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	07/10/2024

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505 Based on interviews and record review, the facility failed to develop a comprehensive care plan for one of three sampled residents (Resident 1) who was refusing to participate in Restorative Nurse Assistant (RNA) program due to pain. This deficient practice had the potential to result in unidentified interventions to address Resident 1 ' s refusal and negatively affect the resident ' s well-being. Findings: A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (a condition when the lungs could not get enough oxygen into the blood), metabolic encephalopathy (brain disorder) and UTI. The Admission Record indicated Resident 1 was discharged from the facility on 4/22/2022. A review of Resident 1 ' s History and Physical (H&P), dated 1/29/2022, indicated Resident 1 did not have the capacity to understand and make decisions. A review of Resident 1 ' s Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 2/9/2022, indicated Resident 1 was able to understand and be understood. The MDS indicated Resident 1 required limited assistance (resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance) to extensive assistance (resident involved in activity, staff provide weight-bearing support) for activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, bed mobility, and transfers (how resident moves to and from lying position, turns side to side and positions body while in bed). A review of Resident 1 ' s Order Summary Report, dated 7/3/2024, indicated Resident 1 was on a Restorative Nurse Assistant (RNA) program to ambulate (walk) using a front wheeled walker daily five times a week as tolerated. A review of Resident 1 ' s progress note, dated 4/6/2022, indicated Resident 1 had been complaining of pain and refused to walk with RNA for the past five days. The progress note indicated Resident 1 stated he was in pain, was not able to walk or stand, and was reported to the charge nurse. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s RNA Documentation Survey Report, dated 3/2022 and 4/2022, indicated Resident 1 refused to walk on 3/30/2022, 4/1/2022, 4/2/2022, 4/5/2022, 4/6/2022, 4/8/2022, 4/12/2022-4/14/2022, and 4/19/2022-4/21/2022. During a concurrent interview and record review on 7/9/2024 at 9:50 a.m. with the Assistant Director of Nursing (ADON), Resident 1 ' s progress notes were reviewed. The ADON stated, the notes indicated Resident 1 refused to walk with RNA for five days due to pain. The ADON stated, Resident 1 ' s refusal to participate in RNA due to pain should have been care planned. The ADON stated the care plan ' s purpose was to be the blueprint of the resident ' s care. During a concurrent interview and record review on 7/10/2024 at 1:39 p.m. with the ADON, Resident 1 ' s care plans were reviewed. The ADON stated, a care plan for noncompliance was created on 4/21/2022. The ADON stated, the initiation of the care plan was delayed and should have been created after the RNA first documented the resident ' s refusal, however, was not completed. A review of the facility ' s policy and procedure (P&P) titled, Care Plans-Comprehensive, dated 9/2010, indicated individualized comprehensive care plans that included measurable objectives and timetables to meet the resident ' s medical, nursing, mental, and psychological needs were developed for each resident. The P&P indicated the care planning/interdisciplinary team was responsible for the reviewing and updating of care plans when there had been a significant change in the resident ' s condition.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505 Based on interview and record review, the facility failed to thoroughly assess and monitor an elevated skin (lump like) for an increase in size, for one of three sampled residents (Resident 1) according to the physician ' s order and the facility ' s Policy and Procedure (P&P). This deficient practice had the potential to result in a delay in necessary treatment and worsening of the skin condition/lump for Resident 1. Findings: A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (a condition when the lungs could not get enough oxygen into the blood), metabolic encephalopathy (brain disorder) and UTI. The Admission Record indicated Resident 1 was discharged from the facility on 4/22/2022. A review of Resident 1 ' s History and Physical (H&P), dated 1/29/2022, indicated Resident 1 did not have the capacity to understand and make decisions. A review of Resident 1 ' s Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 2/9/2022, indicated Resident 1 was able to understand and be understood. The MDS indicated Resident 1 required limited assistance (resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance) to extensive assistance (resident involved in activity, staff provide weight-bearing support) for activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, bed mobility, and transfers (how resident moves to and from lying position, turns side to side and positions body while in bed). A review of Resident 1 ' s Order Summary Report, dated 7/3/2024, indicated Resident 1 had a physician ' s order to monitor elevated skin (lump like) on left posterior thigh for pain, drainage and increase in size every shift, on 1/28/2022. A review of Resident 1 ' s progress notes, dated 1/29/2022, indicated Resident 1 had an elevated skin (lump like) on left posterior thigh on admission. The notes indicated there were no measurements indicating the size of the resident ' s lump. A review of Resident 1 ' s progress note, dated 4/6/2022, indicated Resident 1 had been complaining of pain and refused to walk with the Restorative Nursing Assistant (RNA) for the past five days. The progress note indicated Resident 1 stated he was in pain and was not able to walk or stand and it was reported to the charge nurse. A review of Resident 1 ' s Treatment Administration Record (TAR), dated 7/3/2024, indicated there were check marks for monitoring the elevated skin on left posterior thigh for pain, drainage, and increase in size every shift. The TAR indicated the treatment was administered during that shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/3/2024 at 10:49 a.m. with Licensed Vocational Nurse (LVN 1), Resident 1 ' s Order Summary Report and progress notes were reviewed. LVN 1 stated Resident 1 had an order to monitor the lump on the resident ' s left thigh for pain, drainage, and increase in size. LVN 1 stated, there were no measurements of the size of the lump and if there were no measures, staff could not tell if the lump was increasing in size. During a concurrent interview and record review on 7/9/2024 at 10:05 a.m. with the Assistant Director of Nursing (ADON), Resident 1 ' s physician orders and Treatment Administration Record (TAR) were reviewed. The ADON stated Resident 1 ' s physician order indicated to monitor the size of the resident ' s lump. The ADON stated, nurses should have obtained measurements the lump to monitor for changes in size according to the physician ' s order, however, was not done. A review of the facility ' s Treatment Nurse Job Description dated 2003, indicated the Treatment Nurse ' Medical Care Function included identifying, managing and treating skin disorders and primary and secondary lesions such as skin abrasions (scrape), ulcers, benign tumors, as well as providing assessment services to residents. A review of the facility ' s undated P&P titled, Skin Assessment/Evaluation indicated it was the facility ' s policy to monitor resident ' s skin condition to ensure any changes in skin condition would be addressed and reported to the physician for proper treatment and intervention. The P&P indicated, upon identification of a wound, a full wound assessment including its location, size and description would be completed and documented in the resident ' s clinical records. Changes in the resident ' s skin condition identified would be reported to the physician for proper treatment regimen.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505 Based on interview and record review, the facility failed to implement proper pain management to one of three sampled residents, (Resident 1). This failure had the potential to result in a decline in activities of daily living and mobility when pain was not managed. Findings: A review of Resident 1 ' s Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (a condition when the lungs cannot get enough oxygen into the blood), metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), and urinary tract infection [(UTI), an infection in any part of the urinary tract). Resident 1 ' s Admission Record indicated Resident 1 was discharged from the facility on 4/22/2022. A review of Resident 1 ' s History and Physical (H&P), dated 1/29/2022, indicated Resident 1 did not have the capacity to understand and make decisions. A review of Resident 1 ' s Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 2/9/2022, indicated Resident 1 was able to understand and be understood. The MDS indicated Resident 1 required extensive assistance for activities of daily living such as dressing, toilet use, and personal hygiene. The MDs indicated Resident 1 required limited assistance from staff with bed mobility, transfers, and walking in room. The MDs indicated Resident 1 required supervision from staff for eating, and locomotion on the unit. A review of Resident 1 ' s Restorative Nursing Assistant (RNA) weekly summary, dated 4/6/2022, indicated Resident 1 had complained of pain (dates not specified) and had been refusing to walk and stand with the RNA for the past five days (dates not specified). The progress note indicated the RNA had reported Resident 1 ' s complaint of pain to the charge nurse. The progress notes indicated on 4/6/2024 at 4:35 p.m., the Registered Nurse 1 (RN1) received a physician order of Norco 5-325 milligram ([mg, a unit of measurement) 1 tablet to be given every 12 hours as needed for moderate to severe pain. However, Resident 1 ' s progress notes did not indicate RN1 assessed Resident 1 ' s pain status after the RNA report. The Medication Administration Record (MAR) did not indicate Resident 1 was provided Norco medicine ordered as needed for pan. During a concurrent interview and record review on 7/9/2024 at 9:45 a.m., with the Assistant Director of Nursing (ADON), Resident 1 ' s progress notes and MAR for April 2022 were reviewed. The ADON stated the RNA notes indicated Resident 1 had complained of pain. The ADON stated the progress notes did not indicate if Resident 1 ' s pain was assessed. The ADON stated the MAR did not indicate if Resident 1 was given Norco for pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON stated if an RNA reported to the Charge Nurse a resident had pain during exercise, the charge nurse would assess the resident and document the result of assessments. The ADON stated Resident 1 ' s progress notes did not indicate pain assessment was performed. The DON stated the pain assessment was not done and Resident 1 ' s pain was not managed. The ADON stated if Resident 1 ' s pain was not managed, Resident 1 ' s range of motion or ambulation could decline. A review of the facility ' s policy and procedure (P&P), titled Pain Assessment and Management, dated 11/30/2022, indicated the facility should conduct a comprehensive pain assessment when there is a significant change in condition and when there is an onset of new pain or worsening of existing pain. The P&P indicated the facility should implement the medication regimen as ordered and carefully document the results of the interventions. The P&P indicated the facility was to document the resident ' s reported pain level with adequate detail to gauge the status of pain and the effectiveness of interventions for pain, as necessary, in the resident ' s medical record.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505 Based on interview and record review, the facility failed to ensure timely notification to the physician was conducted for one of three sampled residents ' (Resident 1) abnormal urinalysis (analysis of urine by physical, chemical, and microscopical means to test for the presence of disease) results. This deficient practice resulted in the delay of the urinary tract infection ([UTI] when bacteria enter the urinary tract; kidneys, bladder, or urethra) treatment for Resident 1. Findings: A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (a condition when the lungs could not get enough oxygen into the blood), metabolic encephalopathy (brain disorder) and UTI. The Admission Record indicated Resident 1 was discharged from the facility on 4/22/2022. A review of Resident 1 ' s History and Physical (H&P), dated 1/29/2022, indicated Resident 1 did not have the capacity to understand and make decisions. A review of Resident 1 ' s Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 2/9/2022, indicated Resident 1 was able to understand and be understood. The MDS indicated Resident 1 required limited assistance (resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance) to extensive assistance (resident involved in activity, staff provide weight-bearing support) for activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, bed mobility, and transfers (how resident moves to and from lying position, turns side to side and positions body while in bed). A review of Resident 1 ' s Change of Condition Evaluation (COC), dated 3/22/2022, indicated Resident 1 had cloudy urine (not normal), increased weakness, and poor oral intake (reduced consumption of food by mouth). The COC indicated a urinalysis ([UA] a test of the urine) and culture and sensitivity ([CS] a test to find which bacteria caused the infection and what antibiotic could treat it) were ordered by the physician. A review of Resident 1 ' s UA laboratory report dated 3/24/2022, indicated the UA was collected and resulted on 3/24/2022. The laboratory report result indicated the urine was turbid (caused by cloudy urine), had white blood cells ([WBC] normal reference range 0-2) and presence of small a bacteria (normal reference range none). The laboratory report indicated the physician was notified of the test results on 4/4/2022. A review of Resident 1 ' s urine culture laboratory report dated 3/24/24, indicated the CS was collected on 3/24/2022 and resulted on 3/28/2022. The laboratory report result indicated multiple organisms were isolated, had probable contaminant and to repeat culture, if indicated. The urine culture report indicated the physician was notified of the result on 3/28/2022 and had no new orders. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/2/2024 at 3:52 p.m. with the Infection Prevention Nurse (IPN), Resident 1 ' s UA laboratory report dated 3/24/2022 and progress notes were reviewed. The IPN stated she reported the urine CS results to the physician on 3/28/2022 but was not sure if the UA results were reported to the physician. The IPN stated she did not report the UA results to the doctor since the UA results were received on 3/24/2022. The IPN stated she did not see any notes indicating a nurse reported the abnormal UA results to the physician. During a concurrent interview and record review on 7/9/2024 at 9:28 a.m. with the Assistant Director of Nursing (ADON), Resident 1 ' s UA laboratory report was reviewed. The ADON stated the UA result was received on 3/24/2022 and the doctor was notified on 4/4/2022. The ADON stated the doctor notification on 4/4/2022 was late. The ADON stated, the delay in reporting of abnormal laboratory UA results to the physician could lead to the delay in care and could result in complications. A review of the facility ' s policy and procedure (P&P) titled, Lab and Diagnostic Test Results-Clinical Protocol, dated 11/2018, indicated a nurse would identify the urgency of communicating with the physician based on physician request, the seriousness of any abnormality, and the individual ' s current condition. The P&P indicated if the resident had signs and symptoms of acute illness or condition change and he/she was not stable or improving, or there were no previous results for comparison, then the nurse would notify the physician promptly to discuss the situation, including a description of relevant clinical findings as well as the test results. The P&P also indicated when facility staff notify physicians, facility staff should document information about when, how, and to whom the information was provided and the response in the progress notes of the medical record.