

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Kei-Ai South Bay Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379</p> <p>Based on interview, and record review, the facility failed to follow its policy and procedure (P&P) titled, Transfer and Discharge Notice, when three of three residents (Resident 1, 2, 3) and their representatives did not receive written notification of transfer after transfer to the general acute care hospital (GACH).</p> <p>This failure had the potential for Resident 1's, Resident 2's, and Resident 3's representatives to not know their transfer rights and destination of the residents' transfers.</p> <p>Findings:</p> <p>1. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. The Admission Record indicated Resident 1 had a history of subdural hematoma (a collection of blood outside of a blood vessel between the skull and brain). The Admission Record indicated Resident 1 had a responsible party.</p> <p>During a review of Resident 1's History and Physical (H&P), dated 7/27/2024, the H&P indicated Resident 1 did not have the capacity to make medical decisions due to mental and physical condition.</p> <p>During a review of Resident 1's Physician Orders, dated 12/24/2024, the Physician Orders indicated Resident 1 was ordered to transfer to a GACH 1.</p> <p>During a review of Resident 1's Progress Note, dated 12/24/2024, the progress notes indicated Resident 1 was transported to GACH 1 via ambulance.</p> <p>During an interview on 2/6/2025 at 3:30 p.m. with Registered Nurse (RN 1), RN 1 stated licensed nurses did not provide written Notification of Transfer to Resident 1 or their resident representative. RN 1 stated Resident 1's right may be violated if their representative was not notified in writing of Resident 1's transfer.</p> <p>(continued on next page)</p>

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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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 2/6/2025 with Director of Nursing (DON), Resident 1's Physician Orders dated 12/24/2024, Progress Notes dated 12/24/2024, and P&P titled Transfer or Discharge Notice, dated December 2016, were reviewed. The DON stated Resident 1 was transported to GACH 1 on 12/24/2024. The DON stated a written notice of transfer was not provided to Resident 1 or their representative. The DON stated the P&P indicated written notice must be provided to resident representative for all transfers. The DON stated a written notice was not provided to Resident 1. The DON stated the facility did not have a process for providing written notices of transfer.</p> <p>2. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE]. The Admission Record indicated Resident 2 had a history of hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain). The Admission Record indicated Resident 2 had an emergency contact.</p> <p>During a review of Resident 2's H&P, dated 1/18/2025, the H&P indicated Resident 2 had the capacity to make medical decisions.</p> <p>During a review of Resident 2's Transfer Form, dated 1/18/2025, the Transfer Form indicated Resident 2 was transferred to GACH 2. The Transfer Form indicated Resident 2's emergency contact was notified about the transfer and clinical situation via telephone.</p> <p>During an interview on 2/6/2025 at 3:30 p.m. with RN 1, RN 1 stated licensed nurses did not provide written Notification of Transfer to Resident 2 or their representative.</p> <p>During a concurrent interview and record review on 2/6/2025 at 4:00 p.m. with the DON, Resident 2's clinical record was reviewed. The DON stated a written notice of transfer was not provided to Resident 2 or their representative.</p> <p>3. During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE]. The Admission Record indicated Resident 3 had a history of quadriplegia (paralysis from the neck down, including legs, and arms).</p> <p>During a review of Resident 3's H&P, dated 1/22/2025, the H&P indicated Resident 3 had the capacity to make medical decisions.</p> <p>During a review of Resident 3's Transfer Form, dated 1/18/2025, the Transfer Form indicated Resident 3 was transferred to GACH 1. The Transfer Form indicated Resident 2's emergency contact was notified about the transfer and clinical situation via telephone.</p> <p>During an interview on 2/6/2025 at 3:30 p.m. with RN 1, RN 1 stated licensed nurses did not provide written Notification of Transfer to Resident 3 or their representative.</p> <p>During a concurrent interview and record review on 2/6/2025 at 4:00 p.m. with the DON, Resident 3's clinical record was reviewed. The DON stated a written notice of transfer was not provided to Resident 3 or their representative.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 2/6/2025 at 4:00 p.m., the facility's P&P titled Transfer or Discharge Notice, dated December 2016, was reviewed. The DON stated the P&P indicated written notification of transfer must be provided to residents and their representatives to inform them of the reason, time, and location of transfer. The DON stated the written notice would notify residents of their rights, such as their right to appeal the transfer. The DON stated the facility does not have a process in place to notify residents and their representatives in writing.</p> <p>During a review of the facility's P&P titled, Transfer or Discharge Notice, dated 12/2016, the P&P indicated the resident and/or representative should be notified in writing the reason for the transfer or discharge, the effective date and location of discharge, statement of resident's right to appeal, the facility's bedhold policy, the Ombudsman's information, name and phone number of the state health department.</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379</p> <p>Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled, Physician Services, which indicated physicians must perform the initial face-to-face visit, sign admitting physician orders, and perform alternating visits with a non-physician practitioner (NPP), for one of three residents (Resident 1).</p> <p>This failure had the potential for Resident 1 to not be thoroughly assessed, not receive safe and adequate care.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. The Admission Record indicated Resident 1 had a history of subdural hematoma (a collection of blood outside of a blood vessel between the skull and brain), end stage renal disease (ESRD-irreversible kidney failure) with dependency on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and multiple myeloma (blood cancer). The Admission Record indicated Resident 1 had a responsible party.</p> <p>During a review of Resident 1's History and Physical (H&P), dated 7/27/2024, the H&P indicated Resident 1 did not have the capacity to make medical decisions due to mental and physical condition. The H&P was signed by a NPP.</p> <p>During a review of Resident 1's Physician Orders, dated 7/24/2024, the Physician Orders were signed by an NPP.</p> <p>During a review of Resident 1's Physician Progress Notes dated 8/2/2024, 8/21/2024, 9/2/2024, 9/22/2024, 10/8/2024, 10/20/2024, 11/3/2024, 11/13/2024, 11/20/2024, and 12/5/2024, the Physician Progress Notes indicated they were signed by an NPP.</p> <p>During a concurrent interview and record review on 2/6/2025 with Director of Nursing (DON), Resident 1's Physician Orders dated 7/24/2024, H&P dated 7/27/2024, Physician Progress Notes dated 8/2/2024, 8/21/2024, 9/2/2024, 9/22/2024, 10/8/2024, 10/20/2024, 11/3/2024, 11/13/2024, 11/20/2024, and 12/5/2024, P&P titled Physician Services dated April 2013, and Code of Federal Regulations (CFR- federal law) 483. 30(c) dated 10/4/2026, were reviewed. The DON stated, the P&P indicated physician visits, frequency of visits, progress notes, and physician orders should have been provided in accordance with current regulations, which indicated physicians must perform the initial face-to-face visit, sign admitting physician orders, and can perform alternating visits with an NPP. The DON stated all of Resident 1's Physician Orders on admission, H&P, and Physician Progress Notes were signed by an NPP. The DON stated there was no evidence in Resident 1's chart that Resident 1's physician had face-to-face contact with Resident 1. The DON stated Resident 1's care could have been compromised and unsafe.</p> <p>During a review of the facility's P&P titled Physician Services, dated April 2013, the P&P indicated physician visits, frequency of visits, progress notes, and physician orders should be provided in accordance with current regulations.</p> <p>(continued on next page)</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Code of Federal Regulations (CFR- federal law) 483.30(c), dated 10/4/2016, the CFR indicated NPPs may not perform the initial comprehensive visit or write admission orders for residents in skilled nursing facilities. The CFR indicated a physician may not delegate a task when the regulations specify that the physician must perform it personally. The CFR indicated physicians and NPPs may alternate in-person visits and that physicians must write, sign, and date progress notes at each visit.</p>		