

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 04/16/2025
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>49537</p> <p>Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse (willful infliction of injury which includes, but is not limited to, hitting, slapping, punching, biting, and kicking) for one of two sampled residents (Resident 1). On 4/10/2025 at around 4:42 PM, Certified Nurse Assistant 1 (CNA 1) grabbed Resident 1's shirt from the back and caused the shirt to choke Resident 1 from the neck area and CNA 1 slap Resident 1's back which made a loud smacking noise.</p> <p>This failure resulted in Resident 1 to experience physical abuse from CNA 1 and had the potential to affect the resident's emotional, mental, and psychosocial (relating to social factors and individual thought and behavior) well-being.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 3/11/2025 with diagnoses that included, but not limited to, delirium (a serious disturbance in a person's mental abilities that results in a decreased awareness of one's environment and confused thinking), depression (a common and serious mental health disorder that negatively affects how you feel, think, act, and perceive the world), dementia (a progressive state of decline in mental abilities), and mood disorder (a mental health condition characterized by persistent and significant changes in mood that interfere with daily functioning and well-being).</p> <p>During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 3/1/2025, the MDS indicated Resident 1 had severe impairment of cognitive (capable of remembering, learning new things, concentrating or making decisions that affect everyday life) skills for daily decision making. The MDS indicated Resident 1 required set up or clean up assistance (Helper sets up or cleans up; resident completes the activity. Helper assists only prior to or following the activity) with eating, oral, and personal hygiene. The MDS indicated Resident 1 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with upper body dressing. The MDS indicated Resident 1 required partial/moderate assistance (Helper lift, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, lower body dressing and putting on/taking off footwear. The MDS also indicated Resident 1 required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathing self.</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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/15/2025 at 2:47 PM with CNA 2, CNA 2 stated she was at the nurses' station 1 on 4/10/2025 around 4:42 PM when CNA 1, who was assigned one-to-one monitoring (1:1 monitoring involves a single staff member providing continuous supervision to a resident for a specific period, ensuring their safety and well-being) for Resident 1, held Resident 1's shirt from the back which also caused the shirt to choke Resident 1 from the front neck area as Resident 1 got up from the chair. CNA 2 stated as Resident 1 started to walk towards the desk, Resident 1 turned towards CNA 1 and threw a cup of water at CNA 1's face. CNA 2 stated CNA 1 then slapped Resident 1's back with CNA 2's left hand which made a loud slapping sound. CNA 2 stated staff cannot hit resident's back when residents are being aggressive to staff. CNA 2 stated the Administrator (ADM) also witnessed the incident.</p> <p>During an interview on 4/15/2025 at 2:55 PM with CNA 3, CNA 3 stated, CNA 3 was also at the nurses' Station 1 on 4/10/2025 at 4:42 PM when Resident 1 stood up from the chair to grab something at the desk, CNA 1 grabbed Resident 1's shirt from the back and caused the shirt to choke Resident 1 from the neck area and that was when Resident 1 threw a cup of water at CNA 1's face. CNA 3 stated she saw CNA 1 slap Resident 1's back which made a loud smacking noise.</p> <p>During a concurrent interview and record review on 4/15/2025 at 4 PM with ADM, the facility's surveillance video recorded on 4/10/2025 at 4:42 PM was reviewed. The surveillance video showed, Resident 1 was seated in a chair at the nurses' station 1 while then Resident 1 stood up and walked closer to the desk while CNA 1 grabbed Resident 1's shirt from the back, Resident 1 turned to CNA 1 and threw a cup of water to CNA 1's face. The video surveillance showed CNA 1 then hit Resident 1's back with CNA 1's left hand. ADM stated, according to the video surveillance the facility staff that slapped Resident 1's back was CNA 1. ADM stated he was standing ADM's office door facing nurses' station 1 on 4/10/2025 at 4:42 PM and witnessed CNA 1's physical abuse to Resident 1. ADM stated Resident 1 was seated in a chair at the nurses' station 1 then Resident 1 stood up and walked towards the desk. ADM stated CNA 1 held onto Resident 1's shirt from the back to stop Resident 1 from throwing a cup of water to CNA 1's face. ADM stated CNA 1 did not follow the facility's policy on abuse.</p> <p>A review of the facility's Policy and Procedures (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, indicated:</p> <p>Residents have the right to be free from abuse,. This includes physical abuse.</p> <p>Protect residents from abuse, by anyone including, but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, friends, visitors, and/or any other individual.</p> <p>Develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents.</p> <p>Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive, or emotional problems.</p> <p>Implement measures to address factors that may lead to abusive situations, for example: adequately prepare staff for caregiving responsibilities; help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts.</p> <p>(continued on next page)</p>		

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