STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555438	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kei-Ai Los Angeles Healthcare Center	2221 Lincoln Park Ave Los Angeles, CA 90031

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36395 Based on interview and record review the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding risks, benefits and alternatives offered) for one of five sampled residents (Resident 1). For Resident 1, the facility failed to obtain informed consent before starting Resident 1 on the following psychotropic medications (drugs that affect the mind, emotions and behavior) on 12/19/24. 1. Trazadone 12.5 milligrams (mg., metric unit of measurement, used for medication dosage and/or amount) orally at bedtime for depression. 2. Wellbutrin extended release (XL) 150 mg. orally one tablet daily for depression. 3. Duloxetine 30 mg. orally two capsules two times a day for depression. 4. Brexpiprazole one mg. one tablet orally at bedtime for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). This deficient practice resulted in Resident 1 not given the right to know the risks and benefits of taking the Trazadone, Wellbutrin XL, Duloxetine and Brexipiprazole and alternative treatment available. Findings: During a review of the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including morbid obesity, cerebral infarction (loss of blood flow to part of the brain) with left sided weakness and major depressive disorder. During a review of Resident 1 ' s Minimum Data Set (MDS, resident assessment tool) dated 12/4/24, indicated Resident 1 was cognitively intact. Te MDS indicated Resident 1 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, personal hygiene and set up with eating. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Verification of Informed Consent for Psychotropic Medications dated 12/19/24 indicated an informed consent for Trazodone 12.5 mg at bedtime, Wellbutrin XL 150 mg. daily, Duloxetine 30 mg, two capsules two times a day and Brexipiprazole one mg. tablet at night. The Consent were signed by the physician, however, Resident 1 or Resident 1 ' s responsible party ' s signature was missing. During a review of Resident 1 ' s Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident)) indicated Resident 1 was administered Brexipiprazole 1 mg tablet by mouth at 9 p.m., from 12/19/24 to 12/23/24, 12/25/24, and from 12/27/24 to 1/3/25. During a review, the same MAR indicated Resident 1 was administered the Duloxetine oral capsules 30 mg by mouth two capsules, two times a day at 9 a.m. and 5 p.m. from 12/18/24 to 1/15/25. During a review, the same MAR indicated Resident 1 was administered the Trazadone 12.5 mg at 9 p.m. from 12/19/24 to 1/12/25 and 1/14/25. During a review, the same MAR indicated Resident 1 was given the Wellbutrin XL150 mg at 9 am from 12/19/24 to 1/15/25. During a concurrent interview and record review on 1/31/25 at 11:41 a.m., Resident 1 ' s Verification of Informed Consent for Psychotropic Medications for Trazadone 12.5 mg., Wellbutrin XL 150 mg. tablet, Duloxetine 30 mg. two capsules, and Brexipiprazole 1 mg. tablet were reviewed with the registered nurse supervisor (RNS 1). RNS 1 stated Resident 1 ' s Informed Consent Forms were signed by the physician but not signed by Resident 1 or Resident 1 ' s responsible party (RP). RNS 1 stated Resident 1 was unable to sign the Informed Consent Forms, but two nurses should sign the Informed Consent as witnesses that Resident 1 consented to take the psychotropic medications. During a concurrent interview and record review on 1/31/25 at 11:49 a.m., Resident 1 ' s Verification of Informed Consent for Psychotropic Medications for Trazadone 12.5 mg Wellbutrin XL 150 mg. tablet, Duloxetine 30 mg. two capsules and Brexipiprazole 1 mg. were reviewed with the director of nursing (DON). DON stated consent should be obtained from Resident 1 or Resident 1 ' s RP prior to administration of the psychotropic medications. DON stated obtain the signature from Resident 1 or Resident 1 ' s RP and two nurses will sign the Informed Consent as witnesses. During a review of the facility Policy and Procedures (P&P) titled Informed Consent Policy reviewed on 10/10/24, indicated, it is the policy of the facility to involve residents in their care decisions by facilitating information and obtaining consent that included the use of psychotropic drugs. The same P&P indicated, the attending physician determines the capacity of the resident to make decisions and give informed consent on his/her admission orders or progress notes. If the resident is determined to no have the capacity to make informed decisions, a surrogate decision maker is identified. The same P&P indicated, when processing a new order or an increase in psychotropic drugs, the following must be done that included obtain informed consent from resident or responsible party. When an order for psychotropic drug is obtained, the licensed nurse verifies with the attending physician that informed consent has been obtained. The licensed nurse documents this verification on the Informed Consent Form.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36395 Based on interview and record review the facility failed to provide toileting (maintain perineal hygiene after voiding or bowel movement) and personal hygiene for one of five sampled residents (Resident 1). For Resident 1, who was frequently incontinent (involuntary loss of control) of bowel and bladder and refused personal and toileting hygiene multiple times after each episode of incontinence, the facility failed to: 1. Involve Resident 1 ' s responsible party (RP) to discuss the plan of care regarding Resident 1 ' s refusal of personal and toileting hygiene after each episode of incontinence. 2. Notify the physician regarding Resident 1 ' s refusal of hygiene care. These deficient practices resulted in Resident 1 with unpleasant smell, poor hygiene and had the potential for Resident 1 to develop infection and pressure ulcer (wounds that occur from prolonged pressure the skin). Findings: During a review of the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including morbid obesity, cerebral infarction (loss of blood flow to part of the brain) with left sided weakness and major depressive disorder. During a review of Resident 1 ' s Minimum Data Set (MDS, resident assessment tool) dated 12/4/24 indicated Resident 1 was cognitively intact. Resident 1 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, personal hygiene and set up with eating. The MDS indicated Resident 1 was always incontinent of urine and bowels. During a review of Resident 1 ' s Care Plan initiated on 12/18/24 indicated Resident 1 had potential for limitations in activities of daily living (ADL) self-performance secondary to depressive symptoms. The care plan goal included Resident 1 will not develop decline in ADL self-performance and will maintain current functional status in ADL functions and mobility. Care Plan interventions included encourage family members and friends to be part of the positive reinforcement and to increase level of activity participation. During a review of Resident 1 ' s Care Plan initiated on 12/19/24 indicated Resident 1 had the potential for injury related to nonadherence and/or Resident chooses not to elect to the following that included hygiene needs, showers, and peri care. The care plan goal indicated Resident 1 will be informed of risks and consequences of choices that they make daily through the next review date. Interventions included report non-compliant behavior to the physician and responsible party/surrogate decision maker. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Care Plan initiated on 12/25/24 indicated Resident 1 was resistive to care related to adjustment to the nursing home. The care plan goal indicated Resident 1 will cooperate through the next review date. Care plan intervention included to educate resident/family/caregivers of the possible outcome of not complying with treatment or care. During a review, the Nurses Notes dated 12/22/24 at 10:52 p.m., indicated Resident 1 initially refused incontinence brief change despite several attempts and clear explanations about the importance of changing the briefs to prevent infection. The Notes indicated after multiple attempts; Resident 1 agreed to have the soiled briefs changed. The Notes indicated Resident 1 ' s briefs were heavily wet, and the bed linens were soiled. The Notes indicated following the change, the odor in the room improved, which was noted by other residents (roommates) who had previously complained about the smell. During a review, the Nurses Notes dated 12/24/24 at 5:50 a.m., indicated Resident 1 was offered briefs change but Resident 1 refused. The Nurses Notes indicated Resident 1 was explained the importance of being cleaned at this time to prevent bedsores and to maintain hygiene but Resident 1 continued to refuse. During a review of the Nurse Notes dated 1/6/25 at 1:54 p.m., indicated Resident 1 had increasing confusion and Resident 1 refused toileting hygiene. During a review of the Nurses Notes dated 1/8/25 at 3 a.m., indicated Resident 1 was visibly confused and refusing briefs change after multiple attempts. The Notes indicated Resident 1 expressed .preference for remaining in a wet condition. During an interview on 1/30/25 at 12:18 pm. licensed vocational nurse (LVN 1) stated Resident 1 was incontinent of bowel and bladder and would refuse to be changed at times. LVN 1 stated she would administer pain medication before changing Resident 1 but when ready to be changed, Resident 1 would refuse. LVN 1 stated she tried to convince Resident 1, but Resident 1 continue to refuse. LVN 1 stated Resident 1 was smelly. During an interview on 1/30/25 at 12:55 p.m., LVN 2 stated Resident 1 refused hygiene care and would also refuse skin assessments. LVN 2 stated Resident 1 was explained the risks for bedsores (wounds that occur from prolonged pressure on the skin) but Resident 1 continue to refuse. LVN 2 stated Resident 1 had the right to refuse. During an interview on 1/31/25 at 11:49 a.m., the director of nursing (DON) stated Resident 1 consistently refused hygiene care from staff due to pain on movement. Resident 1 would be given pain medication prior to personal hygiene, but at times still refuse to have the soiled briefs changed. DON stated an interdisciplinary team meeting (IDT, professionals from different discipline will work together to provide the greatest benefit for the resident) on 12/30/24 with Resident 1 ' s responsible party (RP) was held, but the focus of the IDT was for Resident 1 to be transferred to the general acute hospital (GACH 1) for further evaluation and treatment. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up concurrent interview and record review on 2/10/25 at 11:13 a.m., Resident 1 ' s Progress Notes were reviewed with LVN 3. LVN 3 stated the last IDT meeting with Resident 1 ' s RP concerning Resident 1 ' s refusal of hygiene care was 12/14/23. The IDT was held at Resident 1 ' s bedside with Resident 1 ' s RP in attendance. LVN 3 stated the IDT discussed including Resident 1 ' s refusal of care and the risks for bedsores. The Notes indicated Resident 1 and Resident 1 ' s RP agreed for the Resident 1 to receive hygiene care. However, LVN 3 stated she was unable to find a follow-up IDT since 12/14/23 regarding Resident 1 ' s refusal of the incontinent care and the notification of the physician. During a review of the facility Policy and Procedures (P&P) titled Activities of Daily Living (ADLs), Supporting reviewed on 10/10/24 indicated, residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The same P&P indicated, interventions to improve or minimize a resident ' s functional abilities will be in accordance with the resident ' s assessed needs, preferences, stated goals and recognized standards of practice. During a review of the facility Policy and Procedures titled Care Planning (IDT) Policy reviewed on 10/10/24 indicated, all residents will have comprehensive care plan to meet their individual needs that is prepared by the interdisciplinary team (IDT) within seven days after completion of the comprehensive assessment and periodically reviewed and revised after subsequent assessments.