STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555306	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kei-Ai South Bay Healthcare Center	15115 S Vermont Ave Gardena, CA 90247

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** 45657 Based on interview and record review, the facility failed to implement its Policy and Procedure (P&P) titled, Abuse Reporting and Investigation dated 1/10/2024 which indicated, all allegations of abuse would be reported to the California Department of Public Health (CDPH) within 2 hours for two of five sampled residents (Resident 1 and Resident 4) after Resident 1 threw water towards Resident 4. This deficient practice had the potential for the underreporting of abuse incidents and a delay in the investigation by the CDPH. Findings: A review of Resident 1 ' s Admission Record, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including respiratory failure (condition that makes it difficult to breath), hemiplegia (paralysis that affects one side of the body) and hemiparesis (muscle weakness one side of the body) following cerebral infarction (stroke). A review of Resident 1 ' s History and Physical (H&P) dated 12/6/2023, indicated Resident 1 had the capacity to decisions. A review of Resident 1 ' s Minimum Data Set ([MDS] a standardized care assessment and care screening tool), dated 3/12/2024, indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 required partial to moderate assistance (helper did less than half of the effort) for Activities of Daily Living (ADLs) such as bed mobility (how the resident moved in bed), transfer (how resident moved between surfaces to and from bed, chair, wheelchair), upper body dressing, and required substantial/ maximal assistance (staff did more than half the effort) for toilet use, showering, lower body dressing and putting on/taking off footwear. A review of Resident 1 ' s Care Plan focused on Resident 1 ' s potential to be physically aggressive r/t (related to) throwing water at roommate (Resident 4) dated 3/14/2024, the Care Plan indicated the Resident ' s goal was not to harm self or others and would verbalize understanding of need to control physically aggressive behavior. A review of Resident 1 ' s Change in Condition (COC) dated 3/14/2024, the COC indicated Resident 1threw water at roommate. The COC indicated Resident 1 informed Certified Nursing Assistant (CNA) he threw water at his roommate when CNA asked Resident 1 why the floor and roommate ' s bed was wet. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/2024 at 9:45 a.m. with Resident 1, Resident 1 stated, he threw water towards his roommate a few months ago because Resident 4 was opening and closing the curtain. A review of Resident 4 ' s Admission Record indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including traumatic subdural hemorrhage (brain bleed), muscle weakness and other abnormalities of gait and mobility (unable to walk in a typical way). A review of Resident 4 ' s H&P dated 5/13/2024, indicated Resident 4 did not have the capacity to understand and make medical decisions. A review of Resident 4 ' s MDS dated [DATE], indicated Resident 4 ' s could not understand and be understood by others. The MDS indicated Resident 4 required substantial/maximal assistance form staff for ADLs such as dressing, personal hygiene, bed mobility, transfer and walking. During an interview on 5/9/2024 at 12:50 p.m. with CNA 5, CNA 5 stated, she walked in Resident 1 and Resident 4 ' s room (on 3/14/2024) and saw the floor and Resident 4 ' s bed was wet. CNA 5 stated Resident 1 informed her he was upset that Resident 4 kept touching and making noises with the curtains and threw the water at Resident 4. During an interview on 5/9/2024 at 6:20 p.m. with Licensed Vocational Nurses (LVN) 2, LVN 2 stated, (on 3/14/2024) CNA 5 reported to her, the allegation that Resident 1 threw water at Resident 4. LVN 2 stated, Resident 1 informed her he threw water at Resident 4, because Resident 1 was upset with the sound of the curtain ' s movement. LVN 2 stated, she did not report the incident because she thought it not physical abuse and the water barely touched Resident 4. During an interview on 5/10/2024 at 12:40 p.m. with the Director of Nursing (DON), the DON stated she was not aware of the incident between Resident 1 and Resident 4 until this morning. The DON stated, it was not acceptable for Resident 1 to throw water towards Resident 4 and any kind of abuse needed to be reported to the CDPH within two hours, however, was not done. The DON stated it was important to report abuse and allegations of abuse to the CDPH to ensure the incidents were investigated and to prevent future abuse. A review of the facility ' s P&P titled, Abuse Reporting and Investigation dated 1/10/2024 indicated, All alleged violations involving abuse, including but not limited to neglect, exploitation, or mistreatment, injury of an unknown origin and misappropriation of property , shall be reported by Abuse Prevention Coordinator (APC)/ Designee to local CDPH, LTC Ombudsman and Local Enforcement either by telephone, e-mail or in writing (SOC 341) immediately: within 2 hours after the allegation is made or reported if alleged violation involves abuse with or without serious bodily injury.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview and record review, the facility failed to thoroughly investigate an allegation of abuse and separate two of five sampled residents (Resident 1 and Resident 4) after Resident 1 reported to Certified Nurse Assistant (CNA) 5, he threw water at Resident 4 on 3/14/2024. This deficient practice had the potential to result in unidentified abuse and ongoing abuse for Resident 4. Findings: A review of Resident 1 ' s Admission Record, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including respiratory failure (condition that makes it difficult to breath), hemiplegia (paralysis that affects one side of the body) and hemiparesis (muscle weakness one side of the body) following cerebral infarction (stroke). A review of Resident 1 ' s History and Physical (H&P) dated 12/6/2023, indicated Resident 1 had the capacity to decisions. A review of Resident 1 ' s Minimum Data Set ([MDS] a standardized care assessment and care screening tool), dated 3/12/2024, indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 required partial to moderate assistance (helper did less than half of the effort) for Activities of Daily Living (ADLs) such as bed mobility (how the resident moved in bed), transfer (how resident moved between surfaces to and from bed, chair, wheelchair), upper body dressing, and required substantial/ maximal assistance (staff did more than half the effort) for toilet use, showering, lower body dressing and putting on/taking off footwear. A review of Resident 1 ' s Change in Condition (COC) dated 3/14/2024, the COC indicated Resident 1 threw water at roommate. The COC indicated Resident 1 informed Certified Nursing Assistant (CNA) he threw water at his roommate when CNA asked Resident 1 why the floor and roommate ' s bed was wet. During an interview on 5/9/2024 at 9:45 a.m. with Resident 1, Resident 1 stated, he threw water towards his roommate a few months ago because Resident 4 was opening and closing the curtain. A review of Resident 4 ' s Admission Record indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including traumatic subdural hemorrhage (brain bleed), muscle weakness and other abnormalities of gait and mobility (unable to walk in a typical way). A review of Resident 4 ' s H&P dated 5/13/2024, indicated Resident 4 did not have the capacity to understand and make medical decisions. A review of Resident 4 ' s MDS dated [DATE], indicated Resident 4 ' s could not understand and be understood by others. The MDS indicated Resident 4 required substantial/maximal assistance form staff for ADLs such as dressing, personal hygiene, bed mobility, transfer and walking. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/9/2024 at 9:40 a.m., Resident 1 and Resident 4 were observed in the same room. During an interview on 5/9/2024 at 12:50 p.m. with CNA 5, CNA 5 stated, she walked in Resident 1 and Resident 4 ' s room (on 3/14/2024) and saw the floor and Resident 4 ' s bed was wet. CNA 5 stated Resident 1 informed her he was upset that Resident 4 kept touching and making noises with the curtains and threw water at Resident 4. CNA 5 stated she reported the incident to the Charge Nurse (Licensed Vocational Nurse [LVN 2]). CNA 5 also stated she was not asked to provide any statement or interviewed as part of an investigation of the incident. During an interview on 5/9/2024 at 6:20 p.m. with Licensed Vocational Nurses (LVN) 2, LVN 2 stated, (on 3/14/2024) CNA 5 reported to her, the allegation that Resident 1 threw water at Resident 4. LVN 2 stated, Resident 1 informed her he threw water at Resident 4, because Resident 1 was upset with the sound of the curtain ' s movement. LVN 2 stated, she did not report the incident because she thought it not physical abuse and the water barely touched Resident 4. During an interview on 5/10/2024 at 12:40 p.m. with the Director of Nursing (DON), the DON stated, Residents involved in an alleged abuse should be separated and the facility should investigate the incident. The DON stated, she was not aware of the incident between Resident 1 and Resident 4 until this morning and had started the investigation of the incident today. The DON also stated she had just instructed the Social Services Director (SSD) to initiate a room change to separate Residents 1 and 4 from each other. A review of the facility ' s Policy and Procedure (P&P) titled, Abuse Reporting and Investigation dated 1/10/2024 indicated, it was the facility ' s policy to thoroughly investigate reports of all allegations of abuse, to keep residents safe and prevent from future or recurrent potential abuse. The P&P indicated, the Abuse Prevention Coordinator (APC) should provide a safe environment for the resident and if the suspected perpetrator was another resident, the residents should be separated. The P&P indicated the APC should conduct the investigation and interview individuals who may have information relevant to the allegation, including but not limited to interview the person(s) reporting the incident, interview witnesses to the incident and review all events leading up to the alleged incident.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview and record review, the facility failed to accurately document provision of Restorative Nursing Assistant (RNA) services for three of three sampled residents (Resident 1, Resident 5 and Resident 6). This deficient practice had the potential to negatively affect delivery of care/services to Residents 1, 5 and 6. Findings: A review of Resident 1 ' s Admission Record, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including respiratory failure (condition that makes it difficult to breath), hemiplegia (paralysis that affects one side of the body) and hemiparesis (muscle weakness one side of the body) following cerebral infarction (stroke). A review of Resident 1 ' s History and Physical (H&P) dated 12/6/2023, indicated Resident 1 had the capacity to decisions. A review of Resident 1 ' s Minimum Data Set ([MDS] a standardized care assessment and care screening tool), dated 3/12/2024, indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 required partial to moderate assistance (helper did less than half of the effort) for Activities of Daily Living (ADLs) such as bed mobility (how the resident moved in bed), transfer (how resident moved between surfaces to and from bed, chair, wheelchair), upper body dressing, and required substantial/ maximal assistance (staff did more than half the effort) for toilet use, showering, lower body dressing and putting on/taking off footwear. A review of Resident 1 ' s physician orders dated 3/12/2024, indicated RNA to provide Active Assistance Range of Motion (AAROM) to bilateral lower extremities ([BLE] both legs) everyday 5 times a week as tolerated. A review of Resident 1 ' s Restorative Documentation Survey Report, dated 4/2024 and 5/2024 indicated there was no documentation of Resident 1 received RNA services on 4/1/24, 4/11/24, 4/17/2024, 4/23/2024, 4/24/2024, 4/25/2024, 5/2/2024 and 5/4/2024. During an interview on 5/8/2024 at 2:30 p.m. with Resident 1 in Resident 1 ' s room, Resident 1 stated, he was receiving RNA services. Resident 1 stated, RNA exercised his lower extremities, 5 times a week and sometimes on weekends. A review of Resident 5 ' s Admission record indicated Resident 5 was admitted to the facility on [DATE], with diagnoses including osteoarthritis (joint disease in which tissues in join break down over time) muscle weakness and other abnormalities of gait and mobility (unable to walk in a typical way). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 5 ' s H&P dated 5/6/2023, indicated Resident 5 had the capacity to understand and make decisions. A review of Resident 5 ' s MDS dated [DATE], indicated Resident 5 ' s could understand and be understood by others. The MDS indicated Resident 5 required substantial/ maximal assistance with ADLs such as toilet use, showering, dressing and transfer. A review of Resident 5 ' s physician orders dated 2/6/2024, indicated RNA to ambulate (walk) Resident 5 using platform walker every day, 5 times a week as tolerated and Active Range of Motion (AROM) to bilateral upper extremities ([BUE] both arms) 5 times a week as tolerated. A review of Resident 5 ' s Restorative Documentation Survey Report, dated 4/2024 and 5/2024 indicated, there was no documentation of Resident 5 receiving RNA therapy on 4/1/24, 4/2/24, 4/5/2024, 4/12/2024, 4/16/2024, 4/18/2024, 4/19/2024, 4/20/2054, 5/3/2024 and 5/4/2024. During an interview on 5/10/2024 at 1:40 p.m. with Resident 5 in Resident 5 ' s room. Resident 5 Resident 5 stated, she was weak, unable to walk and unable to sit down on her chair and now she was able to perform these activities. Resident 5 stated, the nurses helped her to the chair using the stand-up machine and was receiving RNA services. A review of Resident 6 ' s Admission record indicated Resident 6 was admitted to the facility on [DATE] and re admitted on [DATE], with diagnoses including contracture (tightening of the muscles, tendons, skin and nearby tissues that causes the joints to become very stiff) of the right hand, obesity (too much body fat) and major depressive disorder (lack of energy, poor concentration). A review of Resident 6 ' s H&P dated 1/24/2024 indicated Resident 6 did not have the capacity to make medical decisions. A review of Resident 6 ' s MDS dated [DATE] indicated Resident 6 could understand and be understood by others. The MDS indicated Resident 6 was dependent on staff for ADLs such as dressing, toilet use, shower and lower body dressing. A review of Resident 6 ' s physician orders dated 12/7/2023 indicated RNA to provide AAROM to BUE, passive range of motion (PROM) to the resident ' s right wrist and fingers 5 times a week as tolerated and apply wrist hand splint (device that provides support) up to 4 hours daily everyday 5 times a week as tolerated. A review of Resident 6 ' s physician orders dated 5/6/2024, the physician orders indicated Resident 6 had an order for Physical Therapist (PT) orders everyday 3 times a week for 4 weeks for therapeutic exercises, therapeutic activities, gait training. A review of Resident 6 ' s Restorative Nursing Documentation Survey Report dated 4/2024 and 5/2024 indicated, there was no documentation of Resident 6 receiving RNA services on 4/1/24, 4/2/24, 4/5/2024, 4/16/2024, 4/18/2024, 4/19/2024, 4/20/2024, 5/2/2024, and 5/4/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/9/2024 at 11:34 a.m. with RNA 1, Resident 1 ' s Restorative Documentation Report dated 4/2024 and 5/2024 were reviewed. RNA 1 stated Resident 1 received RNA services 5 times a week as ordered. RNA stated, provision of RNA services must be documented daily and did not see documentation RNA was completed on some dates. RNA 1 stated, sometimes she had to assist as a Certified Nurse Assistant and was not able to complete documentation. During an interview on 5/9/2024 at 1:11 p.m., with Registered Nurse (RN), RN stated, RNA services were completed to prevent Resident decline in terms of mobility and overall health. RN stated, when RNA did not document the therapy, it would be hard to determine the status of the therapy program for the resident. During an interview on 5/10/2024 at 12:40 p.m., with the Director of Nursing (DON), the DON stated, RNAs were responsible in documenting the services provided. The DON stated, if the RNA did not document, it could be taken as the services not provided as ordered. The DON also stated it was important to ensure consistency in the documentation of RNA services for the patient ' s well-being. During a concurrent observation and interview on 5/10/2024 at 1:45 p.m. with Resident 6, Resident 6 was observed wearing a blue splint on the right hand. Resident 6 stated, she received RNA services and that she was better and able to get up to her chair and attend activities. During an interview on 5/16/2024 at 4:14 p.m. with RNA 2, RNA 2 stated, RNA 2 stated, all assigned residents received RNA services as ordered and was not sure why there were missed documentation. During an interview on 5/16/2024 at 4:20 p.m., with RNA 3, RNA 3 stated, RNA 3 stated, he always provided RNA services to residents as ordered. RNA 3 stated he was using his phone to complete his documentation and did not reflect on the RNA sheets. A review of the facility ' s Job Description titled, Restorative Care Nurse dated 2003, indicated Restorative Care Nurse were delegated the administrative authority, responsibility and accountability necessary for carry ' s out assigned duties. Job function included maintaining treatment records, resident files and progress notes as required. A review of the facility ' s P&P titled, Charting and documentations dated 7/2017 indicated, all services provided to the resident, progress toward the care plan goals or any changes in the residents medical, physical condition should 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 P&P also indicated documentation in the medical record would be objective, complete and accurate.