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	08/09/2022

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36395 Based on interview and record review, the facility failed to identify and ensure one of two sampled residents (Resident 1), who was diagnosed with an ileus (muscles of the intestines do not allow food to pass through, resulting in a blocked intestine), after complaining of severe abdominal pain, and a distended abdomen (abnormally swollen stomach outward) with loose green stools received care, treatment, and services in accordance with the physician ' s order and policy and procedure by failing to: -Assess and monitor Resident 1 for abdominal distention, abdominal pain, and diarrhea for 72 hours, in accordance with the facility ' s policy. -Develop a care plan to address Resident 1 ' s identified problems of abdominal distention, abdominal pain, diarrhea and ileus. -Immediately notify the physician when Resident 1 had a low oxygen saturation level of 91% on 5/13 and 88% on 5/14/2022 (normal range between 95% to 100%, Oxygen saturations below 90% is very concerning and indicates an emergency). -Follow the physician ' s order to titrate (maintain saturations within a prescribed target range) Resident 1 ' s oxygen saturation (amount oxygen carried in the blood) level to greater than 92% every shift. As a result, on 5/14/2022 at 8:45 a.m., Resident 1 complained of pain rated at 10 out of 10 (the most severe pain), with an oxygen saturation rate below normal at 85%. Resident 1 was transferred to the General Acute Care Hospital (GACH), underwent emergency surgery for an exploratory laparotomy and total colectomy (ELTC - abdominal surgery to find the cause of the abdominal pain and removal of colon), and an ileostomy (surgery where part of the small intestine is diverted through an opening in the stomach). Findings: A review of the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including muscle weakness and unsteadiness on feet. (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 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the Physician ' s Order dated 2/7/2022 and May 2022 Medication Administration Record (MAR) indicated to titrate Resident 1 ' s oxygen to keep the oxygen saturation greater than 92% every shift. A review of Resident 1 ' s care plan for risk of difficulty breathing and pain initiated on 2/8/2022, indicated Resident 1 was at risk for difficulty in breathing related to asthma (airways become narrow and swell making it hard to breathe). The care plan interventions indicated to observe for signs and symptoms of respiratory distress, report to the physician, as needed, increased respirations and decreased pulse oximetry, check oxygen saturation as ordered and administer oxygen as ordered. According to a review of the care plan for pain initiated on 2/8/2022, Resident 1 had a potential for an alteration in comfort related to altered mental status and weakness. The interventions included to observe and assess pain location, duration, frequency, and strength, determine cause of pain and activity that aggravates pain, notify physician if the interventions were unsuccessful or if current complaint was a significant change from resident ' s experience of pain. A review of the quarterly Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 5/12/2022 indicated Resident 1 was disoriented to year, month, and day, required supervision (oversight, encouragement, or cuing) when eating and extensive assistance (resident involved in activity, staff provide weight bearing support) with activities of daily living (ADLs). The MDS indicated Resident 1 was not steady moving on and off toilet, was frequently incontinent of bowel and bladder, with an active diagnosis of renal insufficiency (poor function of the kidneys due to disease) and malnutrition. A review of the Medication Administration Record (MAR) dated 5/12/2022 at 10:50 a.m., indicated Resident 1 complained of pain rated as six out of 10 (moderate pain, zero indicates no pain, 10 indicates the most severe pain). The MAR indicated Resident 1 was administered Tylenol (pain medication) 325 milligrams (mg) two tablets for pain. A review of the Situation Background Assessment Response (SBAR) dated 5/12/2022 at 11:30 a.m., indicated Resident 1 had a distended abdomen with a complaint of severe pain when her abdomen was touched, a poor appetite, and had three episodes of loose green stool (bowel movement). The nurse practitioner (NP 1) was notified and gave orders to: -Keep Resident 1 nothing by mouth (NPO) except for medications. -Obtain a stool specimen (fecal sample) for clostridium dificile (C. diff). -Blood tests. -Urinalysis (urine test to diagnose and monitor various illness) and Kidney Ureter Bladder (KUB) test stat (immediately). -Administer 5% Dextrose and 0.45% Sodium Chloride intravenously (IV, a therapy that delivers fluid into veins in the body) at 60 milliliters every hour (ml/hr.) every shift for dehydration for three days. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the Radiology Result Report dated 5/12/2022 at 1:38 p.m., indicated Resident 1 had mild to moderate ileus (a temporary and often painful lack of movement in the intestines, a serious condition, if left untreated it can cut off blood supply to the intestines and cause tissue death) with mild increased feces in the colon (long, tube-like organ that carries waste to be expelled from the body). A review of the Progress Notes dated 5/12/2022 at 5:04 p.m., indicated the nurse practitioner (NP 1- registered nurse with advanced training and education to diagnose and prescribe medications) was notified of the KUB result and gave an order to administer Resident 1 a Dulcolax (medicine for constipation) suppository rectally followed by a fleets enema (medicine for constipation) after 45 minutes even if Resident 1 had a bowel movement due to the Dulcolax suppository. The NP also ordered to repeat the KUB on 5/13/2022. According to a review of the progress notes dated 5/12/2022 at 9:59 p.m., Resident 1 ' s abdomen remained distended with discomfort when palpated. The notes indicated Resident 1 was given the Dulcolax suppository and a fleets enema and had loose green stool throughout the shift. A review of the Pain Monitoring sheet dated 5/12/2022 indicated Resident 1 had mild pain during the evening and the night shift. A review of the nurse ' s notes dated 5/13/2022 at 2:07 a.m., indicated Resident 1 denied pain or discomfort. However, there was no documentation that the licensed nurse assessed or monitored Resident 1 ' s abdomen for distention, bowel sounds (sounds made by moving food, fluid and gasses in the intestines heard by using the stethoscope [device used to listen sounds produced within the body]) and tenderness. A review of the nurse ' s notes dated 5/13/2022 at 7:31 a.m. indicated Resident 1 had a pain score of 0. However, there was no documentation the licensed nurse assessed or monitored Resident 1 ' s abdomen for distention, bowel sounds, and tenderness. A review of the progress notes dated 5/13/2022 at 1:47 p.m. indicated Resident 1 had no complaints of pain and had no episodes of diarrhea. However, there was no documentation that the licensed nurse assessed or monitored Resident 1 ' s abdomen for distention, listened for bowel sounds, or palpitated for abdominal tenderness during the afternoon and night shift. A review of the Radiology Results Report dated 5/13/2022 at 1:51 p.m., indicated Resident 1 had prominent nonspecific gas-filled loops of bowel. (This will fall in between the normal bowel and grossly abnormal blocked bowel). A review of the Weights and Vitals Summary indicated on 5/13/2022 at 7:59 p.m. Resident 1 had an oxygen saturation of 91% while on oxygen via nasal cannula (rate of oxygen was not documented). There was no documented evidence the physician was notified or consulted with or that Resident 1 ' s oxygen level was titrated as ordered by the physician. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	According to a review of the SBAR dated 5/14/2022 at 8:25 a.m., Resident 1 complained of abdominal distention with pain to touch. Resident 1 ' s pain score was rated as 10 out of 10 (most severe pain) and her oxygen saturation level was 84% to 85% on five liters of oxygen via face mask. Resident 1 stated she wanted to go to the hospital. NP 2 was notified and gave an order to transfer Resident 1 to GACH 1. A review of the Prehospital Care Report dated 5/14/2022 indicated Resident 1 had abdominal pain and a distended and rigid abdomen making it difficult to breath and a low oxygen saturation level. A review of the GACH 1 emergency room documentation dated 5/14/2022 at 11:49 a.m., indicated Resident 1 ' s chief complaint was abdominal pain for three days with reports of shortness of breath. On examination, Resident 1 had a distended abdomen, with tenderness and guarding. A review of the GACH 1 Surgical Consultation dated 5/14/2022 at 4:13 p.m., indicated Resident 1 had small liquid bile (yellow-green fluid produced in the liver that helps digest fat) for stool and the Computed tomography (CT scan, a procedure that uses a computer linked to an x-ray machine to make a series of detailed pictures of areas inside the body) of the abdomen indicated a concern for mesenteric ischemia (decreased or blocked blood flow to the intestine). The GACH surgical consultation indicated Resident 1 was then taken to the operating room for emergency surgery for exploratory laparotomy for possible bowel resection (surgical procedure to remove part or all the colon). A review of the Surgical Documentation Operative Report dated 5/14/2022 at 11:20 p.m., indicated Resident 1 had an exploratory laparotomy, total colectomy and end ileostomy (removal of colon). During an interview on 7/14/2022 at 12:21 p.m., the clinical record was reviewed with Registered Nurse 2 (RNS 2) and RNS 3. RNS 2 and RNS 3 were unable to find a care plan that would address Resident 1 ' s abdominal distention, abdominal pain, diarrhea, or ileus. RNS 2 stated when Resident 1 had a change of condition on 5/12/2022 of abdominal pain, abdominal distention, diarrhea, and ileus a care plan should have been created to help guide the plan of care for Resident 1. RNS 2 stated the care plan would include an alteration in comfort related to ileus. The goal may include Resident 1 would verbalize relief from pain and the interventions would include assess for pain, repositioning, administer Tylenol for pain, monitor for pain, reassess and to notify the physician if the pain was not relieved. During a telephone interview with NP 1 on 7/14/2022 at 4:02 p.m., NP 1 stated she was notified on 5/12/2022 that Resident 1 had KUB that indicated Resident 1 had a mild to moderate ileus with moderate feces in the colon. NP 1 stated she gave orders to administer IV fluid, to keep Resident 1 NPO, and blood tests. NP 1 stated Resident 1 ' s blood test results were acceptable and there was no indication for Resident 1 to go the GACH 1. NP 1 stated if Resident 1 continued to complain of abdominal pain she would have given an order to send Resident 1 to the GACH 1. On 7/18/2022 at 2:40 p.m., during a telephone interview with RNS 1, Resident 1 ' s SBAR dated 5/12/2022 was reviewed with the RNS 1. RNS 1 stated Resident 1 should have been monitored for 72 hours from 5/12/2022 for abdominal pain, abdominal distention, and loose green stool. RN 1 stated the 72- hour monitoring was done to monitor the progress or intervene if there were changes and to notify the physician for the changes. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 7/18/2022 at 3:30 p.m., Resident 1 ' s clinical record was reviewed with the director of nursing (DON). The DON stated she was unable to find documentation that assessment or monitoring for Resident 1 ' s abdominal distention and abdominal pain for the afternoon and night shift was done on 5/13/2022. The DON stated Resident 1 had a change of condition on 5/12/2022 and Resident 1 should be monitored for 72 hours. The DON further stated when Resident 1 ' s oxygen saturation was 91% on 5/13/2022 at 7:59 p.m. and 88% on 5/14/2022 at 12:02 a.m., interventions should have been implemented, documented and if needed, notify the physician. A review of the facility ' s undated policy titled, Change of Condition Reporting, indicated it was the policy of the facility to identify changes in the resident ' s condition and the resident ' s condition will be communicated to the primary physician and / or / his / her designee for proper management. The policy further indicated: -For life threatening change, the licensed nurse will inform the primary physician and/or his/her designee (alternate physician, on-call physician, nurse practitioner, physician assistant or medical director) of the resident status as soon as possible before, during or after the change of condition. The resident observation and assessment information, nursing intervention, physician contacts and resident ' s responsible party notification will be documented under the progress note section. -For acute medical change, any sudden or serious change in a resident ' s condition manifested by a marked change in physical or psychological status of the resident will be communicated by the licensed nurse to the physician and/or his/her designee with a request for physician visit promptly and/or acute care evaluation. -For routine medical change, unusual signs and symptoms and any deviation from the resident ' s baseline condition will be communicated to the attending physician and or his/her designee promptly. Document resident change of condition and response in the nursing progress notes on 24- hour report and update resident care plan as indicated. The licensed nurse assigned to the resident will continue the observation, assessment, and documentation every shift for at least 72 hours or until condition has stabled. A review of the facility policy titled, Care Plans, dated 2/5/2016 indicated care plans will be initiated upon resident ' s condition change, incident or identified problems. Care plans will include the identified problem, long-term and short-term goals which are measurable and with a timeframe.