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	06/24/2025

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** Based on interview and record review the facility failed to revise and update the care plan for one of four sampled residents (Resident 1). For Resident 1 the facility failed to update the care plan when Resident 1's Alprazolam (medication used to treat anxiety disorder) was discontinued on 4/10/25. This deficient practice resulted in inaccurate reflection of the actual care provided to Resident 1. Findings: During a review of the admission Record indicated the facility admitted Resident 1 on 3/6/25 and re-admitted on [DATE] with diagnoses including anxiety disorder, mood disorder and generalized muscle weakness. During a review of the Minimum Data Set (MDS, resident assessment tool) dated 4/12/25 indicated Resident 1 had moderately impaired cognitive skills. Resident 1 was dependent (helper does all the effort) with toileting hygiene, upper/lower body dressing, putting on/taking of footwear, personal hygiene, substantial assistance with oral hygiene and supervision with eating. During a review of the Physician Order dated 4/8/25 at 7:10 p.m., indicated, an order to give Resident 1 Alprazolam one milligram (mg- metric unit of measurement, used for medication dosage and/or amount),) by mouth every 12 hours as needed for anxiety manifested by unrealistic fear for 14 days. During a review of Resident 1's Care Plan initiated on 4/9/25 indicated Resident 1 had altered mood pattern related to anxiety manifested by expression of unrealistic fear. The care plan goal indicated Resident 1 will have no adverse consequences from medication through the next review date. Interventions included to give Resident 1 Alprazolam tablet as ordered. During a review of Resident 1's Care Plan initiated on 4/9/25 indicated Resident 1 uses anti-anxiety medication, Alprazolam, related to anxiety disorder. The care Plan goal indicated Resident 1 will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. The care plan interventions included to administer anti-anxiety medications as ordered by the physician and to monitor for side effects and effectiveness every shift. During a review of the Physician Order dated 4/10/25 at 7:30 a.m., indicated to discontinue the Alprazolam one mg. for Resident 1. (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

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	06/24/2025

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/24/25 at 11:29 a.m., Resident 1's Care Plan initiated on 4/9/25 was reviewed with the assistant director of nursing (ADON 2). ADON 2 stated Resident 1 had a physician order on 4/8/25 to give Resident 1 Alprazolam one mg. as needed for 14 days. ADON 2 stated the alprazolam was discontinued on 4/10/25. ADON stated the care plan should have been discontinued on 4/10/25 when the alprazolam was discontinued. During an interview on 6/24/25 at 2:54 p.m., the acting director of nursing (ADON 1) stated when Resident 1's Alprazolam was discontinued on 4/10/25, Resident 1's care plan for the alprazolam should also be discontinued at the same time. 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 assessments of residents are ongoing and care plans are revised as information about the residents and the residents condition change.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to follow their policy on infection control for cleaning and disinfection of re-usable devices. During observation on 6/24/25 at 10:13 a.m., five oxygen concentrators (type of medical device used for delivering oxygen to individuals with breathing-related disorders) that were not sanitized (reduces the number of germs on objects and surfaces to levels considered safe) were observed in the supply room. This deficient practice had the potential to contaminate the clean supplies of the unit used by other residents. Findings: During observation and concurrent interview on 6/24/25 at 10:13 a.m., licensed vocational nurse (LVN) 1 stated there are five oxygen concentrators kept in the supply room that were not covered with plastic. LVN 1 stated the five concentrators were used by the residents and are waiting to be picked up by the hospice company. LVN 1 stated if the concentrators were sanitized it would be covered with plastic. LVN 1 also stated the supply room is where they keep the clean supplies for the other residents. During an interview on 6/24/25, at 10:18 a.m., the infection preventionist (IP) stated the five oxygen concentrators were not sanitized and awaiting to be picked up by the hospice company. IP further added there is no separate room to store the used concentrators. During an interview on 6/24/25 at 2:54 p.m., the assistant director of nursing (ADON 1) stated the used oxygen concentrators should be separated from the clean area to prevent contamination. ADON 1 stated the concentrators should be sanitized and covered with plastic so the staff will know that the concentrators were sanititized. During a review of the facility's policy and procedures titled Cleaning and Disinfection of Resident-Care Items and Equipment reviewed on 4/30/25 indicated reusable items are cleaned and disinfected between residents that included oxygen concentrators. The same Policy indicated after disinfection, the equipment will be covered and stored in a designated location until used.