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	02/27/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician as indicated in the interdisciplinary team (IDT, comprises professionals from various disciplines who work in collaboration to address a patient with multiple physical and psychological needs) meeting documentation for one of three sampled residents (Resident 1) reviewed for notification requirements.This failure resulted in Resident 1 experiencing emotional distress, uncertainty, and Resident 1 remains without physician review or documented medical evaluation related to discharge appropriateness from 2/19/2026 to 3/1/2026. During a record review of Resident 1's admission Record, indicated Resident 1 was admitted to the facility on [DATE], with diagnosis of chronic kidney disease (damage to the kidneys so they cannot filter blood the way they should).During a record review of Resident 1's Minimum Data Set (MDS- resident assessment tool) , dated, indicated Resident 1 had capacity to make decisions. The MDS indicated Resident 1 required clean up assistance for eating, oral hygiene, and maximal assistance for toileting, showering, lower body dressing, putting on footwear. The MDS indicated Resident 1 required partial assistance for lying to sitting, chair transfer, and supervision assistance for upper body dressing and personal hygiene.During a record review of Resident 1's progress notes, dated 2/19/2026, the progress notes revealed documentation that an Interdisciplinary Team (IDT) meeting was held on 2/19/2026 to discuss Resident 1's desire to discharge home. The IDT stated Resident 1 will remain in the facility to support full recovery then discharge home once deemed appropriate safe by medical doctor (MD). The progress notes indicated Resident 1 had expressed a desire to go home since September 12, 2025.During a record review of Resident 1's Care Plan, dated 8/8/2025, the Care Plan indicated:Evaluate and discuss with the resident/family the prognosis for independent assisted living.Identify, discuss and address limitation, risks, and benefits and needs for maximum independence.Establish a pre-discharge plan with the resident/family and evaluate progress and revise plan.Make arrangements with required community resources to support independence post-discharge homes care, PT, OT, MD, Nurse.Monitor for and address episodes of anxiety, fear, distress.During an interview on 2/27/2026 at 1:50 PM with Resident 1, in Resident 1's room, Resident 1 sat down on his wheelchair and verbalized experiencing emotional distress related to the facility's failure to clearly communicate discharge goals, discharge planning, and delays in progressing toward discharge. Resident 1 stated he has resided at the facility since August 2025, and for six months he has been frustrated due to the lack of updates regarding discharge process and uncertainty about the steps needed to facilitate a safe return to the community. Resident reported feeling uninformed and expressed concern that the absence of clear communication and planning has prolonged his stay and impacted his emotional and financial well-being. Resident 1 stated he thinks the facility will not let him go home because they want to take advantage of receiving his Social Security Benefits allowance, and stated he feels captured in the facility. Resident 1 stated he had a meeting regarding his request to (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: 555438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
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	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	go home, but nothing was further done. Resident 1 stated he had not even seen a doctor since he arrived at the facility.During an interview on 2/27/2026 at 3 PM with Social Services (SS), the SS staff stated she is part of the IDT and stated that Resident 1 was not deemed safe to discharge. The SS failed to provided documentation outlining the specific clinical, functional, or safety factors that made discharge not feasible. The SS stated Resident 1 had decision-making capacity related to discharge, but had not updated Resident 1 on his discharge goals after the IDT meeting on 2/19/2026. The SS also stated she had not notified the physician as stated on the summary of the IDT meeting notes.During an interview on 2/27/2026 with the Director of Nursing (DON), the DON stated as of 2/27/2026, the resident remains in the facility without documented discharge goals or a documented rationale explaining why discharge home is not feasible. The DON stated some goals and planning to be discussed is to assess if modifications need to be made to the resident's home such as grab bars, wheelchair access, make sure they educate resident on risks and ensure home health as follow up care. The DON stated in Resident 1's case it may be necessary to notify Adult Protective Services to follow up on resident. DON stated he usually participates in the IDT meeting, but could not remember if he was part of the meeting with Resident 1, however, someone from the team should have notified the MD to evaluate Resident 1 to determine discharge goals. The DON stated failure to document discharge planning efforts and resident-centered goals resulted in Resident 1 remaining in the facility without a clear plan, explanation, or pathway toward discharge.Documentation from the IDT meeting dated 2/19/2026 stated that the physician would be notified regarding the resident's request for discharge and the team's determination that discharge was not deemed safe.Record review as of 2/27/2026 revealed:No documentation that the physician was notified.No physician progress note addressing discharge appropriateness.No physician order related to discharge planning or safety concerns.No follow-up documentation indicating consultation occurred.Staff interview confirmed that the physician had not yet been notified.During a review of the facility's policy and procedure titled Change of Condition Reporting dated 3/2025, indicated it is the policy of this facility that changes in resident condition will be communicated to the primary physician for proper management. Any sudden or serious change in a resident's condition manifested by a marked change in physical or psychological status of the resident will be communicated by the Licensed Nurse to the physician with a request for physician visit promptly and acute care evaluation.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and document discharge goals and failed to provide a documented rationale for determining discharge was not feasible for one of three sampled residents (Resident 1) reviewed for discharge planning.This failure resulted in Resident 1 verbalizing experiencing emotional distress due to the facility's failure to clearly communicate discharge goals, discharge planning, and delays in progressing toward discharge.During a record review of Resident 1's admission Record, indicated Resident 1 was admitted to the facility on [DATE], with diagnosis of chronic kidney disease (damage to the kidneys so they cannot filter blood the way they should).During a record review of Resident 1's Minimum Data Set (MDS- resident assessment tool) , dated, indicated Resident 1 had capacity to make decisions. The MDS indicated Resident 1 required clean up assistance for eating, oral hygiene, and maximal assistance for toileting, showering, lower body dressing, putting on footwear. The MDS indicated Resident 1 required partial assistance for lying to sitting, chair transfer, and supervision assistance for upper body dressing and personal hygiene.During a record review of Resident 1's progress notes, dated 2/19/2026, the progress notes revealed documentation that an Interdisciplinary Team (IDT) meeting was held on 2/19/2026 to discuss Resident 1's desire to discharge home. The IDT stated Resident 1 will remain in the facility to support full recovery then discharge home once deemed appropriate safe by medical doctor (MD). The progress notes indicated Resident 1 had expressed a desire to go home since September 12, 2025.During a record review of Resident 1's Care Plan, dated 8/8/2025, the Care Plan indicated:Evaluate and discuss with the resident/family the prognosis for independent assisted living.Identify, discuss and address limitation, risks, and benefits and needs for maximum independence.Establish a pre-discharge plan with the resident/family and evaluate progress and revise plan.Make arrangements with required community resources to support independence post-discharge homes care, PT, OT, MD, Nurse.Monitor for and address episodes of anxiety, fear, distress.During an interview on 2/27/2026 at 1:50 PM with Resident 1, in Resident 1's room, Resident 1 sat down on his wheelchair and verbalized experiencing emotional distress related to the facility's failure to clearly communicate discharge goals, discharge planning, and delays in progressing toward discharge. Resident 1 stated he has resided at the facility since August 2025, and for six months he has been frustrated due to the lack of updates regarding discharge process and uncertainty about the steps needed to facilitate a safe return to the community. Resident reported feeling uninformed and expressed concern that the absence of clear communication and planning has prolonged his stay and impacted his emotional and financial well-being. Resident 1 stated he thinks the facility will not let him go home because they want to take advantage of receiving his Social Security Benefits allowance, and stated he feels captured in the facility. Resident 1 stated he had a meeting regarding his request to go home, but nothing was further done. Resident 1 stated he had not even seen a doctor since he arrived at the facility.During an interview on 2/27/2026 at 3 PM with Social Services (SS), the SS staff stated she is part of the IDT and stated that Resident 1 was not deemed safe to discharge. The SS failed to provided documentation outlining the specific clinical, functional, or safety factors that made discharge not feasible. The SS stated Resident 1 had decision-making capacity related to discharge, but had not updated Resident 1 on his discharge goals after the IDT meeting on 2/19/2026.There were no documented discharge goals developed in collaboration with the resident.There was no documented assessment of the resident'sThere was no documentation of exploration of community supports, services, or alternative discharge options.The resident care plan did not reflect discharge planning interventions or measurable objectives.The record did not (continued on next page)

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	555438	A. Building B. Wing	02/27/2026

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reflect ongoing communication with the resident regarding next steps.During an interview on 2/27/2026 with the Director of Nursing (DON), the DON stated as of 2/27/2026, the resident remains in the facility without documented discharge goals or a documented rationale explaining why discharge home is not feasible. The DON stated some goals and planning to be discussed is to assess if modifications need to be made to the resident's home such as grab bars, wheelchair access, make sure they educate resident on risks and ensure home health as follow up care. The DON stated in Resident 1's case it may be necessary to notify Adult Protective Services to follow up on resident. DON stated he usually participates in the IDT meeting, but could not remember if he was part of the meeting with Resident 1, however, someone from the team should have notified the MD to evaluate Resident 1 to determine discharge goals. The DON stated failure to document discharge planning efforts and resident-centered goals resulted in Resident 1 remaining in the facility without a clear plan, explanation, or pathway toward discharge.During a review of the facility's policy and procedures (P&P) titled Transfers, Bed holds, and Discharges out of the facility dated 4/2025, indicated The IDT will reevaluate the resident's potential for discharge on a weekly basis to identify changes that required modification of the discharge plan. The discharge plan will be updated and changes documented in the medical record. The SSD will updated the resident's comprehensive care plan to include the discharge plan. The physician will document the basis of the discharge when a resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.During a review of the facility's P&P titled Discharge Summary and Plan dated 4/2025, the P&P indicated the discharge summary will include a description of the resident's discharge potential (the expectation of discharging the resident from the facility within the next three months). If it is determined that returning to the community is not feasible, it will be documented why this is the case and who made the determination. A copy of the following will be provided to the resident in the resident's medical records:An evaluation of the resident's discharge needsThe post discharge planDischarge summary.