STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555438	A. BUILDING _____ B. WING _____	**05/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent falls and injury to one of two sampled residents (Resident 1). Resident 1, who required assistance with transfers and walking and used the toilet, was not provided with a toileting plan to anticipate needs and avoid Resident 1 transferring and walking unassisted. This deficient practice resulted in Resident 1 sustaining a fall on 1/15/20, while trying to go to the restroom to use the toilet. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on 1/5/20 and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS- standardized assessment and care-screening tool) dated [DATE], indicated Resident 1 was disoriented, needed one-person to two or more physical assistance with transfers and walking. Resident 1 was frequently incontinent of urine and was incontinent of bowel. A review of Resident 1's Bowel and Bladder Assessment form dated 12/19/19 at 8:50 p.m. and 1/4/20 at 5 p.m., indicated Resident 1 was assessed continent of bladder and bowel functions. The Assessment indicated Resident 1 was not a candidate for toileting program because Resident 1 was continent. A review of Resident 1's Care Plan created on 1/6/20, indicated Resident 1 was at high risk for falls and injury as a result of mental compromise, physical limitation related to poor safety awareness, bladder and bowel incontinence. A review of the Situation, Background, Assessment, and Recommendations (SBAR) dated 1/15/20, timed at 5:40 a.m., indicated at 5 a.m., Resident 1 was found lying face down on the floor in his room. Resident 1 was moaning and grimacing with bleeding from a cut to the forehead and bridge of the nose. The licensed nurse notified Resident 1's primary physician, who ordered transferring Resident 1 to General Acute Care Hospital 1 (GACH 1) emergency room (ER) for sutures (stitches) of the laceration (skin cut). During an interview and concurrent review on 2/3/20 at 11:48 a.m., Resident 1's clinical record was reviewed with Registered Nurse Supervisor (RNS 1). RNS 1 stated Resident 1 was going to the restroom to void but fell by the bed side. RNS was unable to find evidence, Resident 1 was on a toilet scheduled plan to avoid unassisted transfers.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure accurate documentation of care plan for Resident 1. The Care Plan indicated Resident 1 had a fall because Resident 1 got out of bed unassisted and slipped on wet floor. This deficient practice failed to provide an accurate representation of what occurred when Resident 1 had a fall. Findings: A review of the Admission Records indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of the Minimum Data Set (MDS, standardized care and screening tool) dated [DATE], indicated Resident 1 was disoriented to year, month and day. Resident 1 needed one person to two or more physical assistance with activities of daily living (ADLs). During a review of the Resident 1's Care Plan dated 1/15/20, indicated Resident 1 had an .actual fall incident as evidenced by poor judgment, poor safety awareness .'. Resident 1 .got out of bed unassisted, slipped on wet floor. During interview and concurrent review on 2/19/20, at 2:28 p.m. Resident 1's Care Plan dated 1/15/20 was reviewed with RNS 4. RNS 4 stated no one reported that Resident 1 slipped and fell because the floor was wet. RNS 4 stated if the floor was wet, an investigation will be conducted to determine the cause. During a telephone interview and concurrent review on 2/21/20 at 1:49 p.m., Resident 1's Care Plan was reviewed with the director of nursing (DON). DON stated Resident 1's Care Plan dated 1/15/20 indicating Resident 1 fell because the floor was wet was not accurate. DON stated when Resident 1 fell , the floor was dry. A review of the facility's policy on Charting and Documentation, revised on 7/2017, indicated documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. A review of the facility's policy on Care Plans, Comprehensive Person-Centered, revised on 12/2016, indicated the care plan interventions are chosen only after careful data gathering, proper sequencing of events, and careful consideration of the relationship between the resident's problem areas and their causes and relevant decision making.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.