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	07/31/2025

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 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 interview and record review, the facility failed to provide staff supervision for 2 of three sampled residents (Resident 1 and 2) by failing to ensure Resident 1 and Resident 2 were separated immediately by staff when Resident 2 was verbally aggressive towards Resident 1.This failure resulted in Resident 2 hitting Resident 1 on the left side of the face. Findings: During a review of Resident 1's admission Record (Front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included end stage renal disease ([ESRD] - irreversible kidney failure) on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed), chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), and Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool), dated 7/19/2025, the MDS indicated, Resident 1's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated, Resident 1 required maximal assistance (helper does more than half the effort) from staff with toileting hygiene and lower body dressing.During a review of Resident 2's admission Record, the admission Record indicated, Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included urinary tract infection ([UTI] - an infection in the bladder/urinary tract), bilateral (both) below the knee amputation (a surgical procedure where a portion of the lower leg, below the knee joint, is removed), and chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing). During a review of Resident 2's MDS, dated [DATE], the MDS indicated, Resident 2's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated, Resident 2 required supervision (helper provides verbal cues) from staff with toileting hygiene and lower body dressing. During a review of Resident 1's Change in Condition Evaluation, dated 7/21/2025, the Change in Condition Evaluation indicated, Resident 1 was hit by Resident 2. During a phone interview on 7/31/2025 at 12:21 p.m., with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated she was inside the room when she saw Resident 2 who came outside the room in his wheelchair going back to his bed. CNA 1 stated when Resident 1 passed by Resident 2's sitting on his wheelchair eating lunch, CNA 1 saw Resident 2 was verbally aggressive and calling out names and told Resident 1 to get out of his way. CNA 1 stated she was standing between Resident 1 and Resident 2. CNA 1 stated she told Resident 2 to be nice to Resident 1 then Resident 2 suddenly swayed his right-hand hitting Resident 1 on left side of his face. CNA 1 stated she thought she could talk to Resident 1, but his behavior got worst. CNA 1 stated she should have wheeled Resident 1 outside of the room at the time when he was exhibiting verbally aggressive behavior. CNA 1 stated the incident could have been prevented if she called for help and separated Resident 1 and Resident 2 immediately. During an interview on 7/31/2025 at 1:05 p.m., with the Director of Staff Development (DSD), the DSD stated if resident has (continued on next page)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verbally aggressive behavior with other resident, the initial intervention is to separate them immediately to de-escalate (diminish/minimize) the situation in order to prevent potential harm. During an interview on 7/31/2025 at 1:47 p.m., with the Director of Nursing (DON), the DON stated it is the facility's responsibility to provide supervision to prevent an accident and for the safety and welfare of the residents. The DON stated for resident-to-resident altercation to act promptly by separating them immediately to prevent further altercation. During a review of the facility's policy and procedure (P&P), titled Safety and Supervision of Residents, dated 7/2017, the P&P indicated, Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. During a review of the facility's P&P, titled Resident-to-Resident Altercation, dated 11/29/2022, the P&P indicated, the facility acts promptly and conscientiously to prevent and address recurrent altercations. The P&P also indicated residents involved will be separated immediately, and measures to calm or diffuse the situation will be instituted.