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	09/19/2024

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 0684 Level of Harm - 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** 46144 Based on interview and record review, the facility failed to provide the necessary care and services for one of three sampled residents (Resident 1) by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 2 reassessed Resident 1 after a change of condition ([COC] a sudden or gradual change in a patient's physical, cognitive, behavioral, or functional status) of wheezing (when breathing becomes difficult due to narrowed or blocked airways in the lungs), vomiting, and sweating on [DATE] at 8:00 a.m. This deficient practice resulted in Resident 1's death, at 10:57 a.m., approximately 3 hours after she was observed with shortness of breath, wheezing, vomiting, and sweating. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 1's diagnoses included hydrocephalus (a condition in which fluid accumulates in the brain), diabetes mellitus (when the body is unable to control the amount of glucose in the blood), aphasia (a language disorder that affects a person ' s ability to understand and express written and spoken language), gastro-esophageal reflux disease (a chronic condition that occurs when stomach contents leak into the esophagus, causing irritation), gastrostomy ([G-tube] a surgical opening in the stomach for nutrition, hydration, and medication), and right sided hemiplegia (in ability to move one side of the body) and hemiparesis (weakness to one side of the body). During a review of Resident 1's care plan titled, At risk for aspiration (when food, liquid, or other material is inhaled into the lungs), dehydration, and tube feeding intolerance ., dated [DATE], the care plan indicated Resident 1 will be free from signs and symptoms of dehydration daily. The staff interventions indicated to observe and report signs and symptoms of tube feeding intolerance such as nausea and vomiting, aspiration, choking, cough, change of level of consciousness, increase in shortness of breath, wet voice, gurgled sounding voice, and congestion. (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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(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 - Actual harm Residents Affected - Few	During a review of Resident 1's care plan titled, Impaired nutritional and hydration status related to dependence on enteral feed (a method of delivering nutrients and fluids directly into the digestive system through a tube) dated [DATE], the care plan indicated Resident 1 will show evidence of good hydration. The staff interventions included to observe and report coughing, choking, vomiting, congestion, gurgling sounding voice, cyanosis (a bluish discoloration of the skin resulting from poor circulation or inadequate oxygenation of the blood), runny nose, teary eyes, increase temperature, throat clearing, shortness of breath, rhonchi (abnormal breath sounds that resemble snoring or gurgling)/wheezing to the physician and speech therapist (a licensed professional who assesses and treats communication and swallowing disorders) promptly. During a review of Resident 1's History and Physical (H&P), dated [DATE], the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a comprehensive assessment and care-screening tool), dated [DATE] the MDS indicated, Resident 1's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 1 was dependent on staff for personal hygiene, showering, and dressing. The MDS indicated Resident 1 required the use of tube feeding (a method of providing nutrition, fluids, and medications directly into the stomach through a tube). During a review of Resident 1's Order Summary Report, indicated active orders as of [DATE], indicated to administer Tylenol (medication used to relive mild pain) 325mg 2 tablets via G-tube every 6 hours as needed for fever, Ipratropium-Albuterol Solution (a medication that dilates the airways of the lungs) 0XXX,d+[DATE]. 5 milligram ([mg] a unit of mass or weight) per (/) milliliter ([ml] a unit of measurement), inhale orally every 4 hours as needed for shortness of breath, wheezing, and congestion via nebulizer (a small machine that turns liquid medicine into a mist that be easily inhaled) and Zofran (a medication used to prevent nausea and vomiting) 4mg 1 tablet via G-tube every 4 hours as needed for nausea and vomiting. During a review of Resident 1's Change in Condition Evaluation, dated [DATE] at 8:00 a.m. the COC Evaluation indicated Resident 1 had an episode of wheezing, vomiting of clear mucous (viscous [thick] secretions produced by the mucous membranes [moist inner linings of nose, mouth, lungs, and stomach]), and sweating. The COC Evaluation indicated Resident 1's physician was not notified. During a review of Resident 1's Paramedic Run Sheet, dated [DATE] at 10:29 a.m., the Paramedic Run Sheet indicated 911 (an emergency number for any police, fire, or medic) was called at 10:29 a.m. Paramedics arrived at the facility at 10:35 a.m. and continued cardiopulmonary resuscitation ([CPR] an emergency life-saving procedure that is done when breathing or heartbeat has stopped). Paramedics pronounced Resident 1 deceased at 10:57 a.m. During a review of Resident 1's Progress Notes, dated [DATE] at 11:15 a.m., the Progress Notes indicated, Resident 1 had wheezing, sweating, and vomited at 7:45 a.m. The Progress Notes indicated Resident 1 was treated for the symptoms, reassessed, and administered 2 liters (L, unit of measurement) of oxygen. (continued on next page)

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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 - Actual harm Residents Affected - Few	During an interview on [DATE] at 1:28 p.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated Resident 1 was total care (provides all the care for a patient during their shift). CNA 3 stated on [DATE] at 7:45 a.m., Resident 1 looked tired and had lots of saliva (a bodily fluid) coming out of her mouth. CNA 3 stated she reported the resident ' s condition to LVN 2. CNA 3 stated LVN 2 gave Resident 1 a breathing treatment around 8:00 a.m. CNA 3 stated she found Resident 1 unresponsive around 10:13 a.m. and called for help. During a concurrent interview and record review on [DATE] at 1:45 p.m., Resident 1 ' s care plan titled, At risk for aspiration (when food, liquid, or other material is inhaled into the lungs), dehydration, and tube feeding intolerance ., dated [DATE], was reviewed with LVN 1. LVN 1 stated Resident 1 ' s condition changed, and the physician needed to be notified because the resident had shortness of breath, wheezing, vomiting, and sweating per the care plan. LVN 1 stated it was important to notify the physician for the safety and the care of the resident. LVN 1 stated calling the physician would have helped to prevent these conditions from worsening. During a telephone interview on [DATE] at 3:07 p.m. with LVN 2, LVN 2 stated on [DATE] at 7:40 a.m. CNA 2 notified her (LVN 2) that Resident 1 vomited and was sweating. LVN 2 stated she assessed Resident 1 and observed Resident 1 had shortness of breath, was wheezing and sweating. LVN 2 stated she observed vomit on Resident 1 ' s shirt and on the side of the resident ' s mouth. LVN 2 stated on [DATE] at 7:50 a.m. she administered Ipratropium-Albuterol Solution 0XXX,d+[DATE].5 mg/ml, Zofran, and Tylenol. LVN 2 stated at 7:51 a.m., she removed Resident 1 ' s blankets. LVN 2 stated at 8:04 a.m., she took Resident 1 ' s vital signs (measurements of the body ' s basic functions) and the readings were as follows: 1. Blood pressure was ,d+[DATE] millimeters of mercury ([mm/hg] a unit of measurement for pressure, normal range ,d+[DATE]mm/hg), 2. Pulse was 68 (a measurement of a patient's heart rate, normal range ,d+[DATE] beats per minute), 3. Respirations was 22 (number of breaths per minute, normal range 12 to 20), 4. Temperature was 98.5 Fahrenheit (a scale for measuring temperature, normal range 97F to 99F), 5. Oxygen saturation was 95 percent (%) (measures how much oxygen is in the blood, normal range 95% to 100%). LVN 2 stated there were no documented follow-up vital signs after interventions and treatment were provided to Resident 1. LVN 2 stated, If it was not documented then it was not done. LVN 2 stated she did not notify Resident 1's physician of the change of condition because she wanted to administer medications to the other residents in the facility. LVN 2 stated Resident 1's airway should have been the priority. LVN 2 stated it was very important to reassess the resident to assess the effectiveness of the interventions. LVN 2 stated not reassessing and not notifying the physician placed Resident 1 at risk for worsening of her condition. (continued on next page)

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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 - Actual harm Residents Affected - Few	During a telephone interview on [DATE] at 11:15 a.m. with Registered Nurse (RN) 1, RN 1 stated LVN 2 did not report that Resident 1 had shortness of breath, wheezing, vomited and was sweating. RN 1 stated Resident 1's symptoms were considered a change of condition. RN 1 stated once the medications were given to Resident 1, LVN 2 should have reassessed Resident 1 at least 15 minutes after the breathing treatment was administered. RN 1 stated LVN 2 should have reassessed resident's oxygen saturation again after 30 minutes. RN 1 stated LVN 2 should have reassessed and monitored Resident 1 in 15 to 30 minutes intervals to see if the interventions were effective. RN 1 stated the interventions should have been documented in detail, and the physician notified when the symptoms were identified. RN 1 stated if the physician was called another treatment such as an Xray (used to create images of the inside of the body to help diagnose and treat a variety of conditions) could have been ordered. RN 1 stated due to Resident 1 ' s risk for aspiration the Xray would show if the resident had an infection or aspirated (the act of breathing in food or liquid into the lungs). RN 1 stated LVN 1's failure to notify his physician when the resident was observed with shortness of breath, wheezing, vomiting, and sweating, might have resulted in Resident 1's death. During a concurrent interview and record review on [DATE] at 2:30 p.m., Resident 1's care plans titled, At risk for aspiration, dehydration, and tube feeding intolerance ., dated [DATE], and Impaired nutritional and hydration status related to dependence on enteral feed, dated [DATE] were reviewed with the Assistant Director of Nursing (ADON). The ADON stated Resident 1 was at risk for aspiration. RN 1 stated the care plan interventions indicated to call Resident 1' s physician promptly for signs and symptoms of shortness of breath, wheezing, and vomiting. The ADON stated Resident 1's physician was not notified for the sign and symptoms to be corrected with new interventions, and possibly new physician orders. During a concurrent interview and record review on [DATE] at 2:40 p.m., Resident 1's Change in Condition Evaluation, dated [DATE] was reviewed with the ADON. The ADON stated Resident 1's physician was not notified of the resident's change of condition. The ADON stated the physician should have been called as soon as possible because Resident 1 was vomiting and sweating. The ADON stated 30 minutes after treatment, a new set of vitals should have been documented and Resident 1 should have been reassessed. The ADON stated Resident 1 was found unresponsive at 10:13 a.m. and was pronounced dead at 10:57 a. m. The ADON stated if the physician was notified earlier, the physician would have probably ordered a stat (immediately without delay) Xray to rule out aspiration to prevent worsening the condition of the resident. During a concurrent interview and record review on [DATE] at 2:50 p.m., Resident 1's Progress Notes, dated [DATE] at 11:15 a.m. was reviewed with the ADON. The ADON stated reassessing a resident within 30 minutes after interventions were performed was a generalized standard of practice. The ADON stated the vital signs were not documented and that meant the vital signs were not done. The ADON stated auscultation (listening to the sounds of the body) of Resident 1's lung sounds were not documented, and it was unclear if the treatment was effective. (continued on next page)

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	555306	A. Building B. Wing	09/19/2024

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Charge Nurse, dated 2003, the P&P indicated, the Charge Nurse was delegated the administrative authority, responsibility, and accountability necessary for carrying out you assigned duties. The P&P indicated to chart nurses notes in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident ' s response to the care. The P&P indicated to notify the resident's attending physician and next of kin when there is a change in the resident's condition and ensure that residents who are unable to call for help are checked frequently. The P&P indicated to review care plans daily to ensure that appropriate care is being rendered, inform the Nurse Supervisor of any changes, and ensure the nurses' notes reflect that the care plan is being followed when administering nursing care or treatment. During a review of the facility ' s policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated ,d+[DATE], the P&P indicated, prior to notifying the physician the nurse will make detailed observations and gather relevant and pertinent information. The P&P indicated the staff will monitor and document the resident's progress and response to treatment and the physician will adjust accordingly.

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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 - Few	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** 46144 Based on interview and record review, the facility failed to document vital signs after treatment for shortness of breath, wheezing, vomiting, and sweating interventions were performed, for one of three sampled residents, (Resident 1). This failure had the potential for vital signs not taken, the necessary care and services Resident 1 would have needed not provided, and contributed to Resident 1 ' s death on [DATE] at 10:57 a.m. Findings: During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 1 ' s diagnoses included hydrocephalus (a condition in which fluid accumulates in the brain), diabetes mellitus (when the body is unable to control the amount of glucose in the blood), aphasia (a language disorder that affects a person ' s ability to understand and express written and spoken language), gastro-esophageal reflux disease (a chronic condition that occurs when stomach contents leak into the esophagus, causing irritation), gastrostomy ([G-tube] a surgical opening in the stomach for nutrition, hydration, and medication), and right sided hemiplegia (in ability to move one side of the body) and hemiparesis (weakness to one side of the body). During a review of Resident 1 ' s History and Physical (H&P), dated [DATE], the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set ([MDS] a comprehensive assessment and care-screening tool), dated [DATE] the MDS indicated, Resident 1 ' s cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 1 was dependent on staff for personal hygiene, showering, and dressing. The MDS indicated Resident 1 required the use of tube feeding (a method of providing nutrition, fluids, and medications directly into the stomach through a tube). During a telephone interview on [DATE] at 3:07 p.m. with LVN 2, LVN 2 stated on [DATE] at 7:40 a.m., Resident 1 vomited and was sweating. LVN 2 stated she assessed Resident 1 and observed Resident 1 had shortness of breath, was wheezing and sweating. LVN 2 stated she observed vomit on Resident 1 ' s shirt and on the side of the resident ' s mouth. LVN 2 stated on [DATE] at 7:50 a.m. she administered Ipratropium-Albuterol Solution 0XXX,d+[DATE].5 mg/ml, Zofran, and Tylenol. LVN 2 stated at 7:51 a.m., she removed Resident 1 ' s blankets. LVN 2 stated at 8:04 a.m., she took Resident 1 ' s vital signs. LVN 2 stated there were no documented follow-up vital signs after interventions and treatment were provided to Resident 1. LVN 2 stated she did not document the next set of vitals after reassessing Resident 1. LVN 2 stated, If it was not documented then it was not done. (continued on next page)

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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 - Few	During a telephone interview on [DATE] at 11:15 a.m. with Registered Nurse (RN) 1, RN 1 stated Resident 1 ' s symptoms were considered a change of condition. RN 1 stated once the medications were given to Resident 1, LVN 2 should have reassessed Resident 1 at least 15 minutes after the breathing treatment was administered, reassessed resident ' s oxygen saturation again after 30 minutes. RN 1 stated LVN 2 should have reassessed and monitored Resident 1 in 15 to 30 minutes intervals to see if the interventions were effective. RN 1 stated the interventions should have been documented in detail, and the physician notified when the symptoms were identified. During a concurrent interview and record review on [DATE] at 2:50 p.m., Resident 1 ' s Progress Notes, dated [DATE] at 11:15 a.m. was reviewed with the ADON. The ADON stated reassessing a resident within 30 minutes after interventions were performed, was a general standard of practice. The ADON stated the vital signs were not documented and that meant the vital signs were not done. The ADON stated auscultation (listening to the sounds of the body) of Resident 1 ' s lung sounds were not documented, and it was unclear if the treatment was effective. During a review of the facility ' s policy and procedure (P&P) titled, Charting and Documentation, dated , d+[DATE], the P&P indicated, all services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional, or psychosocial condition, shall be documented in the resident ' s medical record and should be communicated. The P&P indicated the resident ' s condition and response to care should be documented. The P&P indicated documentation in the medical record will be objective, complete, and accurate. The P&P indicated documentation of procedures and treatments will include care-specific details, including notification of family, physician, or other staff.