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	08/29/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents' (Resident 1) transfer summary was completed, and telephone report was called to the receiving facility, prior to discharge on [DATE], as indicated in the facility's policy and procedure (P&P) titled, Discharging the Resident. This failure caused Resident 1's discharge to the independent living facility (ILF, a community for active seniors who want to maintain their independence but desire the benefits of a maintenance-free lifestyle and community amenities, such as dining, fitness centers, housekeeping, and social activities) on 8/20/2025, who could not fully provide and accommodate the resident's needs and had the potential to affect the resident's highest practicable physical, mental and psychosocial well-being.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing,) hypertension (HTN-high blood pressure) and hyperlipidemia (a condition characterized by high levels of lipids (fats) in the blood, including cholesterol and triglycerides).During a review of Resident 1's History and Physical (H&P) dated 3/15/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Care Plan titled, Discharge Plan, dated 1/16/2025, the discharge plan indicated Resident 1 would remain in this facility long term. The discharge care plan goals indicated Resident 1 will be assisted post-discharge and the services required to meet needs before discharge. The discharge care plan interventions included identifying Resident 1's needs, discuss and address limitations, risk, benefits and needs for maximum independence. During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 6/5/2025, the MDS indicated Resident 1 had intact cognition. The MDS indicated Resident 1 required supervision or touching assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer and mobility. During a review of Resident 1's Interdisciplinary Team ([IDT] group of healthcare professionals, including resident/ resident representative, working together to provide residents with needed care) meeting notes from 8/11/2025 to 8/20/2025, the notes did not indicate documented evidence that an IDT meeting was done prior Resident 1's discharge on [DATE]. During a review of Resident 1's Social Services (SS) progress notes dated 8/19/2025, the SS progress notes indicated the SS spoke to Resident 1 about possible discharge planning. The SS progress notes indicated Resident 1 was open to the idea of transitioning to a lower level of care facility. During a review of Resident 1's Physicians Orders dated 8/20/2025, the physician's order indicated to discharge Resident 1 to an independent living facility with home health services (an agency that provides skilled medical care to patients in their own homes to treat an illness or injury, often after a hospital stay or for chronic condition) and physical therapy. During an interview on 8/26/2025 at 11:20 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated part of a discharge process is to conduct an IDT meeting, one-week prior residents are being discharged . LVN 1 stated the purpose for an IDT meeting is to discuss Resident 1's needs and to make sure the new place was safe and could accommodate Resident 1's needs. During an interview on 8/26/2025 at 2:42 p.m. with the complainant, the complainant stated, I visited Resident 1 on 8/21/2025 at the ILF, the place was small, and Resident 1 stayed on a couch in the living room. The complainant stated there were 3 more people living at this place and Resident 1 did not have a room for him. The complainant stated this facility could not accommodate Resident 1's needs. During an interview on 8/27/2025 at 9:23 a.m. with the SS, the SS stated IDT meetings are done one-week prior to a resident's discharge. The SS stated Resident 1's IDT meeting was not scheduled prior to the discharge on [DATE]. The SS stated Resident 1's plan of care should have been reviewed to resolve any worries Resident 1 may have before discharge. The SS stated the discharge was only communicated with Resident 1 and the resident was open to the idea to be discharged . The SS stated on 8/20/2025, a discharge coordinator from the ILF called and stated Resident 1 had a room in the ILF. The SS stated Resident 1 was made aware and agreed with transfer to the ILF. The SS stated the communication about Resident 1's discharge was directly with the discharge planner and Resident 1 was discharged to the ILF on 8/20/2025. The SS stated, I was not sure if the place was safe for Resident 1. The SS stated, I failed to call and check with the independent living if they could accommodate Resident 1's needs, such as medications administrations, blood glucose (blood sugar level) checks and if the room was available for him. The SS stated the facility failed to provide Resident 1 a safe discharge to the ILF. During an interview on 8/27/2025 at 10:45 a.m. with the ILF owner (ILFO), the