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	05/21/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36395 Based on interview and record review the facility failed to implement the care plan for one of two sampled residents (Resident 1). For Resident 1, the facility failed to monitor Resident 1 ' s intake and output as indicated in the care plan. This deficient practice had the potential for the facility not to be able to meet the hydration and nutritional needs of Resident 1. Findings: During a review of the Admission Record indicated the facility initially admitted Resident 1 on 3/7/24 and readmitted on [DATE] with diagnoses including heart failure (the heart cannot pump enough blood and oxygen to support other organs in the body), chronic kidney disease (progressive damage and loss of kidney [organ that filters blood) function) and dementia (a progressive state of decline in mental abilities). During a review of Resident 1 ' s Care Plan initiated on 12/29/24, indicated Resident 1 had impaired renal (kidney) function related to chronic kidney disease. The Care Plan goal indicated Resident 1 will be free from signs and symptoms of renal complications through the next review date. The care plan intervention included to monitor intake (amount of fluid entering the body) and output (amount of liquid leaving the body). During a review of Resident 1 ' s Minimum Data Set (MDS, resident assessment tool) dated 5/17/25 indicated Resident 1 had severe cognitive impairment and was totally dependent on activities of daily living (ADLs). The MDS indicated Resident 1 was incontinent of urine and bowel. Resident 1 had a gastrostomy tube (GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a concurrent interview and record review on 5/21/25 at 12:37 p.m., with licensed vocational nurse (LVN 1), Resident 1 ' s care plan for impaired renal function initiated on 12/29/24 was reviewed. LVN 1 stated Resident 1 had chronic kidney disease and intervention included to monitor intake and output. LVN 1 further stated Resident 1 had diagnoses that included heart failure and was at risk for fluid overload. LVN 1 stated the monitoring of Resident 1 ' s intake and output was to ensure Resident 1 was receiving enough amount of fluid and calories. LVN 1 stated she was unable to find documentation that Resident 1 ' s intake and output were monitored. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the registered nurse supervisor (RNS 1) on 5/21/25 at 12:57 p.m., RNS 1 stated the certified nursing assistants document that Resident 1 was incontinent. However, RNS 1 was unable to provide documentation that the input and output were monitored as indicated in Resident 1 ' s care plan. During a review of the facility's policy and procedures (P&P) titled Care Plans Comprehensive Person-Centered revised on 4/10/25, the P&P indicated a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident. The same Policy indicated the interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36395 Based on interview and record review the facility failed to ensure the physician order was transcribed accurately for one of two sampled residents (Resident 1). For Resident 1, the facility failed to ensure the gastrostomy tube (GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) feeding start and stop times were accurately documented. The Physician Order dated 4/15/25 at 3 p.m. indicated to give Resident 1 GT feeding of Nutren (tube feeding formula) at 50 milliliters per hour (ml./hr., measure of flow rate) and water at 40 ml/hr. for 16 hours. However, the order indicated to start at 6 p.m. and stop at 6 a.m., (12 hours instead of 16 hours). This deficient practice resulted in inaccurate documentation of Resident 1 ' s medical record and had the potential for Resident 1 not given the adequate nutrition and fluid needed by Resident 1. Findings: During a review of the Admission Record indicated the facility initially admitted Resident 1 on 3/7/24 and readmitted on [DATE] with diagnoses including heart failure (the heart cannot pump enough blood and oxygen to support other organs in the body), chronic kidney disease (progressive damage and loss of kidney [organ that filters blood) function) and dementia (a progressive state of decline in mental abilities). During a review of Resident 1 ' s Minimum Data Set (MDS, resident assessment tool) dated 5/17/25 indicated Resident 1 had severe cognitive impairment and was totally dependent on activities of daily living (ADLs). The MDS indicated Resident 1had a GT. During a review of the physician order dated 4/15/25 at 3 p.m. indicated to give Resident 1 GT feeding of Nutren at 50 ml./hr. for 16 hours by an enteral pump (a medical device used to deliver nutrition). However, the order indicated start at 6 p.m. and stop at 6 a.m. (which is only for 12 hours). 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) dated 4/25, indicated an order to give Resident 1 GT feeding of Nutren at 50 ml/hr. for 16 hours start at 6 p.m. and stop at 6 a.m. The MAR was signed as given from 4/15/25 to 4/30/25. During a review of the Physician order dated 4/15/25 at 1:43 p.m. indicated to give Resident 1 water by GT at 40 ml./hr. for 16 hours start at 6 p.m. and stop at 6 a.m. During a review of Resident 1 ' s MAR dated 4/25 indicated Resident 1 was given water at 40 ml/hr. give over 16 hours, however the time was from 6 p.m. to 6 a.m. The MAR was signed as given from 4/15/25 to 4/30/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/21/25 at 11:46 a.m., Resident 1 ' s MAR dated 4/25 was reviewed with the registered dietitian (RD). RD stated the GT feeding and the water flush should start at 6 p.m. and finish at 10 a.m. to complete the 16 hours. RD agreed that if GT feeding was given for 12 hours instead of 16 hours Resident 1 may not meet Resident 1 ' s nutritional and hydration needs. During a concurrent interview and record review on 5/21/25 at 12:37 p.m., Resident 1 ' s MAR dated 4/25 was reviewed with licensed vocational nurse (LVN 1). LVN 1 stated Resident 1 ' s GT feeding and water flush was to be given over 16 hours. However, the MAR indicated only 12 hours with start time of 6 p.m. and stop at 6 a.m. LVN 1 stated this is not correct and agreed that the GT feeding should start at 6 p.m. and stop at 10 a.m. During a review of the facility' spolicy and procedures (P&P) titled Charting and Documentation reviewed on 3/27/25, the P&P indicated the medical record should facilitate communication between the interdisciplinary team regarding the resident ' s condition and response to care. The same Policy indicated documentation in the medical record will be objective (not opinionated or speculative), complete and accurate.