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 _____	**05/28/2020**

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 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a physician evaluated, identified and documented, the medical and safety needs of four of six residents (Residents 1, 2, 4, and 5) before ordering the discharge the residents to equal or lower levels of care. The facility discharged Residents 1, 2, 4, and 5, without physician's documentation deeming their transfers safe and necessary. Findings: a. A review of Resident 1's Admission Record indicated the facility admitted the resident on 3/10/20 with [DIAGNOSES REDACTED]. The Admission Record did not include any contact person or representative. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-planning tool) dated 3/16/20, indicated the resident required extensive assistance with one-person physical support with transferring in and out of bed, walking, dressing, personal hygiene, and toilet use. A review of Resident 1's nursing Discharge Summary notes dated 4/3/20, indicated the resident was discharged home with Home Health services. There was no documentation how the resident could take care of herself as Home Health services were not 24 hours a day. Further record review indicated the physician did not document Resident 1's discharge was necessary. The Physician's Discharge Summary form was not signed by the physician. b. A review of Resident 2's Admission Record indicated the facility admitted the resident on 3/5/20 with [DIAGNOSES REDACTED]. A review of Resident 2's MDS dated [DATE], indicated the resident needed limited assistance with bed mobility, transfers, walking, and personal hygiene. A review of Resident 1's nursing Discharge Summary notes dated 4/2/20, indicated the resident was discharged home still needing daily treatment to the sacral pressure sore. The documentation did not include who would be providing care and treatment to Resident 2. Further record review indicated the physician did not document Resident 2's discharge was necessary. The Physician's Discharge Summary form was not signed by the physician. c. A review of Resident 4's Admission Record indicated the facility admitted the resident on 2/18/20 with [DIAGNOSES REDACTED]. A review of Resident 4's MDS dated [DATE], indicated the resident needed extensive assistance with one-person physical assist with bed mobility, transfers, and personal hygiene. A review of Resident 4's nursing Discharge Summary notes dated 3/3/20, indicated the resident was discharged to an Assisted Living Facility (ALF) needing daily treatment to the left stump and other diabetic ulcers. The documentation did not include who would be providing care and treatment to Resident 4. Further record review indicated the physician did not document Resident 4's discharge was necessary. The Physician's Discharge Summary form was not signed by the physician. d. A review of Resident 5's Admission Record indicated the facility admitted the resident on 3/26/16 with [DIAGNOSES REDACTED]. A review of Resident 5's MDS dated [DATE], indicated the resident needed extensive assistance with one-person physical assist with bed mobility, transfers, and personal hygiene. A review of Resident 5's Discharge Order dated 12/27/19, indicated the resident was discharged to a Retirement Care Facility. The documentation did not include who would be providing care and treatment to Resident 5. Further record review indicated the physician did not document Resident 5's discharge was necessary. The Physician's Discharge Summary form was not signed by the physician. During an interview on 5/13/20 at 1:45 pm., the Director of Nursing (DON) stated the doctors that order the transfers and discharges of residents out of the facility do not write transfer and discharge notes. The DON stated there were no discharge progress notes written by a physician in the medical records of R1, R2, R4, and R5. On 5/15/20 at 3:15 pm, during an interview, the Administrator (ADM) stated the licensed nurses have been documenting the rationale for the transfers or discharges of residents. During a review of the facility's policy and procedures, and a concurrent interview with ADM on 5/15/20 at 3:15 pm, the ADM stated the facility's policy and procedure for transfers and discharges does not address some of the regulations that pertain to transfers and discharges, and will be updated. The ADM stated the physicians of R1, R2, R4, and R5, should have documented the reasons for their discharges but did not.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** Based on interview and record review the facility failed to notify in writing four of six sampled residents (Residents 1, 2, 4, and 5) or their responsible parties, about the proposed discharges as soon as possible, before the transfer or discharge, and provide the contact information, such as address and telephone number of the receiving facility. This deficient practice result Cross reference F622 Findings: a. On 5/13/20 at 1:45 pm., during a review of Resident 1's medical record and a concurrent interview with the DON, the document Notice of Proposed Transfer/Discharge, dated 4/3/20, indicated the facility notified Resident 1 on the same day of discharge. b. On 5/13/20, at 2 pm., during a review of Resident 2's medical record and a concurrent interview with the DON, the document Notice of Proposed Transfer/Discharge, dated 4/2/20, indicated the facility notified Resident 2 of the same day of discharge. c. On 5/13/20, at 2:30 pm., during a review of Resident 4's medical record and a concurrent interview with the DON, the document Notice of Proposed Transfer/Discharge, dated 3/3/20, indicated the facility notified Resident 4 of his discharge on the same day of discharge. d. On 5/13/20, at 2:45 pm., during a review of Resident 5's medical record and a concurrent interview with the DON, the document Notice of Proposed Transfer/Discharge, dated 12/27/19, indicated the facility notified Resident 4 of her discharge on the same day of discharge. On 5/15/20 at 3:15 pm, during an interview, the administrator stated all residents should be provided a written notice of discharge at least 30 days before her discharge.

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.