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	03/21/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 45411 Based on interview and record review, the facility failed to ensure an accurate MDS was completed for 2 of 18 residents (Resident #10 and #18) reviewed for MDS assessment accuracy. 1. The facility failed to accurately document Resident #18's pacemaker on his MDS. 2. The facility inaccurately documented that Resident #10 used restraints on her MDS. This failure could place residents at risk for not receiving care and services to meet their needs. Findings included: Resident #10 Record review of Resident #10's admission record indicated she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, lack of coordination, abnormal posture, reduced mobility, and a history of falling. She was [AGE] years old. Record review of Resident #10's Quarterly MDS assessment dated [DATE] indicated: Section P - Restraints and Alarms, P0100. Physical Restraints - A. Bed rail was used less than daily. Record review of Resident #10's care plan dated 03/21/24 indicated: Problem: Resident uses DME. Resident has quarter side rails to assist with repositioning and transfers. Goal: Resident will experience no injury from the use of DME through the next review date (most recent revision date 09/25/23). (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: Assess for adverse effects of DME use such as incontinence, skin breakdown, decrease functional ability and confusion, and consult with physician. Ensure valid consent on chart prior to initializing restraint. Monitor for changes in mental status and changes in functional level and report to MD as needed. Record review of Resident #10's physician order summary report dated 03/21/24 indicated in part: 2 quarter side rails to assist her with bed mobility and transfers (order status active; order date 02/01/23) Resident #18 Record review of Resident #18's admission record dated 03/20/2024 indicated he was admitted to the facility on [DATE] with diagnoses of Parkinson's and pacemaker. He was [AGE] years of age. Record review of Resident #18's MDS with an ARD (assessment reference date) of 01/09/2024 did not indicate Resident #18 used a pacemaker. Record review of Resident #18's physician order report dated 3/21/24 indicated in part: Check pacemaker order status active. During an interview on 03/21/24 at 11:26 AM, the DON stated that Resident #10's bed rails were not in use as a restraint so there would not be anything in the charting system to indicate they were. She stated that the MDS nurse told her (the DON) that she had accidently checked the bed rails button in the restraint section when she was completing Resident #10's most recent quarterly MDS. The DON stated that an MDS modification had already been started to correct the error. The DON stated that the bed rails were never intended to be a restraint for Resident #10 and that she only used the bed rails for positioning and mobility while she was in bed. The DON stated she was not sure how both she and the MDS Coordinator overlooked that the restraint section of the Quarterly MDS had information checked when Resident #10 had never had that section populated before. During an interview on 03/21/24 at 12:04 PM, the MDS Coordinator said Resident #18's pacemaker should have been on the MDS, but it got missed. The MDS coordinator said they would have to update the MDS to indicate the resident had a pacemaker. During an interview on 03/21/24 at 12:05 PM, the DON said it was her responsibility to make sure the MDS's were updated and revised as needed and that she had not noticed that the pacemaker was not in the Resident #18's MDS and that it should have been. During an interview on 03/21/24 at 2:07 pm, the MDS Coordinator stated that she had no idea why she checked the bed rails box in the restraint section of Resident #10's Quarterly MDS. She stated she had always coded Resident #10 as no restraints on her past MDS assessments. She stated it was just human error. She stated she had made the correction and submitted the modification MDS for approval. The MDS Coordinator stated that type of error could affect a resident's care plan, quality measures, the type and amount of documentation to be done for or on the resident, the monitoring and daily care for the resident as well as the possible adverse effects of a resident being treated as though they had restraints when they did not. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1, October 2024 reflected The RAI process has multiple regulatory requirements . (1) the assessment accurately reflects the resident's status.

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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** 30057 45399 Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 18 residents (Residents #18 and #61) reviewed for care plans in that: The facility failed to ensure Resident #18's Care Plan addressed his pacemaker. The facility failed to ensure Resident #61's Care Plan addressed her code status. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings included the following: Resident #18 Record review of Resident #18's admission record dated [DATE] indicated he was admitted to the facility on [DATE] with diagnoses of Parkinson's and pacemaker. He was [AGE] years of age. Record review of Resident #18's Minimum Data Set (MDS) assessment dated [DATE] indicated in part: Brief Interview Mental Status score was 11 indicating resident had moderately impaired cognition. Record review of Resident #18's care plan revealed his pacemaker had not been care planned. Record review of Resident #18's physician order report dated [DATE] indicated in part: Check pacemaker order status active. Resident #61 Record review of Resident #61's face sheet dated [DATE], indicated he was admitted to the facility on [DATE] with diagnosis of Alzheimer's Disease, dementia, cognitive communication deficit, aphasia (difficulty speaking), anxiety disorder(feelings of fear and anxiety), history of falls, and major depressive disorder (chronic depression) . He was [AGE] years of age. Record review of Resident #61's Minimum Data Set (MDS) dated [DATE] indicated in part: Brief Interview Mental Status = of 0 out of 15 indicating severe cognitive impairment. Record review of Resident #61's care plan revealed his code status had not been care planned. (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 #61's physician order report dated [DATE] indicated in part: CPR (Full Code). During an interview on [DATE] at 12:47 PM, the Social Worker stated that she was solely responsible for starting care plans for code status on all admissions. The Social Worker stated she was unsure why code status was not showing up in the electronic medical records under care plans. During an interview on [DATE] at 11:56 AM, the MDS Coordinator said Resident #18's pacemaker should have been care planned but it got missed. The MDS Coordinator said they would have to update the care plan. During an interview on [DATE] at 11:57 AM, the DON said it was her responsibility to make sure the care plans were updated as needed and that she had not noticed that the pacemaker was not care planned for Resident #18 and it should have been. During an interview on [DATE] at 02:02 PM, the Administrator was made aware that Resident #18's pacemaker was not care planned. The Administrator said it should have been care planned and the pacemaker not being care planned could lead to improper care of the resident. Review of facility policy Comprehensive Care Plans dated [DATE] revealed in part: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights , that includes measurable objectives and timeframes to meet a residents medical , nursing, and mental and psychological needs that are identified in the comprehensive assessment. Person centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #18 and #59) of 4 residents reviewed for infection control. 1. The facility failed to ensure CNA A washed or sanitized her hands prior to putting gloves on or changing her gloves after they became contaminated during incontinent care while assisting Resident #18. 2. The facility failed to ensure CNA B washed or sanitized her hands prior to putting gloves on or changing her gloves after they became contaminated during incontinent care while assisting Resident #59. This failure could place resident's risk for cross contamination and the spread of infection. Findings include: RESIDENT #18 Record review of Resident #18's admission record dated 03/20/2024 indicated he was admitted to the facility on [DATE] with diagnoses of Parkinson's, muscle wasting and atrophy (loss of skeletal muscle mass). He was [AGE] years of age. Record review of Resident #18's MDS dated [DATE] indicated Resident #18's BIMS score was 11 indicating the resident's cognition was moderately impaired. Urinary continence = Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding). Bowel continence = Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement). Record review of Resident #18's care plan dated 02/15/24 indicated in part: Problem: Resident has actual and or potential impairment to skin integrity r/t Parkinson's and incontinence and confusion. Goal: Resident will have no skin complications/impairments through the review date. Interventions: Apply moisture barrier cream to groin/peri area every shift until healed. Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Preventative skin care after incontinent episodes per facility protocol. C.N.A's to apply barrier cream as needed after incontinent episodes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 03/19/24 at 11:15 AM, CNA A performed incontinent care for Resident #18. CNA A entered the resident's room and put gloves on without washing or sanitizing her hands first. CNA A performed peri-care by wiping the resident's penis and scrotum area. The resident had urinated, and the brief was wet. CNA A then removed her gloves and put on a pair of new gloves without washing or sanitizing her hands. CNA A then took a wet wipe and wiped the resident's rectal area, removed the old brief from underneath the resident and placed it in the trash. CNA A then took a clean brief fastened it to the resident, pulled his pants back on while wearing the same gloves that were used to wipe the resident's rectal area and remove the old brief. During an interview on 03/19/24 at 11:24 AM CNA A said she normally washed or sanitized her hands prior to performing patient care. CNA A said she had gotten nervous and forgotten to wash or sanitize her hands prior to putting gloves on. CNA A said she should have changed her gloves prior to touching the new brief and pulled Resident #18's pants up. CNA A said if she did not wash her hands or changed her gloves it could lead to cross contamination and spread of germs. CNA A said the failure occurred because she got nervous and missed some of the steps. Resident #59 Record review of Resident #59's admission record dated 03/21/2024 indicated resident was admitted to the facility on [DATE] with diagnosis that include Alzheimer's Disease with Early onset, Dementia, history of falling, pain, and muscle wasting and atrophy. Resident #59 was [AGE] years of age. Record review of Resident #59's MDS dated [DATE] indicated her BIMS score was 99 indicating resident was unable to be interviewed for mental status. The MDS revealed the resident had short and long-term memory problems, and her Cognitive skills for daily decision making was severely impaired. Resident #59's MDS indicated she was always incontinent of urine (no episodes of continent voiding) and always incontinent of bowel movements (no episodes of continent bowel movements). During an observation on 03/19/24 at 11:40 AM, CNA B entered Resident #59's room and donned gloves without washing hands or using hand sanitizer first. CNA B performed perineal care for Resident #59 by wiping the resident's vaginal area front to back. The resident was turned to the side and CNA B wiped the resident's bottom. CNA B removed the urine soiled brief from under the resident and discarded it in the trash. Without changing gloves, CNA B placed the clean brief under the resident. The resident was then turned to allow the brief to be adjusted. CNA B removed gloves and did not use hand sanitizer or washed hands. CNA B then pulled the resident's pants up and covered resident with a blanket. CNA B gathered and removed the trash from the room. During an interview on 03/20/24 at 01:59 PM, LVN D stated that staff should be performing hand hygiene prior to performing incontinent care. LVN D stated staff should be sanitizing their hands between glove changes between dirty and clean steps of incontinent care. LVN D stated that after incontinent care, after throwing trash away, staff should wash their hands. CNA B was unavailable for interview. During an interview on 03/21/24 at 12:08 PM, the DON said it was her expectation for staff to wash or sanitize their hands prior to putting gloves on. The DON said staff were expected to wash or sanitize their hands in between glove changes. The DON said staff were expected to change their gloves when they went from dirty to clean. The DON said if staff did not wash or sanitize their hands or changed gloves at the appropriate times it could lead to cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/21/24 at 02:00 PM, the Administrator was made aware of CNA A's incontinent care observation. The Administrator said the CNA should have washed or sanitized her hands prior to putting on gloves. Th Administrator said the CNA should have changed gloves prior to touching the clean brief and Resident #18's clothes. The Administrator said the failure could lead to cross contamination and spread of germs. Record review of the facility's policy titled Perineal care dated 10/24/22 indicated in part: It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible and to prevent and assess for skin breakdown. Perineal care refers to care of the external genitalia and the anal area. Perform hand hygiene and put on gloves. If perineum is grossly soiled turn resident on side remove any fecal material with toilet paper, then remove and dis/card. Cleanse buttocks and anus, front to back; vagina to anus females, scrotum to anus in males, using a separate washcloth or wipes. Re-position resident in supine position. Change gloves if soiled and continue with perineal care. Record review of the facility's policy titled Hand hygiene dated 10/24/22 indicated in part: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub. Staff will perform hand hygiene when indicated using proper technique consistent with accepted standards of practice. The use of gloves does not replace hand hygiene. If you task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.