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	03/11/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise the care plan to include person-centered safety measures such staff supervision and monitoring for one of five sampled residents (Resident 1) who was at high risk for falls, had decreased postural alignment (misalignment or imbalance of the body's musculoskeletal structures), poor standing balance (moderate assistance and upper extremity support to stand and reach without loss of balance; unable to weight shift) and impaired safety awareness. This deficient practice resulted in Resident 1 having unwitnessed falls on 11/22/2025, 11/24/2025 and 11/28/2025, and placed the resident at risk for injuries, hospitalization or death. Findings:During a review of Resident 1's admission record, the admission record indicated Resident 1 was admitted on [DATE] with diagnoses including history of falling with a fracture (broken bone) of the left femur (thigh bone), anxiety disorder (excessive and persistent worry that interferes with life), abnormalities of gait (manner of walking) and mobility, and muscle weakness.During a review of Resident 1's Morse Fall Risk Screen dated 11/9/2025, the Risk Screen indicated Resident 1 had a history of falling and had a weak gait requiring the use of crutches, cane or walker. The Risk Screen indicated Resident 1 was at a high risk for falls. During a review of Resident 1's Physical Therapy (PT) Evaluation and Plan of Treatment dated 11/10/2025, the PT Evaluation indicated Resident exhibited new onset of decrease in strength, functional mobility, reduced ability to safely ambulate and decreased postural alignment. Resident 1 had fair (maintains balance with minimum assistance or upper extremity support) dynamic sitting balance (the ability to maintain postural control and stability while seated and moving, such as reaching, shifting weight, or turning) and poor standing balance. The PT Evaluation indicated Resident 1's safety awareness was impaired. Risk factors included risk for falls and further decline in function due to physical impairments and associated functional deficits. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 11/15/2025, the MDS indicated Resident 1 had moderate cognitive (ability to think and reason) impairment. The MDS indicated Resident 1 required substantial/ maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, and partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or libs, but provides less than half the effort) with transfers (moving between surfaces to and from bed, chair, and wheelchair) and walking 10 feet. During a review of Resident 1's Care Plan titled, High risk for falls and injury related to recent fall in the last 30 days. dated 11/9/2025, the Care Plan goals indicated Resident 1's risk factors would be managed to minimize falls and injury. The Care Plan interventions indicated for nursing to provide assistance with ADLs, transfers, ambulation and toileting.During a review of Resident 1's Change of Condition (COC) dated 11/22/2025, the COC indicated Resident 1 was status post (s/p) an unwitnessed fall. The COC indicated Certified Nursing Assistant (CNA) 1 observed Resident 1 at the edge of the bed attempting to scoot himself up onto the bed. Resident 1 stated he was using his urinal and slid off the bed and sat on the floor. During a review of Resident 1's Interdisciplinary Team (IDT- a group of healthcare professionals from different (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disciplines who work together to manage the resident's care) Meeting dated 11/24/2025, the IDT indicated (on 11/22/2025) patient stated he was using his urinal and slid off the bed and sat on the floor. The IDT indicated diagnosis/predisposing factors included resident perceiving self as independent and forgets to call for assistance. New interventions indicated falling star program (visual safety initiative to identify residents at high risk for falls such as the use of yellow wristband as a form of communication reminding staff to provide increased attention, supervision and focus on the resident). During a review of Resident 1's Care Plan titled, Actual Fall Incident as Evidenced by Unwitnessed Fall dated 11/22/2025, the Care Plan interventions indicated staff were to check and assess Resident 1 for the presence of pain or injury and explain to the resident the need to call the nurse for assistance. The Care Plan did not address monitoring or supervision for Resident 1. During a review of Resident 1's COC dated 11/24/2025, the COC indicated Resident 1 was s/p an unwitnessed fall. Resident 1 was found sitting on the floor at the bedside and stated he accidentally slid down from the bed. During a review of Resident 1's IDT Meeting dated 11/25/2026, the IDT Meeting indicated Resident 1 was found sitting on the floor at the bedside. Resident 1 stated he accidentally slid down the bed while sitting at the edge of the bed. The IDT Meeting indicated diagnosis/predisposing factors included resident perceive self as independent and forgets to call for assistance. New Interventions indicated (team) reminded Resident to use call light for assistance. During a review of Resident 1's Care Plan titled, Resident 1 has an actual fall incident found sitting on the floor at bedside dated 11/24/2025, the Care Plan interventions indicated to check range of motion post fall, neuro check, physical therapy consult. The Care Plan did not indicate address monitoring or supervision for Resident 1. During a review of Resident 1's COC dated 11/28/2025, the COC indicated Resident 1 was s/p an unwitnessed fall. Resident 1 was found on the floor with the bed alarm functioning and alerting nursing staff. No apparent injuries were noted. During a review of Resident 1's Care Plan titled, Resident 1 has an actual fall incident found sitting on the floor at bedside dated 11/28/2025, the Care Plan interventions indicated to check and assess resident for presence of pain, change in range of motion, fictional mobility, obtain vital signs, explain to the resident the need to call the nurse for assistance, keep room and common areas free of clutter. The Care Plan did not address monitoring or supervision for Resident 1. During an interview on 3/11/2026 at 1:53 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated when residents were identified as high risk for falls upon admission, nurses would place the bed in the lowest position, ensure the call light was within reach, educate the resident, assist residents when getting out of bed and using the bathroom, and provide frequent monitoring. LVN 1 stated when Resident 1 continued getting up from the bed, additional interventions could have included moving the resident closer to the nurse's station. LVN 1 stated it was important to update the care plan to include interventions such as indicating the frequency of monitoring and supervision needed for the resident. LVN 1 stated the care plan should be updated after each fall to ensure resident safety and prevent potential fractures. During a concurrent interview and record review on 3/11/2026 at 4:28 p.m. with the Assistant Director of Nursing (ADON), Resident 1's care plans dated 11/22/2025, 11/24/2025, and 11/28/2025 were reviewed. The ADON stated the care plans did not indicate the frequency with which Resident 1 was to be monitored or supervised. During an interview on 3/12/2026 at 11:45 a.m., with the Director of Nursing (DON), the DON stated nurses were required to follow the postˆfall procedures, which included updating the care plan. The DON stated care plans should be developed or updated and individualized for each resident to reflect the care the resident would receive from the nursing staff. The DON stated this was essential because, in the case of Resident 1's actual falls, nurses needed to provide close supervision and monitoring. The DON stated that Resident 1's care plan should have included specific and clear interventions because he had fallen three times, and it was necessary to prevent any future falls or complications. During a review of the facility's policy and procedures (P&P) titled Comprehensive Person-Centered Care Planning dated 12/2016, the P&P indicated identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident. Assessment of residents is ongoing, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and care plan is revised as information about the residents and the resident condition changes. The interdisciplinary team must review and update the care plan: when there has been a significant change in residents' conditions, and when the desired outcome is not met.