

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2025
NAME OF PROVIDER OR SUPPLIER Kei-Ai Los Angeles Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents' medical records are complete and accurate for two of three sampled residents (Resident 1 and Resident 2). The facility failed to: 1. Document in Resident 1's medical record that a nurse-to-nurse report was given on 9/8/25 when Resident 1 was discharged to Facility A on 9/8/25. 2. Document in Resident 2's medical record that a nurse to nurse report was given on 9/17/25 when Resident 2 was discharged to Facility B on 9/17/25. These deficient practices resulted in inaccurate and incomplete records for Resident 1 and Resident 2. 1. During a review of the admission Record indicated the facility admitted Resident 1 on 8/1/25 with diagnoses including cerebral infarction (a medical condition that occurs when the blood flow to the brain is disrupted), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and generalized muscle weakness. During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 9/6/25 indicated Resident 1 was cognitively intact. Resident 1 was dependent on toileting hygiene, shower/bathe, lower body dressing, putting off footwear, substantial assistance (helper does more than the effort) with oral hygiene, upper body dressing and moderate assistance with eating. During a review of the Physician Order dated 9/6/25 at 1:24 p. m., indicated an order to transfer Resident 1 to Facility A on 9/8/25. The physician order indicated a nurse to nurse report required, please call. and the telephone number was listed for Facility A. 2. During a review of the admission Record indicated the facility admitted Resident 2 on 6/18/25 with diagnoses including spinal stenosis (narrowing in the spine), DM and history of falling. During a review of the MDS dated [DATE], indicated Resident 2 was cognitively intact. Resident 2 was totally dependent on toileting hygiene, shower/bathe, upper/lower body dressing, putting on/taking off footwear and substantial assistance with oral hygiene and eating. During a review of the Physician Order dated 9/17/25 at 8:30 a.m., indicated an order to discharge Resident 2 on 9/17/25 to Facility B. The Physician order included nurse to nurse report required and Facility B's phone number was listed. During a concurrent interview and record review on 9/26/25 at 9:27 a.m. with the assistant director of nursing (ADON 1), Resident 2's Nurses Notes dated 9/17/25 were reviewed. ADON 1 stated Resident 2 was discharged to Facility B on 9/17/25. ADON 1 stated Resident 2 left the facility at around 9 a.m. and she gave report at 10 a.m. to the receiving nurse at Facility B. ADON 1 stated she did not document that she gave report to the receiving nurse in Facility B. During an interview on 9/26/25 at 9:44 a.m., the discharge planner (DP) stated Resident 2 had a physician order (dated 9/17/25) for discharge to Facility B. DCP further stated the physician order included to give nurse to nurse report. DCP stated the purpose of the report is to ensure that Facility B was aware that Resident 2 was coming and the nurse-to-nurse report would include what the medications Resident 2 was taking. During a concurrent interview and record review on 9/26/25 at 10:48 a.m., with the ADON 2, Resident 1's Nurses Notes dated 9/8/25 were reviewed. ADON 2 stated Resident 1 was discharged to Facility A on 9/8/25. ADON 2 stated she was unable to find documentation that a nurse-to-nurse report was given to Facility A on 9/8/25. ADON 2 stated the reason for giving nurse-to-nurse report was to ensure Facility A was aware that Resident 1 was coming. ADON 2 stated the report would include the physician discharge instructions and what medications Resident 1 was taking. ADON 2 further added the documentation was important to show .what we did. for Resident 1. During a review of the facility Policy titled Charting and Documentation reviewed on 3/27/25, indicated all services provided to the resident, progress toward the care plan goals or any changes in the resident's medical, physical, functional or psychosocial condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. The same Policy indicated documentation of procedures and treatments will include care-specific details including notification of family, physician or other staff if indicated.</p>		