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	03/24/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of three residents (Residents 1 and 2) were treated with respect and dignity and failed to honor residents' right to refuse care from the outside contracted phlebotomist on 3/11/2026 at 4 AM during a blood draw procedure at resident's bedside.This failure resulted in:Resident 1 reported that the phlebotomist was unprofessional, harsh, and rude during the procedure. Resident 1 stated that despite verbally telling the phlebotomist to stop, he continued inserting the needle, causing distress and discomfort.Resident 2 reported the phlebotomist was rough and unprofessional. As a result of this experience, Resident 2 refused further services from the phlebotomist, which led to a delay in necessary lab work, treatment, and diagnosis.Other residents remained at risk of experiencing similar disrespect and potentially abusive care.During a review of Resident 1's admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of presence of left artificial knee joint following joint replacement surgery.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 3/11/2026, the MDS indicated Resident 1 had the cognitive skills to daily decision making. The MDS indicated Resident 1 required partial assistance to shower, ability to dress below waist, put on footwear, sit to stand, toilet transfer, and was independent to eat. The MDS indicated Resident 1 required supervision for oral hygiene, toileting, upper body dressing, sit to lying, roll left and right, and lying to sitting on side of bed. During a review of Resident 1's Nursing Progress Notes, dated 3/11/2026, the Nursing Progress Notes indicated staff was aware of Resident 1's complaints regarding the phlebotomist's conduct. The Nursing Progress Notes indicated Resident 1 asked the Phlebotomist to stop but continued what he was doing. The Nursing Progress Notes indicated staff explained to Resident 1 that the facility would report the Phlebotomist to the Core lab company Administrator. There was no documented evidence the facility took immediate action to ensure resident safety or prevent the phlebotomist from continuing to provide services to other residents.During a review of Resident 2's admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnosis of Spinal Stenosis (is a chronic condition characterized by the narrowing of spaces within the spine, putting pressure on the nerves that travel through it).During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had the cognitive skills to daily decision making. The MDS indicated Resident 2 required supervision to eat, partial assistance for oral hygiene, personal hygiene, roll left and right, maximal assistance for sit to lying, lying on side of bed, upper body dressing, and was dependent on staff for toileting, showering, lower body dressing and putting taking off footwear. During a review of Resident 2's Nursing Progress Notes, dated 3/11/2026, the Nursing Progress Notes indicated staff was aware of Resident 2's complaints regarding the phlebotomist conduct rude and harsh and Resident 2 refused blood to be withdrawn on 3/11/2026. The Nursing Progress Notes indicated the Charge Nurse tried to convince Resident 2 to get her blood drawn but Resident 2 adamantly refused. During a telephone interview on 3/24/2026 at 12 PM with Resident 1, Resident 1 stated she was still very upset at the incident that occurred on 3/11/2026 at the facility because the man who had tattoos who came to draw her blood was very rude as he did not introduce himself. Resident 1 stated she asked him for his name, and he did not (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	respond to her with his name. Resident 1 stated the phlebotomist had no name badge or identification, he came in her room around 4 am and said he was going to draw her blood, she asked him why and who he was but he proceeded to insert the needle in her arm not using a tourniquet, and he was forceful almost in a stabbing manner and it caused her a lot of pain. She yelled at him to stop the procedure, but he continued to re-insert the needle to draw her blood. Resident 1 stated she felt her rights were violated and the incident caused her anguish and anxiety. This incident, along with other issues made her want to leave the facility against medical advice (AMA), so she called her husband to pick her up. Resident 1 stated the phlebotomist never provided her with his name, but her roommate (Resident 2) was a witness to the incident that happened on 3/11/2026.During an interview on 3/24/2026 at 1:19 PM with Resident 2, Resident 2 stated that on 3/11/2026 she heard the discussion between Resident 1 and the phlebotomist early in the morning around 4 AM. Resident 2 stated there was a male phlebotomist who was very rude, I heard when he came to draw her blood, I could hear her asking him for his name and asked him to stop poking her and she was screaming in pain, but she complained that he stabbed her with the needle anyway. She reported to this to the nurses when they came to talk to her later that morning. Resident 2 stated she had also experienced the same negative experience with the same phlebotomist on a previous date prior to 3/11/2026. In fact, after the first time he drew blood from her on 3/7/2026, her arm was bruised for a week. He came in my room didn't identify himself, said he was here to draw my blood, he was rough, I was trying to tell him I have small veins. He kept holding my arm down I told him it hurt and he told me to cool off. He came back again a week after on 3/11/2026 around 4 AM and once again he didn't acknowledge himself. He doesn't knock, just pulls the curtain open. I told him to get out. I was a certified phlebotomist for 25 years so I know his technique is not good at all. I reported to pinky next day. He left me bruises. He uses a stabbing technique. It hurt a lot. He came back a few minutes later with one of the male nurses that work night shift and the nurse asked me if I would let the phlebotomist draw my blood, I again told him no he's not touching me because he does not know how to properly draw blood and he inflicts pain despite me telling him that I have small veins and I already know I am a hard stick. The male nurse and the phlebotomist left the room and did not draw my blood. Resident 2 stated the interaction with the phlebotomist caused her distress.During an interview on 3/24/2026 at 1:41 PM with the Registered Nurse Supervisor (RNS), the RNS stated that on 3/11/26 the Charge Nurse informed her that Resident 1 was packing her bags stating she wanted to go home. The RNS stated she went to talk to Resident 1 who reported the incident with the phlebotomist, which the RNS then reported to the Case Manager and the Social Worker. The RNS stated Resident 2 also complained about the phlebotomist and tried to explain what she heard between Resident 1 and the phlebotomist. The RNS stated she attempted to call the core lab to identify the phlebotomist but was unsuccessful and also failed to document and follow up thoroughly, which placed residents at risk for continued harm. The RNS stated when a resident says I don't want this as it relates to services provided but staff continues to proceed with care or services, this could be identified as abuse and staff should have reported the issue to the Administrator to further investigate the concerns reported by Resident 1 and 2.During an interview on 3/24/2026 at 1:58 PM with the Case Manager (CM), the CM stated the morning of 3/11/2026, Resident 1 was adamant to leave the facility. Resident 1 expressed dissatisfaction with late medication, poor food quality, and reported that the phlebotomist did not introduce himself and caused pain during blood draw. The CM offered a grievance form, which Resident 1 declined. She refused to wait for the doctor, signed out AMA, and left with her husband. Resident 2 confirmed the phlebotomist was unprofessional and did not identify himself. The CM notified the Administrator about the resident leaving AMA and concerns about the phlebotomist on 3/12/26 but did not provide further incident details. No investigation into the phlebotomist's conduct had been conducted as of 3/24/2026. During an interview on 3/24/2026 at 2:08 PM with the Charge Nurse (CN), the CN stated that on 3/11/2026, while administering medications in the morning, she observed Resident 1 packing her belongings. The CN stated she informed the RN supervisor and Case (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Manager, who then went in to speak with Resident 1. The resident's husband was already present at the bedside. The CN stated regarding the phlebotomist, she is unfamiliar with his identity as they typically arrive before the start of the morning shift at 7:00 AM. The CN stated Resident 2 reported to her that a phlebotomist had been rough with her and she listened to her concerns; however, the CN did not report the incident or investigate further. During an interview on 3/24/2026 at 2:15 PM with the Director of Staff Development (DSD), the DSD stated that about two weeks ago, Resident 2 made a complaint regarding the phlebotomist after her roommate in bed B, Resident 1, considered leaving against medical advice (AMA). The RN supervisor and case manager were working to find a solution. Resident 2 explained that Resident 1 wanted to leave because of issues with the phlebotomist, describing him as having heavy hands. Resident 2 agreed, saying the phlebotomist was very harsh. In these situations, staff are required to notify the administration about concerns with an external company. Forcing a resident to do something without their consent violates their rights.There was no record of the facility initiating an investigation to identify the phlebotomist, investigate Resident 1 and 2 concerns, and notify the contracted laboratory company. As of 3/24/2026, no interventions were implemented to prevent further incidents.During an interview on 3/24/2026 at 3:50 PM with the Director of Nursing (DON), the DON stated he was unaware of any issues with the contracted phlebotomist but noted communication with the vendor could be improved by facility staff. The DON emphasized that professionalism is required, residents can refuse blood draws, and in such cases, the nurse and physician should be promptly informed. The DON stated the phlebotomist should better educate residents about procedures as lab tests are essential for timely diagnosis and treatment; poor service or delays in blood draws may risk delayed care.During a review of the facility's policy and procedures (P&P) titled Resident Rights, dated 4/2025, the P&P indicated residents are to be treated with respect, kindness, and dignity, be free from abuse, neglect, and self-determination. Residents will be informed of, participate in care planning and treatment and have the facility respond to his or her grievances.During a review of the facility's P&P titled Requesting, Refusing and or discontinuing care or treatment, dated 4/2025, indicated residents will be informed of the type of caregiver or professional that will provide the care, risks and benefits of proposed treatment or care. If resident refuses care or treatment the Charge Nurse or DON will meet with the resident to determine why the resident is requesting refusing treatment, try to address resident's concerns and discuss alternative options. The resident will not be coerced, intimated, or manipulated for refusing care or treatment. The interdisciplinary team will assess the resident's needs and offer the resident alternative treatments.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from abuse and failed to report, investigate, and take action on allegations of abuse reported to facility staff on 3/11/2026, involving an outside contracted phlebotomist for two of three residents (Residents 1 and 2) reviewed for abuse concerns. This failure resulted in:Resident 1 reported that the phlebotomist was unprofessional, harsh, and rude during the procedure. Resident 1 stated that despite verbally telling the phlebotomist to stop, he continued inserting the needle, causing distress and discomfort.Resident 2 also reported the phlebotomist was rough and unprofessional. As a result of this experience, Resident 2 refused further services from the phlebotomist, which led to a delay in necessary lab work, treatment, and diagnosis.Other residents remained at risk of experiencing similar disrespect and potentially abusive care.During a review of Resident 1's admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of presence of left artificial knee joint following joint replacement surgery.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 3/11/2026, the MDS indicated Resident 1 had the cognitive skills to daily decision making. The MDS indicated Resident 1 required partial assistance to shower, ability to dress below waist, put on footwear, sit to stand, toilet transfer, and was independent to eat. The MDS indicated Resident 1 required supervision for oral hygiene, toileting, upper body dressing, sit to lying, roll left and right, and lying to sitting on side of bed. During a review of Resident 1's Nursing Progress Notes, dated 3/11/2026, the Nursing Progress Notes indicated staff was aware of Resident 1's complaints regarding the phlebotomist's conduct. The Nursing Progress Notes indicated Resident 1 asked the Phlebotomist to stop but continued what he was doing. The Nursing Progress Notes indicated staff explained to Resident 1 that the facility would report the Phlebotomist to the Core lab company Administrator. There was no documented evidence the facility took immediate action to ensure resident safety or prevent the phlebotomist from continuing to provide services to other residents.During a review of Resident 2's admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnosis of Spinal Stenosis (is a chronic condition characterized by the narrowing of spaces within the spine, putting pressure on the nerves that travel through it). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had the cognitive skills to daily decision making. The MDS indicated Resident 2 required supervision to eat, partial assistance for oral hygiene, personal hygiene, roll left and right, maximal assistance for sit to lying, lying on side of bed, upper body dressing, and was dependent on staff for toileting, showering, lower body dressing and putting taking off footwear. During a review of Resident 2's Nursing Progress Notes, dated 3/11/2026, the Nursing Progress Notes indicated staff was aware of Resident 2's complaints regarding the phlebotomist conduct rude and harsh and Resident 2 refused blood to be withdrawn on 3/11/2026. The Nursing Progress Notes indicated the Charge Nurse tried to convince Resident 2 to get her blood drawn but Resident 2 adamantly refused. During a telephone interview on 3/24/2026 at 12 PM with Resident 1, Resident 1 stated she was still very upset at the incident that occurred on 3/11/2026 at the facility because the man who had tattoos who came to draw her blood was very rude as he did not introduce himself. Resident 1 stated she asked him for his name, and he did not respond to her with his name. Resident 1 stated the phlebotomist had no name badge or identification, he came in her room around 4 am and said he was going to draw her blood, she asked him why and who he was but he proceeded to insert the needle in her arm not using a tourniquet, and he was forceful almost in a stabbing manner and it caused her a lot of pain. She yelled at him to stop the procedure, but he continued to re-insert the needle to draw her blood. Resident 1 stated she felt her rights were violated and the incident caused her anguish and anxiety. This incident, along with other issues made her want to leave the facility against medical advice (AMA), so she called her husband to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pick her up. Resident 1 stated the phlebotomist never provided her with his name, but her roommate (Resident 2) was a witness to the incident that happened on 3/11/2026.During an interview on 3/24/2026 at 1:19 PM with Resident 2, Resident 2 stated that on 3/11/2026 she heard the discussion between Resident 1 and the phlebotomist early in the morning around 4 AM. Resident 2 stated there was a male phlebotomist who was very rude, I heard when he came to draw her blood, I could hear her asking him for his name and asked him to stop poking her and she was screaming in pain, but she complained that he stabbed her with the needle anyway. She reported to this to the nurses when they came to talk to her later that morning. Resident 2 stated she had also experienced the same negative experience with the same phlebotomist on a previous date prior to 3/11/2026. In fact, after the first time he drew blood from her on 3/7/2026, her arm was bruised for a week. He came in my room didn't identify himself, said he was here to draw my blood, he was rough, I was trying to tell him I have small veins. He kept holding my arm down I told him it hurt and he told me to cool off. He came back again a week after on 3/11/2026 around 4 AM and once again he didn't acknowledge himself. He doesn't knock, just pulls the curtain open. I told him to get out. I was a certified phlebotomist for 25 years so I know his technique is not good at all. I reported to pinky next day. He left me bruises. He uses a stabbing technique. It hurt a lot. He came back a few minutes later with one of the male nurses that work night shift and the nurse asked me if I would let the phlebotomist draw my blood, I again told him no he's not touching me because he does not know how to properly draw blood and he inflicts pain despite me telling him that I have small veins and I already know I am a hard stick. The male nurse and the phlebotomist left the room and did not draw my blood. Resident 2 stated the interaction with the phlebotomist caused her distress.During an interview on 3/24/2026 at 1:41 PM with the Registered Nurse Supervisor (RNS), the RNS stated that on 3/11/26 the Charge Nurse informed her that Resident 1 was packing her bags stating she wanted to go home. The RNS stated she went to talk to Resident 1 who reported the incident with the phlebotomist, which the RNS then reported to the Case Manager and the Social Worker. The RNS stated Resident 2 also complained about the phlebotomist and tried to explain what she heard between Resident 1 and the phlebotomist. The RNS stated she attempted to call the core lab to identify the phlebotomist but was unsuccessful and also failed to document and follow up thoroughly, which placed residents at risk for continued harm. The RNS stated when a resident says I don't want this as it relates to services provided but staff continues to proceed with care or services, this could be identified as abuse and staff should have reported the issue to the Administrator to further investigate the concerns reported by Resident 1 and 2.During an interview on 3/24/2026 at 1:58 PM with the Case Manager (CM), the CM stated the morning of 3/11/2026, Resident 1 was adamant to leave the facility. Resident 1 expressed dissatisfaction with late medication, poor food quality, and reported that the phlebotomist did not introduce himself and caused pain during blood draw. The CM offered a grievance form, which Resident 1 declined. She refused to wait for the doctor, signed out AMA, and left with her husband. Resident 2 confirmed the phlebotomist was unprofessional and did not identify himself. The CM notified the Administrator about the resident leaving AMA and concerns about the phlebotomist on 3/12/26 but did not provide further incident details. No investigation into the phlebotomist's conduct had been conducted as of 3/24/2026. During an interview on 3/24/2026 at 2:08 PM with the Charge Nurse (CN), the CN stated that on 3/11/2026, while administering medications in the morning, she observed Resident 1 packing her belongings. The CN stated she informed the RN supervisor and Case Manager, who then went in to speak with Resident 1. The resident's husband was already present at the bedside. The CN stated regarding the phlebotomist, she is unfamiliar with his identity as they typically arrive before the start of the morning shift at 7:00 AM. The CN stated Resident 2 reported to her that a phlebotomist had been rough with her and she listened to her concerns; however, the CN did not report the incident or investigate further. During an interview on 3/24/2026 at 2:15 PM with the Director of Staff Development (DSD), the DSD stated that about two weeks ago, Resident 2 made a complaint regarding the phlebotomist after her roommate in bed B, Resident 1, considered leaving (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	against medical advice (AMA). The RN supervisor and case manager were working to find a solution. Resident 2 explained that Resident 1 wanted to leave because of issues with the phlebotomist, describing him as having heavy hands. Resident 2 agreed, saying the phlebotomist was very harsh. In these situations, staff are required to notify the administration about concerns with an external company. Forcing a resident to do something without their consent violates their rights.There was no record of the facility initiating an investigation to identify the phlebotomist, investigate Resident 1 and 2 concerns, and notify the contracted laboratory company. As of 3/24/2026, no interventions were implemented to prevent further incidents.During an interview on 3/24/2026 at 3:50 PM with the Director of Nursing (DON), the DON stated he was unaware of any issues with the contracted phlebotomist but noted communication with the vendor could be improved by facility staff. The DON emphasized that professionalism is required, residents can refuse blood draws, and in such cases, the nurse and physician should be promptly informed. The DON stated the phlebotomist should better educate residents about procedures as lab tests are essential for timely diagnosis and treatment; poor service or delays in blood draws may risk delayed care.During a review of the facility's policy and procedures (P&P) titled Abuse and Neglect, dated 4/10/2025, indicated Abuse is defined as willful infliction of injury, intimidation, or punishment with resulting in physical harm, pain or mental anguish. Neglect is defined as the failure of the facility to provide services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The staff will investigate alleged abuse and neglect to clarify what happened and identify possible causes.