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 _____	**06/12/2020**

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 protection from physical abuse when a Certified Nurse Assistant (CNA 1) did not appropriately respond to a behavior issue manifested by one of two sampled residents (Resident 1). This deficient practice had the potential to affect the physical, mental and psychosocial well-being of the resident. Findings: An unannounced visit was conducted to investigate a facility reported incident which was started on April 25, 2019. A review of the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had [DIAGNOSES REDACTED]. A review of the Director of Nurses' (DON's) Interview Statement with the Licensed Vocational Nurse (LVN 1) on April 8, 2019 at 8 AM, indicated LVN 1 was on her break past 10 PM on April 7, 2019, when LVN 1 heard an argument in the activity room. LVN 1 saw Resident 1 and CNA 1 about to charge at each other. LVN 1 ran screaming to the activity room and placed herself between CNA 1 and Resident 1. CNA 1 was able to push Resident 1 on the wall and made Resident 1 sit on a chair. Resident 1 covered his face with his hand, and CNA 1 held Resident 1's hand and used Resident 1's hand to hit Resident 1's face three times. LVN 1 was yelling at CNA 1 to stop while being in-between the CNA and the Resident. Resident 1 started kicking. CNA 1 reached out to hit Resident 1's thigh four times. After both CNA 1 and Resident 1 were separated, LVN 1 assessed Resident 1. Resident 1 was unable to remember what had happened. Resident 1 also denied any pain. A review of the SBAR Communication Form (document used by the facility to communicate change of condition of the resident) dated April 8, 2019 at 12:15 AM, indicated Resident 1 had a 0.3 cm (centimeter - unit of measurement) scratch on the left eyebrow. A review of the Interview Statement with the CNA 1 on April 9, 2019 at 10 AM, indicated CNA 1 was in the activity room keeping an eye on a new, fall risk resident while watching TV. Resident 1 entered the room and turned off the TV after CNA 1 told Resident 1 not to do so. Then the fall risk resident started to get up from her chair, Resident 1 walked towards CNA 1 and the fall risk resident. CNA 1 instructed Resident 1 to move out but continued walking towards them. CNA 1 pushed Resident 1 on the wall and sat Resident 1 on the chair. Resident 1 started kicking so CNA 1 hit Resident 1 on the thigh for one time. During an interview with the Assistant Administrator (AA), on January 16, 2020 at 3:47 PM, the AA confirmed that the incident did happen on April 7, 2019. The AA expected CNA 1 to know what triggered Resident 1's behavior, and when there was escalation of the behavior to calm Resident 1 down and then deal with the behavior after. During an interview with the Director of Staff Development (DSD) on January 16, 2020 at 4:07 PM, the DSD stated he was surprised on what happened to CNA 1 with Resident 1. The DSD stated in the case of Resident 1, CNA 1 should have let Resident 1 cool down. The DSD added CNA 1's behavior towards Resident 1 was unacceptable. A review of the facility policy and procedure titled, Prohibition of Abuse, Neglect, and/or Misappropriation of Resident Property and Mandated Reporting, with effective date March 9, 2019, indicated all residents shall be free from mistreatment, neglect, abuse, exploitation and misappropriation of resident property by anyone, including, but not limited to, facility staff, other residents, consultants, contractors or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals who provide care and services on behalf of the facility.
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 document the incident between a Certified Nurse Assistant (CNA 1) and a resident anywhere in the resident's record for one of two sampled residents (Resident 1). The failure had the potential to provide inaccurate representation of the resident's experience which could affect the physical and psychosocial well-being of the resident. Findings: An unannounced visit was conducted to investigate a facility reported incident which was started on April 25, 2019. A review of the Face Sheet for Resident 1, indicated Resident 1 was admitted [DATE]. Resident 1 had [DIAGNOSES REDACTED]. A review of the Director of Nurses' (DON's) Interview Statement with the Licensed Vocational Nurse (LVN 1) on April 8, 2019 at 8 AM, indicated LVN 1 was on her break past 10 PM on April 7, 2019 when LVN 1 heard argument in the activity room. LVN 1 saw Resident 1 and CNA 1 about to charge at each other. LVN 1 ran screaming to the activity room and placed herself between CNA 1 and Resident 1. CNA 1 was able to push Resident 1 on the wall and made Resident 1 sit on a chair. Resident 1 covered his face with his hand, and CNA 1 held Resident 1's hand and used Resident 1's hand to hit Resident 1's face three times. LVN 1 was yelling at CNA 1 to stop while being in-between the CNA and the Resident. Resident 1 started kicking. CNA 1 reached out to hit Resident 1's thigh four times. After both CNA 1 and Resident 1 were separated, LVN 1 assessed Resident 1. Resident 1 was unable to remember what had happened. Resident 1 also denied any pain. A review of the Progress Notes for Resident 1 from April 7, 2019 to April 17, 2019, there was no documentation of the incident between Resident 1 and CNA 1. During an interview with the Medical Records Director (MRD) on January 16, 2020 at 2:48 PM, the MRD stated the incident between CNA 1 and Resident 1 should be documented on the Change of Condition (COC/SBAR Communication Form - document used by the facility for any change of condition of the resident). After reviewing Resident 1's chart, the MRD stated she could not find any documentation on the chart on what happened between Resident 1 and CNA 1. A review of the facility policy and procedure titled, Change of Condition Reporting, undated, indicated to document resident change of condition and response in nursing progress notes, on 24-Hour Report (24 Hour Report Form) and update resident Care Plan, as indicated.

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.