offered her bed baths. During an observation on 04/02/24 at 10:03 a.m. Resident #87 was in his room. Resident #87's hair appeared greasy. During an interview on 04/02/24 at 10:15 a.m. CNA G stated the resident on the whole south side (200, 300, and 400 hallways) of the building and some of the 100 hallway residents did not have hot water in their rooms. CNA G stated he had just returned that week and was unsure of exactly when the hot water went out on the south side. CNA G stated he worked the week prior and the water was out then. CNA G thought the hot water had been out for about 1 week. CNA G stated staff was giving everyone bed baths and a good wipe down due to there being no hot water. During an interview on 04/02/2024 at 10:19 a.m. Resident #71 stated there had been no hot water to shower in his room for about a week. Resident #71 stated he showered on the other side of the building in an empty room. During an interview on 04/02/24 at 10:47 a.m. Resident #82 stated he could only receive bed baths and was not able to ambulate to shower in the bathroom. Resident #82 stated he had not had a bed bath since the week prior. A follow up interview on with Resident #82 on 04/04/24 at 5:00 p.m. Resident #82 stated he asked to file a grievance that day and after he was given a bed bath the same day. During an observation and interview on 04/02/24 at 10:49 a.m. Resident #22's hair appeared greasy. Resident #22 stated there had been no hot water in her room for over a week. Resident #22 stated she showered once, but it was too cold for her to wash her hair. Resident #22 stated she was told they were waiting on a part to fix the hot water in the building. Resident #22 was asked by this surveyor if staff had offered her to shower on the other side of the building in an empty room. Resident #22 stated no one had asked her if she wanted to shower in an empty room with hot water. Resident #22 stated she did not know that was an option. Resident #22 asked if other residents had been offered to shower in a room with hot water. Resident #22 stated she was upset that no one had offered her to shower in a room with hot water. During an interview on 04/02/2024 at 10:54 a.m. Resident #70 stated there was no hot water in his room for two weeks. Resident #70 stated he had to go to another hallway on the other side of the building to shower. During an observation and interview on 04/03/2024 at 10:47 a.m. Resident #33 had a foul smell and his hair appeared greasy. Resident #33 stated he had not showered in about a week because his room had no hot water and it was cold. Resident #33 said he did not want to use cold water to shower because he felt he could get sick. Resident #33 stated staff offered him to go to the other side of the building to shower but he did not want to shower in another room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/05/24 at 10:36 a.m. the Maintenance Director stated the hot water had not been working for about 1.5 to 2 weeks. He stated there were two hot water heaters supplying the hot water on the south side of the building and both were not working. The Maintenance Director stated I try to go room by room to make sure there is not hot water there, I turn on the hot water side and there can't be water on two sides, or the water heater is not working. I wrote zeros on the log because there is no temperature there. One water heater went out and then 2 days later the other one went out and we needed to replace them as soon as possible for patient care. The Maintenance Director stated he went to tell the Administrator in person that the water heaters were down in person verbally. The Maintenance Director was unsure of the exact day the water heater first went out and the day he notified the Administrator. During an interview on 04/05/24 at 5:40 p.m. The Administrator stated the Maintenance Supervisor notified her on 03/26/23 that one hot water heater flooded and shorted out the other hot water heater. The Administrator stated during that time they were instructed all staff there were 2 rooms available on the north side of the building for residents to use to shower. The Administrator stated it was an inconvenience for everyone and some residents were fine with showering on the other side of the building. The Administrator stated herself, the DON, and the ADON on the south side of the building went up and down the hallways to notify residents they were able to shower in two rooms located on the northside of the building. The Administrator stated she was not aware of any residents who wanted a regular shower but were only provided a bed bath. The Administrator stated she discussed the hot water issue with cooperate and from what they could read there was no reason to make a report to the state. Record review of a document titled LogBook Documentation, dated 04/04/24, revealed temperatures taken for rooms 101, 108, 201, 211, 300, 306, 316, 401, 408, 417 had temperature of 0 degrees F on 03/25/24. A second date of 04/01/24 showed the following temperatures: room [ROOM NUMBER] 108 degrees F room [ROOM NUMBER] 109 degrees F room [ROOM NUMBER] 108 degrees F room [ROOM NUMBER] 108 degrees F Record review of the facility's policy titled Resident Rights, dated reviewed 02/20/21, stated Policy: The facility will inform the resident both orally and in writing in a language that the residents understand of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility will also provide the resident with prompt notice (if any) of changes in any State or Federal laws relating to resident rights or facility rules during the resident's stay in the facility. Receipt of any such information must be acknowledged in writing .Resident Rights .8. Safe environment. The residents has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely . 47611

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45857 Based on interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency, for 8 of (Resident #17, #22, #33, #55, #70, #71, #87, and #92) 54 residents reviewed for allegations of abuse, neglect, exploitation, and mistreatment, in that: 1. The Administrator did not report to the state agency Resident #17's incident in December 2023, when it was reported she had missing rings. 2. The Administrator did not report to the state agency residents did not have access to hot water for an indetermined amount of time from at least 03/26/24 to 04/04/24. This failure could place residents at risk for abuse, neglect, exploitation, and/ or mistreatment. Findings included: 1. On 4/4/24 at 11:17 am interview with LVN ADON B - She stated resident #17's POA told her about missing rings. Stated POA told her the rings were not the same rings she was admitted with. She stated that she informed the DON and Administrator. She stated that the facility did an investigation. Stated the prior activity director had observed a visitor with the resident when the resident was at the beauty salon. Unknown who the visitor was. She stated she is unsure if it was reported to the state. On 4/4/24 at 11:59 am interview with the DON - she stated she was made aware of the allegation of missing ring. She stated she spoke to the administrator and an internal investigation was completed. She stated she is not sure if there was any documentation done regarding the investigation. She stated she would collaborate with the administrator and the administrator would make the report to the state. On 4/5/24 at 6:00 pm interview with staff Administrator - stated the incident was between September and October of last year. There was internal investigation done, stated spoke to all the staff members that had seen her hands. The activity director at the time, saw a lady was in the beauty shop with the resident and that person had the rings. She stated she spoke to the POA about that and that the POA stated that person is a neighbor and that she had not spoken to that person. Stated the resident had the rings on that Thursday while at the beauty shop. Stated POA told her that there was a different ring on the resident's hand. Stated she encouraged her to report it to the police. Was this reported? No, because the rings are not lost. How does facility staff ensure resident personal property is kept safe from loss or theft? At this point, with jewelry we will take a picture of it. We do the inventory on admission or the first couple of days. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility Admission Agreement booklet showed, It is the policy of the facility that all personal items need to be inventoried and labeled for identification prior to being placed in the room. There was no facility record to review as the facility did not report the incident. 2.During an interview on 04/02/2024 at 9:13 a.m. Resident #94 stated the water in her room was ice cold. Resident #94 stated she used the shower in her room to shower and it had been cold every time she used it for the past couple of weeks. During an observation and interview on 04/02/2024 at 9:35 a.m. Resident #55 was laying in bed. Resident #55 hair appeared greasy. Resident #55 stated she wanted to take a real bath. Resident #55 stated the staff would only give her a bed bath and she kept asking them to give her a bath in a shower. Resident #55 stated staff just did not want to let her shower and did not know if the water in her bathroom was hot or not because she could not get to the bathroom without staff helping her. Resident #55 stated staff told her she could only have a bed bath. During an interview on 04/02/2024 at 9:38 a.m. Resident #92 stated the facility had not had hot water for 3 weeks. Resident #92 stated staff only offered her bed baths. During an observation on 04/02/24 at 10:03 a.m. Resident #87 was in his room. Resident #87's hair appeared greasy. During an interview on 04/02/24 at 10:15 a.m. CNA G stated the resident on the whole south side (200, 300, and 400 hallways) of the building and some of the 100 hallway residents did not have hot water in their rooms. CNA G stated he had just returned that week and was unsure of exactly when the hot water went out on the south side. CNA G stated he worked the week prior and the water was out then. CNA G thought the hot water had been out for about 1 week. CNA G stated staff was giving everyone bed baths and a good wipe down due to there being no hot water. During an interview on 04/02/2024 at 10:19 a.m. Resident #71 stated there had been no hot water to shower in his room for about a week. Resident #71 stated he showered on the other side of the building in an empty room. During an interview on 04/02/24 at 10:47 a.m. Resident #82 stated he could only receive bed baths and was not able to ambulate to shower in the bathroom. Resident #82 stated he had not had a bed bath since the week prior. A follow up interview on with Resident #82 on 04/04/24 at 5:00 p.m. Resident #82 stated he asked to file a grievance that day and after he was given a bed bath the same day. During an observation and interview on 04/02/24 at 10:49 a.m. Resident #22's hair appeared greasy. Resident #22 stated there had been no hot water in her room for over a week. Resident #22 stated she showered once, but it was too cold for her to wash her hair. Resident #22 stated she was told they were waiting on a part to fix the hot water in the building. Resident #22 was asked by this surveyor if staff had offered her to shower on the other side of the building in an empty room. Resident #22 stated no one had asked her if she wanted to shower in an empty room with hot water. Resident #22 stated she did not know that was an option. Resident #22 asked if other residents had been offered to shower in a room with hot water. Resident #22 stated she was upset that no one had offered her to shower in a room with hot water. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/02/2024 at 10:54 a.m. Resident #70 stated there was no hot water in his room for two weeks. Resident #70 stated he had to go to another hallway on the other side of the building to shower. During an observation and interview on 04/03/2024 at 10:47 a.m. Resident #33 had a foul smell and his hair appeared greasy. Resident #33 stated he had not showered in about a week because his room had no hot water and it was cold. Resident #33 said he did not want to use cold water to shower because he felt he could get sick. Resident #33 stated staff offered him to go to the other side of the building to shower but he did not want to shower in another room. During an interview on 04/05/24 at 10:36 a.m. the Maintenance Director stated the hot water had not been working for about 1.5 to 2 weeks. He stated there were two hot water heaters supplying the hot water on the south side of the building and both were not working. The Maintenance Director stated I try to go room by room to make sure there is not hot water there, I turn on the hot water side and there can't be water on two sides, or the water heater is not working. I wrote zeros on the log because there is no temperature there. One water heater went out and then 2 days later the other one went out and we needed to replace them as soon as possible for patient care. The Maintenance Director stated he went to tell the Administrator in person that the water heaters were down in person verbally. The Maintenance Director was unsure of the exact day the water heater first went out and they day he notified the Administrator. During an interview on 04/05/24 at 5:40 p.m. The Administrator stated the Maintenance Supervisor notified her on 03/26/23 that one hot water heater flooded and shorted out the other hot water heater. The Administrator stated during that time they instructed all staff there were 2 rooms available on the north side of the building for residents to use to shower. The Administrator stated it was an inconvenience for everyone and some residents were fine with showering on the other side of the building. The Administrator stated herself, the DON, and the ADON on the south side of the building went up and down the hallways to notify residents they were able to shower in two rooms located on the northside of the building. The Administrator stated she was not aware of any residents who wanted a regular shower but were only provided a bed bath. The Administrator stated she discussed the hot water issue with cooperate and from what they could read there was no reason to make a report to the state. 47611

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with the comprehensive person-centered care plan and in accordance with professional standards of practice for 2 of 21 Residents (Resident #65 and Resident #47) reviewed for quality of care. 1. The facility failed to obtain medical information needed to monitor the parameters of the cardiac pacemaker for Resident #65. 2. The facility failed to obtain a physician's order for Resident #47 to treat diarrhea after twenty-three instances of loose bowel movements in the last thirty days. This failure could place residents at risk for not having care and services provided to meet their needs. The findings included: 1. Record review of Resident #65's face sheet, dated 04/05/2024 revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), diabetes (a chronic, long-lasting health condition that affects how your body turns food into energy), hyperlipidemia (elevated cholesterol), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), mood disturbance and anxiety, shortness of breath, presence of cardiac pacemaker (an electronic device that is implanted in the body to monitor heart rate and rhythm; stimulates the heart with electrical impulses to maintain or restore a normal heartbeat), and lack of coordination. Record review of Resident #65's most recent significant change MDS assessment, dated 03/22/2024 revealed the resident was severely cognitively impaired for daily decision-making skills. Record review of Resident #65's comprehensive care plan, with revision date 03/14/2024 revealed the resident had a cardiac pacemaker related to cardiac dysrhythmia and was at risk for activity intolerance and pacemaker failure. It revealed interventions that included to monitor/document/report to physician any signs or symptoms of altered cardiac output or pacemaker malfunction such as dizziness, syncope, difficulty breathing, pulse rate lower than programmed rate, or blood pressure lower than baseline and pulse rate at least monthly to verify it is not below the minimum rate settings. Record review of Resident #65's Order Summary Report dated 04/05/2024 revealed there was no order to monitor the parameters of the cardiac pacemaker and no documentation identifying normal pacemaker pulse limits/parameters. Record review of Resident #65's temporary Implanted Device Identification Card revealed the resident's cardiac pacemaker was implanted on 03/04/2022. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 04/05/2024 at 4:41 p.m., Resident #65 revealed he had a cardiac pacemaker implanted a long time ago and pointed to the left upper chest. Resident #65 could not elaborate on monitoring or maintenance and stated he had no problems with the pacemaker. During an interview on 04/05/2024 at 4:43 p.m., RN C revealed Resident #65 had a cardiac pacemaker and it was located on the resident's left upper chest. RN C stated, Resident #65's cardiac pacemaker was checked maybe every 6 months, so for us we can't check it. RN C further revealed, Resident #65 did not have parameter orders but was not sure if the family refused. RN C stated, we should be checking for parameters and that would determine if it (the cardiac pacemaker) was functioning as it should. 2. Record review of Resident #47's face sheet, dated 04/05/2024, reflected a [AGE] year-old male with an admitted [DATE] and a primary diagnosis of major depressive disorder (clinical depression). Record review of Resident #47's Quarterly MDS, dated [DATE], reflected Resident #47 was cognitively intact and no gastrointestinal concerns remarked. Record review of Resident #47's Order Summary, dated 04/05/2024, reflected no active orders for antidiarrheals or other medications used to treat loose bowel movements. Record review of Resident #47's EHR POC, dated 04/05/2024, reflected in the last thirty days, Resident #47 had a total of thirty-two bowel movements, of which twenty-three were described as loose or unformed. Interview on 04/02/2024 at 10:03 AM, Resident #47 stated he had been experiencing loose bowel movements for the last few weeks. Resident #47 stated he had reported the instances of loose bowel movements to his nurse (name unknown) but has not received any changes to help relieve the diarrhea. Resident #47 stated he received continence assistance by the facility aides and that they see him having loose bowel movements based on his brief changes. Resident #47 stated he was receiving plenty of fluids and does not feel dehydrated but wished the diarrhea would end. Interview on 04/05/2024 at 1:42 PM, LVN E stated she has been at the facility for the last four years but stated she has generally worked PRN and worked more frequently recently. LVN E stated she had cared for Resident #47 about three total shifts and stated she had not been informed by the aides or by Resident #47 that he had concerns with loose bowel movements. LVN E stated she did not see Resident #47 on any medication used to treat loose bowel movements. She stated that was typically completed by the charge nurse if they were informed by the aides that the resident was experiencing loose bowels. LVN E stated she generally received good communication from the aides. LVN E stated that in the morning meetings they will discuss changes reflected in the POC that trigger significant changes such as a trend of loose bowel movements. (continued on next page)

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	675437	A. Building B. Wing	04/05/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/05/2024 at 5:10 p.m., the DON revealed Resident #65 had a cardiac pacemaker and stated, I know there is a little machine, and a cardiologist follows up. The DON revealed nursing judgement was used for a resident change in condition and to notify the physician. The DON stated, I will ask the Administrator about that aspect. Nurses should be using their nursing judgement. The DON additionally stated she was unaware of Resident #47's loose bowel movements. She stated the expectation was for aides to inform the charge nurse of changes in resident's bowel movements if they have a trend of being loose so contact can be made with the physician to get an order for an antidiarrheal. The DON stated during the morning meetings they discuss changes in a resident's condition and that a resident having prolonged diarrhea could lead to dehydration. A policy and procedure for cardiac pacemakers was not provided by the Administrator when requested on 04/05/2024 at 5:14 p.m. Record review of provided facility policy regarding quality of care, titled Clinical Practice Guidelines ADL Care, dated 01/23/2016, reflected Residents participate in and receive the following person centered care . Toileting/Continence: toileting or receiving assistance with toileting or receiving incontinence care 45307

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39075 Based on observations, interviews, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 4 of 21 residents (Resident #51, Resident #33, Resident #70 and Resident #71) reviewed for accidents and hazards in that: 1. The facility failed to ensure Resident #51 did not have a pair of scissors in his room. 2. The facility failed to ensure Resident #33, Resident #70, and Resident #71 did not have disposable razors left on their bathroom counters. This failure could place residents at risk of harm or injury and contribute to avoidable accidents. The findings included: 1. Record review of Resident #51's face sheet, dated 4/2/24, revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included atherosclerosis (disease of the arteries characterized by plaque deposit of fatty material on their inner walls) of bypass graft of bilateral legs, diabetes with neuropathy (chronic, long lasting condition that affects how the body turns food into energy with nerve damage), hyperlipidemia (elevated cholesterol), glaucoma (increased pressure within the eyeball causing gradual loss of sight), atrial fibrillation (irregular, rapid heart rate commonly caused by poor blood flow), end stage renal disease (condition in which the kidneys cease functioning on a permanent basis), and long term use of anticoagulants (blood thinners). Record review of Resident #51's most recent MDS admission assessment, dated 3/19/24, revealed the resident was moderately cognitively impaired for daily decision-making skills. Record review of Resident #51's comprehensive care plan, revision date 3/19/24 revealed the resident had an ADL self-care performance deficit and was at risk for not having needs met in a timely manner, with interventions that included to provide shower, shave, oral care, hair care and nail care per schedule and when needed. Further review of Resident #51's comprehensive care plan revealed the resident had impaired visual function and was at risk for injury and a decline in functional ability with interventions that included to anticipate needs and meet as able. During an observation and interview on 4/2/24 at 11:55 a.m., Resident #51 was observed with a large pair of scissors on the resident's bedside table on the right side of the bed. Resident #51 stated he used the scissors to cut open packets of hand warmers. During an observation and interview on 4/4/24 at 10:29 a.m., Resident #51 was observed with a large pair of scissors on the resident's bedside table on the right side of the bed. Resident #51 stated he used the scissors to cut things, like my hot patches, to open them and used the scissors to trim his beard. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 4/5/24 at 12:13 p.m., ADON B observed the large pair of scissors on Resident #51's bedside table on the right side of the bed, and stated, there's no rule for the resident not to have the scissors unless there was a reason, but Resident #51 was capable of using the scissors. ADON B would not elaborate any further. 2. Record review of Resident #33's face sheet, dated 4/5/24, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia (disease that affects memory), major depressive disorder, contracture of the right and left hand (permanent tightening of muscle, tendons, ligaments, or skin which cause joints to shorten and become stiff), abnormal gait and mobility, and need for assistance with personal care. Record review of Resident #33's most recent MDS admission assessment, dated 3/27/24, revealed the resident cognition was intact. Record review of Resident #33's comprehensive care plan, revision date 3/15/24 revealed the resident had cognitive impairment related to a diagnosis of dementia which placed him at risk for a further decline in cognitive and functional abilities. Diagnosis of mild neurocognitive disorder, dementia with interventions to provide opportunities for the resident to make simple choices with ADL care. Encourage participation. Resident has an ADL self-care performance deficit and was at risk for not having needs met in a timely manner, with interventions that included to provide shower, shave, oral care, hair care and nail care per schedule and when needed. Further review of Resident #51's comprehensive care plan revealed the resident had impaired visual function and was at risk for injury and a decline in functional ability with interventions that included to anticipate needs and meet as able. The resident had impaired vision as evidenced by only being able to see headline print in a well illuminated environment related to cortical age-related cataracts, blepharitis of eyelid, dry eye syndrome with interventions to Anticipate needs and meet them as able. Keep call light in reach when in room or bathroom. Resident #33 had fragile skin related to the aging process and was at risk for bruising easily and skin tears, diagnosis of seborrheic dermatitis, psoriasis vulgaris, xerosis cutis with interventions to keep skin clean and dry. Use lotion on dry scaly skin as needed and weekly skin checks to monitor for redness, circulatory problems, pressure sores, open areas, and other changes in skin integrity. Report new conditions to the physician. Resident #33 required the weight bearing assistance of staff to complete his activities of daily living related to functional limitations in range of motion secondary to polio and paraplegia which placed him at risk for not having his needs met in a timely manner with interventions for personal hygiene, extensive assist x1 person, hard to hold things in hand and bathing total assist x1 person provide shower, save, oral care, hair care, and nails care per schedule and when needed. During an observation on 4/3/24 at 10:53 a.m., Resident #33 was observed with two disposable razors on his bathroom counter. Record review of Resident #70's Admission Record, dated 04/05/24, revealed a [AGE] year-old male with an initial admitted [DATE] and a readmitted [DATE]. The Resident had diagnoses that included other sequelae following unspecified cerebrovascular disease (lingering effects or complications that arise as a direct result of a cerebrovascular condition-stroke) and muscle weakness. Record review of Resident #70's Quarterly MDS, dated [DATE], indicated resident had a moderate impairment for cognition. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #70's comprehensive care plan, revision date 3/15/24 revealed the resident had an ADL self-care performance deficit and was at risk for not having needs met in a timely manner, Performance deficit was related to: Impaired balance/impaired coordination , Pain, aphasia (A disorder that affects how you communicate. It can impact your speech, as well as the way you write and understand both spoken and written language. Aphasia usually occurs suddenly after a stroke or a head injury.), neuropathy, leg pain ,back pain herniated skin L2, S1, muscle wasting , pain with interventions that included Personal Hygiene: Supervision with set up and bathing set up to provide shower, shave, oral care, hair care, and nail care per schedule and when needed. During an observation on 4/2/24 at 10:54 a.m., Resident #70 was observed with two disposable razors on his bathroom counter. Record review of Resident #71's Admission Record, dated 04/05/24, revealed a [AGE] year-old male with an initial admitted [DATE]. The Resident had diagnosis that included nontraumatic subarachnoid hemorrhage from unspecified intracranial artery (Bleeding within the subarachnoid space, which is the area between the brain and the tissue covering the brain. It causes sudden, severe headache, nausea, vomiting and loss of consciousness), facial weakness, major depressive disorder, and muscle weakness. Record review of Resident #71's Quarterly MDS, dated [DATE], indicated resident had a moderate impairment for cognition. Record review of Resident #71's comprehensive care plan, revision date 3/14/24 revealed the resident had an ADL self-care performance deficit and was at risk for not having needs met in a timely manner, Performance deficit was related to: Hemiplegia/Hemiparesis (Weakness of one entire side of the body) secondary to a stroke, interventions included personal hygiene: required supervision and bathing required extensive assistance. During an observation and interview on 4/2/24 at 12:21 p.m., Resident #71 was observed with three disposable razors on his bathroom counter. Resident #71 stated the razors were his and he shaved on his own. During an interview on 04/05/24 at 2:17 p.m. the DON stated some residents like to shower independently and staff was still expected to supervise residents for safety. The DON stated she was not aware of residents who shaved on their own. The DON stated residents would not be alone and staff would be there with them and place the razor in the sharps container after use. The DON stated if a resident wanted to shave on their own she would need to see if it was allowed. During an interview on 04/05/24 at 6:14 p.m. the Administrator stated staff does rounds to look for items that were not allowed and if they find something they will call family to pick it up or lock it up. The Administrator stated residents were allowed to shave on their own, so they did not take their independence. The Administrator stated they educate the resident to discard the disposable razor into the sharp's container located in each resident restroom. The Administrator stated the resident had a right to have the razor and they could possibly cut themselves if they were not paying attention. A policy for shaving and resident hygiene was requested and not provided. (continued on next page)

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	675437	A. Building B. Wing	04/05/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45857

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observations, interviews and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 2 of 2 residents (Resident #51, and Resident #82) reviewed for dialysis in that: The facility did not maintain communication, coordination, and collaboration with the dialysis facility for Resident #51 and Resident #82. This deficient practice could affect residents who received dialysis treatments and place them at risk for complications and not receiving proper care and treatment to meet their needs. The findings included: 1. Record review of Resident #51's face sheet, dated 4/2/24, revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included atherosclerosis (disease of the arteries characterized by plaque deposit of fatty material on their inner walls) of bypass graft of bilateral legs, diabetes with neuropathy (chronic, long lasting condition that affects how the body turns food into energy with nerve damage), hyperlipidemia (elevated cholesterol), glaucoma (increased pressure within the eyeball causing gradual loss of sight), atrial fibrillation (irregular, rapid heart rate commonly caused by poor blood flow), end stage renal disease (condition in which the kidneys cease functioning on a permanent basis), and long term use of anticoagulants (blood thinners). Record review of Resident #51's most recent MDS admission assessment, dated 3/19/24, revealed the resident was moderately cognitively impaired for daily decision-making skills and required dialysis treatments. Record review of Resident #51's comprehensive care plan, with revision date 2/18/24 revealed the resident received dialysis related to renal failure and was at risk for potential complications from dialysis, with interventions that included to auscultate shunt site, monitor dialysis dressing, change as ordered, and to report abnormal bleeding to the physician. Record review of Resident #51's Order Summary Report, dated 4/2/24 revealed the following: - Check the AV shunt (site (area accessed for dialysis treatment) site to left arm for bleeding. If bleeding was present, apply pressure and notify the physician. Every shift, with order date 3/28/24 and no end date. -Hemodialysis treatments to be performed via shunt to left arm at dialysis clinic as indicated on the following days of the week: M/W/F with a chair time of 10:20 a.m., with order date 3/28/24 and no end date. -Observe the resident upon return from dialysis. Notify the physician of any abnormal findings. Every shift for Dialysis, with order date 3/15/24 and no end date. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Check dialysis shunt for thrill and bruit (an abnormal sound that can be heard through an artery caused by turbulent blood flow due to narrowing of the artery, a blood clot or aneurysm. Thrill is an abnormal feeling that can be felt when palpating an artery) to left arm every shift for hemodialysis, with order date 3/28/24 and no end date. -Shunt site left arm was not to be accessed for any reason other than dialysis unless specified by the nephrologist, every shift, with order date 3/28/24 and no end date. Record review of Resident #51's Dialysis Communications Record revealed the following: - the 3/20/24 record revealed the Post-Treatment Facility Nurse Evaluation, Patient Status section, and the Facility Nurse Signature pre and post dialysis were blank. - the 3/22/24 record revealed the Post-Treatment Facility Nurse Evaluation and Post Facility Nurse Signature were blank and the Dialysis Staff Pre-Treatment and Post-Treatment weight and vital signs and Dialysis Staff signature were blank. - the 3/25/24 record revealed the Post-Treatment Facility Nurse evaluation, the post dialysis Facility Nurse Signature, and the Dialysis Staff Post-Treatment weight section were blank. - the Dialysis Communication Record for 3/27/24 was missing - the 3/29/24 record revealed the Facility Nurse Signature for pre and post dialysis was blank, and the Dialysis Staff Post-Treatment Section was missing the resident's weight. - the 4/1/24 record revealed the Post-Treatment Facility Nurse Evaluation, Patient Status section and the Facility Nurse Signature for pre and post dialysis were blank. - the 4/3/24 record revealed the Post-Treatment Facility Nurse Evaluation, Patient Status section and the Facility Nurse Signature for pre and post dialysis were blank. During an observation and interview on 4/4/24 at 10:23 a.m., Resident #51 revealed he went to dialysis treatments on Monday, Wednesday, and Friday. Resident #51 pointed to his left upper arm and revealed the location of the dialysis port. Resident #51 stated he was given a notebook by the facility nursing staff and instructed to give the notebook to the dialysis center staff and upon return he gave the notebook back to the facility nursing staff. Resident #51 stated, that's every time I go to dialysis. Resident #51 revealed he did not have any issues or concerns with dialysis treatments. 2. Record review of Resident #82's face sheet, dated 04/04/24, revealed an initial admitted [DATE] and a readmitted [DATE] with diagnoses that included type 2 diabetes and end stage renal disease. Record review of Resident #82's most recent MDS admission assessment, dated 3/26/24, revealed the resident cognition was intact for daily decision-making skills and required dialysis treatments. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #82's comprehensive care plan, with revision date 3/14/24 revealed the resident received dialysis related to renal failure and was at risk for potential complications of dialysis. Resident had an AV fistula, with interventions that included to Encourage resident to attend scheduled dialysis appointments Monitor/document/report to physician any signs or symptoms of infection at the access site such as redness, swelling, warmth, pain, or purulent drainage. Record review of Resident #82's Order Summary Report, dated 4/2/24 revealed the following: Dialysis Monday-Wednesday-Friday .with an order date of 02/05/2024 and no end date. There were no orders to monitor the shunt to take vitals before or after dialysis. During an interview on 4/4/24 at 10:55 a.m., ADON A revealed, Resident #82's dialysis binder was lost when the resident went to the hospital and was never recovered. ADON A revealed the facility had been having trouble getting the dialysis binders back from the dialysis center and when it occurred the facility nursing staff were supposed to call the dialysis center to get the Dialysis Communications Record back. ADON A revealed Resident #82 had been to the dialysis clinic on 4/3/24 but could not locate the Dialysis Communications Record for the visit from the day before. During an interview on 4/4/24 at 11:24 a.m., ADON B revealed, the facility used to input the pre and post dialysis assessments directly into the electronic record, but that feature had since been taken away, a couple of months ago. ADON B further stated, all the Dialysis Communications Record sheets were placed in a binder that was given to the resident when they went to dialysis and then returned to the facility. ADON B revealed, when the binder got full, the sheets were emptied out and sent to medical records to be uploaded. ADON B revealed, facility nursing staff were responsible for ensuring the dialysis clinic staff completed their portion of the record. If they were not, they were supposed to contact the dialysis clinic for the information. ADON B revealed, we focus more on the weight and if there are new orders from the dialysis clinic. ADON B revealed, the facility nurse typically did not sign the Dialysis Communications Record, as indicated on the sheet, and stated, don't know why, it hadn't been implemented. ADON B stated, completing the Dialysis Communication Record sheets was important because it showed what type of condition the resident was in before leaving the facility and after coming back from dialysis. During an interview on 4/4/24 at 5:49 p.m., the DON revealed, the facility nursing staff completed a pre and post dialysis assessment and the ADON's were responsible for ensuring the Dialysis Communications Record sheets were completed before they were sent to medical records. The DON further revealed, if the dialysis clinic did not complete their portion of the Dialysis Communications Record, facility nursing staff were supposed to call the dialysis clinic to get the missing information. The DON would not elaborate on how there would be a negative effect for not completing the Dialysis Communications Record and stated, any abnormality found would be reported to the doctor. During an interview on 4/4/24 at 7:02 p.m., the Administrator revealed, there needed to be a better process with the Dialysis Communications Records because the record was a communication tool and if not completed there could be a break in communication. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the policy an procedure document titled, Hemodialysis Communication Form, review date 2/14/20, revealed in part, .Care coordination of pertinent patient information between center staff and dialysis provider in a consistent manner .The care facility documents the patient's condition/status prior to dialysis treatment on the upper half of the form and sends the form to the dialysis center with the patient .The dialysis center documents the patient's condition/status after the dialysis treatment on the lower half of the form or sends post dialysis notes and returns it to the care facility with the patient .The licensed nurse completes post dialysis evaluation and documents on the Hemodialysis Communication Form .File and maintain the completed dialysis treatment reports and/or dialysis communication forms in a center specified area/clinical record . 45857

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observations, interviews, and record review the facility failed to ensure that it was free of medication error rate of 5% percent or greater. The facility had a medication error rate of 32% based on 8 out of 25 opportunities, which involved 1 of 3 Residents (Residents #70) reviewed for medication administration, in that: The facility failed to ensure MA D administered 8 medications within acceptable parameters for safe medication administration to resident #70. This failure could place residents at risk for not receiving the intended therapeutic effects of their medications and could contribute to possible adverse reactions. The findings included: Record review of Resident #70's face sheet, dated 4/5/24 revealed a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebrovascular disease (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), dysarthria (difficult or unclear articulation of speech) and anarthria (loss of speech), cognitive communication deficit, memory deficit, diabetes (chronic, long lasting health condition that affects how your body turns food into energy), pain, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), hypertension (elevated blood pressure), chronic kidney disease (longstanding disease of the kidney leading to kidney failure), hyperlipidemia (elevated cholesterol), and lack of coordination. Record review of Resident #70's most recent quarterly MDS assessment, dated 3/6/24 revealed the resident was moderately cognitively impaired for daily decision-making skills. Record review of Resident #70's Order Summary Report, dated 4/5/24 revealed the following: - Amlodipine 10 mg, give 1 tablet by mouth in the morning for hypertension, hold for systolic blood pressure less than 110, with order date 5/9/22 and no end date - Aspirin 81 mg, give 1 tablet by mouth in the morning with order date 8/3/23 and no end date - Lisinopril 20 mg, give 1 tablet by mouth two times a day related to hypertension, hold if systolic blood pressure is less than 110, with order date 12/8/23 and no end date - Carvedilol 12.5 mg, give 1 tablet by mouth every morning and at bedtime related to hypertension, hold for systolic blood pressure below 110 or pulse below 60; give with food, with order date 3/15/22 and no end date - Cilostazol 100 mg, give 1 tablet by mouth every 12 hours for intermittent claudication, with order date 10/25/22 and no end date (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Jardiance 25 mg daily, give 1 tablet by mouth in the morning for diabetes, with order date 10/27/21 and no end date - Vitamin D 50 mcg/2000 IU, give 1 tablet by mouth in the morning related to muscle weakness, with order date 11/27/23 and no end date - Pregabalin 75 mg, give 1 capsule by mouth two times a day related to neuropathy, with order date 3/1/23 and no end date Record review of Resident #70's Medication Administration Record (MAR) for April 2024, revealed Amlodipine 10 mg, Aspirin 81 mg, Jardiance 25 mg, Carvedilol 12.5 mg, Cilostazol 100 mg, Lisinopril 20 mg and Pregabalin 75 mg were scheduled for administration at 8:00 a.m., and Vitamin D 50 mcg/2000 IU was scheduled for administration at 9:00 a.m. Observation during the medication pass on 4/5/24 revealed MA D administered the aforementioned medications to Resident #70 beginning at 10:31 a.m. and ending at 10:39 a.m. During an interview on 4/5/24 at 10:39 a.m., MA D revealed, Resident #70's medications were administered late because the keys to the medication cart were lost. MA D revealed, the keys were recovered and provided to her just as the State Surveyor observed the medication pass. MA D revealed, the DON and ADON A instructed her to administer medications to Resident #70 and was told they would adjust the times. MA D stated, I'm assuming they are going to call the doctor? MA D revealed, the medications administered to Resident #70 were medications scheduled for 8:00 a.m. medication pass. During an interview on 4/5/24 at 1:35 p.m., the DON revealed, medications given late were considered a medication error. A policy and procedure for medication error was not provided by the Administrator when requested on 04/05/2024 at 5:14 p.m.

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	675437	A. Building B. Wing	04/05/2024

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observations, interviews, and record review the facility failed to ensure the drugs and biologicals used in the facility must be labeled and stored in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions and the expiration date when applicable for 1 of 22 resident rooms (Resident #51's room): The facility failed to ensure Resident #51's medications were stored properly in the facility. This deficient practice could affect residents who received medications for treatments and could result in less potent or an adverse effects and drug diversion. The findings included: Record review of Resident #51's face sheet, dated 4/2/24, revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included atherosclerosis (disease of the arteries characterized by plaque deposit of fatty material on their inner walls) of bypass graft of bilateral legs, diabetes with neuropathy (chronic, long lasting condition that affects how the body turns food into energy with nerve damage), hyperlipidemia (elevated cholesterol), glaucoma (increased pressure within the eyeball causing gradual loss of sight), atrial fibrillation (irregular, rapid heart rate commonly caused by poor blood flow), end stage renal disease (condition in which the kidneys cease functioning on a permanent basis), and long term use of anticoagulants (blood thinners). Record review of Resident #51's most recent MDS admission assessment, dated 3/19/24, revealed the resident was moderately cognitively impaired for daily decision-making skills. During an observation and interview on 4/2/24 at 11:55 a.m., Resident #51 was observed with the following: - 3 vials of eye drops - one package of over-the-counter allergy gel capsules - two tubes of anti-fungal cream - one tube of hydrocortisone cream (used to treat a variety of skin conditions, such as a rash) - one bottle with a pharmacy label for Sevelamer Carbonate 800 mg tablets (prescribed to control phosphorus levels) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #51 stated, those are mine, referring to the medications, and further stated, the pharmacy at the VA hospital approved the medications. Resident #51 stated, maybe two nurses knew about the medications but could not identify them. Resident #51 further stated, every time the nurses need more eye drops, he would take a vial out of the chest of drawers and give it to the nurse. Resident #51 revealed he had applied the eye drops himself, but I put too much. During an observation and interview on 4/5/24 at 12:13 p.m., ADON B stated, Resident #51 was new to the facility and was not allowed to self-administer his own medications. ADON B stated, nursing staff were in charge of administering Resident #51's medications. ADON B revealed, Resident #51, administering his own medications, could cause the resident to take too much of a medication and could result in an adverse effect. During an interview on 4/5/24 at 2:15 p.m., the DON stated, Resident #51 should not have had any medications in his room and further stated, the facility did not allow residents to self-administer medications. The DON stated, if Resident #51 was truly self-administering medications, it should not be happening, but Resident #51 is alert and oriented and he would be ok. Record review of the facility policy and procedure, titled Medication Storage, dated 1/20/21, revealed in part, . It is the policy of this facility to ensure all medications housed on our premises will be stored, dated and labeled according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .All drugs and biologicals will be stored in locked compartments (i.e., medication carts .medication rooms) .Only authorized personnel will have access to the keys to locked compartments .

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47611 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. 1. There were two plastic storage containers of food in the dry storage room that was not properly sealed. 2. There was a dented can of pineapples stored in the dry storage room. 3. There was a bag of brownie mix that expired on [DATE] stored in the dry storage room. 4. There was a container of disinfectant wipes on top of the ice dispenser. 5. The microwave was dirty and had old food particles inside. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: Observation on [DATE] at 8:56 AM in the dry storage room revealed two clear 10-gallon food storage containers on a rack. The lids on the storage containers were not properly sealed onto the container, exposing the contents to the ambient air in the dry storage room and potential contamination by pathogens, bacteria and pests. There was a 107 oz can of pineapples that was dented. There was an bag of brownie mix that expired on [DATE]. There was a container of disinfectant wipes on top of the ice dispenser and the microwave was soiled and had food particles inside. During an interview on [DATE] at 9:12 AM with the Dietary Manager she acknowledged the microwave was dirty, the can of pineapples was dented, the disinfectant wipes were on top of the ice machine, and the lids were not tightly sealed onto the containers, and the contents inside the container were exposed to the ambient air in the dry storage room and potential bacterial and pest and cross contamination. Record review of the facility's policy titled, Preventing Food Contamination From the Premises, undated, revealed: (a) Food Storage. (1) Food shall be protected from contamination by storing the food: (B) where it is not exposed to splash, dust or other contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed ,d+[DATE].17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, , d+[DATE].11, revealed: Preventing Contamination from the Premises - Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 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 3 Residents (Residents #62) reviewed for infection control. The facility failed to ensure LVN E used appropriate hand hygiene and did not wear a gown when providing medications through a feeding tube to Resident #62 who was on enhanced barrier precautions. This deficient practice could place residents at risk of infection for transmission of communicable diseases and a decline in health. The findings included: Record review of Resident #62's face sheet, dated 4/5/24, revealed a [AGE] year-old female, admitted to the facility on [DATE], with diagnoses that included protein-calorie malnutrition, chronic kidney disease, shortness of breath, dysphagia (difficulty or discomfort swallowing), heart failure and gastrostomy (feeding tube) status. Record review of Resident #62's most recent quarterly MDS assessment, dated 1/24/24 revealed the resident was severely cognitively impaired for daily decision-making skills and had a feeding tube. Record review of Resident #62's comprehensive care plan, revision date 3/14/23 revealed the resident had a feeding tube related to dysphagia, risk for aspiration, weight loss and aspiration. Observation on 4/5/24 at 7:37 a.m., revealed Resident #62 had a sign on the resident's entry indicating the resident was on Enhanced Barrier Precautions and Providers and Staff Must Also: Wear gloves and gown for the following High-Contact Resident Care Activities .feeding tube . During an observation on 4/5/24 at 7:37 a.m., during the medication pass, LVN E did not initially wear a gown when providing medications via a feeding tube to Resident #62 who was on Enhanced Barrier Precaution. LVN E had difficulty passing the medications through Resident #62's feeding tube and left the bedside to obtain a tool to unclog the feeding tube. LVN E then returned to the medication cart, took a gown from the bottom drawer of the medication cart, put the gown on and put on a pair of gloves without using appropriate hand hygiene. LVN E returned to Resident #62's bedside and applied eye drops to the resident while she continued to use the same gloves. LVN E then removed her gloves, sanitized her hands and put on a new pair of gloves. LVN then placed her right hand into her scrub pocket and pulled out a pulse oximeter. LVN E obtained Resident #62's oxygen saturation and placed the pulse oximeter back into her scrub pocket. LVN E used the same gloves she had placed in her scrub pocket, did not use appropriate hand hygiene, and continued with medication administration. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/5/24 at 9:31 a.m., LVN E revealed, Resident #62 was on enhanced barrier precaution and realized she was not wearing a gown during the medication pass. LVN E stated, not wearing the gown was considered an infection control issue and the barrier was necessary for residents who had feeding tubes to prevent spread of infection. LVN E stated she was not aware she had not been using appropriate hand hygiene but confirmed she had placed her gloved hand in her scrub pocket and should not have done that because it was an infection control issue. During an interview on 4/5/24 at 1:53 p.m., the DON stated, wearing a gown for a resident on enhanced barrier precaution was to provide an extra barrier for the resident and the staff because the resident had a higher susceptibility for infection. The DON stated, it's for the resident's protection. The DON further revealed, it was her expectation the nurse should practice appropriate hand hygiene by changing her gloves when LVN E put her gloved hand in her scrub pocket because it was considered cross contamination. The DON revealed, hands should be washed or sanitized before and after glove changes. Record review of the facility policy and procedure, titled Infection Prevention and Control Program, revision date 10/27/22 revealed in part, .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 diseases and infections as per accepted national standards and guidelines .All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services .hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures .