| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555438 | A. Building<br>B. Wing | 02/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kei-Ai Los Angeles Healthcare Center | 2221 Lincoln Park Ave<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36395<br><br>Based on interview and record review, the facility failed to obtain the discharge order from the primary physician in accordance with professional standard of practice for one of three sampled residents (Resident 1). For Resident 1 the facility failed to:<br><br>1.Obtain discharge order from Resident 1 ' s primary physician before discharging Resident 1 on 1/23/25. The facility entered a telephone order from the primary physician on 1/22/25 that Resident 1 was for discharge home on 1/23/25. However, the primary physician did not give the discharge order.<br><br>2.Ensure accurate entry in Resident 1 ' s Progress Note on 1/21/25 at 9:01 pm that an order was obtained to discharge Resident 1 home on 1/23/25. The entry did not indicate which physician gave the discharge order.<br><br>These deficient practices resulted in inaccurate record for Resident 1 and falsification of physician orders.<br><br>Findings:<br><br>During a review of the Admission Order indicated the facility admitted Resident 1 on 12/26/24 with diagnoses including after care following surgery, unsteadiness on feet and generalized muscle weakness.<br><br>During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 1/1/25 indicated Resident 1 was cognitively intact. Resident 1 was dependent (helper does all the effort) with putting on/taking off footwear, substantial assistance (helper does more than half the effort) with lower body dressing and toileting hygiene, supervision with oral/personal hygiene, upper body dressing and independent with eating.<br><br>During a review of Resident 1 ' s Case Manager Note dated 1/21/25 at 9:01 p.m., indicated obtained order for last cover date (LCD, final day where a provider will pay for the facility stay) of 1/22/24 and to discharge Resident 1 home on 1/23/25.<br><br>During a review of Resident 1 ' s primary physician telephone order dated 1/22/25 at 2:07 p.m., entered by licensed vocational nurse (LVN) 1 indicated the primary physician gave order to discharge Resident 1 home on 1/23/25.<br><br>(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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 1 ' s primary physician telephone order dated 1/22/25 at 5:39 pm., entered by registered nurse supervisor (RNS) 1 indicated an order to discharge Resident 1 home on 1/23/25.<br><br>During a review of the Nurses Notes dated 1/23/25 at 12:48 p.m., indicated Resident 1 was discharged home on 1/23/25 at 12:15 p.m. The Notes indicated Resident 1 ' s primary physician was aware.<br><br>During a review of the Primary Physician Progress Note dated 1/24/25 at 11:09 p.m. indicated Resident 1 was discharged on [DATE]. The Note indicated the primary physician nor the primary physician ' s team did not give discharge orders for Resident 1.<br><br>During a concurrent interview and record review on 2/11/25 at 11:16 a.m., Resident 1 ' s case manager note dated 1/21/25 and Physician Progress Note dated 1/24/25 were reviewed with the case manager (CM 1). CM1 stated Resident 1 was given the last covered date notice on 1/22/25 and was discharged home on 1/23/25. The CM 1 stated Resident 1 ' s primary physician should be notified regarding the last covered date and get an order for discharge. CM 1 stated Resident 1 ' s primary physician spoke to CM 1 and informed the CM1 that the primary physician nor his team did not give an order to discharge Resident 1 on 1/23/25. CM 1 stated Resident 1 ' s discharge order was given on 1/22/25 but CM 1 did not know who gave the discharge order.<br><br>During a concurrent interview and record review on 2/11/25 at 11:32 a.m., Resident 1 ' s physician telephone order dated 1/22/25 was reviewed with the registered nurse supervisor (RNS 1). RNS 1 stated she entered a telephone order on 1/22/25 to discharge Resident 1 on 1/23/25. RNS 1 stated she is not sure if Resident 1 ' s discharge order was clarified with Resident 1 ' s primary physician.<br><br>During an interview on 2/11/25 at 12:10 p.m., the director of nursing (DON) stated the physiatrist (a physician who specializes in physical medicine and rehabilitation) wrote an order on 1/23/25 to discharge Resident 1 home on 1/23/25. The DON stated the primary physician should be informed of Resident 1 ' s discharge. The DON stated the nursing staff should have communicated with Resident 1 ' s primary physician.<br><br>During a telephone interview on 2/11/25 at 6:10 p.m., licensed vocational nurse (LVN 1) stated he did not remember who gave the order to discharge Resident 1. LVN 1 stated I think the nursing supervisor told me that the resident (Resident 1) was for discharge. LVN 1 stated he did not talk with Resident 1 ' s primary physician.<br><br>During a telephone interview on 2/11/25 at 6:12 p.m., CM 2 stated he was unable to remember which physician gave the order to discharge Resident 1 on 1/23/25. CM 2 stated even though Resident 1 ' s physiatrist gave an order for discharge, Resident 1 ' s primary physician should be notified to get the discharge order. CM 2 stated Resident 1 ' s primary physician is the main decision maker for Resident 1 ' s care while at the facility.<br><br>During a review of the facility's policy and procedures (P&P) titled Transfer or Discharge, Preparing a Resident reviewed on 10/10/24, the P&P indicated nursing services is responsible for obtaining orders for discharge or transfer, as well as the recommended discharge services and equipment.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility's P&P titled Charting and Documentation reviewed on 10/10/24, the P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. The same Policy indicated entries may only be recorded in the resident ' s clinical record by licensed personnel in accordance with state law and facility policy. |