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	08/13/2025

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident had the right to be free from abuse for one of ten residents (Resident #1) reviewed for abuse/neglect. The facility failed to protect Resident #1's right to be free from abuse which resulted in Resident #1 being pushed from behind by Resident #2 and caused her to fall as she was walking out of resident #2 room and sustained a knee scrape on both knees. These failures have the potential to result in serious injury or death as a result of abuse. The findings included:Record review of Resident #1's face sheet revealed an [AGE] year-old female initially admitted on [DATE], with diagnoses of Alzheimer's Disease with late on set (a progressive disease that destroys memory and other important mental functions), Insomnia(a common sleep disorder characterized by difficulty falling asleep, staying asleep, or both, leading to insufficient or poor-quality sleep),Unspecified mood disorder, Dementia (A group of thinking an social symptoms that interferes with daily functioning), Anxiety(a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), depression(a group of conditions associated with the elevation or lowering of a person's mood). Record review of Resident #1's MDS Quarterly dated 06/03/2025 revealed Resident #1 had a BIMS Score of 06-severe cognitive impairment and needed extensive assistance with all ADLs.Record review of Resident #1's Care Plan date initiated on 06/30/25 revealed Resident #1 had an ADL self-care performance deficit related to Alzheimer's Dementia and is resistant to care from staff. Resident #1 is dependent on staff for meeting emotional, intellectual, physical, and social needs related to Alzheimer's disease, Dementia, Depression, Anxiety, and Mood Disorder. Intervention included administered psychoactive medications as ordered monitored and documented for side effects and effectiveness. Monitor and record mood to determine if problems seem to be related to external causes for example medications, treatments, concern over diagnosis. Observe for signs and symptoms of mania or hypomania racing thoughts or euphoria; increased irritability; frequent mood changes; pressured speech; flight of ideas; marked change in need for sleep; agitation or hyperactivity. [NAME] is an elopement risk/wanderer related to Dementia and her interventions included distracting resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book.Record review of Resident #1's progress notes dated 06/13/2025 to 07/14/2025 revealed on 06/26/25 at 5:15 PM Resident #1 was noted by CNA wandering into Resident's #2 room. Resident #1 walked out of Resident's #2 room when the CNA saw Resident #1 be pushed from behind by Resident #2 and landed on her knees. Resident #1 noted with redness and small superficial abrasions to both knees and no swelling was noted. Resident #2 refused to have vital signs taken, refused as needed pain medication, and refused complete head-to-toe assessment. Resident#2 yelled out, Get away from me. You're hurting me. The physician was notified along with facility administrator and director of nursing. Patient family member was also notified. Patient showing no signs of distress noted at this time.Record review of Resident #1's incident report conducted by Administrator/Abuse Coordinator dated 06/26/25 at 7:05 AM, Incident revealed Resident #1 wondered to Resident #2 doorway. When Resident #1 was leaving Resident #2 pushed Resident #1 from behind and caused her to fall to her knees in the hall and causing small abrasions to both knees. Resident #2 is a [AGE] year-old female initially admitted on [DATE] with diagnosis of Alzheimer's Disease with early onset, frontotemporal neurocognitive disorder, dementia with behavior disturbance, restlessness and agitation, insomnia, major depressive disorder, personal history of urinary tract infections.Record review of Resident #2's Quarterly MDS dated [DATE] revealed a BIMS score of 05-severe cognitive impairment and needed extensive assistance with all ADLs no behaviors were noted in the assessment. Record review of Resident #2's Care Plan date initiated 06/26/25 revealed, the resident has an ADL self-care performancedeficit related to a diagnosis of Dementia. Resident #2 is dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits Resident #2 is at risk for distressed and fluctuating mood symptoms related to anxiety and depression. Resident #2 displays agitation and restlessness and prefers to eat meals away from other residents due to anxiety and noise. Monitor, document, and report as needed any adverse reactions to anti-anxiety therapy like drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and impulsive behavior, hallucinations. judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects include Mania, hostility, rage, aggressive or impulsive behavior, hallucinations