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	06/18/2026

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 prevent a fall for one (1) of two sampled residents (Resident 1) who was assessed to be dependent (helper does all of the effort, resident does none of the effort to complete the activity) with wheeling 50 feet with two turn and needed partial/moderate assistance (helper does less than half the effort; helper lifts, holds or supports trunk or limbs but provides less than half the effort) during transfer from chair to bed by:Failing to accurately assess and document a Fall Risk Evaluation form (a clinical assessment tool used by nursing staff to calculate a resident's likelihood of falling) and develop a resident-centered care plan (a care plan developed and implemented to meet his or her preferences and goals, and addressed the resident's medical, physical, mental, and psychosocial needs) after Resident 1's assisted fall (an event where a resident begins to lose their balance or fall, and a caregiver or nurse is present and physically steps in to slow the resident's descent to the ground or another surface) on 6/4/2026, in accordance with the facility's policy and procedure (P&P).Failing to provide partial/moderate assistance when Resident 1 wheeled himself from the hallway into the resident's room and the facility staff did not provide contact guard assistance (CGA- when the therapist maintains constant, light physical contact for safety and balance) during Resident 1's transfer from wheelchair to the resident's bed on 6/9/2026. This deficient practice placed Resident 1 at risk for another fall.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 was readmitted on [DATE] with diagnoses that included repeated falls, hypertensive heart disease with heart failure (when long-term, unmanaged high blood pressure causes the heart muscle to thicken and weak making it difficult for the heart to pump of relax properly), and depression (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/4/2026, the MDS indicated Resident 1 was assessed having severely (never/rarely made decisions) impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, rolling left and right, sit to lying, and lying to sitting on side of bed. The MDS indicated Resident 1 required partial/moderate assistance with toileting hygiene, upper/lower body dressing, sit to stand, chair/bed-to-chair transfer, toilet transfer, walking 10 feet (ft.- unit of measurement for distance), and walking 50 ft. with two turns. The MDS further indicated Resident 1 used a manual wheelchair and was dependent on wheeling 50 feet with two turns. During a review of Resident 1's Physical Therapy (PT) Treatment Encounter Note, dated 6/8/2026, the PT Treatment Encounter Note indicated Resident 1 required CGA with sit to stand, bed transfer, and wheelchair transfer. During a review of Resident 1's Order Summary Report, dated 6/18/2026, the Order Summary Report indicated Resident 1 was taking the following medications:Amlodipine besylate (medication for high blood pressure or hypertension oral tablet 5 milligrams (mg- unit of measurement for weight) give 1 tablet (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	by mouth two times a day, with a start date of 4/29/2026.Escitalopram oxalate (medication used to treat major depressive disorders) 5 mg give 1 tablet by mouth one time a day, with a start date of 4/29/2026.Hydralazine HCl (medication used to treat moderate to severe high blood pressure) 100 mg give 1 tablet by mouth two times a day, with a start date of 4/29/2026. During a review of Resident 1's Progress Note, dated 6/4/2026, at 2:45 AM, the progress notes indicated under the Post Fall Evaluation note, Resident 1 had a witnessed fall (an event where someone-such as a staff member, bystander, or family member-directly sees a person lose their balance and come to rest inadvertently on the floor, ground, or other lower surface) on 6/4/2026 at 2:45 AM in Resident 1's room while Resident 1 was adjusting his body to be more comfortable. During a review of Resident 1's Interdisciplinary Team (IDT- a group of healthcare professionals from different disciplines who collaborate to provide comprehensive and coordinated care for a resident) Narrative Form, dated 6/5/2026, at 3:33 PM, the IDT Narrative Form indicated on 6/4/2026 at around 2:45 PM, Resident 1's bed alarm (a safety and monitoring device designed to alert caregivers when a person attempts to leave their bed unassisted) activated, staff responded immediately and noted Resident 1 was attempting to get out of bed without assistance and was safely guided to a seated position on the floor by nursing staff. The IDT narrative form did not indicate interventions such as supervising Resident 1 while in the wheelchair and to address the resident's safety awareness to prevent another fall. During a review of Resident 1's Fall Risk Evaluation form, dated 6/4/2026, the Fall Risk Evaluation form indicated Resident 1 has not had any falls in the past three months and did not take antihypertensive (a class of medication or treatment regimen used to treat hypertension) and psychotropic medications (a prescription drug that alters chemical levels in the brain to affect a person's mind, emotions, perceptions, or behavior). The Fall Risk Evaluation form indicated Resident 8 is at low risk for fall. During a review of Resident 1's Care Plan, dated 8/21/2025, the Care Plan indicated Resident 1 was at risk for falls/injury related to generalized weakness, impaired cognition, poor safety awareness, judgment, poor coordination, use of medications such as antihypertensive, psychotropic, anticonvulsant, and history of repeated falls. The Care Plan indicated an intervention to provide the resident with a safe and clutter-free environment. The Care Plan did not indicate it was revised to address Resident 1's fall on 6/4/2026. During a review of Resident 1's Care Plan, dated 6/4/2026 to 6/9/2026, there was no Care Plan initiated to address Resident 1's actual fall on 6/4/2026. During a review of Resident 1's Progress Note, dated 6/9/2026, at 10:08 PM, the Progress Note indicated Resident 1 had an unwitnessed fall on 6/9/2026, at 3:45 PM in Resident 1's room while attempting to self-transfer into bed. During a review of Resident 1's IDT Narrative Form, dated 6/10/2026, at 1:40 PM, the IDT Narrative Form indicated on 6/9/2026, at approximately 9 PM, Resident 1 remained seated in his wheelchair at the nursing station after the resident's family left and shortly after, the resident wheeled himself to his room and while attempting to transfer from wheelchair to bed, the resident fell on top of the floor mat. The IDT Narrative Form indicated Resident 1 had episodes of forgetfulness.During an interview on 6/18/2026, at 12 PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 had a tendency to stand up on his own and transfer from his bed to his wheelchair and vice versa. LVN 1 stated Resident 1 had a bed alarm which sounded when Resident 1 sat on the edge of the resident's bed but there was no chair alarm (a safety and monitoring device designed to alert caregivers when a person attempts to get up from their chair or wheelchair unassisted). LVN 1 stated she did not know if Resident 1 had a history of fall prior to the resident's fall on 6/9/2026. LVN 1 stated Resident 1 needed partial/ moderate assistance from staff during transfers and Resident 1 was at risk of falling if the resident stood up on his own or transferred without assistance from staff. LVN 1 stated Resident 1 needed to be watched while the resident is in his wheelchair due to the resident's tendency to stand up from his wheelchair. During an interview on 6/18/2026, at 12:17 PM, with LVN 2, LVN 2 stated Resident 1 was initially able to do everything on his own when he was initially admitted to the facility and recently needed more assistance after he returned from staying at a general acute care hospital on 4/26/2026. LVN 2 also (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident 1 was no longer able to stand up on his own after the resident returned to the facility on 4/26/2026. LVN 2 stated Resident 1 was at risk for falls because the resident believed he (Resident 1) was still able to do things by himself. LVN 2 stated Resident 1 had a witnessed fall on 6/4/2026 at around 2:30 AM when Resident 1 tried to get out of his bed. LVN 2 stated she (LVN 2) did not create a care plan for the actual fall or updated Resident 1's care plan for risk for falls after Resident 1 fell on 6/4/2026 to add interventions such as supervising the resident while the resident is in the wheelchair and addressing the resident's safety awareness. During an interview on 6/18/2026, at 12:51 PM, with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated he did not know the exact details of Resident 1's previous fall before 6/9/2026 or the reason why Resident 1 was a fall risk. CNA 1 stated he just assumed Resident 1 was a fall risk because the resident had a bed alarm (a monitoring device designed to alert caregivers immediately when a resident attempts to get out of bed). CNA 1 stated, on 6/9/2026, at approximately 9 PM, Resident 1 sat on the resident's wheelchair outside the resident's room. CNA 1 stated Resident 1 refused to get wheeled back to his room and wanted to stay in the hallway. CNA 1 stated he started charting in front of room [ROOM NUMBER] which was across the hall from Resident 1's room. CNA 1 stated he did not have a visual of Resident 1 while he was charting by room [ROOM NUMBER]. CNA 1 stated he heard a loud sound from Resident 1's room while charting and CNA 1 went inside Resident 1's room and found Resident 1 on his elbow on the floor next to the resident's wheelchair. CNA 1 stated he did not notice Resident 1 wheel himself from the hallway to the resident's room. CNA 1 stated Resident 1 needed staff's partial to moderate assistance when transferring from the resident's wheelchair to the bed and resident was usually able to wheel himself while (MDS indicated Resident 1 is dependent when wheeling himself). During an interview on 6/18/2026, at 1:26 PM, with the Director of Rehab (DOR), the DOR stated Resident 1 tries to do things on his own because he was forgetful and did not know his debility and realize how weak the resident has gotten. DOR stated Resident 1 only asked for help when standing up from wheelchair to walk. DOR stated Resident 1 fatigued easily and needed contact guard or 1 person stand by assist during transfers. DOR stated Resident 1 fell on 6/4/2026 and again on 6/9/2026 and the resident should have gotten more supervision after the resident fell on 6/4/2026 because the resident sometimes gets confused and lacked insight regarding his (Resident 1) physical condition and abilities. During a concurrent interview and record review on 6/18/2026, at 2:09 PM, with Registered Nurse 1 (RN 1), Resident 1's Care Plans were reviewed. RN 1 stated Resident 1 fell in his room during night shift on 6/4/2026. RN 1 stated Resident 1 was at risk for falls because he always tried to get out of the bed by himself and overestimated his strength when it comes to transferring from bed to chair. RN 1 stated Resident 1's Care Plan for fall should have been revised and updated with new interventions on fall prevention and resident safety after his fall on 6/4/2026. RN 1 stated, if Resident 1's care plan was revised or a new care plan was initiated to address Resident 1's fall on 6/4/2026 to add interventions such as supervision while the resident is in his wheelchair and to address the resident's safety awareness could have been implemented to prevent another fall incident such as the fall that happened on 6/9/2026. During the same concurrent interview and record review on 6/18/2026, at 2:09 PM, with RN 1, Resident 1's Fall Risk Evaluation form dated 6/4/2026 was reviewed. RN 1 stated Resident 1's Fall Risk Evaluation form was not accurate. RN 1 stated the Fall Risk Evaluation form indicated Resident 1 has not had a fall in the past three months even if Resident 1 fell on 6/4/2026. RN 1 stated the Fall Risk Evaluation form also indicated Resident 1 was not taking any antihypertensive and psychotropic medications. RN 1 stated it was important for the licensed nurse to assess Resident 1's fall risk accurately so the correct interventions for fall prevention and safety are added to the care plan. During an interview on 6/18/2026, at 2:52 PM, with LVN 3, LVN 3 stated Resident 1 had a history of trying to get up from the bed without assistance. LVN 3 stated, on 6/9/2026, Resident 1 sat on his wheelchair in the hallway with his family from 7:30 PM to 9 PM. LVN 3 stated, at approximately 9 PM, Resident 1's family left the facility and Resident 1 stayed in the hallway. LVN 3 stated CNA 1 proceeded to chart across the (continued on next page)

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During an interview on 6/18/2026, at 4:24 PM with the Director of Nursing (DON), the DON stated Resident 1 needed partial to moderate assistance for transfers. The DON stated Resident 1 felt like he (Resident 1) was still strong even if there has been a decline in his functional ability. The DON stated Resident 1 has had three falls in the facility since his original admission on [DATE]. The DON stated Resident 1 had a witnessed fall on 6/4/2026 and an unwitnessed fall on 6/9/2026. The DON stated Resident 1's fall on 6/4/2026 was discussed during the IDT meeting on 6/5/2026 but the interventions discussed to prevent further falls were not resident specific care plans and were not added to Resident 1's care plan (risk for fall and no actual fall care plan) after 6/4/2026. The DON stated it was the responsibility of the licensed nurse on duty to revise the care plan after the fall to ensure the proper interventions such as providing supervision to Resident 1 while in the wheelchair and to address the resident's safety awareness of trying to get up on his (Resident 1) own for fall prevention and safety are communicated to the staff. The DON stated Resident 1's fall risk was not accurately assessed and documented on the Fall Risk Evaluation form dated 6/4/2026 and resulted in a score of 8 which placed Resident 1 low risk for fall. The DON stated an inaccurate Fall Risk Evaluation can lead to future falls because the wrong fall prevention interventions will be followed and implemented. During a review of the facility's policy and procedure (P&P), titled, Safety and Supervision of Residents, revised on 7/2017, the P&P indicated:The facility strives to make sure the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.The facility's individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents.The interdisciplinary care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.Implementing interventions to reduce accident risks and hazards shall include communicating specific interventions to all relevant staff, ensuring that interventions are implemented and documenting interventions. During a review of the facility's P&P, titled, Charting and Documentation, revised on 7/2017, the P&P indicated:All services provided to the resident, progress toward the care plan goals, or any changed in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.The following information is to be documented in the resident medical record: objective observations, changes in the resident's condition, and progress toward or changes in the care plan goals and objectives.Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. During a review of the facility's P&P, titled, Falls and Fall Risk, Managing, revised on 3/2018, the P&P indicated:Based on previous evaluations and current date, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. During a review of the facility's P&P, titled, Care Plans, Comprehensive Person- Centered, revised 3/2023, the P&P indicated:A (continued on next page)

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