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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056127 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/03/2024 |
| NAME OF PROVIDER OR SUPPLIER Live Oak Rehab Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 537 W Live Oak San Gabriel, CA 91776 | |

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) |
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| <p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48143</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three sampled resident (Resident 1) was free of unnecessary physical restraint (any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person). On 4/1/2024 at 3:30 am, Licensed Vocational Nurse (LVN) 1 and LVN 2, tied Resident 1 with a white linen from waist down, and tied at the back of the wheelchair which restricted the resident from movement and getting up from her wheelchair.</p> <p>This deficient practice resulted to unnecessary restraint and placed the resident at risk of physical harm from impeding the circulation of resident's whole body from the restraint and it can also cause psychosocial harm, skin break down for Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s admission record, it indicated Resident 1 was initially admitted on [DATE] and readmitted on [DATE], with diagnoses of, unspecified cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain), encounter for attention to gastrostomy (a surgical opening into the stomach. a gastrostomy may be used for feeding, usually via a feeding tube called a gastrostomy tube) dysphagia (swallowing difficulties) and anxiety disorder (persistent and excessive worry that interferes with daily activities).</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 1/3/2024, the MDS indicated Resident 1 was not able to follow commands, and required moderate assistance with the toilet, personal hygiene, change of position and transfer.</p> <p>A review of the Resident 1 history and physical, dated 1/12/2024, indicated Resident 1 does not have the capacity to understand and make decisions.</p> <p>During an interview on 4/2/2024 at 10:01 am, with the Director of Nurses (DON), the DON stated her LVN (Licensed Vocational Nurse) 1 reported to her about Resident 1 was restrained by a fitted bedsheet to her own wheelchair on 4/1/2024 morning near Nursing Station 1 7:15 am.</p> <p>(continued on next page)</p> |

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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| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: Facility ID: 056127 | If continuation sheet Page 1 of 3 |

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| <p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 4/2/2024 at 11:32 am, with LVN 1, LVN 1 stated she was checking for Resident 1 ' s G-tube (a tube inserted through the belly that brings nutrition directly to the stomach site) for assessment around 8 am on 4/1/2024 in the shower room with Certified Nursing Assistant 1 (CNA1) and Resident 1. LVN1 stated CNA1 reported to her about Resident 1 was restrained by a white linen/ bed sheet in her wheelchair on 4/1/024 morning when CNA1 came to work on 4/1/20224 morning around 7:05 am.</p> <p>During a telephone interview on 4/2/2024 at 12:58 pm, with (CNA1). CNA1 stated Resident 1 was not in her own room. CNA1 stated she found Resident 1 in Nursing Station 1 near the front lobby area as soon as she arrived at work around 7 am on 4/1/2024. CNA1 stated Resident 1 was in her wheelchair with a white linen/ bedsheets tied around the resident ' s waist to the back of her own wheelchair on 4/1/2024 around 7 am. CNA1 stated she reported about Resident 1 ' s restraint to LVN 1 in the shower room.</p> <p>During an observation and interview on 4/2/2024 at 9:25 am in Resident 1 ' s room. CNA3 and LVN1 was changing Resident 1. Resident 1 was asked if she knew where she is, and Resident 1 stated I do not know my name.</p> <p>During a telephone interview on 4/2/2024 at 3:55 pm, with LVN 3, LVN3 stated she was assisting LVN2 to monitor Resident 1 for the night of 3/31/24 for the shift of 11 pm to 7 am of 4/1/2024. LVN3 stated LVN2 and LVN3 had tried to put Resident 1 ' s abdominal binder (compression belts that encircle abdomen) backward, Resident 1 was able to get it off. LVN3 stated LVN2 and her then tried to put a white bed sheet around Resident 1 ' s waist area to prevent her from pulling out her G-tube again. LVN3 stated the time was near 4 am when they tied Resident 1 ' s waist with a white bedsheets and tied it at the back of wheelchair.</p> <p>During a concurrent interview and facility ' s surveillance video located at Nursing Station 1 review on 4/2/2024 at 4:15 pm with the DON and Administrator (ADM), the DON and ADM validated in the surveillance video time stamped on 4/1/24 at 3:30 am Resident 1 sitting on the wheelchair while LVN 2 and LVN 3 tying Resident 1 with a white linen around the waist and tied it to the back of the wheelchair. The facility ' s video surveillance also showed, LVN2 and LVN3 placing a resident gown on top of the tied white bed sheet.</p> <p>During a concurrent interview and record review on 4/3/2024 at 2:25 pm with the DON, the facility ' s policy, and procedure (P&P) titled, Use of Restraints, revised in April 2017 was reviewed. The P & P indicated, Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. The DON stated LVN2 and LVN3 should have tried to put Resident 1 ' s abdominal binder back a few more times to R1 instead of tying the resident with a white bedsheets to her wheelchair.</p> <p>During a concurrent interview and record review on 4/3/2024 at 2:30 pm with ADM, ADM stated LVN2 and LVN3 were not supposed to use physical restrain to the facility ' s residents for safety purpose without trying other less restrictive alternatives.</p> <p>(continued on next page)</p> | | |

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