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	03/18/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 of 5 residents (Resident #1) reviewed for accuracy and completeness of clinical records.The facility failed to ensure LVN A documented Resident #1's blood pressure on the eMAR when Resident #1's amlodipine (blood pressure medication) was held on March 3rd, 8th, 12th, and 16th of 2026. This failure could place residents at risk of not receiving proper care or having needs met due to inappropriate documentation.The findings included:Record review of Resident #1's face sheet dated 03/17/26 revealed a [AGE] year-old female with an original admission date of 04/27/21 and a current admission date of 05/05/25. Diagnosis included Essential Primary Hypertension (chronic high blood pressure with no single, identifiable cause, developing slowly over time). Record review of Resident #1's Comprehensive MDS assessment dated [DATE] revealed a BIMS score of 7 which indicated severe cognitive impairment. Record review of Resident #1's comprehensive care plan dated 03/17/26 revealed the problem The resident has hypertension initiated 05/06/25. An intervention listed for the problem included Give anti hypertensive medications as ordered. initiated on 05/06/25. Record review of Resident #1's order summary dated 03/17/26 revealed an active order for amlodipine oral tablet 10 mg Give 1 tablet by mouth one time a day for hypertension related to ESSENTIAL (PRIMARY) HYPERTENSION. Hold for blood pressure less than 100/60 initiated on 05/06/25. Record review of Resident #1's eMAR for March 2026 revealed no blood pressure was recorded on 03/03/26, 03/08/26, 03/12/26, and 03/16/26. All dates were signed by LVN A indicating amlodipine was held because Resident #1's blood pressure was less than 100/60. In an interview with LVN A at 8:37 AM on 03/18/26, LVN A stated she always checked Resident #1's blood pressure before administering any blood pressure medication. LVN A stated when she held amlodipine she was able to sign the eMAR without entering the blood pressure she had measured. LVN A stated she was confident Resident #1's blood pressure was outside of the physician's parameters on the 4 days she held the medication in March. LVN A stated it was important to have accurate and complete documentation in a resident's medical record in case their medications needed to be adjusted or any trends in the blood pressure readings needed to be monitored. In an interview with the DON at 9:09 AM on 03/18/26, the DON stated a resident's blood pressure should always be measured before any blood pressure medication was administered. The DON stated the blood pressure should be documented in the eMAR regardless of whether the medication was administered. The DON stated it was important to always document blood pressure readings so an accurate history could be obtained when reviewing a resident's medical record to adjust medication dosages appropriately. Record review of the facility policy Medication Administration dated 10/24/22 revealed the following policy: .17. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR.

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