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	05/22/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided with care consistent with professional standards of practice, physicians orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 3 of 5 (Resident #32, #47, #2) residents reviewed for respiratory care. The facility failed to ensure Resident #32's oxygen was administered at the physician's orders of 2.5 liters per minute on 05/19/25. The facility failed to ensure Resident #47's oxygen was administered at the correct setting of 3 liters per minute on 05/20/2025 at 8:56 AM. The facility failed to ensure Resident #2's oxygen was administered at the correct setting of 3 liters per minute on 05/19/2025 at 10:31 AM. These failures could place residents at risk for symptoms and manifestations of hypoxia, the decreased perfusion of oxygen to the tissues and a decreased quality of care. The findings include: facility on 04/12/24. Resident #32 had a diagnosis which included Review the physician's orders or facility protocol for oxygen administration. Resident #47's oxygen was administered at the incorrect setting of 2.5 liters per minute on 05/20/25 at 8:56 AM. Respiratory Failure with Hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions), Shortness of breath, Hypoxemia (A low level of oxygen in the blood), and Chronic Obstructive Pulmonary Disease (A group of lung diseases that block airflow and make it difficult to breathe). Record review of Resident #32's physician order summary dated 04/25/25 revealed O2 at 3 Liters Per Minute via nasal cannula continuously maintain O2 saturation greater than 92 percent as needed for hypoxia. Record review of Resident #32 Care plan revealed Resident #32 has oxygen therapy related to COPD respiratory failure, shortness of breath, and hypoxia. Interventions dated 07/11/2024 O2 via nasal prongs at 2-3 Liters continuous. Record review of Resident #32's Significant Change Minimum Data Set, dated [DATE] revealed an active diagnosis of CODP (Chronic Obstructive Pulmonary Disease), Respiratory failure, Dyspnea (shortness of breath) with exertion and lying flat. (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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview of Resident #32 on 05/20/25 at 08:56 AM revealed oxygen tubing was connected, oxygen setting was at 4.50 liters per minute, Resident #32 stated she was doing fine. No respiratory distress noted. Record review of Resident #47's face sheet, dated 05/21/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #47 had a diagnosis which included Acute Respiratory Failure with Hypoxia, Pneumonia due to Coronavirus, Pleural Effusion (a buildup of fluid between the tissues that line the lungs and the chest), and Chronic Obstructive Pulmonary Disease and shortness of breath. The physician's orders or facility protocol for oxygen administration. Resident #2's oxygen was administered at the incorrect setting of 2.5 liters per minute on 05/19/25 at 10:31 AM. Record review of Resident #47's physician order summary dated 05/15/25 revealed, O2 at 3 Liters Per Minutes via nasal cannula continuously maintain O2 sats greater than 92% as needed for hypoxia. Record review of Resident #47's care plan revealed the resident had oxygen therapy related to hypoxia initiated on 01/21/25. The care plan interventions indicated oxygen settings of O2 via nasal cannula as ordered. Record review of Resident #47's Minimum Data Set, dated [DATE] revealed an active diagnosis of Active Pneumonia, Asthma COPD (Chronic Obstructive Pulmonary Disease), Respiratory failure, Chronic Lung Disease. Observation and interview of Resident #47 on 05/19/2025 at 09:44 AM revealed that the oxygen tubing was connected and the oxygen setting was set at 2 liters per minute. Resident #47 stated she was breathing fine. Record review of Resident #2's face sheet, dated 05/19/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had a diagnosis which included COPD (Chronic Obstructive Pulmonary Disease), and Acute Respiratory Failure with Hypoxia. Record review of Resident #2 care plan dated 02/08/24 revealed she had oxygen therapy related to COPD. The interventions indicated the oxygen setting at 3 liters per minute via nasal cannula. Record review of Resident #2's physician order summary dated 05/15/25 revealed O2at 3 liters per minute via nasal cannula continuously maintain O2 sats > 92% as needed for hypoxia. Record review of Resident #2's Significant Change Minimum Data Set, dated [DATE] revealed an active diagnosis of Asthma, CODP (Chronic Obstructive Pulmonary Disease), Chronic Lung Disease, and Respiratory Failure. Observation on 05/19/25 at 10:21 AM of Resident #2 revealed resident was lying down in bed and the oxygen tubing was connected to concentrator set at 2.5 liters per minute. In an interview on 05/21/25 at :04 PM with CNA N she observed and stated Resident #32 ' s oxygen concentrator was set at 4.5 liters per minute. CNA N stated she did not know what the settings should be set at and the CNA's were not responsible for the concentrator settings. The nursing staff were responsible for checking the oxygen concentrators. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/21/2025 at 1:30 PM, CNA R R observed and stated #47 ' s oxygen concentrator was set at 2.5 liters per minute. CNA R stated she did not know what the settings should be set. The CNA's were not responsible for the settings; only the nursing staff were responsible for checking the oxygen concentrators. In an Interview with on 05/21/2025 at 1:44 PM CNA Robserved and stated Resident #2 ' s oxygen concentrator was set at 2.5 liters per minute. The CNA R stated she did not know what the settings should be. The CNA's are not responsible for the concentrator settings the nursing staff were responsible for checking the oxygen concentrators. In an interview on 05/21/25 at 1:51 PM with LVN C she stated that at the start of every shift the LVNs were responsible for ensuring the settings on the oxygen concentrators matched the physician orders. LVN C stated she had not checked the settings on the oxygen concentrator for Resident #32 the last 4 days and admitted she forgot to check them. She stated not having the correct setting can cause the CO2 levels to be high or high levels or O2 each leading to problems such as oxygen poisoning or toxicity and can lead to lung damage and potentially life-threatening complications. In an interview on 05/21/25 at 2:01 PM with LVN C she stated that at the start of every shift the LVNs are responsible for ensuring the settings on the oxygen concentrators matched the physician orders. LVN C stated she had not checked the settings on the oxygen concentrator for Resident#47 the last 4 days she had forgotten.The levels were set at 2.5 liters per minute and correct settings were to be at 3 liters per minute when verified them in the room on her laptop. She stated not having the correct setting can cause Hypoxemia to a condition of levels of oxygen in the blood are low. This can lead to insufficient oxygen delivery, potentially resulting in low blood oxygen saturation. Symptoms of low oxygen in blood are shortness of breath, chest pain, or bluish coloring of skin. In an interview on 05/21/25 at 2:14 PM with LVN C she stated that at the start of every shift the LVNs are responsible for ensuring the settings on the oxygen concentrators match the physician orders. LVN C stated she had not checked the settings on the oxygen concentrator for Resident#2. The last 4 days the levels were set at 2.5 liters per minute and correct settings were to be at 3 liters per minute and admitted she forgot to checked the settings. LVN C Verified the setting on her lab top as the interview was conducted. She stated not having the correct setting can cause Hypoxemia a condition of levels of oxygen in the blood are low. This can lead to insufficient oxygen delivery, potentially resulting in low blood oxygen saturation. Symptoms of low oxygen in blood are shortness of breath, chest pain, or bluish coloring of skin. In an interview with ADON K 05/21/25 at 2:27 PM she stated each nurse in every shift, every day, and in all wings should be checking resident oxygen concentrators as part of their rounds. ADON K stated CNA's were not responsible for the oxygen concentrators setting. Nurses should be ensuring the oxygen delivery to the resident but need to be reporting any discrepancies as soon as they find one. The ADON stated Accuracy in administrating all doctor's orders for oxygen should be followed as written by the doctor if a discrepancy is noted, it is to be suspended until it is verified by the ordering doctor. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 05/21/25 at 02:47 PM she stated any doctor's orders for oxygen are to be followed as directed. The nurse on duty for each shift was responsible for verifying the oxygen concentrator was at the correct setting each shift. Following the doctor's orders ensured that the resident was getting enough oxygen to prevent hypoxemia, hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions or oxygen toxicity. Record review of the facility's Oxygen Administration Program policy dated 10/02/2010 reflected All residents will be assessed for the Oxygen Administration at the time of admissions, on a quarterly basis, and upon significant change in condition thereafter. Based on the results of this assessment, specific interventions will be to ensure correct settings and avoid any complications. The following is a list of commonly used interventions that may be considered to minimize improper settings symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion; signs or symptoms of oxygen toxicity (i.e., tracheal irritation, difficulty breathing, or slow, shallow rate of breathing); signs or symptoms of cyanosis(bluish or grayish color of the skin, nails, lips and around the eyes

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to ensure that residents were free of significant medication errors for 2 of 8 residents (Resident #100 and Resident #235) reviewed for pharmacy services. 1. The facility failed to ensure Resident #100 received the correct dose of phenytoin sodium (anticonvulsant medication) extended oral capsule during his stay from [DATE] - [DATE] at the facility. Resident #100 received 900 mg at bedtime instead of the ordered 300 mg at bedtime for all seven nights he was in the facility, leading to a phenytoin level of 37.1 ug/mL, indicating phenytoin toxicity (normal 10-20 ug/ml). 2. The facility failed to ensure Resident #235's order for Carbamazepine (anticonvulsant medication) 2 tablets by mouth in the morning for seizures to equal 400 mg in the morning and 1 tablet by mouth at bedtime for seizures to equal 100 mg in the evening was ordered and dispensed correctly on [DATE]. Resident #235 received 200 mg at bedtime on [DATE]. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 4:25 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because new polices implemented to prevent future errors were still in process. These failures could place residents at risk of medical complications and not receiving the therapeutic effects of their medications. The findings included: Record review of Resident #100's face sheet dated [DATE] revealed a [AGE] year-old male with an admission date of [DATE] and a discharge date of [DATE]. Pertinent diagnosis included epilepsy (a neurological disorder characterized by recurrent seizures, which are episodes of abnormal brain activity). Record review of Resident #1's PPS MDS assessment dated [DATE] revealed a BIMS score of 3 (severe impairment) Record review of Resident #1's care plan dated [DATE] revealed the problem Medication error- resident received wrong dosage of dilantin (brand name of phenytoin)- order transcribed in error. dilantin toxicity of 37. 1 altered mental status initiated on [DATE] and cancelled on [DATE]. Interventions listed for the problem included: - Correct dose of medication clarified initiated on [DATE] and cancelled on [DATE]. - Sent to ER for [evaluation] and treatment initiated on [DATE] and cancelled on [DATE]. (continued on next page)

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Staff education on [medication reconciliation] initiated on [DATE] and cancelled on [DATE].

Record review of Resident #100's order summary dated [DATE] revealed a discontinued order for Phenytoin Sodium Extended Oral Capsule 300 MG (Phenytoin Sodium Extended). Give 3 capsule by mouth at bedtime for seizures created on [DATE] by LVN A and discontinued on [DATE].

Record review of the admitting orders for Resident #100 dated [DATE] listed the medication order Phenytoin Sodium Extended 100 MG Oral Capsule Dose/Route/Freq: Take 3 capsules (300 mg) by mouth daily at bedtime for seizure disorder.

Record review of the laboratory results from a local hospital dated [DATE] revealed the laboratory results for Resident #100 Phenytoin Level to be 37.1, with the stated normal range between 10.0 - 20.0 ug/mL were resulted at 3:58 pm.

Record review of the Emergency Department Note from a local hospital dated [DATE] revealed a diagnosis for Resident #100 of Phenytoin poisoning of undetermined intent at 4:54 PM.

Record review of the MAR for Resident #100 dated [DATE] revealed the order Phenytoin Sodium Extended Oral Capsule 300 MG (Phenytoin Sodium Extended) Give 3 capsule by mouth at bedtime for seizures with a start date of [DATE] and a discontinued date of [DATE]. The medication was signed off as administered on the nights of [DATE] - [DATE] by nursing staff.

Record review of the nurse progress note by LVN A dated [DATE] at 5:39 PM revealed [Resident #100] arrived to facility via family vehicle from home . [MD] notified of resident arrival, all medication list received upon admission has been approved by [MD]. Facetime visit with [MD] has been performed, no new orders received.

Record review of the change in condition note by LVN A dated [DATE] at 2:37 PM revealed [Resident #100] appearing to be weak to upper and lower extremities and noted to have a slower response to commands., started [DATE], since started it has gotten: Better.

Record review of the nurse progress note by LVN B dated [DATE] at 10:39 AM revealed [Resident #100] noted with confusion this morning, yelling and moaning that he wants to go to his room even though resident already in his room/bed . weakness, unable to feed self, unable to transfer to wheelchair. Resident RP updated on residents' condition and in agreeance to sending resident to hospital.

Record review of the nurse progress note by the DON dated [DATE] at 5:33 PM revealed Medication error noted on Dilantin dosage. MD and RP notified. Resident remains in ER for evaluation. Resident was experiencing [altered mental status] and ataxia (poor muscle control that affects balance, coordination, speech and eye movements) and slowed speech.

In an interview with LVN A on [DATE] at 12:41 PM, LVN A stated she entered the phenytoin order for Resident #100 into PCC on [DATE] when he was admitted to the facility. LVN A stated when she read the medication list, she interpreted it as 3 capsules of 300 mg at bedtime for a total of 900 mg. LVN A stated anytime she had a question about a medication order she asked an ADON or the DON for clarification, but she was confident she was correct at the time she input this order.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LVN A stated it was important for a resident to receive the correct dose of their medication because otherwise a resident could be hospitalized or possibly die. In an interview with LVN B on [DATE] at 2:21 PM, LVN B stated Resident #100's baseline level of function on [DATE] was much worse than when she last saw him on [DATE]. LVN B stated the sharp decrease in level of functioning over such a short time for Resident #100 led to her recommending he be sent to the hospital for evaluation. LVN B stated if a resident received the incorrect dose of their medication for an extended period of time it could lead to death. In an interview with ADON K on [DATE] at 2:38 PM, ADON K stated the two ADONs and DON reviewed medication orders of the previous day during their daily morning meetings. ADON K stated the DON was not at the morning meeting on [DATE], so it fell to the two ADONs to review medication orders. ADON K stated Resident #100's medication order for phenytoin was not reviewed during the morning meeting on [DATE] and she did not know exactly why they did not review it. ADON K stated after the incident they implemented a new white board system to better keep track of their tasks in morning meetings. ADON K stated if a resident received the wrong dose of a medication for an extended period, they might be hospitalized and die. In an interview with ADON L on [DATE] at 3:12 PM, ADON L stated it was both ADONs' responsibility to check the new admission orders of Resident #100 during the morning meeting of [DATE]. ADON K stated she did not know why they did not review Resident #100's phenytoin order. ADON K stated after the incident with Resident #100, they instituted a new policy where all new admission orders needed to be verified by two nurses at the time of entry into PCC. ADON K stated if a resident received the incorrect dose of one of their medications for an extended period, they could be hospitalized or even die. In an interview with the DON on [DATE] at 3:48 PM, the DON stated she was not at the facility on [DATE] for the morning meeting. The DON stated during morning meetings, the ADON's and the DON reviewed everything related to new admissions. The DON stated the ADONs should have verified the phenytoin order for Resident #100 was correct during the morning meeting on [DATE]. The DON stated since the incident, they added an initial nurse to review new admission orders that were put into PCC. The DON stated they now reviewed everything about a new admission as a group in the morning meetings. The DON stated they added a white board to organize their morning meetings, so nothing gets forgotten. The DON stated they had not had any problems since they implemented the new system. The DON stated if a resident took an incorrect dose of medication could led to a decrease in ADL's, decline in mental function, and then eventually death. In an interview with the CP on [DATE] at 5:40 PM, the CP stated she did an admission review of Resident #100's orders on [DATE]. The CP stated she caught the discrepancy on [DATE] and immediately notified the facility to investigate it. The CP stated the phenytoin order in PCC caught her attention because it was different from the admitting paperwork and the dose of 900 mg at bedtime seemed high. The CP stated she typically reviewed all new admission orders within a week of admission into the facility. The CP stated adverse effects of phenytoin toxicity included coma, confusion, tremors, nausea, and vomiting. The CP stated Resident #100 could have eventually died if they continued to receive the increased phenytoin dose but was unable to predict how long the increased dose would take to kill him. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the MD on [DATE] at 6:11 PM, the MD stated he did not remember the conversation he had with LVN A confirming Resident #100's admission orders on [DATE]. The MD stated a dose of 900 mg of phenytoin at bedtime might not catch his attention as being too high. The MD stated typically the extended-release version of phenytoin would be anywhere between 300 mg to 750 mg, but that he had seen 450 mg BID before. The MD stated phenytoin toxicity could cause cardiac arrythmias (irregular heartbeats that can be too fast, too slow, or irregular) and eventually death. The MD stated there were too many variables to determine how long death would have taken for Resident #100 at the increased dose of phenytoin. The MD stated he saw the resident on [DATE]. The MD stated they had an ad hoc meeting over Resident #100 on [DATE]. 2. Record review of Resident #235's face sheet dated [DATE] revealed an [AGE] year-old female with an admission date of [DATE]. Pertinent diagnosis included Other Seizures (sudden, uncontrolled electrical disturbances in the brain that can cause temporary changes in behavior, movement, or awareness). Record review of Resident #235's Comprehensive MDS dated [DATE] revealed a BIMS score of 11 (moderate impairment). Record review of Resident #235's comprehensive care plan dated [DATE] did not reveal anything related to carbamazepine use to prevent seizures. Record review of Resident #235's order summary dated [DATE] revealed an active order for carbamazepine Oral Tablet Chewable 200 MG (Carbamazepine) Give 1 tablet by mouth at bedtime for seizures TO EQUAL 100 MG IN THE EVENING initiated on [DATE]. The MAR also revealed an active order for carbamazepine Oral Tablet Chewable 200 MG (Carbamazepine) Give 2 tablet by mouth in the morning for seizures to equal 400 mg IN THE MORNING initiated on [DATE]. Record review of the MAR for Resident #235 dated [DATE] revealed the order carbamazepine Oral Tablet Chewable 200 MG (Carbamazepine) Give 1 tablet by mouth at bedtime for seizure TO EQUAL 100 MG IN THE EVENING with a start date of [DATE]. The medication was signed off as administered on the nights of [DATE] - [DATE] by nursing staff. In an interview with LVN C on [DATE] at 10:55 AM, LVN C stated she administered medications to Resident #235 on the evening of [DATE]. LVN C stated Resident #235 requested that her medications were crushed before she ingested them. LVN C stated she did not remember specifically about the carbamazepine if she gave the full 200 mg tablet or not. LVN C stated she did not break any tablets in half before crushing them to administer them to Resident #235. LVN C stated it was important to give the correct dose of medication to a resident so it could have its intended therapeutic effect. In a follow-up interview with the CP on [DATE] at 12:13 PM, the CP stated if Resident #235 received an extra 100 mg in the evening one time, she may experience slight sedation related side effects. The CP stated the overall harm caused to the resident could have been minimal after just one dose with the minor daily dose increase from 500 mg to 600 mg. During an observation of the 500-hall medication cart on [DATE] at 12:42 PM, there were no tablets of carbamazepine that were 100 mg for Resident #235, only 200 mg tablets. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a follow-up interview with the DON on [DATE] at 12:45 PM, the DON stated the interventions they implemented after the first incident involving Resident #100 focused on ensuring new admittance orders were accurate. The DON stated the carbamazepine order could have been more precise, but it was a different issue since it was not a new admittance order. The DON stated if a nurse found a discrepancy between the MAR and the label on the medication, they should verify what the correct order was by calling the doctor. In an interview with LVN D on [DATE] at 1:50 PM, LVN D stated she administered medications to Resident #235 on the evenings of [DATE] and [DATE]. LVN C stated she cut the 200 mg carbamazepine tablet in half before she administered it to Resident #235. LVN D stated giving the wrong dose of a medication to a resident could harm them. Record review of the facility policy titled Medication Administration implemented on [DATE] revealed the following: .20. Correct any discrepancies and report to nurse manager. Record review of the facility policy titled Medication Reconciliation implemented on [DATE] revealed the following: .4. admission Processes: a. Verify resident identifiers on the information received. b. Compare orders to hospital records, etc. Obtain clarification orders as needed. c. Transcribe orders in accordance with procedures for admission orders. d. Order medications from pharmacy in accordance with facility procedures for ordering medications. e. Verify medications received match the medication orders. 5. Daily processes: .b. Verify medication labels match physician orders and consider rights of medication administration each time a medication is given. c. Obtain and transcribe any new orders in accordance with facility procedures. Obtain clarification as needed. d. Order medications from pharmacy in accordance with facility procedures for ordering medications. e. Verify medications received match the medication orders. This was determined to be an Immediate Jeopardy (IJ) on [DATE]. The ADM and DON were notified. The ADM was provided with the IJ template on [DATE] at 4:25 PM. The following Plan of Removal submitted by the facility was accepted on [DATE] at 9:02 AM: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[DATE] LETTER OF CREDIBLE ALLEGATION FOR REMOVAL OF IMMEDIATE JEOPARDY Attention Sir or Madam: On [DATE], the Facility was notified by the surveyor that immediate jeopardy had been called and the Facility needed to submit a letter of removal. The Facility respectfully submits this Letter for a Plan of Removal pursuant to Federal and State regulatory requirements. The immediate jeopardy is as follows: Issue: F 760 - Medication Error The facility failed to: - The facility failed to ensure Resident #100 received the correct dose of phenytoin sodium extended oral capsule during his stay from 04/17 /25 - [DATE] at the facility - The facility failed to ensure Resident #235's order for Carbamazepine 2 tablets by mouth in the morning for seizures to equal 400 mg in the morning and give 1 tablet by mouth at bedtime for seizures to equal 100 mg in the evening was ordered and dispensed correctly on [DATE]. Actions for Resident Involved - Resident # 100 was discharged on [DATE]. - On [DATE], the licensed nurse completed a head-to-toe assessment, vital signs and neurological check on Resident #235 and findings revealed no abnormalities noted. Attending physician was notified and no new orders were given. Identify residents who could be affected: - On [DATE], the Director of Nursing and/or Designee completed medication reconciliations to ensure that medications are given as ordered and documented on the MAR. (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	05/22/2025

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- On [DATE], the Director of Nursing and/or designee conducted a review of all residents' changes in conditions, changes in level of care and signs and symptoms that possibly could have been medication toxicity for the last 30 days. None was identified. - On [DATE], the Director of Nursing and/or designee conducted a review of all admissions/readmissions and ER visits for the last 30 days to ensure medication orders are reconciled. - On [DATE], the Director of Nursing and/or designee conducted a toxicity Monitoring orders for all drugs with narrow therapeutic range and were added to EMAR. - On [DATE], DON and/or Designee completed 100% medication reconciliation and MAR to Cart audit to ensure that medication on hand matches order and are administered as ordered. Action Taken/ System Change: - On [DATE], All licensed nurses were re-educated by the Director of Nursing or designee on the following: - Abuse/Neglect and Exploitation - Medication Administration Policy and Seven Rights of medication administration - Medication Reconciliation - Change of Condition-signs/symptoms of medication toxicity and Md/RP notifications - Clinical admission Process in EMR completed on [DATE] - 2 nurse verification on all new admission/readmission orders (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- On [DATE], 100% licensed nurses were re-educated on the following: - Medication Administration Policy and Seven Rights of medication administration - Medication Reconciliation on new and medication order changes - Verification of medication label prior to medication administration - Beginning [DATE], licensed nurses who are out on PTO/ FMLA/ Leave of Absence will have the re-education completed prior to the start of their next scheduled shift. - Beginning [DATE] and ongoing, newly hired licensed nurses will receive this training during orientation prior to providing care to residents. The training will include the above-stated educational components. - Admission/readmission/new and medication order changes will be reviewed during the morning clinical meeting to ensure orders have been reconciled with hospital records and verified with physician. New and medication order changes will be reviewed to ensure medication is administered as ordered to include verification of medication label to match physician's orders. Review will also ensure that monitoring of adverse effects is ordered, completed, and documented and physician is notified for abnormal findings. - Weekend RN and/or ADON will complete and review Medication reconciliation for admission/readmissions/new orders/medication order changes over the weekend. Completion date: [DATE] Monitoring: - (continued on next page)

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Beginning [DATE] and going forward, the Director of Nursing will monitor compliance with medication administration policy and the seven rights of medication administration. - Beginning [DATE] and going forward, Director/Designee will monitor compliance each weekday morning of new admission/readmission reconciliation completion and review medication order listing report to ensure new and changed medications are administered as ordered. - Beginning [DATE], the Administrator will attend the morning clinical meeting to ensure the Director of Nursing and/or designee reviews the order listing and medication reconciliation process is followed during clinical meetings. - On [DATE], An Ad Hoc QAPI meeting was held with the Medical Director, Facility Administrator, Director of Nursing, and Regional Clinical Specialist to review the plan of removal. We respectfully submit this action plan for the removal of Immediate Jeopardy. Administrator Verification of Plan of Removal: In interviews beginning on 12:41 PM on [DATE] and ending on [DATE] at 1:47 PM with staff from multiple shifts, the DON, ADM, LVN A, LVN B, LVN C, LVN D, RN E, LVN F, LVN G, LVN H, RN I, LVN J, ADON K, ADON L, LVN M, CNA N, CNA O, CNA P, RN Q, CNA R, CNA S and LVN T were able to identify the proper procedures to follow when creating new admittance orders, recognizing possible side effects of various drug toxicities, identifying high risk drugs that needed to be monitored more closely, and what to do when they encountered a discrepancy with an order. Record review and verification of the corrective action implemented by the facility beginning on [DATE]: - On [DATE], completed medication reconciliations to ensure that medications were given as ordered and documented on the MAR - verified by interview with the DON on [DATE]. - On [DATE], conducted a review of all residents' changes in conditions, changed in level of care and signs and symptoms that possibly could have been medication toxicity for the last 30 days - verified by interview with the DON on [DATE] and record review of change of condition list. - (continued on next page)

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE], conducted a review of all admission/readmissions and ER visits for the last 30 days to ensure medication orders are reconciled - verified by interview with the DON of [DATE]. - On [DATE], conducted a toxicity monitoring orders for all drugs with narrow therapeutic range and added to MAR - verified by interview with the DON on [DATE] and the CP on [DATE]. - On [DATE], completed 100% medication reconciliation and MAR to cart audit to ensure that medication on hand matches orders were administered as ordered - verified by interview with the DON on [DATE] and observation of med pass by this state surveyor on [DATE]. - On [DATE], all licensed nurses were re-educated by the DON on abuse/neglect, medication administration, medication reconciliation, change of condition signs and symptoms, clinical admission process, two nurse verification on all new admission/readmission orders - verified by interview with the DON on [DATE] and various staff from [DATE] - [DATE]. Staff were able to explain the various processes that were put in place. - On [DATE], 100% of licensed nurses were re-educated on medication administration policy, medication reconciliation, and verification of medication label prior to medication administration - verified by interview with the DON on [DATE] and various staff from [DATE] - [DATE]. Staff were able to explain the various processes that were put in place. - Admission/readmission/new and medication order changes will be reviewed during the morning clinical meeting to ensure orders have been reconciled with hospital records and verified with physician. New and medication order changes will be reviewed to ensure medication is administered as ordered to include verification of medication label to match physician's orders. Review will also ensure that monitoring of adverse effects is ordered, completed and documented and physician is notified for abnormal findings - verified through interview with the DON on [DATE]. - Weekend RN and/or ADON will complete and review medication reconciliation for admission/readmissions/new orders/medication order changes over the weekend - verified by interview with the DON on [DATE]. - (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Beginning [DATE], the DON will monitor compliance with medication administration policy and the seven rights of medication administration by keeping up with staff training. - verified by interview with the DON on [DATE]. - Beginning on [DATE], the DON will monitor compliance each weekday morning of new admission/readmission reconciliation completion and review medication order listing report to ensure new and changed medications are administered as ordered - verified by interview with the DON on [DATE]. - Beginning on [DATE], the ADM will attend the morning clinical meeting to ensure the DON or designee reviews the order listing and medication reconciliation process is followed during clinical meetings - verified by interview with the ADM on [DATE]. - On [DATE], an Ad Hoc QAPI meeting was held with the MD, ADM, DON, and Regional Clinical Specialist to review the POR - Verified by interview with the ADM and DON on [DATE] and record review. The ADM was informed the Immediate Jeopardy was removed on [DATE] at 4:10 PM. The facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.