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	08/26/2022

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 0825 Level of Harm - Actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 36395 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who had diagnoses including dementia (loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life) was provided supervision while eating, per the comprehensive assessment, and was provided speech therapy services (treatment of impairments and disorders of speech, voice, language, communication and swallowing). The facility failed to: -Implement care plan interventions of stand by assist for Resident 1 during self-feeding. -Develop a care plan with appropriate interventions to address Resident 1's behavior of eating rapidly, per the Speech Therapist assessment on 10/18/2021. -Assess Resident 1 for dysphagia (difficulty in swallowing) as recommended on 10/19/2021, per the Physical Medicine and Rehabilitation Medical Consultant's Initial Evaluation. As a result, on 11/6/2021 at 9:10 a.m., during breakfast, Resident 1 choked on his food, became unresponsive and needed the Heimlich maneuver (emergency procedure for removing foreign object lodged in the airway that is preventing a person from breathing). Resident 1 was transferred to the general acute hospital (GACH) by paramedics where Resident 1 was intubated (medical procedure in which a tube is placed into the windpipe through the mouth or nose), admitted to the Intensive Care Unit (ICU) for acute respiratory distress syndrome (ARDS, life threatening condition where the lungs [a group of organs and tissues for breathing] cannot provide the body with enough oxygen) and septic shock (serious condition when an infection causes extremely severe low blood pressure and organ failure). Findings: A review of the Admission Record indicated the facility readmitted Resident 1 on 10/13/2021, with diagnoses including cerebral infarction (the blood circulation in the brain is suddenly disrupted) affecting the left side of the body, encephalopathy (abnormal brain function or structure) and dementia. A review of the Care Plan initiated on 10/14/2021 indicated Resident 1 had self- care deficit as evidenced by requiring assistance with: Transfers - moderate assistance (requires more help than touching) (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 0825 Level of Harm - Actual harm Residents Affected - Few	Gait - moderate assistance Self- feeding - standby assistance (presence of another person within reach) Toileting - moderate assistance. The Care Plan interventions indicated to provide verbal, visual and physical cues as indicated, instruct resident on the use of adaptive equipment when eating, personal hygiene and dressing, avoid rushing resident and give rest periods to conserve energy. A review of the Speech Therapy Evaluation and Plan of Treatment dated 10/18/2021 indicated Resident 1 had impaired memory, confusion, lack of insight and awareness causing problem solving and safety awareness concerns. The evaluation indicated Resident 1 needed speech therapy services which included to enhance cognitive skills (able to receive, interpret and understand messages), promote safety awareness and facilitate immediate memory in order to enhance quality of life by improving ability to participate in meaningful interactions and increase participation with ADLs. A review of the Minimum Data Set (MDS, standardized assessment and care screening tool) dated 10/19/2021 indicated Resident 1 was disoriented to year, month and day, needed supervision (oversight encouragement or cuing) while eating, and limited assistance (resident highly involved with activity staff provide guided maneuvering of limbs or other non-weight bearing assistance) with walking. The MDS indicated Resident 1 required extensive assistance (resident involved in activity, staff provide weight bearing support) with bed mobility, transfer, dressing, toilet use and personal hygiene. According to a review of the Physical Medicine and Rehabilitation Medical Consultant's Initial Evaluation dated 10/19/2021, at 7:01 p.m., Resident 1 had some weakness in the left and lower extremities and had mild right side facial droop (facial weakness that may cause one corner of the mouth to droop). The Physician's Initial Evaluation indicated recommendations that included speech language pathology (study of the cause and effects of a disease or injury) and evaluation, and treat as appropriate to assess for dysphagia, speech language disorder, higher cognitive function and to improve safety awareness. A review of the Speech Therapy Discharge Summary with dates of service 10/18 - 10/29/2021, indicated Resident 1 was often confused, forgetful and impulsive. The Summary indicated Resident 1 did not make much progress due to status of cognitive skills with frequent forgetfulness, confusion and anxious behavior/tendencies. The discharge recommendation indicated for frequent monitoring and observation of Resident 1 due to tendencies to escape and wander, resulting in falls, somewhat impulsive behaviors. (The discharge recommendation did not indicate Resident 1 needed cuing and reminders to eat slowly to prevent choking). A review of the Care Plan revised on 10/29/2021 by speech therapy, indicated Resident 1 had impaired cognition secondary to memory, orientation, problem solving/safety awareness deficits. The goal indicated Resident 1 will enhance cognitive skills and prevent further decline in function. The Care Plan interventions indicated Resident 1 to receive speech therapy three times a week for 60 days for cognition-memory, safety awareness, problem solving and orientation. (No other intervention addressing Resident 1's identified behavior of eating rapidly, needs cuing to slow down when eating to prevent choking). (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Few	A review of the Situation, Background, Appearance, Review and Notify (SBAR) Communication Form, dated 11/6/2021, no time, indicated Resident 1 was eating breakfast when Resident 1 became unresponsive to verbal and touch stimuli. Resident 1 was noted to have food and fluids inside his mouth. The SBAR indicated Resident 1's mouth was emptied of its contents and Heimlich maneuver was performed. Food and liquid were ejected from the mouth and Resident 1 began breathing and gasping. Resident 1 was taken to his room and smaller particles of food and fluids were suctioned. Resident 1 was administered oxygen. The SBAR indicated the paramedics arrived and took over Resident 1's care. A review of the Prehospital Care Report Summary dated 11/6/2021 indicated Resident 1 choked during breakfast, aspirated and became short of breath. The Care Report indicated Resident 1 had audible wheezes (the shrill whistle or coarse rattle heard when the airway is partially blocked) and audible rhonchi (harsh, rattling sounds that resemble snoring) with oxygen saturation of 50% (amount of oxygen in the blood, normal range is 95% to 100%). The paramedics administered albuterol (medicine to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing and chest tightness) by nebulizer (machine that turns liquid medication into a mist for breathing) with no effect. The Care Report indicated Resident 1 was placed on continuous positive airway pressure (CPAP, breathing therapy device that delivers air to a mask worn over the nose and/or mouth to help consistent breathing) and given albuterol and the oxygen saturation increased to 97%. Resident 1 was transported to GACH 1. According to a review of GACH 1 Emergency (ER) Documentation dated 11/6/2021 at 9:56 a.m., Resident 1 was noted eating breakfast and began to choke. The ER Documentation indicated Resident 1 arrived in respiratory distress (having trouble breathing), diaphoretic (profuse perspiration) and tachypneic (breathing rapidly). Resident 1 was intubated (medical procedure where a tube is placed into the windpipe through the nose or mouth and connected to a breathing machine to help with breathing) and noted to have some debris in airway during intubation. A review of the Cardiology Consult dated 11/10/2021 at 10:35 p.m., indicated Resident 1 was admitted to the intensive care unit (ICU) for acute respiratory distress syndrome (ARDS, life-threatening condition where the lungs [a group of organs and tissues that work together to help a person breathe] cannot provide the body's vital organs with enough oxygen) and septic shock (life threatening condition when the blood pressure drops to a dangerously low level). Resident 1 was placed on four pressors (medication to increase the blood pressure) and started on antibiotics for septic shock due to aspiration pneumonia (occurs when food or liquid is breathed into the airways or lungs, instead of being swallowed. During an interview on 7/29/2022, at 9:06 a.m., the Speech Therapist (ST) stated she did not assess or evaluate Resident 1 for dysphagia on 10/18/2021 because she observed right away that Resident 1 did not have swallowing problems and was on regular diet. The ST stated she concentrated on assessing Resident 1's cognitive skills, as Resident 1 was forgetful, eats quickly, needed cuing to eat slowly and at appropriate intervals to prevent choking. The ST stated Resident 1 needed reminders to eat slowly because Resident 1 stuffs his mouth with food and tends to eat rapidly. The ST stated there was no documentation that she communicated her assessment to the care team. (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/29/2022 at 9:10 a.m., CNA 1 stated she was feeding another resident when Resident 1 choked while eating breakfast. CNA 1 stated Resident 1 was seated at another table, and she was not within reach of Resident 1. CNA 1 stated her back was towards Resident 1. Resident 1 was eating independently, and no one informed her that Resident 1 needed to have someone beside him while eating. During a telephone interview on 8/2/2022 at 2:25 p.m., CNA 2 stated she was in the dining room (not within reach of Resident 1) feeding another resident when Resident 1 choked. CNA 2 stated she thinks that the potatoes were too big. On 8/5/2022, at 1:03 p.m., during a telephone interview, the physician assistant (PA) stated when the Medical Rehabilitation Consultant Physician (MD Consultant) had a recommendation for dysphagia assessment the therapist has to follow the recommendation. During a telephone interview on 8/11/2022, at 2:16 p.m., the Medical Rehabilitation Consultant Physician (MD Consultant) stated he made the recommendation to evaluate Resident 1 for dysphagia because Resident 1 had history of encephalopathy, subdural hematoma (type of bleed inside the head) and had facial droop. The MD Consultant stated the nursing staff informed him that Resident 1 had occasional cough while eating and he had a concern that Resident 1 had a risk for aspiration. The MD Consultant stated Resident 1's next of kin informed him about the aspiration concern and when he made recommendations, he expected the facility to follow his recommendations. The MD Consultant further stated the facility did not inform him that Resident 1 choked on his food on 11/6/2021. During a telephone interview on 8/12/2022 at 2:28 p.m., the Director of Nursing (DON) stated the dysphagia assessment was important to find out if the resident had difficulty swallowing and if not done in a timely manner the resident was at risk for choking and aspiration. During a telephone interview on 8/15/2022, at 2:29 p.m., the DON stated she was unable to find documentation that Resident 1 tended to eat rapidly and required cuing to eat slowly. The DON stated there should be communication between the rehabilitation department and nursing, and that Resident 1 needed to be monitored and supervised while eating. On 8/16/2022, at 3:48 p.m., during a telephone interview, Resident 1's Next of Kin (NOK) stated when Resident 1 was discharged from the GACH it was difficult for her to watch Resident 1 because Resident 1 used to walk, talk and eat by himself. The NOK stated after Resident 1 choked, he did not talk anymore, did not move and was being fed through a gastrostomy tube (GT, tube inserted through the abdomen directly into the stomach used to give food and medicines). During a telephone interview on 8/17/2022 at 9:46 a.m., the facility's Director of Rehabilitation stated the MD Consultant was notified on 10/29/2021 about Resident 1's behavior of eating rapidly, but no order was given. The Rehab Director stated Resident 1 needed cuing to slow down when eating. During a telephone interview on 8/23/2022 at 2:26 p.m., the MD Consultant stated he was the consultant physician that made the recommendation to evaluate Resident 1 for dysphagia. The MD Consultant stated the facility was supposed to notify the primary physician that Resident 1 needed a dysphagia evaluation based on his evaluation of Resident 1. (continued on next page)

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F 0825 Level of Harm - Actual harm Residents Affected - Few	A review of the facility policy titled, Rehabilitation Services, dated 1/1/2017 indicated Speech Language Therapy shall be provided in an agreement with qualified contracted resources. There shall be written administrative and resident care policies and procedures developed for each rehabilitation services provided. The policy and procedure shall cover consultation, the responsibility of the attending physicians, coordination of services, reporting mechanism to communicate with attending physicians. A review of the facility policy titled, Care Planning, with an effective date of 10/1/2017 indicated licensed nurses and other Interdisciplinary Team (IDT) members will develop preliminary plan to meet the resident's immediate care needs at the time of admission. The IDT shall complete a comprehensive care plan within seven days of completion of the MDS. The IDT members include but not necessarily limited to attending physician, MDS coordinator, licensed nurses who was responsible for the resident and therapists as applicable. Care planning shall include review of clinical issues, discharge planning, coordination of care and management of resources. Care Plans are revised during Resident Assessment Instrument (RAI, resident comprehensive assessment) schedules and as changes in the resident's condition dictates or in preparation for discharge. A review of the facility policy titled, Supporting Activities of Daily Living (ADLs), revised on 3/2018 indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming and oral care) b. mobility (transfer and ambulation, including walking) c. elimination (toileting) d. dining (meals and snacks) e. communication (speech, language and any functional communication systems). The policy indicated interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, stated goals and recognized standards of practice. The resident's response to interventions will be monitored, evaluated and revised as appropriate.