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	05/14/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851 Based on interview and record review the facility failed to ensure the resident call light system (a communication tool used in medical facilities to facilitate communication between residents and healthcare providers; by allowing residents to signal when they need assistance. The system typically includes call buttons or pull cords in resident rooms or bathrooms, often with visual indicators like dome lights outside the rooms to alert staff) remained functional on 5/3/2025 - 5/4/2025 for 71 out of 71 residents on the second floor of the facility. By failing to ensure staff reset bathroom call lights after being triggered. This deficient practice had the potential to result in injury or harm due to residents not being able to call for facility staff as needed for help and/or during an emergency. Findings: (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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s Incident Response Timeline and Action Plan (IAP) dated 5/3/2025, the IAP indicated the facility had a call light system malfunction (when a piece of equipment fails to function normally) on the second floor. The IAP indicated on 5/3/2025 at 6:11 PM second floor staff noted that the call light panel located at the nurse ' s station had call lights for all rooms/beds activated. The IAP indicated the facility supervisor, Administrator (ADM), Maintenance Director (MD), Director of Nursing (DON), and Director of Staff Development (DSD) were notified of the call light malfunction and instructed nursing staff to perform a sweep of the residents to ensure their safety and needs were met. The IAP indicated that all residents were determined to be safe and had their needs met when the initial sweep was completed. The IAP indicated the call light malfunction affected only the second floor. The IAP indicated that the nursing staff continued to make rounds (a period where nurses and other healthcare professionals visit residents in their rooms to assess their condition and address any resident concerns on the second floor every 15 minutes. The IAP indicated the MD performed an assessment of the call light system panel and contacted the call light system vendor (a person or company that sells a specific good or service) for emergency service. The IAP indicated the earliest vendor service availability for the call light system would be the following morning. The IAP indicated additional staff were added to the night shift on 5/3/2025 and the day shift of 5/4/2025 to focus on resident rounding every 15 minutes. The IAP indicated on 5/4/2025 at 8:20 AM the maintenance staff verified the call light system was fully restored and was functioning again. The IAP indicated there were no events that affected the residents ' well-being and quality of care and quality of life during the time the call light system was not functioning. The IAP indicated on 5/5/25 at 7:06 AM the call light vendor arrived at the facility and performed a complete inspection of the call light system. The IAP further indicated the vendor technician identified the root cause of the call light malfunction as a bathroom call light switch in room [ROOM NUMBER] that did not properly reset. During a review of Resident 4 ' s Admission Record, the Admission Record indicated the facility readmitted the resident on 10/4/2021 with diagnoses that included disorder of autonomic nervous system (condition where the nerves responsible for regulating involuntary bodily functions like heart rate, blood pressure, digestion, and body temperature don't work properly), history of falling, contracture (a stiffening/shortening at any joint, that reduces the joint range of motion), muscle weakness, mild cognitive impairment (some impairment in the ability to think, understand, and reason), and Transient Ischemic Attach (TIA, a temporary blockage of blood flow to the brain that causes stroke-like symptoms). During a review of Resident 4 ' s Minimum Data Set (MDS, a resident assessment tool) dated 2/4/2025, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated the resident was dependent on help for eating, oral hygiene, toileting hygiene, showering/bathing himself, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. During a concurrent observation and interview on 5/14/2025 at 12:14 PM with Resident 4, in Resident 4 ' s room, Resident 4 was observed lying in bed with an adaptable call light (a type of call light designed for individuals with disabilities, allowing them to activate a call system through alternative methods, such as a switch, rather than a button) within the resident ' s reach. Resident 4 stated the call light system was not working all night on 5/3/2025. Resident 4 stated he had to use a hand bell to call the nursing staff that night. Resident 4 stated the call light was important because he used the call light to call the nursing staff when he needed help getting changed or if he was not feeling well. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/14/2025 at 12:55 PM with MD 1, MD 1 stated on 5/3/2025 at around 6:15 PM he was called and informed the call light system was not working on the second floor. MD 1 stated at around 7:50 PM he went to the facility to look at why the call light system was not working. MD 1 then contacted the call light system vendor, but they were not available until the next day. MD 1 stated the call light system started working again on the morning of 5/4/2025. MD 1 stated the call light system vendor came to the facility on [DATE] and determined the cause of the call light system malfunction was the call light in the bathroom of room [ROOM NUMBER]. MD 1 stated someone had pulled the call light in the bathroom of room [ROOM NUMBER] but did not reset the call light switch properly. MD 1 stated the call light system on the second floor went into safety mode because the call light switch in the bathroom of room [ROOM NUMBER] was not properly reset. MD 1 stated while the call light system was not working on the second floor the residents were provided with red hand bells so they could call the nurses when they needed help. MD 1 stated it was important to ensure the call light system was working so the residents have a way to call the nurses when they need help. During an interview on 5/14/2025 at 3:38 PM with the DON, the DON stated the call light system on the second floor stopped functioning on 5/3/2025. The DON stated the vendor technician was able to determine that the cause of the call light system malfunction was a call light switch in the bathroom of room [ROOM NUMBER]. The DON stated the bathrooms in the resident rooms have a call light switch, when the call light is activated facility staff had to manually reset the call light by putting the call light switch up when they are done assisting the resident. The DON stated that on 5/3/2025 when someone tried to reset the call light in the bathroom of room [ROOM NUMBER], they did not put the call light switch all the way up, instead they positioned the call light switch halfway up which caused the call light system to malfunction. The DON stated the call lights stopped working in all the rooms on the second floor. The DON stated the call light system started working again on 5/4/2025 at 8:20 AM The DON stated staff had to properly reset the call light in the bathrooms after triggered by placing the call light switch all the way up. The DON stated residents used the call lights to call staff when they needed assistance. The DON stated it was important for the call system to work to maintain resident safety and prevent injury or harm. During a review of the facility ' s policy & procedure (P&P) titled Resident Call System reviewed 4/10/2025, the P&P indicated Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor .The resident call system remains functional at all times.