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	09/23/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) was free from unnecessary restraints (a method or device that restricts a patient's freedom of movement or normal access to their body) by failing to: 1.Ensure Certified Nursing Assistant 2 (CNA2) did not wrap a linen sheet around Resident 1's legs and tied it to Resident 1's bedframe to restrict Resident 1's movement on 9/11/2025. This failure resulted in Resident 1's movement being restricted and had the potential for Resident 1 to develop an injury, impaired circulation (a condition where blood flow is reduced or blocked in certain areas of the body), skin breakdown (damage to the skin that can lead to open wounds and infections), and/or pain. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 7/25/2024 with diagnoses that included type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland), and hyperlipidemia (high levels of cholesterol in the blood). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 8/8/2025, the MDS indicated the resident had severe cognitive impairment (a significant decline in the ability to think, understand, and reason). The MDS indicated Resident 1 was dependent on help for eating, oral hygiene, toileting hygiene, showering, bathing himself, upper body dressing, lower body dressing, personal hygiene, putting on footwear, and taking off footwear. During a review of Resident 1's Nurses Notes dated 9/12/2025 at 7:45 PM, the Nurses Notes indicated that around 11:35 PM on 9/11/2025 a Certified Nursing Assistant (CNA1) called the attention of Registered Nurse 1 (RN 1) to Resident 1's room. The Nurses Notes indicated that upon entering Resident 1's room, the resident was noted on his bed with his legs crossed and a sheet wrapped in his lower legs to keep them from sliding off the bed. The Nurses Notes indicated Resident 1 had a history of sliding his legs all over the bed, keeping his legs crossed, and dangling his legs over the bed. During a review of Resident 1's Nurses Notes dated 9/12/2025 at 10:42 PM, the Nurses Notes indicated on 9/11/2025 Resident 1 was noted in bed with his legs crossed. The Nurses Notes indicated Resident 1 had a sheet wrapped on his lower legs to keep them from sliding off the bed. During a review of Resident 1's Nurses Notes dated 9/13/2025 at 12:15 AM, the Nurses Notes indicated that at approximately 11:35 PM on 9/11/2025 a CNA (unidentified) called RN 2 to Resident 1's room. The Nurses Notes indicated that upon RN 2's entrance to Resident 1's room, the resident was noted to be lying in bed with his legs crossed. The Nurses Notes indicated a sheet had been wrapped around Resident 1's lower legs in an apparent attempt to keep them from sliding off the bed. The Nurses Notes indicated that the supervising nurse was notified immediately, and the sheet was promptly removed. During a review of the facility's undated document titled Investigation, the document indicated RN 1, RN 2, CNA 1, and CNA 2 were interviewed. The document indicated RN 1 saw Resident 1 with his legs crossed and a sheet wrapped around his lower leg area. The document indicated RN 2 noticed sheets were wrapped around Resident 1's legs. The document indicated CNA 1 found Resident 1 with a sheet wrapped around the resident's legs. The document indicated CNA 2 put a sheet around Resident 1's legs to keep the resident safe so the resident would not fall and get hurt. The document indicated that CNA 2 mentioned Resident 1 kept trying to get out of bed. The document indicated CNA 2 was suspended pending an investigation of the incident. The document indicated CNA 2 later resigned from his position as a CNA at the facility. During a review of the facility document titled Verification of Incident Investigation/Administrative Summary dated 9/17/2025, the Verification of Incident Investigation/Administrative Summary indicated that while providing routine care to Resident 1 a CAN (unidentified) loosely wrapped a sheet around the resident's feet and then snuggly tucked the ends into each side of the bed in an effort to prevent the resident from shifting and/or potentially sliding out of bed. The Verification of Incident Investigation/Administrative Summary indicated another staff member noticed Resident 1 had a sheet wrapped around his feet and immediately proceeded to unwrap the resident's feet. The Verification of Incident Investigation/Administrative Summary indicated the action (Resident 1's feet being wrapped with a sheet) was identified as a suspicion of involuntary (an action that is not made by choice) restraint. The Verification of Incident Investigation/Administrative Summary indicated staff (unidentified) confirmed observing Resident 1 with a sheet wrapped around his legs which was determined to have admitted ly been applied by CNA 2. The Verification of Incident Investigation/Administrative Summary

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to report an allegation of staff to resident abuse to the California Department of Public Health (CDPH) and the ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) within two hours from when one of three sampled residents (Resident 1) was found with a linen sheet wrapped around Resident 1's legs and tied to his bedframe. This failure had the potential to result in a delay of an onsite inspection by CDPH and had the potential for Resident 1 to experience ongoing abuse.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 7/25/2024 with diagnoses that included type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland), and hyperlipidemia (high levels of cholesterol in the blood). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 8/8/2025, the MDS indicated the resident had severe cognitive impairment (a significant decline in the ability to think, understand, and reason). The MDS indicated Resident 1 was dependent on help for eating, oral hygiene, toileting hygiene, showering, bathing himself, upper body dressing, lower body dressing, personal hygiene, putting on footwear, and taking off footwear. During a review of the document titled Report of Suspected Dependent Adult/Elder Abuse dated 9/12/2025, the document indicated the facility was reporting neglect (a form of abuse in which there is a failure of a caregiver to meet a person's basic physical and emotional needs, leading to actual or potential harm). The document indicated Resident 1 was the victim and Certified Nursing Assistant (CNA 2) was the suspected abuser. The document indicated Resident 1 was noted with a sheet applied by a staff member as an intervention to prevent his legs from falling off the bed. The document indicated an investigation by the facility had been initiated. The document indicated the incident occurred on 9/11/2025 at 11:30 PM. During a review of a fax confirmation from the facility to CDPH dated 9/12/2025 at 8:30 PM, the fax confirmation indicated the facility notified CDPH of Resident 1's allegation of abuse. During a review of an email from the facility to the Ombudsman dated 9/12/2025, the email indicated the facility notified the Ombudsman of Resident 1's allegation of abuse. During a review of Resident 1's Nurses Notes dated 9/12/2025 at 7:45 PM, the Nurses Notes indicated that around 11:35 PM on 9/11/2025 a Certified Nursing Assistant (CNA1) called the attention of Registered Nurse 1 (RN 1) to Resident 1's room. The Nurses Notes indicated that upon entering Resident 1's room, the resident was noted on his bed with his legs crossed and a sheet wrapped in his lower legs to keep them from sliding off the bed. The Nurses Notes indicated Resident 1 had a history of sliding his legs all over the bed, keeping his legs crossed, and dangling his legs over the bed. 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