

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  08/07/2025
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)
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.  (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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to develop a care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) for one (1) of two (2) sampled residents (Resident 1), when Resident 1 was noted to have a decline in the resident's cognitive skills (ability to understand and make decisions), mobility (ability to move or be moved) and function for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) assistance, based on the Change of Condition Minimum Data Set (MDS - a resident assessment tool), dated 7/16/2025. This failure had the potential for Resident 1 to experience a lack of care, and/or care that is not personalized to the resident's specific needs, which could negatively affect the resident's overall well-being. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included a history of falling, cerebral infarction (also known as a stroke, a condition where part of the brain tissue dies due to a lack of blood supply), dementia (a progressive state of decline in mental abilities) and displaced intertrochanteric fracture (a break in the upper part of the high bone [femur], specifically in the area between the femoral neck and the lesser trochanter [a bony prominence or projection on the femur near the hip joint, serving as an attachment site for muscles], where the broken pieces have shifted out of alignment) of left femur. During an interview on 8/6/2025 at 1:03 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated when she started caring for Resident 1 around 4/2025, Resident 1 was more independent with care, alert and not cognitively confused and used a front wheel walker (FWW- is a mobility aid with 2 wheels on the front legs, that helps provide stability and balance while walking) before experiencing multiple falls. LVN 1 stated prior to the resident's fall on 7/21/2025, Resident 1 was noted to need assistance from 2 certified nursing assistants (CNAs) with transfers and unable to use a FWW until cleared by physical therapists on 8/5/2025. During an interview on 8/7/2025 at 2:42 PM with LVN 3, LVN 3 stated she noticed Resident 1 has experienced changes in the resident's cognition and dependence levels since working with the resident 3 weeks ago. LVN 3 stated Resident 1 had episodes of confusion, short term memory and repeatedly asks the same questions. LVN 3 stated this was a change from Resident 1's baseline. LVN 3 also stated Resident 1 used to be more independent with ADLs and able to walk with FWW, but now required partial/moderate assistance (helper does less than half the effort needed to complete the activity) and supervision from staff with transfers and ADLs. During a concurrent interview and record review on 8/7/2025 at 3:03 PM with the Minimum Data Set Nurse (MDSN), Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/18/2025, Change of Condition MDS, dated 7/16/2025 and Resident 1's medical chart dated 2/3/2025 through 8/7/2025 were reviewed. The MDSs indicated from 6/18/2025 and 7/16/2025: a. Resident 1's cognitive skills declined from moderately impaired noted on 6/18/2025 to severely impaired noted on 7/16/2025. b. Resident 1's functional eating ability declined from setup or clean-up assistance (helper helps only prior to or following the activity completion) noted on 6/18/2025 to supervision or touching assistance (helper provides verbal cues, touching/steadying and/or contact guard assistance during activity) noted on 7/16/2025. c. Resident 1's oral hygiene ability declined from supervision or touching assistance noted on 6/18/2025 to partial/moderate assistance noted on 7/16/2025. d. Resident 1's toileting hygiene (the ability to maintain perineal hygiene [refers to the care and cleaning of the region between the genitals and the anus]) ability declined from partial/moderate assistance on 6/18/2025 to dependent (helper does all effort needed to complete activity) noted on 7/16/2025. e. Resident 1's ability to transfer from chair to bed/bed to chair and complete position change of sit to stand/ stand to sit, declined from supervision or touching assistance on 6/18/2025 to substantial/maximal assistance (helper does more than half the effort needed to complete the activity) noted on 7/16/2025. f. Resident 1's ability to complete toilet transfers (the ability to get on and off a toilet or commode) and walk (varied distances of 10 feet [ft- plural for foot, a unit of length equal to 12 inches], 50 ft and/or 150 ft) declined from supervision or touching assistance noted on 6/18/2025 to not attempted due to medical condition or safety concerns noted on 7/16/2025. Resident 1's medical chart did not indicate a developed care plan for Resident 1's decline in cognitive and functional abilities. The MDSN stated Resident 1's current care plan only reflected Resident 1 with moderately impaired cognitive skills and did not reflect her current condition of severely impaired cognitive skills. The MDSN also stated Resident 1's medical chart did not reflect any specific interventions for Resident 1's functional ability</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (continued on next page)

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to ensure one (1) of two (2) sampled residents (Resident 1) received adequate supervision and assistance to prevent accidents and injuries, by failing to provide the assistance needed to Resident 1 who was assessed to be dependent (helper does all effort needed to complete activity) to facility staff while toileting on 7/21/2025. This deficient practice resulted in Resident 1 having an unwitnessed fall and being found sitting in front of the toilet in the resident's restroom after the resident was left unattended by facility staff on 7/21/2025. Resident 1 experienced left inner thigh pain with a rating of 7 out of 10 (a tool for assessing pain intensity using scale 0 to 10, where 0 represents no pain and 10 represents the worst pain imaginable). Resident 1 underwent x-ray (an imaging study that takes pictures of bones and soft tissues) of left upper leg (femur/ thigh bone) on 7/21/2024 and result showed a left acute minimally displaced intertrochanteric fracture (a break in the upper part of the thigh bone [femur], specifically in the area between the femoral neck and the lesser trochanter [a bony prominence or projection on the femur near the hip joint, serving as an attachment site for muscles], where the broken pieces have shifted out of alignment). Resident 1 was sent to General Acute Care Hospital (GACH) emergency room (ER) on 7/21/2025, admitted to the GACH's medical surgical unit (a specialized area where patients receive care for a wide range of medical and surgical conditions. These units handle patients recovering from surgery, managing chronic illnesses, or requiring treatment for acute medical issues) on 7/22/2025 and underwent left hip open reduction internal fixation (ORIF- a surgical procedure used to treat fractures or dislocations by realigning the broken bones and stabilizing them with screws, plates, or rods) on 7/25/2025. Resident 1 stayed in GACH from 7/22/2025 until 7/28/2025 (7 days). Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE], with diagnoses that included cerebral infarction (also known as a stroke, a condition where part of the brain tissue dies due to a lack of blood supply) and dementia (a progressive state of decline in mental abilities). The admission records also indicated diagnosis of history of falling with onset (the first date that a resident experiences the first symptoms of a medical condition) on 2/3/2025 and repeated falls with onset date of 4/16/2025. During a review of Resident 1's Fall Risk Evaluation, dated 7/14/2025, the Fall Risk Evaluation indicated Resident 1 is at a high risk of falls. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/16/2025, the MDS indicated Resident 1 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 1 was dependent (helper does all effort needed to complete activity) with toileting hygiene (the ability to maintain perineal hygiene [refers to the care and cleaning of the region between the genitals and the anus]), shower/bathing and lower body dressing and substantial/maximal assistance (helper does more than half the effort needed to complete the activity) with personal hygiene and upper body dressing. The MDS indicated Resident 1 had impairments on both lower extremities (hips, knees, ankles, feet), substantial/maximal assistance with sit to stand mobility (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed) and toilet transfers (the ability to get on and off a toilet or commode) were not evaluated due to medical condition or safety concerns. The MDS also indicated a bed and w/c alarm were used in Resident 1's care. During a review of Resident 1's Change of Condition (COC)/Situation, Background, Assessment, Recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Interact Assessment Form, dated 7/21/2025, the COC/ SBAR Assessment Form indicated Resident 1 had an unwitnessed fall at 8:50 AM and was found sitting in front of the toilet in the resident's restroom. The COC/ SBAR Assessment Form indicated the assigned Certified Nursing Assistant (CNA) 2 assisted Resident 1 onto a shower chair and into the resident's restroom, then left [the restroom] to grab something from Resident 1's bed. The COC/SBAR indicated CNA 2 then found Resident 1 sitting on the restroom floor. The COC Assessment Form also indicated Resident 1 stated tried to stand up to grab the toilet paper in front of the resident when Resident 1 lost her balance and fell onto the floor. The COC/ SBAR Assessment Form indicated at 2:43 PM, Resident 1 complained of left inner thigh pain with a rating of 7 out of 10 and Norco (the brand name of a medication that combines two pain-relieving drugs: hydrocodone and acetaminophen) 5-325 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) was administered to Resident 1. During a review of Resident 1's Medication Administration Record (MAR) dated 7/21/2025 the MAR indicated</p>		