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	01/29/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's environment was free from accident hazards such as call light and bed control cords that could be used to wrap the resident's fingers with for one (1) of two (2) sampled residents (Resident 1). This deficient practice had the potential to result in injuries related to Resident 1's behavior of wrapping her fingers onto call light cord. Findings: During a review of Resident 1's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses that included aphasia (a disorder that makes it difficult to speak) following cerebral infarction (a medical condition that occurs when brain tissue dies due to a lack of blood flow and oxygen) and gangrene (the death and decay of a body tissue, usually caused by a sudden loss of blood supply) not elsewhere classified. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 1/20/2026, the MDS indicated Resident 1 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 was dependent (helper does all the effort) on oral, toileting, and personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear. During a concurrent observation and interview on 1/29/2026 at 9:55 AM, Resident 1 was sitting on her customized wheelchair with red discoloration on her left middle finger (approximately 1.25 inch from the tip of the finger) and a band of a darker red mark (approximately 1/4/inch) around the same middle finger at the base. Residents bed was observed with tangled call light cords hanging on the inner side of the upper quarter bed side rail (a short rails often referred to as half rails, placed near the head of the bed generally designed to provide stability and support) and coiled cables of the bed control hanging on the upper left side of the bed. Resident 1 nods when asked if she had placed her left middle finger in the tangled call light cord beside her bed. During an interview on 1/29/2026 at 10:15 AM, Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 could twist and wrap her fingers with the coiled cables of the bed control and the tangled call light cords. LVN also stated the bed control cables, and the call lights should be put away from the resident to prevent Resident 1 from accidentally harming herself since she was not capable of using both the call lights and bed control. LVN 1 further stated anything that could possibly harm Resident 1 should be put away. During an interview on 1/29/2026 at 11 AM, Certified Nursing Assistants 1 (CNA 1) stated she was told in a huddle a week and a half ago that Resident 1 likes to play and tie things around her finger and that someone caught the resident on time trying to wrap her finger. CNA 1 also stated that the call light with the tangled cord was on Resident 1's bed and the bed control with coiled cable was hanging on the left side of the bed when she got Resident 1 out of bed this morning. CNA 1 further stated the cord, and the cables could pose a safety hazard for Resident 1 because the resident could pull and use them to wrap her fingers. During an interview on 1/29/2026 at 11:15 AM, CNA 2 stated she had seen Resident 1 grab (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the light cord and wrap it on her finger back in December 2025 and took it away from the resident. CNA 2 also stated to ensure safety for Resident 1, the staff should put away things that could possibly be used by the resident to wrap her fingers with. During an interview on 1/29/2026 at 11:30 AM, the Director of Nursing (DON) stated before Resident 1 came to the facility the resident already had a history of gangrene on her left pointer finger from wrapping her finger which was resolved. The DON also stated 1 of the CNAs noticed on Tuesday (1/27/2026) that Resident 1 was wrapping the string of her gown and gastrostomy tube (GT, a tube inserted directly through the abdominal wall into the stomach to provide nutrition, fluids, and medications) on her finger, CNA removed everything but did not tell anyone. DON further stated the CNA should have notified other staff to ensure Resident 1 was being monitored and the behavior was care planned. The DON stated tangled call light cords and coiled cables of the bed control are safety hazards for Resident 1. During a concurrent interview and review of Resident 1's care plan on 1/29/2026 at 12:15 PM with the DON. The DON stated she could not find any care plan related to the resident's behavior of wrapping her fingers on things. DON also stated Resident 1's care plan that focused on risk for injury dated 7/21/2025 was not specific to the resident's behavior and interventions related to providing the resident with a safe environment were not implemented. During an interview on 1/29/2026 at 1:03 PM, CNA 3 stated she had observed Resident 1 wrapped her fingers with the cord of her gown and the GT during her rounds on Tuesday night of 1/27/2026 but did not notify any of the staff. During a review of the facility's Policy and Procedure (P&P) titled, Safety and Supervision of Residents, revised July 2017, the P&P indicated that the facility strives to make the environment as free from accidental hazards as possible. The P&P also indicated that the residents' safety, supervision and assistance to prevent accidents are facility wide priorities. The P&P further indicated that safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes.