

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195597	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Live Oak		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record reviews and interviews the facility failed to report alleged allegations of abuse and neglect in the required timeframe to the State Survey and Certification Agency for 2 (#19 and #70) of 3 residents reviewed for facility reported incidents. Findings: Resident #19 Review of Resident #19's medical record revealed an admission date of 02/21/2020 and diagnoses including atherosclerosis native arteries of left leg with ulceration other foot, insomnia, glaucoma, muscle wasting and atrophy multiple sites, and difficulty in walking. Review of the facility's incident log for dates 03/27/2026 through 07/27/2026 revealed Resident #19 had a fall with injury 07/12/2026 at 5:15 a.m. Review of Resident #19's incident on 07/12/2026 at 5:15 a.m. of alleged neglect [fall with injury] revealed the incident was reported to the State Survey and Certification Agency on 07/13/2026 at 1:44 p.m. Review of resident #19's progress notes revealed in part: 07/12/2026 at 6:18 a.m. Resident #19 had a fall and denied pain. 07/12/2026 at 7:05 p.m. for Resident #19 had complaints of pain, x-ray was completed at 2 p.m., and Tylenol was given at 9:15 a.m. and 5:15 p.m. During a telephone interview on 07/28/2026 at 2:49 p.m., S5LPN confirmed she assessed Resident #19 after the fall on 07/12/2026 at 5:15 a.m. S5LPN reported Resident #19 was found on the side of the bed by the window on the floor. S5LPN further confirmed resident #19 denied pain and had no injuries at time of fall. During an interview on 07/28/2026 at 12:17 p.m., S4Nurse Practitioner reported she ordered an x-ray after Resident #19's fall on 07/12/2026 after Resident #19 complained of pain at 9:00 a.m. S4Nurse Practitioner confirmed Resident #19's x-ray result from 07/12/2026 revealed Resident #19 had a left femur fracture. During an interview on 07/29/2026 at 12:30 p.m., S1DON confirmed Resident #19 had a fall with injury on 07/12/2026 at 5:15 a.m. and the alleged neglect was not reported to state agencies until 07/13/2026 at 1:44 p.m. S1DON acknowledged reporting was out of compliance with the 24 hour window of reporting for neglect. Resident #70 Review of Resident #70's medical record revealed an admission date of 11/19/2021 and diagnoses including dysphagia, amyotrophic lateral sclerosis, neuralgia and neuritis, and chronic kidney disease. Review of the facility's grievance form dated 07/08/2026 revealed in part, Resident #70 reported an agency CNA was assisting him this morning and said he was a crazy f__d up person. Review of Resident #70's incident on 07/08/2026 at 6:30 a.m. of alleged verbal abuse revealed the incident was reported to the State Survey and Certification Agency 07/08/2026 at 3:21 p.m. During an interview on 07/29/2026 at 8:40 a.m., S3CNA Coordinator reported Resident #70 informed her an agency CNA called him a crazy f__d up person on the morning of 07/08/2026. S3 CNA Coordinator reported she informed Resident #70 the agency CNA would no longer be working with him and reported this incident to S1DON. During an interview on 07/29/2026 at 3:15 p.m., S1DON acknowledged Resident #70's incident was discovered on 07/08/2026 at 6:30 a.m. and was reported on 07/08/2026 at 3:21 p.m. S1DON further acknowledged she did not report the allegation of abuse within 2 hours to the appropriate state agency and should have. Review of the (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility's Abuse Prevention Program and Abuse Reporting for Health Center Residents policy with a revision date of 04/23/2028 revealed: Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms directed to residents or at residents within hearing distance, regardless of their age, ability to comprehend, or disability. Review of the facility's Recognizing Signs and Symptoms of Abuse/Neglect policy with a revision date of 04/23/2018 revealed in part: Neglect is defined as failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. Review of the facility's Abuse Prevention Program and Abuse Reporting for Health Center Residents policy with a revision date of 04/23/2018 revealed in part: PURPOSE: It is the policy of The Oaks of Louisiana to ensure that Live Oak Health Center residents have the right to be free from abuse as per S483.13 of the Long Term Care Survey. It is the responsibility of Live Oak Health Center employees, facility consultants, attending physicians, family members, visitors, etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown origin, and theft or misappropriation of resident property to facility management. PROCEDURE: When an alleged case of mistreatment, neglect, injuries of unknown origin, or abuse is reported, the Health Center Administrator, or his/her designee shall adhere to the Department of Health's protocol for reporting such incidents.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interviews, the facility failed to implement the plan of care to meet the needs of 1 (#90) of 29 sampled residents. The facility failed to administer Resident #90's final dose of a diuretic regimen and order imaging for Resident #90 in a timely manner. Findings: Review of Resident #90's medical record revealed an admission date of 05/06/2024 with diagnoses including in part, Alzheimer's disease, hypertension and anxiety disorder. Review of Resident #90's physician orders revealed in part: 06/04/2026 Chest x-ray (Due: 06/04/2026) due to edema 06/04/2026 Lasix 20 mg give 1 po now then give 40 mg po x 3 days Review of Resident #90's June 2026 MAR failed to reveal Resident #90 received the final Lasix 40 mg dose of the ordered 3 day diuretic regimen on 06/08/2026. Review of Resident #90's medical record failed to reveal a 06/04/2026 chest x-ray result. Further review of Resident #90's medical record revealed a chest x-ray dated 06/09/2026 with an impression of a large left-sided pleural effusion with overlying atelectasis versus consolidation. Review of Resident #90's progress notes revealed a nurse's note dated 06/10/2026 at 9:49 a.m. which read in part, Resident #90 was sent out to a local ER for evaluation of large left pleural effusion and SOB. During an interview on 07/28/2026 at 3:00 p.m., S2Unit Manager, reported imaging had not been notified of Resident #90's chest x-ray order on 06/04/2026 until 06/09/2026. S2Unit Manager, acknowledged Resident #90 had not received the final dose of the 3 day diuretic regimen as ordered and had not received a chest x-ray in a timely manner. During an interview on 07/28/2026 at 3:05 p.m., S1DON acknowledged Resident #90 had not received the chest x-ray in a timely manner and had not received the 3rd dose of Lasix 40 mg as ordered.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure 1 (#56) out of 5 residents reviewed for unnecessary medications completed a consent for a psychotropic medication. Findings: Review of Resident #56's medical record revealed an admit date of 08/11/2025 with the following diagnoses, including in part: vascular dementia unspecified severity without behaviors/psych/mood/anxiety, pseudobulbar affect, and depression unspecified. Review of Resident #56's physician orders revealed an order dated 08/25/2025 for Zoloft tablet 25 mg give 1 by mouth daily for depression. Review of Resident #56's medical record failed to reveal a psychotropic consent for Zoloft. During an interview on 07/28/2026 at 2:35 p.m. S2 Unit Manager acknowledged Resident #56 did not have a consent for Zoloft.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation and interview the facility failed to ensure a controlled medication record was maintained and reconciled for 1 of 3 narcotic records reviewed on Medication Cart B. The facility failed to maintain an accurate Phenobarbital count for Resident #58. Findings: Observation of the facility's Medication Cart B on 07/29/2026 at 3:40 p.m. with S3LPN revealed the medication card for Resident #58's Phenobarbital 64.8mg revealed 9 tablets remaining. Further review of the facility's Medication Cart B narcotics binder revealed Resident #58's Phenobarbital 64.8mg narcotic log sheet with a count balance of 10 tablets. During an interview on 07/29/2026 at 3:45 p.m. S3LPN acknowledged Resident #58's Phenobarbital count was incorrect. S3LPN reported she did not sign out Resident #58's Phenobarbital 64.8mg tablet when she administered it and should have. S3LPN stated narcotics should be signed out at the time it was administered. Review of the facility's narcotic administration policy dated 05/19/2011 revealed the following in part: PURPOSE: It is the policy of the facility's nursing staff to be accountable for the ordering, storage and administration of resident medications. This includes an accurate account of each medication received, given and administered. Narcotics must be inventoried at every change of shift.		