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	03/11/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect one (1) of two (2) sampled residents (Resident 1) right to be free from sexual abuse (non-consensual [without the person's permission] sexual contact of any type with a resident who does not wish to engage in sexual activity or may not have the capacity to consent) when Resident 2 was observed in Resident 1's room on top of Resident 1. Resident 2 was observed touching Resident 1's breast while kissing Resident 1 on the lips on 3/7/2026. This failure resulted in Resident 1 being sexually abused by Resident 2 on 3/7/2026 and had the potential to result in Resident 1 experiencing negative psychosocial effects (a person's mental, emotional, social and spiritual health and hopelessness).Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1's diagnoses included cerebrovascular disease (includes conditions that restrict or block blood flow to the brain), cerebral infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area) with aphasia (an impairment of language, affecting the production or comprehension of speech and the ability to read or write), and anxiety disorder (mental health condition marked by persistence, excessive worry, fear, or nervousness that interferes with daily life), During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/20/2026, the MDS indicated Resident 1's cognitive skills (processes of thinking and reasoning) for daily decision making were moderately impaired. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, personal hygiene, sit to lying, lying to sitting on side of the bed, toilet transfer and tub/shower transfer During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and re-admitted [DATE]. Resident 2's diagnoses included chronic obstructive pulmonary disease (COPD, a chronic inflammatory disease that causes obstructed airflow from the lungs), psychosis (a mental disorder characterized by a disconnection from reality), anxiety disorder, and dementia (a progressive state of decline in mental abilities) During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making were cognitively intact. The MDS indicated Resident 2 needed supervision or touching assistance (helper provides verbal cues and/or touching/ steady and/or contact guard assistance as resident completes activity) on oral hygiene, toileting hygiene, shower/ bathe self, lower body, putting on / taking off footwear, personal hygiene, tub/shower transfer, walk 10, and 50 feet. The MDS also indicated Resident 2's mobility with setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) while using a manual wheelchair to wheel 50 to 150 feet (once resident seated in wheelchair, the ability to wheel at least 50 to 150 feet in a corridor or similar space) During a review of Resident 1's Change of Condition (COC, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains), dated 12/17/2025 at 12:15 PM, the COC indicated Resident 1 was in the hallway outside of her room when a (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	male resident (Resident 2) attempted to give Resident 1 a kiss on the cheek. The male resident was immediately pulled away from Resident 1. During a review of Resident 2's COC, dated 3/7/2026 at 8:45 AM, the COC indicated alleged resident to resident interaction between Resident 1 (victim) and Resident 2 which was reported to charge nurse and Registered Nurse Supervisor. Resident 2 denied any alleged inappropriate behavior towards Resident 1). Resident 2 was placed on one-to-one monitoring for safety supervision. A psychiatric evaluation was conducted and Resident 2 was questioned regarding the alleged interaction. Resident 2 denied getting on top of and kissing the other alleged resident (Resident 1). Resident 2 stated the interaction was intended as a greeting gesture by kissing the resident's (Resident 1) hand. During a review of Resident 2's Nurses Progress Notes (NPN), dated 3/7/2026 at 5:45 PM, the NPN indicated Medical Doctor 1 (MD 1) asked Resident 2 if he had gone into another resident's room (Resident 1) on 3/7/2026. Resident 2 answered, Yes, because I just wanted to greet her (Resident 1) since it has been a while since I have seen her, and stated that he knows Resident 1. MD 1 then asked Resident 2 if he had touched Resident 1, kissed her, or gotten on top of her in her bed. Resident 2 responded, No, only to greet her. During an interview on 3/10/2026 at 8:55 AM with Resident 1, Resident 1 nodded her head when asked if a male resident had entered her room on 3/7/2026. Resident 1 also nodded when asked if another Resident (Resident 2) had touched her body. Resident 1 demonstrated touching both of her breasts and the top of her private area (vagina). Resident 1 nodded when asked if she had been touched on both breasts and her private area. Resident 1 once again demonstrated touching her breasts and the top part of her vagina. Resident 1 verbalized that she was lying down on her bed when the incident happened. Resident 1 shook her head when asked if Resident 2 said anything to her. During an interview on 3/10/2026 at 9:27 AM with the Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated, she was administering medications to the residents when Certified Nurse Assistant 1 (CNA1) summoned her to Resident 1's room on 3/7/2026. LVN 1 stated she saw CNA1 wheeling Resident 2 out of Resident 1's room. LVN 1 stated CNA1 reported that Resident 2 was on top of Resident 1. LVN 1 further stated that according to CNA 1, Resident 2 was observed kissing Resident 1's lips while touching her breasts. LVN 1 stated this was inappropriate and it is considered sexual abuse. During an interview on 3/10/2026 at 11:38 AM with CNA 1, CNA 1 stated on 3/7/2026, Saturday at 8:45 AM, CNA 1 was walking the hallway when she saw Resident 1 lying on her bed, in her room, while Resident 2 was on top of her. CNA1 stated she saw Resident 2 touching Resident 1's breast while kissing Resident 1 on the lips. CNA 1 stated Resident 1 was trying to move her face away from Resident 2. CNA1 told Resident 2 to get off Resident 1 and assisted in removing Resident 2 from Resident 1's room. During an interview on 3/10/2026 at 2:58 PM with LVN 2, LVN 2 stated on 12/17/2025, Resident 2 was propelling his wheelchair towards his room when he stopped and tried to get up from his wheelchair and attempted to kiss the cheek of Resident 1 who was also on a wheelchair in the hallway. LVN 2 stated that he was able to stop Resident 2 from kissing Resident 1. LVN 2 stated he separated Resident 2 from Resident 1 immediately. During a concurrent interview and record review on 3/11/2026 at 11:17 AM with MDS Coordinator (MDS 1), Resident 2's Care Plan was reviewed. MDS 1 stated Resident 2 did not have a care plan for inappropriate behavior of attempting to kiss Resident 1 on 12/17/2026. MDS 1 stated there should have been a care plan developed to have included interventions such as close monitoring and providing activities to keep Resident 2 occupied. MDS 1 stated not having a care plan resulted in Resident 2 entering Resident 1's room on 3/7/2026. During a concurrent interview on 3/11/2026 at 11:45 AM with the Director of Nursing (DON), the five (5) day report and the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation Prevention Program, revised 4/2021 were reviewed. The 5-day report indicated that Resident 2 was placed on 1:1 supervision for close monitoring and safety. It also indicated that arrangements are being made for Resident 2's transfer to the hospital for further medical evaluation and management. The DON stated that the P&P indicated the residents have the right to be free from abuse which includes sexual or physical abuse. The DON stated the facility's policy indicated to protect residents from abuse and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	neglect by anyone including but not necessarily limited to facility staff, other residents, visitors and others. The DON stated they should always advocate and protect the residents. The DON added, the facility failed to prevent the abuse because another incident happened between Resident 1 and Resident 2 on 3/7/2026. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation Prevention Program, revised 4/2021, the P&P indicated residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from . verbal, mental, sexual, or physical abuse, . The policy also indicated to protect residents from abuse, neglect. by anyone including but not necessarily limited to facility staff, other residents. visitors or any other individual.