Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056127	A. Building B. Wing	01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Live Oak Rehab Center	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of resident- to resident abuse to local, state and federal officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) within two (2) hours, for 2 of 2 sampled residents (Residents 1 and 2) per facility policy. This resulted in a delay of an onsite inspection by the California Department of Public Health (CAPD) to ensure the alleged abuse was investigated, to protect and prevent further abuse of the residents in the facility.Findings:During a review of Resident 1's admission Record, (undated), the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] with diagnoses that included but not limited to chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), unspecified dementia (a progressive state of decline in mental abilities) and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 1's History & Physical (H&P), dated 6/9/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 12/26/2025, the MDS indicated Resident 1 had modified independent (some difficulty in new situations only) cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 1 needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, oral and personal hygiene and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting hygiene. During a review of Resident 2's admission Record, (undated), the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] with diagnoses that included unspecified dementia, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and peripheral vascular disease. During a review of Resident 2's H&P, dated 5/10/2025, the H&P indicated that Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's MDS, dated 12/12/2025, the MDS indicated Resident 2 with severely impaired cognitive skills for daily decision making. The MDS also indicates Resident 2 was dependent (helper does all of the effort) with oral, personal and toileting hygiene, shower/bathing self and partial/moderate assistance (helper does less than half the effort) with eating. During an interview on 1/23/2026 at 3:21 PM with the Director of Nursing (DON), the DON stated on Wednesday 1/21/2026, she and the Administrator were informed by the Director of Staffing (DSD) regarding an alleged incident between Residents 1 and 2 on Sunday, 1/18/2026, where Resident 2 allegedly slapped Resident 1. The DON also stated she spoke with Certified Nurse Assistant 1 (CNA 1) on 1/21/2026 and CNA 1 stated Resident 1 and Resident 2 allegedly hit each other in the facility's activity room. During an interview on 1/23/2026 at 3:32 PM with the Administrator, the (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated the alleged incident happened on Sunday 1/18/2026 and he was not informed until 1/21/26 and then he investigated the incident without reporting it to any agencies. The Administrator stated it should have been reported on 1/18/26 by the staff or as soon as he was informed on 1/21/26. During an interview on 1/23/2026 at 3:42 PM with the Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated she was informed by a certified nurse assistant (CNA) on the day after the alleged incident, [1/19/2026], that Resident 2 allegedly slapped Resident 1. During an interview on 1/26/2026 at 9:31 AM with CNA 1, CNA 1 stated while in the facility's activity dining room on Sunday 1/18/2026, It looked as if Resident 2 struck Resident 1, from my perspective. During an interview on 1/26/2026 at 12:01 PM with the DON, the DON stated facility did not report the alleged incident of abuse because it was investigated within the facility and there was no evidence that it occurred. The DON stated the alleged hitting or slapping of a resident is considered abuse and per facility policy, the facility should have reported the alleged incident of abuse within 2 hours on Sunday 1/18/2026 to the appropriate agencies. The DON further stated it is the responsibility of the facility staff to report to the appropriate agencies within 2 hours timeframe to protect the residents. During an interview on 1/26/2026 at 12:22 PM with CNA 1, CNA 1 stated on the day of alleged incident [1/18/2026], LVN 1 said she would make a report, but she did not report the alleged incident to the Administrator or any other facility staff that day. During an interview on 1/26/2026 with the Administrator at 12:28 PM, the Administrator stated the facility did not report this alleged incident of abuse to any local, state or federal agencies, but will next time. During a review of the facility's policy titled. Abuse, Neglect, Exploitation or Misappropriation - Reporting and investigating, revised on 9/2022, the policy indicated:All reports of resident abuse are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management.If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be immediately reported to the administrator and to the other officials according to state law.The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies:The state licensing/certification agency responsible for surveying/licensing the facilityThe local/state ombudsmanThe resident's representativeAdult Protective ServicesLaw enforcement officialsThe resident's attending physician; andThe facility medical directorImmediately is defined as within 2 hours of an allegation involving abuse