Accepted
8/12/25
#47923

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555306	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, California, 90247

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Facility Reported Incident Number: 2567759 The inspection was limited to the specific complaint and Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for the Facility Reported Incident: 2567759 (Refer to Ftag 689).	F0000	Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law.	8/11/25
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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	F0689	F689 Corrective action for residents found to have been affected by this deficiency: CNA 1 was provided a one-on-one in-service and education regarding immediate separation and de-escalation of potential resident to resident altercation on 8/4/25. Corrective action for residents that may be affected by this deficiency: On 7/31/25, Director of staff developer/ designee interviewed staff if there are any resident roommate's incompatibility to ensure supervision and communication to prevent potential resident incident.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Dos	8-7-25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555306	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

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F0689 SS = D	Continued from page 1 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 7/16/2025. 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 6/19/2021 and readmitted on 5/31/2025. 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 7/14/2025, 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	F0689	Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not reoccur: On 8/4/25 and 8/5/25, DON/designee provided an in-service and education training to staff regarding facilities P&P on resident -to-resident alteration; to act promptly and conscientiously to prevent and address recurrent altercation, separate immediately and measures to calm or diffuse the situation. Director of staff developer/designee will validate compliance during observation rounds daily, if staff are responding immediately to potential resident incident. Director of staff developer/designee will communicate findings to the DON. Measures that will be put into place to ensure that this deficiency does not reoccur: The above POC will be reviewed in the QAPI committee for 3 months and as needed thereafter. Administrator and/or Designee will report trends.	8/11/25

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F0689 SS = D	Continued from page 2 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 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.	F0689		