POC accepted HPBN 38551 10/9/19

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

11:42:26 a.m.

7/20

PRINTED: 09/27/2019 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES				NO. 09	
STATEMENT	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SU COMPLE	RVEY
						C	1
		555306	B. WING			09/27/	2019
	ROVIDER OR SUPPLIE OUTH BAY HEALTH			15	REET ADDRESS, CITY, STATE, ZIP CODE 115 S VERMONT AVE ARDENA, CA 80247		-
04010	SHAMADY	TATEMENT OF DEFICIENCIES .		-			
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LEC (DENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE C	(X5) DMPLETION DATE
F 000	INITIAL COMME	NTS	F	000	F689 Free of Accidents	. 1	0/27/19
	Department of P	flects the findings of the ublic Health of a Complaint		-	Hazards/Supervision/Devices		
		ing an Abbreviated Survey. er: CA00648151			How corrective action will be accomplished for those residents have been affected by the defici-	s found	to
	Representing the Health Facilities	Department of Health: Evaluator Nurse: 38561			practice A comprehensive assessment of		nt
					l was conducted when he return	ed to th	е .
	complaint invest	was limited to the specific igated and does not represent full inspection of the facility.			facility on July 30, 2019. His ca were updated on July 30, 2019 this current risk factors for fall a	to reflect	t
	Complaint numb	deficiencies issued for per CA00648151			interventions were developed to specific risk factors. Similarly, orders were reviewed on July 30	physicia	n's
F 689 SS=G	Free of Accident CFR(s): 483.25	t Hazards/Supervision/Devices (d)(1)(2)	. F	689	the devices or alarms that were utilized for Resident 1.	to be	
	§483.25(d) Acci	dents. t ensure that -			Resident 1's care plan intervent	tions for	
	§483.25(d)(1) T	he resident environment remains ent hazards as is possible; and			fall and injury prevention are communicated with the staff du	iring	
	§483.25(d)(2)Esupervision and accidents.	ach resident receives adequate I assistance devices to prevent			change-of-shift huddles daily to that interventions are followed	through	
	by:	MENT is not met as evidenced			CNA 1 was provided a one-on- service by the Assistant Directo	or of	9
	review, the faci	ervation, interview and record lity falled to follow physician ent's care plans for use of assistiv	e		Nursing (ADON) on July 23/20 regarding fall prevention and m specifically about communication	nanagem	ent,
	floor mats and for one of three high risk for fai	s bed and wheelchelr alarms and provide the necessary supervisio sampled residents who had a is with injuries (Resident 1). i a history of falls and required			coordinating with the supervisi nurse and assigned CNA when helping out with a resident who assigned to him.	ng licen ever	sed
LABORATO	DRY DIRECTOR'S OR P	ROVIDER/SUPPLIER REPRESENTATIVE'S	HITAKRI	<u>.</u>	TITLE	<u> </u>	O(8) DATE

Any deficiency statement ending with an astarisk (*) 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 data these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

09-27-2019

8/20

PRINTED: 08/27/2019 FORM APPROVED

		A MEDICAID SERVICES				MB NO.	<u> 10938-0391</u>
	NT OF DEFICENCIES I OF CORRECTION	(XI) PROVIDENCUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	•	555306	B. WING		<u> </u>		-
NAME O	F PROVIDER OR SUPPLIER	1		s	TREET ADDRESS, CITY, STATE, ZIP CODE	nai:	27/2019
WC) AI	SOUTH BAY HEALTHO			Ł	5115 8 VERMONT AVE		
VEHAI	300 in day realing	ARE CENTER			BARDENA, CA 80247	•**	
· (X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	19	_	PROVIDER'S PLAN OF CORRECTION	M	. 200
PREPIX TAG	E (EACH DEFICIENT	y must be preceded by full LSC identifying information)	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROX DEFICIENCY)	382	(XI) COMPLETION DATE
F 68	B Continued From p	ono 1	· _	~=-			
		sion with use of alarms to	F	689	2. How the facility will identify	other o	
	nrevent falls was i	not supervised and alarms	1		residents having the potential t		. .
	were not used as	prescribed by the physician.	1		affected by the same deficient		ind
	, , , , , , , , , , , , , , , , , , , ,	order and by are prijestikali.			what corrective action will be t		· ·
		•			The Assistant Director of Nurs]
	This deficient prac	tice resulted in Resident 1	1.		(ADON) will review incidents	_	ļ
	taling three times	within seven (7) days. Resident	1 '		accidents that occurred within		hs ·
	7 Sustained injune	s from the fails on 7/22/19 and			of July 2019 to the present mor		· ·
	Core bossiol (CA)	ransferred to a general acute CH) for evaluation and	1	•	identify any other residents wh		ve
	treatment. This do	ficient practice had the			been affected by the same defi-		
	potential to result i	n further falls and injuries to			practice.		
	Resident 1 and off	ner residents with high risk for		-		•	ļ
-	falls.		1.		The review will focus on ensur	ing thát	
	· ·		1		comprehensive assessment was		
			1		to identify fall risk factors and		*
	Findings:				resident's care plan reflects per		
			-		centered interventions to mitig		kk ·
	A review of Papide	ent 1's Admission Face sheet			This will be completed by Octo		
•	indicated Residen	t 1was admitted to the facility	1		2019.		ľ
• •	on 12/13/18 with a	most recent admission on	1		}		
	4/18/19. Resident	1's diagnoses included	1		If any other resident is identific	ed to be	
	breumetic brein ini	ury (a disruption in the normal	.		affected by the same deficient		the
	function of the bra	in caused by a hump or blow to	1		facility will follow its interdisc		
}	une nead), history	of falling, generalized muscle	1.		team process to assess fall risk		
	Westunder, (St. 118)	niplegia (paralysis [inability to the body) and hemiparesis	1		develop care plan, and commu		
	(Weaknose of this	wie occy) and nemiparesis muscles of the lower face, arm,			interventions for each specific		
	and leg on the left	side of the body), seizure (a			with assigned staff.		1
'	i sudden, uncontrol	led electrical disturbance in the					
	brein that can cau	SB Changes in behavior				-	! •
ļ	movements or fee	linus, and in levels of	1				
	Consciousness) e	nd dementia (decline in	-		An entre de la company de		
٠ ا	thinking skills that	o, problem-solving and other affect a person's ability to	1		<u> </u>		
l	perform everyday	eneu a person's somy (0 schillise)	1				l
·		•			_	٠ ,	
l	A review of a "Mor	se Fall Risk Screen," (a fall risk	:			•	

FORM CMB-2507(02-90) Previous Varsions Obsoleto

Event ID: YENC11

Facility ID: CA910000278

If continuation sheet Page 2 of 10

PRINTED: 09/27/2019 FORMAPPROVED

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

C D9/27/2019

NAME OF PROVIDER OR SUPPLIER

KEI-AI SOUTH BAY HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

15118 8 VERMONT AVE GARDENA, CA 80247

(X4) ID	Summary Statement of Deficiencies	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS)
PREFIX	(Each Deficiency Must be preceded by Full	PREFOX		COMPLETION
TAG	Resulatory or LSC Identifying Information)	TAG		DATE
•				

F 689

F 689 Continued From page 2

assessment), dated 12/13/18, indicated Resident 1 had a score of 65 (a score of 45 and above means high fall risk).

A review of Resident 1's Minimum Data Set (MDS), an assessment and care screening tool, dated 6/19/19, indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 required a one-person physical assist with bed mobility, dressing, eating, tollet use and personal hygiene. The MDS indicated Resident 1 required a two-person physical assist moving to or from a bed, chair and or wheelchair to a standing position.

A review of Resident 1's history and physical (H/P) report, dated 7/5/19, indicated Resident 1 could make his needs known, but could not make medical decisions.

A review of Resident 1's care plan, dated 7/8/19 indicated Resident 1 had high risk for falls and injury, poor judgement and safety awareness, history of falls and limited mobility. The staff's interventions included to keep Resident 1's personal items, including the call light within reach, bed in low position and to keep the room clutter free.

1.A review of Resident 1's care plan, dated 7/22/19, indicated Resident 1 had an actual fall incident on 7/22/19. The staff's interventions included to transfer Resident 1 to the hospital for evaluation, assess the resident for pain, injury, change in range of motion, mobility and level of consciousness (the state of being awake end aware of one's surroundings), provide first aid for presence of injury and to determine the cause of the fall.

3. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur

The DON or ADON will conduct medical record reviews for new admissions daily five times a week and residents post-fall to ensure that the care plan for fall or injury prevention reflects a holistic assessment of every resident and that risk-specific interventions were developed. This will be implemented on October 7, 2019

The licensed nurses were provided an service on Fall Prevention and Management, including the facility's Falling Star Program, by the Nurse Consultant on October 2, 2019. The inservice emphasized the importance of conducting a comprehensive assessment to identify fall risk factors, developing risk-specific care plan, communicating interventions with CNAs, and monitoring effectiveness of interventions.

The CNAs will be provided an in-service on Fall Prevention and Management by the Nurse Consultant on October 7, 2019. The in-service will focus on the role of CNAs in preventing falls and injuries and about the facility's Falling Star program.

FORM CMS-2507(02-00) Provious Versions Obsoleto

Everi ID: YBNC11

Facility ID: CA910000276

If continuation shoot Page 3 of 10

09-27-2019 PRINTED:

10 /20 09/27/2019

		AND HUMAN SERVICES 8 MEDICAID SERVICES			G	FORM/ MB NO	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION .	(XS) DATE	
	•	555306	B. WING	·	•	.006	27/2019
NAME OF F	ROVIDER OR SUPPLIER			51	TREET ADORESS, CITY, STATE, ZIP CODE	J 0012	11/4V 10
. KELYI G	OUTH BAY HEALTHO	ADE CENTED		15	5116 S VERMONT AVE		
VEI-MI 94	JUIN BAT REALING	MAE CENTER.		G	ARDENA, CA 80247		
(X4) (D PREFIX TAG	(EACH DEPICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		Frovider's Flan of Correction (Each Corrective Action Should Cross-Referenced to the Approp Deficiency)	DBE	(%) COMPLETION DATE
F 659	Continued From pa	age 3 ation Background Assessment tion" ([8BAR] an internal	F	689	The facility implemented chan huddles between the licensed to CNAs to discuss residents' spe	iurse and	the
•	communication for 2 p.m., indicated R and sustained a sk	m), dated 7/22/19 and timed at tesident 1 had a fall on 7/22/19 in tear (a wound caused by		•	including fall prevention meas was implemented on September	ures. The er 30, 20	s 19.
	separation of skin				The ADON will post an updat residents in the Falling Star pr the nurse's station weekly to n	ogram b	ł
	7/22/19 and timed Resident 1 was toll bathing, dressing.	ility's "Transfer Form," dated at 2:10 p.m., indicated ally dependent on the staff for tolleting, transfers and eating, il Resident 1 who had a high			informed of residents who are falls. This was completed on 0 2019.	high risl	for
	l feil risk, had a skir	tear on the forehead 0.5 centimeters ([cm] unit of			The Department Managers wi room rounds once a week to e fall prevention interventions a implemented according to eac	nsure tha re being h reside:	t . t's
	dated 7/23/19 indi to the GACH on 7/ 7/25/19, following in Resident 1 aust	ont 1's GACH Progress Note cated Resident 1 was admitted 22/19 and discharged on a fall in the facility that resulted siring a frontal head hematoma od outside of blood vessels).			care plan. Deficient findings of will be reported to the DON a Administrator during the stanfor follow-up. This will be im on October 18, 2019.	nd d-up mee	ting
	7/25/19, indicated bilateral (both) had	ent 1's Physician's orders, dated Resident 1 should have I side bed rails up to assist urning and repositioning in bed.		-	How the facility plans to m performance to make sure that are sustained. The Director of Nursing will	t solution	s .
	dated 7/26/19, ind	ant 1's Morse Fall Risk Screen, icated Resident 1's score was pared to the assessment on		~	trend data from room rounds record reviews monthly and v findings to the Quality Assess	and med will repor sment an	ical t .
	A review of Reside 7/26/19, indicated	ent 1's physician's orders, dated Resident 1 should have a tab at alerts the staff when the			Assurance (QAA) Committee QAPI meeting for further recommendations.		

FORM CMS-2507(02-99) Previous Versions Obscieta

Event ID:YBNC11

Pacifity ID: CA919000276

if continuation shoet Page 4 of 10

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DPH

11:43:18 a.m. 09-27-2019 11 /20 PRINTED: 09/27/2018 FORMAPPROVED

DEPART CENTER	MENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/27/2019 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:	()(2) MUI A BUILT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	•	555309	B. WINE	1		li i	C 27/2019	
NAME OF	PROVIDER OR SUPPLIER			BTR	CEET ADDRESS, CITY, STATE, ZIP CO		ZIIZUIB	
KEI-AI S	OUTH BAY HEALTHO	ARE CENTER			158 vermont ave IRDENA, CA 90247			
(X4) ID PREFIX TAG	FEACH DEFICIENCY	Tement of Depiciencies Y must be preceded by full SC Identifying (Nformation)	PREF TAG	TX .	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	BHOULD BE	CONFLETION CONFLETION	
F 689	alert the staff. This should monitor Res placement and fun physician order als	t up unassisted) while in bed to order also indicated the staff sident 1's tab alarm for ctioning every shift. The o included for Resident 1 to our mat placed for fall	F	689				
	Conference Recomprofessionals that a common goal for a timed at 4 p.m., inc Resident 1 was for a right-side lying pobehind the resident and was transferre 2:25 p.m. and return floor mat at Reside remind the staff who get cut of bad unas	nt 1's interdisciplinary Team of ([iDT] a group of medical work together towards a resident), dated 7/28/19 and floated on 7/22/19 at 1:20 p.m., and on the floor in the room, in seltion with the wheelchair it. Resident 1 sustained injuries d to a GACH on 7/22/19 at med to the facility on 7/26/19, and alone included to use a art 1's bed side, a bed afarm to sen Resident 1 attempted to resident with high fail risk in the alcheir						
	On 7/30/19 at 2:30 facility's Director of Resident 1 was at falls with injuries w stated that on 7/22 tendency of trying tunwitnessed fall wiforehead and was DON stated that at wheelotistr might n reach and there was	p.m., during an interview, the Nursing (DON) stated high risk for fells and had two lithin four days. The DON /19, Resident 1 who had a o grab a whealcheir, had an tha small laceration to the transferred to a GACH. The the time of the fail, the ot have been in Resident 1's a no wheelchair alarm to alert I was attempting to get up		•				
٠.	i unessisted.	nt 1's SBAR form, dated			,			

09-27-2019 12 /20 PKIN 1 ELU: USIZ 1/2U19 FORM APPROVED

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	. USIZ/IZU19 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENCIA (DENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(XS) DAT	0938-0391 E SURVEY PLETED
		555306	B. WING	l		1	C
NAME OF	PROVIDER OR SUPPLIER		. 1	81	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	27/2019
KEI-AI S	OUTH BAY HEALTHC	ARE CENTER			5116 9 VERMONT AVE ARDENA, CA 90247		•
(X4) ED . PREPIX TAG	Summary Sta (Each Deficiency Regulatory or L	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID FREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDEE .	D(A) COMPLETION DATE
F 889	who was readmitte	at 5 p.m., indicated Resident 1 d to the facility two days prior hospital was observed with	Fe	389			
•	dated 7/27/19 and 7/27/19, during had member (FM1) not Resident 1's left an indicated upon ass wrist and left hand. The Note indicated happened to his left was immobilized. A Resident 1's physic on taking pictures of the resident 1's physic on taking pictures of the resident 1's physic on taking pictures.	nt 1's nurses' progress note, timed at 3:30 p.m. Indicated on ch, Resident 1's family lifed a Charge Nurse that m was swollen. The note assment, Resident 1's left were observed to be swollen. I Resident 1 did not know what it hand and that the left wrist according to this noted, was ordered an x-ray (process of a body part to diagnose other disorders) to be done on rist.		•			
	dated 7/29/19 indic a wheelchair on 7/2 abrasion (a skin sc	nt 1's an untimed SBAR form, ated Resident 1 had a fail from 29/19, and sustained an reping or wearing away) and the skin and the soft tissue) to					
•	cated 7/29/19 and cn 7/29/19 at 4 p.m. The note indicated his room with the wante indicated Res	nt 1's nurses' progress note, timed at 6:38 p.m., indicated n., Resident 1 fell on the floor. Resident 1 was on the floor in thesichair next to him. The ident 1 had a reopened frontal					
•	upper facial abrasi- laceration with blee						
	A review of Reside	nt 1's Physician order, dated	1	•		•	}

67(02-99) Previous Versions Clasciale

Event ID: YBNC11

Feelby (D: CAB10900276

If continuation sheet Page 6 of 10

09-27-2019 13 /20 PRINTED: USIZ/12019 FORMAPPROVED

TATEMENT ND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION		(X3) DATI COM	0938-039 SURVEY PLETED
	PROVIDER OR SUPPLIER OUTH BAY HEALTHO	665308 ARE CENTER	9. WING	9TR	EET ADDRESS, CITY, STATE, ZIP O 16 S VERMONT AVE	ODE	t	C 27/2019
(X4) ID FREFIX TAG	SUMMARY STA	Tement of deficiencies / Must be preceded by full so identifying information)	ID PREF TAG	×	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DESTCIENCY)	RHAHA D	な世	(XS) COMPLETIC DATE
F 689	Resident 1 should I device placed on a sound when the reschair unassisted), when the reschair unassisted. This enshould to menitor it functioning every sit functioning every sit A review of Resident Consent for Use of 7/29/19, indicated Fand was to have a wheelchair. A review of an IDT at 6:58 p.m., indicated Fand was to have a wheelchair. A review of an IDT at 6:58 p.m., indicated Fand was to have a wheelchair. A review of an IDT at 6:58 p.m., indicated in fict to his the frontal head on the fer in the left upper ey abrasion on the left upper ey abrasion on the left in the frontal head on the left upper ey abrasion on the left in the frontal head in the frontal head in the frontal head in the left upper ey abrasion on the left in the frontal head in th	at 3:43 p.m., indicated have a sensor pad alarm (a chair or bed that makes a sident tries to get out of bed or while in the wheel chair to alart esident attempted to get up der also indicated the staff ne alarm for placement and hift. At 1's "Verification of Informed Prolonged Davices," dated lesident 1 was at risk for fails sensor pad alarm while in a		389				
	edmitted to the GAI on 7/30/19, followin	CH "Emergency dicated Resident 1 was CH on 7/29/19 and discharged g a forehead laceration and heek. This documentation				•		•

DEPARTMENT OF HEALTH AND HUMAN SERVICES

11:43:58 a.m.

09-27-2019

7-2019 14 /20 FRINTED: 08/27/2018 FORMAPPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					OMB NO	CMB NO. 0938-039		
STATEMENT AND PLAN O	of Deficiencies FCORRECTION	(X1) PROVIDENSUPPLIENCLIA EDENTIFICATION NUMBER:	V BRITT		CONSTRUCTION	(X3) DATE SURVE COMPLETED		
		555306	B. WING		· •	C 09/27/2019		
NAME OF F	ROVIDER OR SUFFLIER			.81	REET ADDRESS, CITY, STATE, ZIP CO	DE C	ELINZIIZ	
KEI-AI SI	OUTH BAY HEALTHO	ARE CENTER	• !	15	116 S VERMONT AVE ARDENA, CA 90247	•		
(X4) ED PREFIX TAG	(EACH CEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL BC (DENTIPYING INPORMATION)	(D PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	CONSTITUTE DOS	
F 689	moving him from a According to this d a left frontal head I blood outside of blaceration and comelbow and left upper A review of a "Sum 7/31/19, indicated fall on 7/22/19 at a sustained a frontal bleeding and was a summary indicated the GACH from 7/2 indicated Resident	opped Resident 1 when wheelchair to the bed, occumentation, Resident 1 had namatema (a collection of cod vessels) with a superficial oblined of pain to the left er arm. Imany of investigation," dated Resident 1 had an unwitnessed opproximately 1:20 p.m., head laceration with minimal transferred to a GACH. The I Resident 1 was admitted to 22/19 to 7/25/19. This report in 1 had a high risk for fall and if mobility, history of falls.		889				
•	On 7/30/19 at 2:30 DON stated that or unwilnessed fall for Certified Nursing A resident in an union The DON stated in the facility and was high fall risk.	p.m., during an interview, the n 7/29/19, Resident 1 had an om a wheelchair after a sesistant 1 (CNA 1) left the cked wheelchair in his room, at CNA 1 was newly hired to not aware Resident 1 was a				•		
	observation and in observed in a recil the dining room an Resident 1 was ob the mid forehead a stated Resident 1	p.m., during a concurrent terview, Resident 1 was ning position in a wheelchair, in id with no wheelchair alarm. served with two lacerations on and the mid upper lip. The DON did not have a chair alarm in ave, to prevent falls and lent.				***************************************		
	On 7/30/19 at 2:58	p.m., during an interview, CNA			•			

Event ID: YENC11

Feelity ID: CAB10000276

if continuation sheet Page 8 of 10

09-27-2019

15/20

	13/60
PRINTED:	02/27/2019
FORM.	APPROVED
ONB NO	0028 0204

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			_		FORM.	09/27/2019 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDENSUPPLIERICIA IDENTIFICATION NUMBER:	(X2) MUI A BUILD		CONSTRUCTION	O	(K3) DATI	0938-0391 E SURVEY PLETED
•		555308	B. WING	ì	•		C .	
NAME OF I	PROVIDER OR SUPPLIER		1	STR	ERT ADDRESS, CITY, STATE, ZII	CODE	09/	27/2019
KEI-AI 8	OUTH BAY HEALTHC	ARE CENTER			is 6 vermont ave RDENA, CA 80247			
(X4) ID PREFIX TAG	BACH DEFICIENCY	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLANOF OF CACH CORRECTIVE ACTU CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD HE APPROPI	BE .	(XS) COMPLETION DATE
F 689	who was very agite because CNA 1 did Resident 1 and Res	ge 8 9/19, CNA-1 left Resident 1 ied unattended in his room, not know how to care for sident 1 was not supposed to due to a history of falls.	F	589			•	
•	stated that on 7/28/ a wheelchair to the Resident 1 did not ! floor met, as presc: 7/28/19. CNA 1 left with an unlocked le thirty minutes later, Resident 1 was fou CNA 1, Resident 1' prevented if Reside	n., during an interview, CNA 1 19, Resident 1 was assisted in room. CNA 1 stated that have a wheelchair alarm or a ibed by the physician on Resident 1 in a wheelchair ff wheel. CNA 1 stated that at approximately 3:30 p.m., nd on the floor. According to a fall could have been and 1 was left in the hallway at supervise the resident.		•				
	micings Activities D who had a history o leaning forward whi stated Resident 1 v	p.m., during an interview, the frector (AD) stated Resident 1 if falls had a tendency of its in the wheelchair. The AD who had two recent falls from not have a wheelchair alarm.						
	vocational Nurse 1 was very egitated a required close super 7/29/19, CNA 1 sho the room unsurservi	, during an interview, Licensed (LVN 1) stated that Resident 1 and had a history of falls and arvision. LVN 1 stated on aud not have left Resident 1 in sed. LVN 1 stated Resident 1				· .	•	
•	7/29/19, when the r Areview of the facil Assessment," with	lat of an alaim in place on						

Event ID:YSNC11

Facility ID: CAS10500276

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		, at		est the				4
CENTER	TMENT OF HEALTH	AND HUMAN SERVICES		•	11:44:31 a.m.		FORM	16/20 U9/2/72U19 APFROVED 0938-0391
STATEMENT AND PLAN O	OF DEFICIENCES OF GORRECTION	(X1) PROVIDENSUPPLIENCIA IDENTIFICATION NUMBER:		TPLE CONSTRUC			(X3) DATE	SURVEY PLETED
		55308	B. WING				•	27/2019
KEI-AI 80	PROVIDER OR SUPPLIER OUTH BAY HEALTHC	CARE CENTER		STREET ACOR 16116 S VERS GARDENA, (CODE	U	·
(X4) ID PREPIX TAG	IEACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LEC EDENTIFYING INFORMATION)	PREFI TAG	K I ÆAC	OVIDERS PLAN OF C H CORRECTIVE ACTIO -REFERENCED TO TH DEFICIENCY	ON SHOULD ! CE APPROPE	DC	COMPLETION DATE
•	resident's risk factoresident centered for relavant assessment A review of the facilities.	ors for falls and establish a rail preventive plan based on the information.	F6			•		
	and incidents, inver a revised date of 7/2 would comply with.	stigating and Reporting," with 12017, indicated the facility current rules and regulations a and or incidents involving a						
•	•			-		•		

FORM CMB-2567(02-99) Pravious Versions Charlete

Event ID: Y9NC11

Facility ID: CA910500278

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09-27-2019

17 /20

PRINTED: 09/27/2019 FORM APPROVED California Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY CONFLETED A RITH DONG. B. WING CA910000276 09/27/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 15115 8 VERMONT AVE KEI-AI SOUTH BAY HEALTHCARE CENTER GARDENA, CA 90247 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S FLAN OF CORRECTION OUS) COMPLETE EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LISC IDENTIFYING INFORMATION) TAG CROSS-REPERENCED TO THE APPROPRIATE **B4836** T22 DIV5 CH3 ART6-72541 Unusual B4835 Occurrences B4835 T22 Div5 Art5-72541 Unusual Occurrences Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from 1. How corrective action will be unnatural causes or other catastrophes and accomplished for those residents found to unusual occurrences which threaten the welfare, have been affected by the deficient eafety or health of patients, personnel or visitors shall be reported by the facility within 24 hours practice either by telephone (and confirmed in writing) or by telegraph to the local health officer and the A comprehensive assessment of Resident Department. An incident report shall be retained 1 was conducted when he returned to the on file by the facility for one year. The facility shall furnish such other pertinent information related to facility on July 30, 2019. His care plans were updated on July 30, 2019 to reflec such occurrences as the local health officer or the his current risk factors for fall and Department may require. Every fire or explosion interventions were developed to address which occurs in or on the premises shall be specific risk factors. Similarly, physician's reported within 24 hours to the local fire authority orders were reviewed on July 30, 2019 for or in areas not having an organized fire service. to the State Fire Marshal. the devices or alarms that were to be utilized for Resident 1. This Statute is not met as evidenced by: Based on interview and record review, the facility Resident 1's care plan interventions for failed to report two unwitnessed fail incidents to fall and injury prevention are the Department of Health Services (DHS), for one communicated with the staff during of three sampled residents (Resident 1), who had two falls in four days and sustained lacerations change-of-shift huddles daily to ensure (deep cuts) to the forehead and upper ilp. that interventions are followed through. This deficient practice placed Resident 1 and CNA 1 was provided a one-on-one inother residents in the facility at risk for neglect. service by the Assistant Director of Nursing (ADON) on July 23, 2019 Findings: regarding fall prevention and management. specifically about communicating and A review of Resident 1's Admission Face sheet coordinating with the supervising licensed indicated Resident 1 was admitted to the facility on 12/13/18, with a most recent admission on nurse and assigned CNA whenever 4/18/19. Resident 1's diagnoces included helping out with a resident who is not traumatic brain injury (a disruption in the normal assigned to him.

Liberating and Certification Division LABORATORY DIRECTOR'S OR PROVIDER/BUPPLIER REPRESENTATIVES BIGNATURE

function of the brain caused by a bump or blow to the head), history of falling, generalized muscle.

TITLE

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Californi	a Department of Put	ilic Health				PPROVE
BTATEMENT OF DEFICIENCIES (XI) PROVIDENCIUPP AND FLAN OF CORRECTION IDENTIFICATION (DXI) PROMDER/BUPPLIER/CLIA IDENTIFICATION HUMBER:			(XX) DATE SURVEY COMPLETED C 69/27/2019	
		CA910800276				
AME OF F	ROVIDER OR SUFPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		7720 (4)
(Ei-Ai 80	DUTH BAY HEALTHC		ERMONT AV A, CA 90247			
(X4) ED 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)		OG) COMPLETI DATE
B4835	(paralysis (inability :	iplegia and hemipareals to movel and weakness of the	B4835	Resident 1's fall incidents on 2019 and July 29, 2019 were	investigat	
	muscles of the low left side of the bad uncontrolled electri	er face, arm, and leg on the r), selzure (a sudden, cal disturbance in the brain		by the California Department Health on July 30, 2019, thus no longer reported.		
	or feelings, and in t dementia (decline i problem-solving an	nges in behavior, movements evels of consciousness) and n memory, language, d other thinking skills that pillty to perform everyday		How the facility will ident residents having the potential affected by the same deficient what corrective action will be	to be t practice:	and
	essessment) dated	te Fall Risk Screen," (a fail risk I 12/13/18, indicated Resident S. A score of 45 and above c.		The Assistant Director of Nu (ADON) will review incident accidents that occurred from the present month to identify	ts and July 2019	io
•	(MDS), an assessed dated 6/19/19, Indi- (thought process) of Resident 1 requires	nt 1's Minimum Data Set nent and care acreening tool, cated Resident 1's cognition was intact. The MDS indicated d a one-person physical assist		who may have been affected deficient practice. The review on identifying incidents and constitute an unusual occurre be completed on October 7, 2	wwill focu accidents the ence. This value. 2019. The	at vill
-	personal hygiene. required a two-pan or from a bad, chai standing position. /	ressing, eating, tollet use and The MDS indicated Resident 1 can physical assist moving to ir and or wheelchair to a According to the MDS, salving antidepressent		reporting procedure will be for any other incident or accident identified to constitute an una occurrence.	t that is	
•	(medication to trea A review of Reside (H/P) report, dated could make needs	t depression) medication. nt 1's history and physical 7/5/19, indicated Resident 1 known, but could not make		What measures will be pu what systemic changes will t make to ensure that the defic does not recur	he facility	ļ
· · · ·	medical decisions: A review of Reside Indicated Resident The staff's Interver Resident 1 to the h	nt 1's care plan, dated 7/22/19, 1 had an actual fall incident. tions included to transfer cospital for evaluation, assess				•

Licensing and Certification Division STATE FORM

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09-27-2019

19/20

PRINTED: 09/27/2019 FORM APPROVED California Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIFLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING: CA810000276 B. WING 09/27/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 16116 8 VERMONT AVE KEI-AI SOUTH BAY HEALTHCARE CENTER GARDENA, CA 80247 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE ID PREFIX (X6) COMPLETE TAG TAG DATE DEFICIENCY B4835 Continued From page 2 B4835 The DON and the Administrator will motion, mobility and level of consciousness. provide first aid for presence of injury, and to review fall incidents daily to ensure that unusual occurrences are reported to the determine the cause of the fall. California Department of Public Health A review of a "Situation Background Assessment (CDPH) promptly as specified in Title 22 and Recommendation" ([SBAR] an internal and in the facility policy. communication form), dated 7/22/19 and timed at 2 p.m., indicated Resident 1 had a fall and All facility staff will be provided an insustained a skin tear (a wound caused by shear, service on Unusual Occurrences, including. friction, and/or blunt force resulting in separation reporting procedures to follow, by the of skin lavers). Nurse Consultant on October 16, 2019. A review of Resident 1's Progress Note, dated 7/22/19 and timed at 1:20 p.m., indicated. 4. How the facility plans to monitor its Resident I was found on the right side lying on the performance to make sure that solutions floor in his room. According to the nursing are sustained progress note, Resident 1 had a frontal (middle of the face) cut measuring one inch with minor bleeding and was transferred to the hospital. The Administrator will present, to the A review of a facility to hospital "Transfer Form," QAA Committee, a monthly report on dated 7/22/19 and timed at 2:10 p.m., indicated incidents and accidents that were reported Resident 1 was totally dependent on the staff for to CDPH during the QAPI meeting to bathing, dressing, tolleting, transfers and eating. ensure compliance to Title 22 This form indicated Resident 1 who had a high requirements and the facility policy on fall risk, had a skin tear on the forehead reporting unusual occurrences. Any measuring 1 by 0.5 centimeters ([cm] unit of recommendations for further review or measurement). additional interventions from the OAA A review of Resident 1's Hospital Transfer Form, Committee will be acted upon by the dated 7/22/19 and timed 1:40 p.m., indicated Administrator. Resident 1 who was non ambulatory (unable to walk), totally dependent on the staff for bathing, dressing, tolleting, transfers and eating, and had a fall with injuries. A review of Resident 1's SBAR form, deted 7/29/19 and timed at 4:10 p.m., indicated

Licensing and Cartification Division

Resident 1 had a fall from a wheelchair and sustained an abrasion (a skin scraping or wearing

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California Department of Public Health

09-27-2019 20/20 PRINTED: 09/27/2019 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CA910000276			(X2) MULTIPLE CONSTRUCTION A BUILDING:			(X3) DATE SURVEY COMPLETED C						
		B. WING			09/27/2019							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 15115 S VERMONT AVE												
KEI-AI SOUTH BAY HEALTHCARE CENTER GARDENA, CA 90247												
(X4) (D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID FREFIX TAG	PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		E COMPLETE DATE						
B4835	Gontinued From page 3		B4835									
	away) and laceration soft tissue) on the 1	on (injury to the skin and the lorehead.										
	A review of Resider 7/29/19 and timed of Resident 1 fell on the Resident 1 was on wheelchair next to progress note, Resident 1 was on wheelchair next to progress note, Resident abrasil accration metal upper facial abrasil accration with blee On 7/30/19 at 2:40 facility's administrat 1's falls that results reported to DHS be result of an abuse. A review of a facilit incidents, investigate revised date of 7/2 comply with currents.	nt 1's progress note, dated B:38 p.m., indicated at 4 p.m., the floor. This note indicated the floor in his room with the him. According to a nursing eldent 1 had a reopened frontal assuring 2.5 cm by 2.1 cm, a viaceration, a 1.2 by 1.5 cm on, and a 1.6 cm.mid-upper lipsding. p.m., during an interview, the data (ADM) stated that Resident and in incerations were not a secure the injuries were not a course the injuries and regulations										
·	Medical device. A review of a facilit "Unusual Occurrer facility would reportable events."	is and or incidents involving a by's undated policy titled, noe Reporting," indicated the tunusual occurrences or other which affect the health or s, employees and visitors as			•							
	required by federa	or state regulations. This id all allegations of abuse and	 		· · · · · · · · · · · · · · · · · · ·							
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