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	05/06/2026

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 provide safety measures and supervision by not assisting, and monitoring to ensure a safe environment for Resident 1. This deficient practice not only lead to Resident 1 had skin discoloration on the left thigh but also had the potential to cause further physical harm and injuries. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. Resident 1's diagnoses including but not limited to generalized muscle weakness (a comprehensive loss of strength throughout the body, making it difficult to perform daily tasks, move muscles effectively, or maintain normal endurance), abnormal posture, unspecified anemia (low levels of healthy red blood cells to carry oxygen throughout your body. Symptoms include fatigue, weakness and feeling short of breath), unspecified dementia with other behavioral disturbance (cognitive decline that is causing notable behavioral issues, such as sleep disruption, sexual disinhibition, or social inappropriateness). During a review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated 3/6/2026, the MDS indicated Resident 1 had moderately impairment (poor judgements, decision making, cues/supervision required) with cognitive (relates to the conscious and unconscious mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with all daily activities and was not attempted to walk due to medial condition or safety concerns. During a review of Resident 1's Change of Condition (COC) Interact Assessment Form Situation, Background, Assessment, and Recommendation communication form (SBAR, a structured framework used in healthcare to ensure concise and effective communication during critical situations, patient handoffs, or provider calls) dated 5/3/2026 at 4 AM, the SBAR communication form indicated Resident 1 had noted with discoloration to left thigh, no indication of discoloration size. During an interview on 5/5/2026 at 4:13 PM with Certified Nursing Aid 2 (CNA 2), CNA 2 stated she found Resident 1's left thigh had bruise (a discolored mark on the skin caused by blood leaking from broken, tiny blood vessels beneath the skin's surface). when she tried to change Resident 1 on 5/3/2026 near 4 AM. CNA 2 stated she was Resident 1's one-to-one sitter (1:1 sitter- a CNA or technician, assigned to provide continuous, dedicated, and uninterrupted observation of a single patient) for two consecutive nights on 5/2/2026 and 5/3/2026, but she did not know how Resident 1 acquired her left thigh bruise CNA 2 stated she then reported to her charge nurse. CNA 2 stated Resident 1 always flailing her hands and kicking her legs in and out of her bed multiple times during her monitoring. During an interview on 5/6/2026 at 7:35 AM with Licensed Vocational Nurse 1(LVN 1), LVN 1 stated CNA 2 reported the bruise on Resident 1's left thigh to her. She did the assessment on Resident 1and reported to the Director of Nursing (DON). LVN 1 stated Resident 1 could not recall how and where she had acquired her bruise. LVN 1 stated she could not find out how Resident 1 acquired her bruise either. During an interview on 5/6/2026 at 11:33 AM with DON, DON stated she could not find out how Resident 1 got her skin discoloration on her left front thigh area. During an interview on 5/6/2026 at (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:05 PM with the Administrator (ADM), ADM stated he could not find out how Resident 1 got her skin discoloration on her left thigh. During review of five days follow up report dated 5/7/2026 indicated, on 5/3/26 resident verbalized pain on left inner thigh, resident presents with anxiety related behaviors including flailing and kicking during episodes of agitation, which may place her at an increased risk for accidental injury. During a review of the Care Plan (a written document detailing a person's health conditions, care needs, and treatment goals, serving as a guide for caregivers to provide consistent, high-quality support) dated 5/3/2026, the Care Plan did not have indication and intervention for Resident 1's hands were flailing and her legs kicking. During a review of the facility's Policy and Procedure (P&P) titled, Injuries of Unknown Origin, undated, was reviewed. The P&P indicated, injuries of an unknown origin will be investigated, investigation will include record review and observations, conclusion will be based on #2 and will determine the origin/cause, if an origin/cause cannot be determined, the injury will be consideredabuse and will be investigated according to the abuse investigation polic and measures to prevent recurrences will be developed During a review of the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised in September 2022, indicated, Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents.