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	05/04/2022

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 0689 Level of Harm - 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** 36395 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who was a high fall risk, unsteady on feet, and required one-person physical assistance with walking, was provided a safe environment and supervision to prevent falls, as indicated in the resident's care plans and the comprehensive assessment. As a result: - On 7/20/2021, after Resident 1 was walking in the hallway without assistance, had an unwitnessed fall in her room, required transfer to General Acute Care Hospital 1 (GACH 1) where she was diagnosed with a left knee fracture (break of a bone) and a laceration (cut) of the left eyelid. - On 12/10/2021, Resident 1 sustained a fall requiring transfer to GACH 2 where she was diagnosed with five rib fractures, a clavicle (bone between the ribcage and shoulder blade that connects the arm to the body) fracture, and pneumothorax (condition occurs when air leaks into the space between the lungs and chest wall). Findings: A review of Resident 1's Admission Record indicated the facility originally admitted the resident on 12/1/2015 with last re-admitted d 2/15/2021. Resident 1's diagnoses included osteoporosis (a condition in which the bones become fragile, thin and breaks easily), unsteadiness on feet, and muscle weakness. A review of Resident 1's Care Plan developed on 4/22/2021 for the resident's high risk for recurrent falls and injury related to osteoporosis, osteoarthritis (condition that causes joints to become painful and stiff) as evidenced by impaired physical mobility, poor balance, unsteady gait (manner of walking), muscle weakness, cognition (ability to comprehend and reason) and communication deficit. The goal was for Resident 1 to be able to follow safe technique when performing functional mobility and activities of daily living (ADLs, such as eating, dressing, transferring, walking, bathing, and personal hygiene) to prevent falls and injury. The interventions included keeping room and common areas free from clutter, assisting the resident with transfer and walking. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Care Plan developed on 4/30/2021 for the resident's risk of joint swelling and pain, pathological fracture (a break of a bone that occurs without trauma and is caused by a preexistent bone condition) and spontaneous fracture (occur in seemingly normal bone with no apparent blunt-force trauma) related to osteoporosis and osteoarthritis as evidenced by decreased bone density and impaired physical mobility. The goal was for Resident 1 to remain free of injuries or complications related to osteoporosis. The interventions included observing resident for falls, educating resident, family/caregivers on safety measures needed to reduce risk of falls (the specific safety measures were not included). A review of Resident 1's Minimum Data Set (MDS, standardized assessment and care-screening tool) dated 5/11/2021, indicated the resident had severely impaired cognition (unable to comprehend, make needs known, or make decision a very hard time remembering things, making decisions, concentrating, or learning). Resident 1 needed one-person physical assist with bed mobility, transfer, and ambulation (walking), dressing, toilet use, personal hygiene, and bathing. Resident 1 was not steady (balanced) and only able to stabilize with staff assistance when moving from seated to standing position, when walking with assistive device, when turning around and facing the opposite direction while walking, when moving on and off the toilet and transfer between bed and chair or wheelchair. According to a review of Resident 1's Fall Risk assessment dated [DATE], the resident was a high fall risk, had history of falls, used an ambulatory (walking) aid such as wheelchair or walker, exhibited impaired gait, and overestimated or forgot limits. A review of Resident 1's Physical Therapy (PT) Discharge Summary dated 6/1/2021 indicated Resident 1 was a high risk for fall and was discharged from PT because the resident had achieved her highest practical level. Resident 1 was able to walk 100 feet using her front wheeled walker (FWW) with contact guard assist (the assisting person has one or two hands on resident's body but provides no other assistance to perform the functional mobility). A review of Resident 1's Change of Condition (COC) form, dated 7/20/2021 timed at 3:30 p.m., indicated the resident tripped on her slipper and fell on her left side. Ice packs were applied to both knees, the laceration (cut) on the eyebrow was cleaned and covered and pain medicine was given. A review of Resident 1's nursing Progress Notes, dated 7/20/2021 timed at 3:40 p.m., indicated at 3 p.m. Resident 1 was in bed reading the newspaper. At 3:30 p.m., Resident 1 was seen walking in the hallway with her walker. At 3:40 p.m., Resident 1 was noted on the floor lying on her side. Resident 1 sustained a laceration on her left eyebrow and complained of pain on both knees. Resident 1's primary physician was notified and gave order to transfer the resident to GACH 1 for evaluation. A review of GACH 1 X-ray result of Resident 1's left knee dated 7/20/2021 indicated the resident had a fracture of the patella (a break of the bone located on the front of the knee joint) with moderate lipohemarthrosis (collection of fat and fluid [blood] within the joint usually following trauma). According to a review of GACH 1 Discharge Summary for Resident 1, dated 7/21/2021, at 1:55 a.m., the resident's left knee was placed in an immobilizer (used to prevent, restrict, or reduce normal movement in the body, a limb, or a joint) to help heal the patella. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's MDS, dated [DATE], indicated Resident 1 required extensive assistance with one-person physical assist with ambulation, was not steady for walking, only able to stabilize with staff assistance, and used a walker / wheelchair when walking with assistive device. A review of Resident 1's Post Fall Care Plan dated 8/19/2021 indicated the resident fell at 2:44 p.m. with no injury. The approaches included frequent visual monitoring, room change near the Nursing Station, involve family for 1:1 supervision (one staff with the resident at all times) with caregiver, apply clip alarm to alert staff, and remind resident not to get up unassisted. A review of Resident 1's Post Fall Care Plan dated 8/26/2021 indicated Resident 1 had an actual fall at 4:35 p.m. with no injury. The approaches included frequent visual monitoring, medication regimen review, clip alarm was changed to pad alarm (monitor activity of sitting resident and that emits an alarm when there is reduction of pressure). A review of Resident 1's Post Fall Care Plan dated 9/30/2021 indicated Resident 1 had actual fall at 7:40 p. m. with no injury, related to unsteady gait, noncompliance did not call for assistance, and perceived self as independent. A review of Resident 1's Post Fall Care Plan dated 10/10/2021 indicated Resident 1 had actual fall at 3:45 p. m. with no injury, related to poor safety judgment, cognitive impairment, does not remember how she ended up on the floor. A review of Resident 1's Post Fall Care Plan dated 10/20/2021 indicated Resident 1 had an actual fall at 4:45 p.m. with no injury, related to balance deficit/shuffling, noncompliance did not call for assistance/use call light, perceived self as independent, perceived self as able to perform task, and ambulated to the restroom. According to a review of Resident 1's Post Fall Care Plan dated of 11/5/2021, Resident 1 had an actual fall at 7:47 a.m. with no injury, related to noncompliance did not call for assistance, perceived self as independent. A review of Resident 1's nursing Progress Notes dated 12/10/2021 timed at 3:55 p.m., indicated a loud thump was heard from Resident 1's room. Resident 1 was found lying on her left side next to the bed and wheelchair. Resident 1 was noted with skin discoloration to left elbow and left temple (located on the side of the head behind the eye between the forehead and the ear), had limited range of motion to left shoulder and pain on left side of chest. The primary physician was notified and ordered STAT (immediately) X-ray of the upper chest and clavicle. A review of Resident 1's X-ray report dated 12/10/2021 indicated the clavicle and left shoulder show no fracture or dislocation. A review of Resident 1's nursing Progress Notes dated 12/11/2021 at 11:10 a.m. indicated Resident 1 complained of chest pain. The primary physician was notified and ordered to send Resident 1 to GACH 2 via paramedics (trained to give emergency medical care to people who are injured or ill). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of GACH 2 History and Physical dated 12/11/2021 at 10:42 a.m. indicated Resident 1 had left eye hematoma (resulted from injury that caused the blood to collect and pool under the skin), left upper chest crepitus (air under the skin that produces unusual crackling sound as the gas is pushed through the tissue), left shoulder /lateral neck/scapular (relating to shoulder blade) ecchymosis (discoloration of the skin that resulted from bleeding underneath the skin) five centimeters (cm) by six cm, left elbow with abrasion (open wound caused by the skin rubbing against a rough surface) and ecchymosis, and left knee ecchymosis. A review of the Orthopedic (branch of medicine that focuses on the diagnosis and treatment of bones, muscles, and ligaments) Inpatient Progress Notes, dated 12/11/2021 indicated computed tomography scan (CT, combines a series of X-ray images taken from different angles around the body and uses computer processing to create cross-sectional images [slices]) included the following injuries: 1. Acute minimally displaced fracture of the left third, sixth and seventh ribs and left segmental rib fractures of the fourth and fifth ribs 2. left pulmonary contusion 3. left pneumothorax 4. left chest wall subcutaneous edema 2. Minimally displaced left distal clavicular fracture 6. likely hemothorax 7. chronic pelvic fractures A review of Resident 1's Admission/Readmission Screen indicated Resident 1 was readmitted to the facility on [DATE]. During a telephone interview on 1/26/2022 at 8:54 a.m., the Director of Nursing (DON) stated Resident 1 had multiple injuries due to previous falls and no surgical interventions were recommended because of the diagnosis of osteoporosis. The DON stated the facility tried everything: frequent monitoring, urinalysis, use of pad alarms for the wheelchair, bed and floor mat, and ran out of options to prevent Resident 1 from falling. During a telephone interview on 1/28/2022 at 4:07 p.m., the DON stated it would be good if Resident 1 had a 24-hour sitter so the sitter could catch Resident 1 right away before she falls. The DON stated Resident 1's family did not want to pay or share the cost of hiring a 1:1 sitter and the facility did not have enough staff to provide Resident 1 with a 1:1 sitter. During a telephone interview on 1/31/2021 at 1:16 p.m., Certified Nursing Assistant 1 (CNA 1) stated when she heard the alarm, she would go immediately to Resident 1's room. CNA 1 stated, CNA's have other residents to take care of and when the alarm is triggered, sometimes they can't hear the alarm, it is too late, and Resident 1 had already fallen. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 1/31/2022, at 3:47 p.m., the Registered Nurse Supervisor (RNS) stated the facility could not provide 1:1 staff to Resident 1. The RNS stated, The alarm may work to prevent falls but sometimes when the pad/chair alarms are triggered by the time the nurse responds to the alarm the resident may already have fallen. During a telephone interview on 2/1/2022 at 5:09 p.m., Resident 1's next of kin (NOK) stated the staff informed the NOK that Resident 1 needed 1:1 supervision but they did not have staff to provide 1:1 supervision and asked for the family to visit to monitor Resident 1. On 2/10/2022, at 8:26 a.m., during an interview with the RNS and a concurrent review of Resident 1's nursing Progress Notes and MDS dated [DATE], the RNS stated and confirmed that on 7/20/2021 Resident 1 was seen by staff walking in the hallway with her FWW and without staff assist. Ten minutes later Resident 1 had an unwitnessed fall and was found on the floor in her room. The RNS stated the MDS indicated Resident 1 needed extensive assistance (resident involved in activity, staff provide weight-bearing support while walking in the room or corridor). On 2/10/2022 at 8:52 a.m., during an interview, the physical therapist stated Resident 1 had physical therapy from 4/23/2021 to 6/1/2021. Resident 1 was not supposed to walk without assistance. Someone was supposed to stay close to Resident 1 while walking in case Resident 1 lost her balance, staff was there to assist. A review of the facility policy titled, Safety and Supervision of Residents, revised on 7/2017 indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The facility's individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive device. The systems approach to safety included: -The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual risk factors and then adjusts interventions accordingly. -Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. -The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition.