STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195597	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Live Oak	600 East Flournoy Lucas Road Shreveport, LA 71115

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40193 Based on record reviews and interview, the faciltiy failed to ensure reportable incidents were reported to the State Survey and Certification Agency for 1 (#86) of 2 (#86, #91) residents reviewed for accidents. The facility failed to report an elopement for Resident #86. Findings: Review of Resident #86's medical records revealed an admitted [DATE] with the following diagnoses, in part: difficulty in walking/not elsewhere classified, age-related physical debility, Alzheimer's disease/unspecified, muscle weakness (generalized) and cognitive communication deficit. Review of Resident #86's MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) 03 indicating severely impaired cognition. Review of Resident #86's Incident Tracking revealed an incident dated 04/16/2024 at 3:47 p.m. - elopement - front of building - nurse was notified by ward clerk on west wing that resident was outside of the front of the facility, walking around the parking lot - assessed resident and notified family and MD (Medical Director) - no injury. Quality indicators: baseline cognition - name YES, other - confused/disoriented. Review of Facility's SIMS (Statewide Incident Managment System) Reports failed to reveal a report for Resident #86's elopement on 04/16/2024. During an interview on 05/22/2024 at 9:40 a.m., S1 Director of Nursing acknowledged Resident #86's elopement on 04/16/2024 was not reported to the State Survey and Certification Agency.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40193 Based on record reviews and interviews, the facility failed to develop and implement a comprehensive person-centered care plan for 1 (#86) of 2 (#86, #91) sampled residents reviewed for accidents. The facility failed to ensure a plan of care for elopement had beed developed and implemented for Resident #86 who had a history of elopement. Findings: Review of Facility's Wandering, Unsafe Resident Policy and Procedure (10/17/2017) revealed: - Purpose: will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. - Procedure: .The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety will be included in the resident's care plan. Review of Resident #86's medical records revealed an admitted [DATE] with the following diagnoses, in part: difficulty in walking/not elsewhere, age-related physical debility, Alzheimer's disease/unspecified, muscle weakness (generalized), unspecified non-displaced fracture of second cervical vertebra and cognitive communication deficit. Review of Resident #86's MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) 03 indicating severely impaired cognition. Review of Resident's Comprehensive Care Plan revealed the following and approaches: - At risk for altered thought processes - staff will assist resident to make simple decision, reality orientation prn (as needed). - At high risk for falls/injury r/t (related to) impaired mobility/unsteady gait/history of falls -04/16/2024 elopement - notified by front desk that was outside the front of the facility walking; No injuries noted. Instructed to notify nurse before going outside alone - voiced understanding. Front desk notified she cannot leave facility without assistance of family or staff. Further review failed to reveal approaches for wandering/elopement. Further review of care plan failed to reveal interventions to prevent elopement. Review of Resident #86's Incident Tracking revealed an incident dated 04/16/2024 at 3:47 p.m. - elopement - front of building - nurse was notified by ward clerk on west wing that resident was outside of the front of the facility, walking around the parking lot. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/22/2024 at 8:40 a.m. S2 MDS Nurse acknowledged the only interventions on Resident #86's care plan for elopement was telling the resident to notify the nurse when she goes outside and notifying the front desk she is not to go outside without staff or family. During an interview on 05/22/2024 at 9:40 a.m. S1 Director of Nursing acknowledged the only interventions on Resident #86's care plan for elopement was telling the resident to notify the nurse when she goes outside and notifying the front desk she is not to go outside without staff or family.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36921 Based on record review and interviews, the facility failed to ensure residents' medical records reflected the resident's advance directive wishes for 1 (#82) of 32 residents reviewed for advance directives in the initial pool. The facility failed to ensure Resident #82's medical record was consistent with the resident's wishes for DNR (Do Not Resuscitate). Findings: Review of the facility's Advance Directive policy dated [DATE] revealed in part: Purpose: It is the policy of _____ that advance directives will be respected in accordance with state law and facility policy. Procedure: 1. Upon admission of a resident to our facility, the social services director or designee will provide written information to the resident concerning his/ her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. 4. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. Review of face sheet revealed Resident #82 was initially admitted to the facility on [DATE] with a current admitted [DATE]. Further review of Resident #82's face sheet revealed full code. Resuscitate: yes. Review of Resident #82's Medical Record (paper chart) revealed: STOP DO Not Resuscitate signed on [DATE]. No code order Certification Statement Form: Do not use a feeding tube, respirator or resuscitation, signed by responsible party on [DATE] and physician signed on [DATE] and [DATE]. Review of Resident #82's care plan revealed I am a full code and I do wish for CPR (cardiopulmonary resuscitation) to be performed with approaches for CPR to be provided to resident as per consent. During an interview on [DATE] at 12:00 p.m. S3 LPN (Licensed Practical Nurse) Unit Manager reported she would check the residents' medical chart in the advance directive tab to determine code status. S3 LPN Unit Manager reviewed Resident #82's medical record (paper chart) and reported the face sheet, facility's code status sheet and No Code order Certification Statement form should all match and confirmed Resident #82's code status did not match throughout the medical record. During an interview on [DATE] at 12:15 p.m. S1 DON (Director of Nursing) reported S4 Social Services Director (SSD) should ensure resident code status/advance directive wishes matched. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:30 p.m. S4 SSD reported Resident #82 was a full code upon admit until the resident and family completed the admission agreement. S4 SSD reported after completing the admission agreement the family chose for Resident #82 to be a DNR. S4 SSD confirmed Resident #82's code status was not updated when family made decision to make Resident #82 a DNR. S4 SSD reported when Resident #82's code status changed, the system should have been updated to reflect Resident #82's DNR status and a new face sheet should have been printed and placed on the chart.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 34708 Based on personnel record reviews and interview, the facility failed to ensure an annual performance review was completed for 1 [S7 Certified Nurse Assistant (CNA)] out of 5 CNA personnel records reviewed. Findings: Review of S7 CNA's personnel record revealed S7 CNA worked for the facility through an agency and had done so since 12/15/2020. Further review of S7 CNA's personnel record failed to reveal documentation of annual performance reviews. During an interview on 05/22/2024 S1 Director of Nursing reviewed S7 CNA's personnel record and acknowledged there was no documentation of annual performance reviews.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36921 Based on record reviews and interviews, the facility failed to ensure dietary services were provided in a safe, sanitary environment to prevent contamination and food borne illness for 98 residents served a meal tray from the kitchen as reported by S5 Assistant Dietary Manager. The facility failed to label frozen uncooked chicken out of its original package in the walk in freezer and failed to clean the meat slicer after each use. Findings: Observations during the initial tour of kitchen with S5 Assistant Dietary Manager on 05/20/2024 at 8:00 A.M. revealed a large unlabeled and undated rectangular silver pan containing frozen uncooked chicken in the walk in freezer and dried debris to bottom of covered meat slicer. During an interview on 05/20/2024 at 8:00 A.M. S5 Assistant Dietary Manager confirmed the frozen uncooked chicken should have been labeled and dated. S5 Assistant Dietary Manager reported the meat slicer should have been cleaned after each use. During an interview on 05/20/2024 at 11:50 A.M. S5 Assistant Dietary Manager confirmed 98 trays were served for breakfast.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 36921 Based on record reviews and an interview, the facility failed to ensure 4 out of 4 glucometers reviewed were maintained in safe operating condition for 11 (#41, #12, #29, #69, #5, #87, #7, #46, #64, #302, #75) residents residing in the facility with orders for glucose monitoring. S3 LPN (Licensed Practical Nurse) Unit Manager provided a list of 11 (#41, #12, #29, #69, #5, #87, #7, #46, #64, #302, #75) residents who resided on Hall A, Hall B, Hall C, and Hall D that received glucometer checks. Findings: Review of facility's Obtaining A Fingerstick Glucose Level policy dated 11/6/2017 revealed in part: Purpose: It is the policy of _____ to obtain a blood sample to determine the resident's blood glucose level. Procedure: Ensure that equipment and devices are working properly by performing any calibrations or checks as instructed by the manufacturer or this facility. Review of facility's glucometer control logs for January 1, 2024 through May 21, 2024 with S3 LPN (Licensed Practical Nurse) Unit Manager revealed glucometer checks were not done on the following dates: Hall A's: January 2024: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10,11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 25, 28, 30, 31 February 2024: 2, 3, 4, 5, 7, 8, 10. 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 22, 26, 29 March 2024: 3, 6, 7, 11, 12, 13, 16, 17, 18, 19, 26, 27, 28 April 2024: 1, 2, 4, 9, 10, 12, 13, 14, 15, 17, 18, 19, 20, 23, 24, 28, 29 May 2024: 1, 2, 4, 5, 6, 7, 8, 11, 12, 13, 16, 17 Hall B's: January 2024: unable to provide documentation that glucometer checks were done for the entire month of January 2024. February 2024: unable to provide documentation that glucometer checks were don for the entire month of February 2024. March 2024: 2, 7, 13, 25 April 2024: 3, 8, 9, 10, 16, 17 (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	May 2024: 1, 2, 8, 9, 10, 11, 16 Hall C's: January 2024: 1, 2, 6, 18, 19, 20, 21, 22, 25, 26, 30 February 2024: 2, 4, 6, 7, 8, 10, 12, 15, 16, 18, 19, 21, 25, 26, 27 March 2024: 3, 5, 6, 10, 11, 12, 14, 15, 16, 17, 18, 19 April 2024: 1, 3, 5, 9, 14, 16, 26, 29, 30 May 2024: 1, 15, 17, 18 Hall D's: January 2024: 2, 3 February 2024: 3, 4, 5, 12, 15, 16, 21, 25 March 2024: 1, 5, 18, 19 During an interview on 05/22/2024 at 1:10 p.m. S3 LPN (Licensed Practical Nurse) Unit Manager reported glucometer checks should be done daily by the floor nurse on the overnight shift, and further acknowledged glucometer checks were not done.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 34708 Based on personnel record reviews and interview, the facility failed to provide at least 12 hours of in-service training per year that included dementia management, resident abuse prevention, and care of the cognitively impaired for 1 [S7 Certified Nurse Assistant (CNA)] out of 5 CNA personnel records reviewed. Findings: Review of S7 CNA's personnel record revealed S7 CNA worked for the facility through an agency and had done so since 12/15/2020. Further review of S7 CNA's personnel record failed to reveal documentation of at least 12 hours of in-service training per year that included dementia management, resident abuse prevention, and care of the cognitively impaired. During an interview on 05/22/2024 S1 Director of Nursing reviewed S7 CNA's personnel record and acknowledged there was no documentation of at least 12 hours of in-service training per year that included dementia management, resident abuse prevention, and care of the cognitively impaired.