STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675104	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Live Oak Nursing and Rehabilitation Center	2951 Hwy 281 George West, TX 78022

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50039 Based on observation, interview, and record review, the facility failed to ensure the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility for 1 (Resident #4) of 5 residents reviewed for resident rights. The facility failed to treat Resident #4 with dignity and respect during perineal care (cleansing of the genital and anal areas) in Resident #4's room on 11/08/24 when CNA F wiped the buttocks of Resident #4 and showed the resident the dirty wipe with feces on it twice. This failure could place residents who require assistance with ADL's at risk of feeling disrespected. Findings included: Record review of Resident #4's face sheet dated 04/15/25 revealed an [AGE] year-old female with an initial admitted [DATE] and a current admitted [DATE]. Pertinent diagnoses included Alzheimer's Disease (progressive brain disorder that primarily affects memory, thinking, and behavior) and an unspecified mood disorder (experiencing mood disturbances but symptoms did not fully meet criteria for a specific mood disorder diagnosis). Record review of Resident #4's Quarterly MDS assessment dated [DATE] section C, cognitive patterns, revealed a BIMS score of 3 (severe impairment). Record review of Resident #4's comprehensive care plan dated 04/15/25 revealed the problem [Resident #4] has an ADL self-care performance deficit r/t Alzheimer's Disease and dementia. [Resident #4] required assistance with x 2 staff for all care need and ADL's r/t behaviors r/t Alzheimer's Dementia. [Resident #4] may be resistive to care or combative during care. Care should be provided by 2 staff members. Redirection and reapproaches should be attempted initiated on 11/19/19 and revised on 11/14/24. Interventions listed for the problem include: - Encourage [Resident #4] to make decisions regarding ADL care. Encourage as much participation as tolerated initiated on 12/24/19. - Usual functioning for toilet hygiene is dependent Initiated on 03/12/24. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's provider investigation report dated 11/20/24 revealed the incident occurred on 11/08/24. Resident's [Family Member] claimed that she had watched her [Resident #4] receive peri-care from nurse aide [CNA F] who had placed blankets accidentally over her face while giving incontinent care and was holding wipes up by her face to show the resident she was soiled in an effort to let the aide perform care. The director of nursing was notified that [Family Member] had observed CNA flinging blankets and wipes during pericare and that the blanket had accidentally landed over her face, and instructed that [CNA F] be sent home pending education. Record review of CNA F's undated witness statement I began changing her and she had a lot of poop but she started to attempt to scratch me again so I tried to show her the wipe with poop on it. I told her look you have doo doo let me change you because you have doo doo. She still continued being combative. I finished cleaning her as best I could and I went to put the blankets back over her and it did land on her face. I quickly tried to remove it and the resident pulled it down before I could pull it down. I didn't purposely put it on her face I was just trying to clean her by myself while she was trying to fight me and it landed there. I finished my care and left resident covered in bed and lowered the bed to the floor and left the room. During an observation of a surveillance video at 4:13 PM on 04/15/25 from Resident #4's room with an unknown timestamp, CNA F was observed showing Resident #4 the dirty cleansing wipe by intentionally holding it up in the air in Resident #4's plain view on two separate occasions. CNA F was observed to reposition Resident #4's blanket for accessibility to Resident #4's perineal area. Resident #4 was observed to immediately remove the blanket away from her face. In an interview with FM 2 at 2:56 PM on 04/15/25, FM 2 stated Resident #4 could become unruly when CNAs attempted to provide perineal care. FM 2 stated she observed the surveillance video of the incident with CNA F and felt it was abuse. FM 2 stated she was disgusted with the way CNA F treated Resident #4 in the surveillance video. An interview was attempted with Resident #4 on 04/15/25 at 4:35 PM but Resident #4 but she did not respond to any questions. In an interview with CNA G at 5:02 PM on 04/15/25, CNA G stated she always treated residents with respect and dignity. CNA G stated she always had a 2nd staff member to help her whenever she assisted Resident #4. CNA G stated she would never wipe a resident and show it to them because that would be demeaning to the resident. During an interview with LVN H at 9:08 AM on 04/16/25, LVN H stated it was not appropriate to show a resident their dirty wipe because it may upset them and cause more agitation in the resident. LVN H stated the resident's face should not be covered when performing care. LVN H stated showing a resident the dirty wipe was not treating a resident with respect and dignity. LVN H stated if she was having trouble with a resident she would leave, wait 10-15 minutes, and then come back with an extra staff member to help provide care. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON at 10:29 AM on 04/16/25, the DON stated she had seen the surveillance video of the incident between CNA F and Resident #4. The DON stated she did not feel like CNA F handled the situation in the most appropriate manner. The DON stated nurses and CNAs were trained to leave the room for a short time and then return with another staff member whenever they were having difficulty providing care to a resident. The DON stated she did not feel like Resident #4 was treated with dignity and respect during this incident. The DON stated it was important to treat a resident with dignity and respect because this was their home and it was their right. The DON stated if residents were not treated with dignity and respect than they could become depressed or anxious about receiving care. Record review of the facility policy titled Promoting/Maintaining Resident Dignity implemented 01/13/23 revealed the following: All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. When interacting with a resident, pay attention to the resident as an individual. Groom and dress residents according to resident preference.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969 Based on observation, interview, and record review, the facility failed to ensure residents had the right to be free from abuse for 2 of 5 residents (Resident #2 and #3) reviewed for abuse, neglect, and exploitation. 1. The facility failed to protect Resident #3 from sexual abuse when Resident #2 slapped Resident #3 on the buttocks on 07/28/24. 2. The facility failed to protect Resident #2 from physical abuse when Resident #3 hit Resident #2 in the face for slapping him on the buttocks on 07/28/24. Findings included: This failure could place residents at risk for physical or psychological harm or injury. Record review of Resident #2's face sheet, dated 04/15/25, revealed an [AGE] year-old male with an original admitted [DATE]. Resident #2's diagnoses included Dementia (a group of symptoms affecting memory, thinking and social abilities), Cognitive Communication Deficit (communication difficulties that arise from cognitive impairments), and High Risk of Heterosexual Behavior (all unprotected heterosexual activities occurring outside of a consistent sexual relationship). Record review of Resident #2's annual MDS assessment, dated 04/08/25, revealed a BIMS score of 05, which indicated severely impaired cognition. The MDS did not indicate any behaviors for Resident #2. Record review of Resident #2's care plan, initiated 08/10/23, revealed the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs; Resident #2's care plan, initiated 04/04/23 and revised 01/07/25, revealed the resident had a behavior problem with inappropriate sexual behavior; Resident #2's care plan, initiated 03/20/24, revealed the resident had the potential to wander and become agitated and restless at times; and Resident #2's care plan, initiated 07/04/24, revealed the resident needed a structured environment. Record review of Resident #2's progress note, dated 07/28/24, revealed Resident #2 slapped Resident #3 on the left buttocks. Resident #3 turned around and punched Resident #2 in the face, knocking his glasses off, and creating a superficial scratch on the bridge of Resident #2's nose and redness to Resident #2's left cheek. Another progress note, dated 07/28/24, revealed Resident #2 had triple antibiotic ointment applied to his nose. Record review of Resident #2's physician orders, dated 07/28/24, revealed an order to apply triple antibiotic ointment to the superficial abrasion to the bridge of Resident #2's nose. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's face sheet, dated 04/16/25, revealed a [AGE] year-old male with an original admitted [DATE] and a current admitted [DATE]. Resident #3's diagnoses included Bipolar Disorder (characterized by extreme mood swings), Schizoaffective Disorder (combined schizophrenia and mood disorder), and Schizophrenia (serious mental health condition that affects how people think, feel, and behave). Record review of Resident #3's significant change MDS assessment, dated 03/26/25, revealed a BIMS score of 09, which indicated moderately impaired cognition. MDS did not indicate any behaviors for Resident #3. Record review of Resident #3's care plan, initiated 10/14/24, revealed resident was dependent on staff for meeting emotional, intellectual, physical, and social needs; Resident #3's care plan, initiated 06/20/24 and revised 09/20/24, revealed resident had a behavior problem including indecent exposure, touching genitals in public, and hitting other residents. Resident #3's care plan, initiated 07/04/24 and revised 09/20/24, revealed resident needed a structured environment. Resident #3's care plan, initiated 07/28/24 and revised 12/12/24, revealed resident had the potential to be physically aggressive and had poor impulse control, and Resident #3 could be triggered for physical aggression when touched by others in a way that he felt inappropriate. Record review of Resident #3's progress note, dated 07/28/24, revealed new order for anxiety medication given due to behavior of punching another resident, and review of other progress notes, dated 08/02/24 and 08/03/24, revealed the resident was sent to a behavior hospital due to aggressive behaviors toward staff and other residents. Record review of Resident #3's psychology note, dated 07/31/24, revealed the resident had history of behaviors and delusions (strongly held false beliefs that conflict with reality) with disorganized speech. In an interview with Resident #2 on 04/14/25 at 1:51 PM, Resident #2 was observed sitting in his wheelchair in his room. He stated he thought he remembered getting hit on the neck one time, but could not remember when or where it happened, or who hit him. In an interview with Resident #3 on 04/14/25 at 1:56 PM, Resident #3 was observed lying in his bed watching television. He stated he did not remember the incident, but thought he remembered hitting a man one time because he tried to steal his goat, but he did not remember when it happened or who the man was. In an interview with CNA-B on 04/14/25 at 2:04 PM, she stated she vaguely remembered the incident, but she knew Resident #2 had a habit of slapping or grabbing people who got close to him. She stated Resident #2 did not mean it aggressively, he forgot that he should not touch other people. She stated Resident #3 was not typically aggressive either, but he thought someone was touching or grabbing his buttocks, so he turned around and slapped him. She stated she understood that these behaviors could impact the residents both physically and/or psychologically. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN-A on 04/14/25 at 2:20 PM, she stated she was not here when this incident with Resident #2 slapping or grabbing Resident #3 occurred. Resident #2 was very grabby, but not in an aggressive way. He liked to touch or grab people as they walked by or got close to him. She stated Resident #3 probably thought he was being grabbed in an inappropriate way, so he responded by turning around and hitting him in the face. She stated she understood that these actions could have caused the residents physical or psychological harm. In an interview with the DON on 04/14/25 at 2:35 PM, she stated Resident #3 had some PTSD from childhood sexual abuse and trauma, so he did not like to be touched by others. She stated Resident #2 was a grabber and a toucher, and he would grab or touch anyone that walked by. When he grabbed or slapped Resident #3 on the buttocks, Resident #3 just reacted instantly by hitting him in the face. She stated Resident #3 had not hit anyone at this facility previously, and he had not hit anyone at this facility since. She stated she understood how this behavior could have caused physical or psychological trauma. She initially stated there had not been anymore issues since this incident, but then proceeded to state next time Resident #2 grabbed Resident #3, Resident #3 did not lose his temper or hit back. Resident #3 just walked away. In an interview with the Administrator on 04/14/25 at 2:55 PM, he stated Resident #2 smacked Resident #3 on the buttocks, but it was not meant as anything sexual or aggressive. He stated Resident #2 had a habit of reaching out and grabbing or tapping people as they walked by, but there had not been any more issues between Resident #2 and Resident #3 since this grabbing or slapping incident on 07/28/24 happened. The administrator stated he saw how this could cause physical or psychological harm to someone, but he also stated that was not the case here because Resident #2 didn't not mean this sexually or in an aggressive manner. In an interview with LVN C on 04/15/25 at 1:40 PM, she stated Resident #2 slapped Resident #3 on the buttocks, and even though Resident #2 did not mean anything by it, Resident #3 did not like to be touched, so Resident #3 hit him back in the face. She stated Resident #2 ended up with a scratch to the top of his nose and some redness to one of his cheeks. She stated Resident #3 did not mean to hit Resident #2, or cause any harm, it was just a reaction to being touched. She stated she understood how Resident #3 might have interpreted this as unwanted sexual behavior even though Resident #2 had a habit of grabbing everyone as they walked by. She also stated she understood how unwanted sexual behavior could cause someone to react aggressively. In an interview with the Regional Nurse on 04/15/25 at 4:50 PM, she stated that sexual abuse was inappropriate or unwanted touching. She also stated this was not considered abuse because it was not willful and there was no intent. She stated nothing was meant sexually or aggressively. Upon reading the facility's Abuse and Neglect Policy, she stated sexual abuse was any non-consensual sexual contact of any type with a resident. She also stated she was not sure how a person would determine when slapping or groping done by Resident #2 was being done in a sexual manner versus a nonsexual manner. The regional nurse stated she understood how Resident #3 could have interpreted this as unwanted sexual behavior, and that was why he reacted the way he did. She understood how these types of behaviors could cause a resident to experience physical or psychological harm. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Abuse, Neglect and Exploitation Policy, implemented 08/15/22, revealed It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Sexual abuse is defined as non-consensual sexual contact of any type with a resident.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on interviews and record reviews, the facility failed to complete a comprehensive assessment within 14 days after a significant change in the physical condition for 1 of 5 residents (Resident #1) whose records were reviewed for assessments. The facility failed to complete a Significant Change MDS assessment for Resident #1 within 14 days after the resident had a fall with major injury (broken right arm) on 04/27/24. This failure placed residents at risk for not having interventions developed to meet their needs for care, assistance, and treatments. The findings included: Record review of Resident #1's admission record reflected a [AGE] year-old-female who was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Her diagnoses included dementia (loss of memory, language, problem solving and other thinking abilities that significantly impairs a person's ability to perform daily activities), history of falling, exudative age-related macular degeneration (an eye condition that causes permanent and rapid central vision loss), lack of coordination, need for assistance with personal care, and muscle wasting and atrophy (loss of muscle mass and strength). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 7, which indicated Resident #1 had severe cognitive impairment. Record review of Resident #1's nurse progress notes dated 04/10/24 to 05/11/24 reflected an entry by LVN D dated 04/27/24 at 12:30am that stated, Resident in room and overheard yelling by CNA. Upon entering room resident noted on floor in supine (on her back) position. Resident c/o right arm/elbow pain. Resident noted moving right arm around constantly. No shortening of limbs noted. Noted with nickel size purple discoloration below right elbow. Resident medicated with APAP 325mg 2 tabs p.o. for pain. Resident denies hitting her head. No further injuries noted. Resident assisted back into bed. Neuros initiated. X-rays to be done. Record review of Resident #1's radiology report dated 04/27/24 at 1:55pm reflected an acute right humeral neck fracture (a sudden onset of a break of the top of the bone of the right arm just below the shoulder). Record review of Resident #1's orthopedic physician notes dated 06/24/24 reflected Resident #1 did not have surgery on her broken right arm. Record review of the completed MDS reports for Resident #1 between 04/16/24 and 07/16/24 reflected a significant change MDS was not completed after Resident #1 fell and broke her proximal right humerus (the top part of the long bone at the top of the arm just below the shoulder) on 04/27/24. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected in section J1800 Resident #1 had fallen since the prior assessment. Section J1900, however, reflected only that Resident #1 had 1 fall with no injury and 1 fall with injury (except major). Resident #1's fall with a major injury that occurred on 04/27/24 was not documented. In an interview on 04/16/25 at 10:44am the DON stated the MDS nurse was responsible for submitting all of the MDS reports as well as any significant change MDS reports. The DON stated the MDS nurse was made aware of significant changes in morning meetings. In an interview on 04/16/25 at 11:55am the MDS nurse stated she had been employed at the facility for 1 year and a fall with a fracture was considered a significant change. The MDS nurse stated she relied on reports from the nurses, the DON, or the ADON to know a significant change needed to be addressed. The MDS nurse stated the time frame for a significant change to be put into the MDS assessment record was 5 to 7 days, but her personal preference was to submit a significant change MDS assessment within 5 days. The MDS nurse stated the quarterly MDS section J1900 dated 07/16/24 should have been coded as a fall with a major injury also because Resident #1 had fallen since the previous quarterly assessment was done on 04/16/24. The MDS nurse stated Resident #1 should have had a significant change MDS assessment done after her fall in April 2024 that resulted in the broken arm. The MDS nurse stated even if the significant change MDS assessment had been done within 14 days of Resident #1's fall, the next quarterly MDS assessment still should have documented the fall with major injury in section J1900. The MDS nurse stated she was not the MDS nurse at the time of Resident #1's fall, but it was the responsibility of the MDS nurse to make sure the significant change MDS assessment was completed. Record review of the facility's Assessment Frequency/Timeliness Policy dated 10/24/22 reflected in part: Policy: The purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current RAI Manual. Policy Explanation and Compliance Guidelines: 3. Within 14 days after the facility determines or should have determined there has been a significant change in the resident's physical or mental condition, a significant change in status assessment will be completed. 7. An entry tracking record will be completed within 7 days of the reentry event.

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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** 49157 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment, and describes services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Resident #1) reviewed for care plans. The facility failed to ensure Resident #1's comprehensive care plan was revised following a significant change assessment which identified a fall occurrence on 04/27/24 in which she sustained a major injury (right arm fracture). This failure could place residents at risk of not receiving the services needed to attain or maintain their highest practicable physical well-being. The findings included: Record review of Resident #1's admission record reflected a [AGE] year-old-female who was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Her diagnoses included dementia (loss of memory, language, problem solving and other thinking abilities that significantly impairs a person's ability to perform daily activities), history of falling, exudative age-related macular degeneration (an eye condition that causes permanent and rapid central vision loss), lack of coordination, need for assistance with personal care, and muscle wasting and atrophy (loss of muscle mass and strength). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 7, which indicated Resident #1 had severe cognitive impairment. Record review of Resident #1's nurse progress notes dated 04/10/24 to 05/11/24 reflected an entry by LVN D dated 04/27/24 at 12:30am that stated, Resident in room and overheard yelling by CNA. Upon entering room resident noted on floor in supine (on her back) position. Resident c/o right arm/elbow pain. Resident noted moving right arm around constantly. No shortening of limbs noted. Noted with nickel size purple discoloration below right elbow. Resident medicated with APAP 325mg 2 tabs p.o. for pain. Resident denies hitting her head. No further injuries noted. Resident assisted back into bed. Neuros initiated. X-rays to be done. Record review of Resident #1's radiology report dated 04/27/24 at 1:55pm reflected an acute right humeral neck fracture (a sudden onset of a break of the top of the bone of the right arm just below the shoulder). Record review of Resident #1's orthopedic physician notes dated 06/24/24 reflected Resident #1 did not have surgery on her broken right arm. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nurse progress notes dated 07/12/24 to 08/12/24 reflected an entry by LVN E dated 07/18/24 at 11:14am that stated in part, LE- this nurse called to memory care unit on 07/17/24 approximately 4:40pm- upon arrival charge nurse assessing resident that had fallen from w/c- resident sitting on floor near table in common area- legs extended out in front of not wearing shoes nor non-slip socks. Full ROM noted to lower extremities- wheelchair behind resident- unlocked. Resident with active bleeding from nares- bridge of nose from laceration and mouth- slight bruising- forming- around eyes and nasal area. Resident is stating, I fell - crying and appearance of nervousness from the bleeding- is holding towel to mouth for the bleeding full ROM to upper extremities noted. Coughing out small blood clots at times. 911 called as well as MD [provider's name] and RP [RP's name]- notified of fall and bleeding- made aware of being sent to [name of hospital] ER for evaluation and treatment. Another entry by LVN F dated 07/17/24 at 9:57pm stated in part, Resident arrived per EMS no acute distress noted . resident with [brand name of wound closure strips] (thin sticky bandages applied to the skin to help small cuts or wounds stay closed) to bridge of nose, small hematoma to top of left eyebrow . according to written report, no acute intracranial (within the skull) abnormalities, does have mildly displaced nasal bone fracture. Record review of Resident #1's care plan with revisions/cancellations dated 04/22/21 reflected Resident #1 was at risk for falls due to her impulsive behavior, dementia, impaired mobility, and a history of falls at home and in the facility with minor injury that was initiated on 04/22/21 and revised on 04/29/24. The only intervention that was added was dated 04/28/24 and stated staff would toilet Resident #1 every 2 hours and PRN. This care plan also reflected Resident #1 had an actual fall with injury due to losing her balance while leaning forward that was initiated on 07/17/24. An intervention that was initiated on 07/09/24 and revised and cancelled on 07/12/24 stated, arm positioning sling on at all times. Another intervention was also initiated on 07/09/24 and revised and cancelled on 07/12/24 stated, referral to orthopedic MD for consult post fracture. The only information in Resident #1's care plan that reflected the fall which resulted in a broken right arm on 04/27/24 were the 2 interventions that were initiated on 07/09/24, 73 days after the fall. In an interview on 04/16/25 at 10:44am the DON stated she thought she may have deleted the fall that occurred on 04/27/24 on the care plan and replaced it with the fall that occurred on 07/17/24 and that was why it did not show on the care plan. The DON stated she did not remember if it was done, on time or late or what. The DON stated she apparently did it wrong when she deleted items instead of marking them resolved or cancelled. The DON stated it was ultimately her responsibility to make sure significant changes got care planned and if things were not care planned, it could result in the resident not receiving the necessary treatment, care and services. The DON stated significant changes were communicated to the interdisciplinary team during morning meetings. In an interview on 04/16/25 at 11:10am, the Regional Nurse stated she would retrain the nursing management staff on care plans to ensure they were being updated correctly. In an interview on 04/16/25 at 11:55am the MDS nurse stated when she completed an MDS, she tried to make sure the care plan was updated to include any new areas of focus and interventions for them. Record review of the facility's Care Plan Revisions Upon Status Change Policy dated 10/24/22 stated in part: Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675104	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Live Oak Nursing and Rehabilitation Center	2951 Hwy 281 George West, TX 78022

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Explanation and Compliance Guidelines: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. c. The team meeting discussion will be documented in the nursing progress notes. d. The care plan will be updated with the new or modified interventions. e. Staff involved in the care of the resident will report resident response to new or modified interventions. f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident's care. h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969 Based on interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 5 residents (Resident #2) reviewed for clinical documentation. LVN-C failed to document a complete and accurate skin assessment for Resident #2 on 07/28/24. This failure could place residents at risk for incomplete or inaccurate clinical records, which could lead to miscommunication, a delay in services, or a potential decline in the resident's health. Findingd included: Record review of Resident #2's face sheet, dated 04/15/25, revealed an [AGE] year-old male with an original admitted [DATE]. Resident #2's diagnoses included Dementia (a group of symptoms affecting memory, thinking and social abilities), Cognitive Communication Deficit (communication difficulties that arise from cognitive impairments), and High Risk of Heterosexual Behavior (all unprotected heterosexual activities occurring outside of a consistent sexual relationship). Record review of Resident #2's annual MDS assessment, dated 04/08/25, revealed a BIMS score of 05, which indicated severely impaired cognition. Record review of Resident #2's care plan, initiated 08/10/23, revealed the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs; and Resident #2's care plan, initiated 07/04/24, revealed the resident needed a structured environment. Record review of Resident #2's progress note, dated 07/28/24, revealed Resident #2 slapped Resident #3 on the left buttocks. Resident #3 turned around and punched Resident #2 in the face, knocking his glasses off, and creating a superficial scratch on the bridge of Resident #2's nose and redness to Resident #2's left cheek. Another progress note, dated 07/28/24 and 08/01/24, revealed Resident #2 had triple antibiotic ointment applied to his nose. Record review of the Provider Investigation Report, dated 07/28/24 at 12:10 PM, revealed a head-to-toe assessment of Resident #2 was completed by LVN - C, and there was a superficial laceration noted to the bridge of Resident #2's nose, as well as some redness to the left cheek. Record review of Resident #2's weekly skin evaluation, dated 07/28/24 at 2:18 PM, revealed Resident #2 was re-assessed by LVN-C, and she documented Resident #2 had no abnormal skin areas or any other skin wounds or skin issues. Record review of Resident #2's physician orders, dated 07/28/24 at 6:00 PM, revealed an order to apply triple antibiotic ointment to the superficial abrasion to the bridge of Resident #2's nose. This order ended on 08/04/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675104	A. Building B. Wing	04/16/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN - C on 04/15/25 at 1:40 PM, she stated Resident #2 slapped Resident #3 on the buttocks, and even though Resident #2 did not mean anything by it, Resident #3 did not like to be touched, so Resident #3 hit him back in the face. She stated Resident #2 ended up with a scratch to the top of his nose and some redness to one of his cheeks. LVN - C initially stated it was a scratch with a break in the skin, but then she changed her wording and stated it was only a red mark that was left by his glasses, and the red mark was gone by the time she did the second assessment. In an interview with the ADON on 04/15/25 at 1:55 PM, she stated the triple antibiotic order began the evening of 07/28/24 and ended on 08/04/24. She stated the triple antibiotic was applied to the abrasion on Resident #2's nose. The ADON also stated maybe LVN - C, who did the initial and follow-up assessment, was not remembering correctly or maybe had just forgotten there was an actual abrasion that required triple antibiotic ointment. She stated skin assessments should be completed accurately so that residents received consistent and adequate care. In an interview with the DON on 04/14/24 at 2:35 PM, she stated Resident #3 had some PTSD from childhood sexual abuse and trauma, so he did not like to be touched by others. She stated Resident #2 was a grabber and a toucher, and he would grab or touch anyone that walked by. When he grabbed or slapped Resident #3 on the buttocks, Resident #3 just reacted instantly by hitting him in the face. She stated it caused a small scratch to the bridge of Resident #2's nose. She stated she was not sure why LVN - C had stated that it was just redness and went away a couple of hours later because it was still there that evening when the order for the triple antibiotic ointment was received to be applied to the abrasion. She agreed that skin assessments should be completed accurately so residents received consistent and adequate care. Record review of the facility's Documentation Policy, implemented 10/24/22, revealed Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. 3. Principles of documentation include but are not limited to: A. Documentation shall be factual, objective, and resident centered.