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	12/12/2022

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** 45524 Based on observation, interview, and record review, the facility failed to identify and ensure one of three sampled residents (Resident 34), who had a dehisced abdominal wound (a partial or total separation of previously approximated wound edges), received care, treatment, and services in accordance with professional standards of practice and the comprehensive assessment by failing to: -Develop and implement Resident 34's person-centered comprehensive care plan with interventions to address the effectiveness of the wound care treatment. -Follow the Physician's Order to clean and treat Resident 34's abdominal wound every day shift and as needed. -Assess and re-evaluate Resident 34's pain on 10/24/2022 and 10/29/2022. As a result, Resident 34 had increased pain due to the abdominal wound dressing was not changed and caused feelings of embarrassment from the smell produced by the increased drainage on the dressing. Findings: A review of the admission record indicated Resident 34 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of unspecified ovary (a cancerous tumor involving the ovary), encounter for other specified surgery after care, and depression. A review of the care plan for alteration in comfort due to pain initiated on 9/29/2022, indicated the interventions were to monitor for side effects of pain medications, evaluate pain for effectiveness, document pain characteristics using pain management scale, observe and report any signs and symptoms of non-verbal pain. A review of the Minimum Data Set (MDS- a standardized assessment and care screening tool), dated 10/2/2022 indicated Resident 34 had a surgical wound, required application of ointments / medication, was cognitively intact (able to make decisions), and required extensive assistance from staff for activities of daily living such as bed mobility, transfers, personal hygiene, toilet use and dressing. (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 10/19/2022, indicated to irrigate Resident 34's abdominal wound with normal saline (salt water and electrolytes used to help clean wounds) and pat dry. Apply Medihoney (dressings aids and supports debridement and a moist wound healing environment in acute and chronic wounds) on all parts of the wound and undermining wound bed, and then apply Calcium Alginate (used on moderate to heavily exudative wounds during the transition from debridement to repair phase of wound healing) Pack with a roll of gauze, cover with an abdominal pad and a dry dressing, then secure with tape every day shift and as needed. According to a review of the medical record, Resident 34 did not have a care plan for the abdominal wound. A review of the Medical Administration Record (MAR) dated 10/24/2022 at 12 PM, indicated Resident 34 received Tramadol 100 milligram (mg, unit of measurement) medication (an opioid pain medication used to treat pain) for moderate to severe pain. The MAR indicated Resident 34 was not assessed for pain including the description or location of the pain and was not re-evaluated for pain after the Tramadol was administered on 10/24/2022. A review of the nursing assignment for 10/29/2022, indicated there was no treatment nurse assigned for the morning or evening shift, to ensure Resident 34's abdominal wound was cleaned and treated every day. According to a review of the Treatment Administration Record (TAR) dated 10/29/2022 (Saturday), Resident 34's abdominal wound treatment was not completed every day, per the physician's order. A review of the MAR dated 10/29/2022 indicated Resident 34 was not assessed for pain including the description or location of the pain on 10/29/2022. During an interview on 11/1/2022 at 3:17 p.m., the medical records assistant (MRA) stated and confirmed Resident 34's abdominal wound treatment was not signed or completed for 10/29/2022, per the physician's order. On 11/1/2022 at 3:30 p.m., during an observation in Resident 34's room and concurrent interview, Resident 34 had a dressing located to her mid abdomen. Resident 34 stated she did not receive wound care treatments on Saturday (10/24/2022). Whenever she asked the staff why she did not receive wound treatments, the response was there was no available staff. Resident 34 stated the drainage collected in the dressing and remained there for several hours causing a very bad odor and it caused an increase in pain. Resident 34 stated the pain would increase to a six out of 10 (using the scale 0-10, 10 being the most severe pain) and she also felt embarrassed due to the odor. During an observation in Resident 34's room, on 11/2/2022 at 10:30 a.m., Resident 34's abdominal wound care was performed by Licensed Vocational Nurse (LVN-2) and Medical Doctor (wound specialist [MD-WS]), the wound measured 18 centimeters (cm, unit of measurement) in length, 5.5 cm in width and 3 cm in depths and was noted to have about 50% slough (dead tissue separating from living tissue) and 50% granulation tissue (a new connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 11/2/2022 at 3:45 p.m., the DON stated missing a wound treatment could negatively affect Resident 34 and cause infections while also causing psychosocial harm of negative feelings. During an interview on 11/3/2022 at 2 p.m., when asked about Resident 34's wound care plan, the Assistant Director of Nursing (ADON) stated that a wound care plan should have been developed for Resident 34 because it helped keep track of the provided treatments and the effectiveness. On 12/1/2022 at 4:30 p.m., during an interview, the ADON stated and admitted that treatments that were not documented were not done and that the risk of missing wound care for Resident 34 would result in worsening of the wound. During an interview with the ADON on 12/1/2022 at 4:32 p.m., when asked about Resident 34's lack of pain assessment, she stated that pain needs to be assessed and evaluated before pain medications were administered. The ADON further stated that not assessing pain before and after would not allow them to evaluate if the ordered treatments for pain were effective. 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. A review of the policy titled, Pain Assessment Management, revised 3/2015 indicated the purpose of this procedure was to develop interventions that are consistent with the resident's needs. The policy indicated a resident's pain and consequences of pain will be assessed, at least each shift, for the response to the interventions. The policy indicated when assessing for pain to gather the characteristics of pain such as intensity, descriptors, location and frequency.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on observation, interview, and record review, the facility failed to identify and ensure two of four sampled residents (Resident 2), who had a wound to the right lateral knee and (Resident 4), who had a wound on the sacro-coccyx (a large, triangular bone at the bottom of the spine, between the hip bones) received care, treatment, and services in accordance with professional standards of practice and the comprehensive assessment by failing to: -Develop a person-centered comprehensive care plan and implement Resident 2's interventions including frequency to check resident's skin, per physician's order and address the effectiveness of the wound care treatment. -Assess and re-evaluate Resident 2's ankle wound before the treatment orders were discontinued. -Follow the Physician's Order to clean and treat Resident 4's sacro-coccyx wound every shift on 1/28/2023 and implement the care plan to provide treatment as ordered. These deficient practices caused an increased risk for deterioration and infection in the wound and had the potential to delay healing for Resident 2 and Resident 4. Findings: a.A review of Resident 2's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (an impairment in the way the body regulates and uses sugar [glucose] as a fuel), an unstageable pressure ulcer (the stage is not clear, the base of the sore was covered by a thick layer of other tissue and pus that may be yellow, grey, green, brown, or black) of the right ankle, and end stage renal disease (a person's kidneys stop functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life) with dependence on dialysis. A review of the Resident 2's Physician's Order dated 1/13/2023 at 11:54 PM, indicated to cleanse with normal saline (chemical name for salt water), the right ankle lateral pressure ulcer, pat dry and apply betadine, cover with dry dressing everday shift for 14 days (through 1/27/2023). A review of the care plan dated 1/14/2023 indicated Resident 2 had altered skin integrity related to pressure ulcer on the right lateral ankle and the resident was at risk for altered comfort status due to the presence of the break down and at risk for infection. The care plan goal indicated to keep the pressure ulcer free from signs and symptoms of pain, redness, swelling, and foul/smelly drainage, to prevent deterioration. The care plan intervention indicated to monitor for pain, discomfort, check resident's skin as well as observing/reporting for signs and symptoms of pain, redness, swelling, and foul/smelly drainage. -no frequency indicated per physician's order A review of the Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/17/2023, indicated Resident 2 had some mild cognitive impairment, required supervision for eating and had a pressure ulcer / injury on body prominence, location was not indicated. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a review of the History and Physical dated 1/17/2023, Resident 2 had the capacity to understand and make decisions. A review of the Situation-Background-Assessment-Recommendation (SBAR- tool that allows health professionals to communicate clear elements of a patient's condition) form dated 1/31/2023 indicated Resident 2's treatment was completed on 1/27/2023, but there were missed treatments on 1/28-1/31/2023. During an observation on 2/1/2023 at 11:58 a.m., Resident 2 had a dry dressing to the side of her right ankle. During a concurrent interview, Resident 2 stated she had not received any treatment for the ankle for two days. During an interview on 2/1/2023 at 12:03 p.m., Licensed Vocational Nurse 1 (LVN 1) stated there was no physician's order for wound care treatments for Resident 2 for 1/28, 1/29, 1/30 or 1/31/2023, even though the wound was still present. LVN 1 stated she called Resident 2's doctor on 1/31/2023 and it was determined that the treatment needed to be continued because the wound was still open. A new physician's order was given on 1/31/32023 to resume wound treatment for Resident 2. LVN 1 stated the wound was staged as undetermined (UTD) because the wound base was covered in slough (dead tissue separating from living tissue). A review of the new Physician's Order dated 1/31/2023 indicated to cleanse Resident 2's right lateral ankle pressure ulcer with normal saline, pat dry and apply betadine, cover with dressing everyday shift for 14 days (through 2/14/2023). During an interview on 2/1/2023 at 3:45 p.m., the Director of Nursing (DON) stated the Interdisciplinary Team (IDT- an approach to healthcare that integrates multiple disciplines through collaboration) was to determine if a treatment was to be continued after the initially prescribed duration comes to an end. The DON stated that the RN supervisors were to conduct random assessments which were brought to the attention of the IDT. The DON stated and confirmed that Resident 2's ankle wound was not assessed before the treatment orders were discontinued. b. A review of Resident 4's admission record indicated the resident was initially admitted to the facility on [DATE] with diagnoses including hypotension (low blood pressure, under 90/60 millimeters of mercury), acute congestive heart failure (a sudden, life-threatening condition in which the heart is unable to pump blood around the body effectively), and cardiomyopathy (disease of the heart muscle that makes it harder for the heart to pump blood to the rest of body). A review of the baseline admission / readmission screen form dated 1/9/2023, indicated Resident 4 had an unstageable pressure injury to the sacral area which measured 5cm x 4cm. A review of the MDS dated [DATE], indicated Resident 4 was cognitively intact and required limited one person assistance for all Activities of Daily Living (ADLs-bed mobility, transfer, walk in room, walk in corridor, locomotion on unit, locomotion off unit, dressing toilet, and personal hygiene) with the exception of eating, which indicated as requiring supervision. The MDS further indicated that Resident 4 had a wound / scar over bony prominence. A review of Resident 4's Physician's Order dated 1/25/2023 at 10:43 p.m., indicated to cleanse the sacro-coccyx pressure ulcer with normal saline, pat dry, apply zinc oxide and leave open to air every shift for 14 days (through 2/8/2023). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a review of the History and Physical dated 1/25/2023, Resident 4 had the capacity to make his own decisions. A review of the care plan dated 1/27/2023 indicated Resident 4 had altered skin integrity related to pressure ulcer on the sacro-coccyx. The care plan goal indicated to keep the pressure ulcer free from signs and symptoms of pain, redness, swelling, and foul/smelly drainage, to prevent deterioration, and that resident will tolerate the treatment and dressing change through the next review. The care plan interventions indicated treatment would be provided as ordered and to monitor for response to treatment. A review of the Treatment Administration Record dated 1/28/2023 (Saturday) for the evening shift indicated the wound care treatment was not signed as administered until after the DON was questioned on 2/1/2023 (four days later). During an interview on 2/1/2023 at 3:43 p.m., the DON stated the expectation was for documentation to be completed by the end of the shift to show that treatments were administered. A review of the policy titled, Charting and Documentation, reviewed 1/2023, indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 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. According to a review of the facility policy titled, Baseline Admission and Readmission Screening, dated 12/2016, the purpose was to determine the basic needs of the resident and to manage the care of the resident properly. The policy indicated that on admission the licensed nurse would complete the baseline admission screening tool in order to determine the skin integrity status of the resident. The policy indicated that any identified skin problem will serve as the initial documentation of the type, staging and description of the skin problem. A review of the facility policy titled, Wound Care, dated 1/2023 indicated the purpose was to provide guidelines for the care of wounds to promote healing. The policy indicated to verify physician's order for the procedure and to apply treatments as indicated. The policy indicated to document the type of wound care given, the date and time wound care given, any change in resident condition, document assessment data including wound bed color, size and any drainage, and the signature and title of person recording the data. Report other information in accordance with facility policy and professional standards of practice.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40994 Based on interview and record review, the facility failed to ensure the accuracy of medical records by falsifying 14 treatment records dated 9/25/2022 as completed on 9/30/2022 for five of 35 sampled residents (Residents 1, 2, 3, 4, and 5). The deficient practice of falsifying the status of treatment records in such a way that the record did not accurately reflect care delivered to the residents had the potential to cause Residents 1, 2, 3, 4, and 5 to experience a diminished quality of life from medical complications (such as infections or worsening of wounds) and psychosocial harm (such as embarrassment from the smell or appearance of wounds) resulting from incomplete treatments. Findings: A review of Resident 1's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including Type II Diabetes Mellitus (a medical condition characterized by the body's inability to control blood sugar which may result in other medical complications such as wounds on the body that are difficult to heal). A review of the treatment order for a bladder scan (a test to determine how much urine is currently in the bladder), dated 9/22/2022, indicated Resident 1 was to receive a bladder scan twice daily between 9/22/2022 and 10/4/2022 during the day and night shift. A review of Resident 1's Treatment Administration Record (TAR) for September 2022, indicated the Licensed Vocational Nurse (LVN 1) documented Resident 1's day-shift bladder scan as completed on 9/25/2022. A review of the Medication Administration Audit Report, dated 11/2/2022, indicated LVN 1 documented Resident 1's bladder scan as completed five days later, on 9/30/2022 at 12:08 PM. A review of Resident 2's Face Sheet indicated the resident was admitted to the facility on [DATE] and discharged from the facility on 10/31/2022 with diagnoses including Type II Diabetes Mellitus. A review of the treatment order for wound treatment of a pressure ulcer on the sacral coccyx area (a wound caused by the breakdown of skin near the tailbone area due to pressure) dated 9/24/2022 indicated Resident 2 was to receive wound cleaning and treatment every day during day shift. A review of Resident 2's TAR for September 2022 indicated LVN 1 documented Resident 2's wound treatment scheduled for the day shift as completed on 9/25/2022. A review of the Medication Administration Audit Report, dated 11/2/2022, indicated LVN 1 documented Resident 2's wound treatment as completed five days later on 9/30/2022 at 12:08 PM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 3's Face Sheet indicated he was originally admitted on [DATE] 2 and most recently readmitted to the facility on [DATE] with diagnoses including Type II Diabetes Mellitus and a pressure ulcer of the sacral region (a wound in an area between the lower back and tailbone). A review of Resident 3's treatment orders for September 2022 indicated he had eight total treatment orders as follows: -An order dated 9/12/22 to cleanse and bandage a skin tear on his right groin (area where the upper thighs meet the lowest part of the abdomen) -an order dated 9/12/22 to provide wound treatment to a pressure ulcer on his left buttock. -An order dated 9/23/22 to provide wound treatment to a pressure ulcer on his sacralcoccyx area -an order dated 9/11/22 to check his upper left extremity (left arm) for swelling, skin breakdown, and bleeding due to skin discoloration. -an order dated 9/11/22 to check his upper right extremity (right arm) for swelling, skin breakdown, and bleeding due to skin discoloration. -an order dated 9/11/22 to check his left shoulder blade for swelling, skin breakdown, and bleeding due to skin discoloration. -an order dated 9/11/22 to check his right shoulder blade for swelling, skin breakdown, and bleeding due to skin discoloration. -an order dated 9/11/22 to check the right side of his neck for swelling, skin breakdown, and bleeding due to skin discoloration. A review of Resident 3's TAR from September 2022 indicated LVN 1 documented all eight treatment orders listed above scheduled for the day shift as completed on 9/25/2022. A review of the Medication Administration Audit Report, dated 11/2/2022, indicated LVN 1 documented Resident 3's treatment for all eight orders listed above as completed five days later, on 9/30/2022 at 12:11 PM. A review of Resident 4's Face Sheet indicated the resident was admitted to the facility 9/20/2022 and discharged [DATE] with diagnoses including Type II Diabetes Mellitus and right hip replacement (surgery to provide an artificial hip join after a hip fracture). A review of Resident 4's treatment order, dated 9/20/2022, indicated to observe the surgical site on the right hip for signs of swelling, skin breakdown or bleeding every shift. A review of Resident 4's TAR from September 2022 indicated LVN 1 documented the treatment order for the day shift as completed on 9/25/2022. A review of the Medication Administration Audit Report, dated 11/2/2022, indicated LVN 1 documented Resident 4's treatment order as completed five days later, on 9/30/2022 at 12:26 PM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 5's Face Sheet indicated the resident was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including generalized muscle weakness and abnormalities of gait and mobility (problems with walking or getting around easily). A review of Resident 5's treatment orders dated 9/15/2022 indicated the resident had the following treatment orders: -an order to check his indwelling catheter (a tube placed into the bladder to remove urine for a resident with an inability to use the toilet) for increased sedimentation, blockage, expulsion, pain/discomfort, leaking, or bleeding every shift. -an order to check if his indwelling catheter was anchored (secured to the thigh to prevent accidental removal). -an order to ensure the catheter bag (used to collect urine) was covered to promote resident dignity. A review of Resident 5's TAR from September 2022 indicated LVN 1 documented all three treatment orders listed above scheduled for the day shift as completed on 9/25/2022. A review of the Medication Administration Audit Report, dated 11/2/2022, indicated LVN 1 documented Resident 5's treatment for all three orders listed above as completed five days later, on 9/30/2022 at 12:12 PM. During an interview on 11/1/2022 at 1:29 PM, LVN 1 stated she started working at this facility as a treatment nurse on the floor on 9/24/2022. LVN 1 stated she is still currently employed here but her last shift worked was 10/22/2022. LVN 1 stated she was assigned to perform treatment on the facility's third floor which had two different treatment carts (treatment carts five and six). LVN 1 stated typically this workload would be split between two different treatment nurses each assigned to a different cart. LVN 1 stated she was asked to cover the third floor for both treatment carts five and six herself on most days she was scheduled, which averaged around 20-25 residents per shift and sometimes more. LVN 1 stated this workload was high, but she was asked to cover it alone due to the fact the facility was short staffed. LVN 1 stated the other nursing staff on the third floor asked her to prioritize the more complicated treatments first and that anything she could not finish would be endorsed over to the other nurses or a nurse supervisor to finish treatments that were not completed. LVN 1 stated if she prioritized the more difficult treatments (treatments that took 45 min or more), she could complete about half of them in her eight-hour hour shift (about 10-12 treatments). LVN 1 stated she would communicate to the facility leadership that the residents marked complete in the electronic health record was what she had done in her shift and residents who did not show complete were endorsed over. LVN 1 stated the Medical Records Assistant (MRA) performed daily audits to see if treatments were not documented as complete. LVN 1 stated the MRA indicated several treatments were not documented completed on the days she worked and facility staff pressured her to sign off that treatments were completed in the TAR, even though she had not completed those treatments. LVN 1 stated she received text messages from the DON indicating that she will be removed from the schedule if she failed to sign off on her treatment records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 1 stated she did not sign any treatment records for treatment she had not done, but worried that the facility may have used her credentials to sign off treatments she had not completed after the fact. LVN 1 stated other staff, including supervising nurses from the third floor, had access to her electronic health record credentials and used them to sign off on treatment records for residents' treatments she had not completed. LVN 1 stated she worked at this facility on the following dates: 9/24, 9/25/2022, 10/1, 10/8, 10/9, 10/14, 10/15, 10/22/2022. During an interview on 11/1/2022 at 2:45 PM, the MRA, MRA stated she performed audits every day on treatment records not signed and she followed up with the nurse responsible by giving them a copy of the audit or leaving it with the Registered Nurse supervisor at the nursing station. The MRA stated that if the nurse listed as responsible on the audit did the treatment, but forgot to sign, she asked them to sign the TAR to indicate the treatment was completed. The MRA stated if the nurse indicated they did not complete the treatment, then she elevated the issue to the DON and ADM for further action. A review of the TAR Audit report, dated 9/26/2022, provided by MRA on 11/1/2022 indicated no incomplete treatment records were found from 9/25/2022. During an interview on 11/2/2022 at 2:30 PM, the MRA stated she did not know why the treatments listed above for Residents 1, 2, 3, 4, and 5 would not appear on her audit performed on 9/26/2022, if they had not been signed as completed in the TAR until 9/30/2022. The MRA stated she may have a different version of her audit report from 9/26/2022. A review of the TAR audit report, dated 9/26/2022, provided by MRA on 11/2/2022 indicated there were incomplete treatments attributed to LVN 1 on 9/25/2022 for Residents 1, 2, 3, 4, and 5 with a notation in the side margin that these were done on 10/5/2022. During a telephone interview on 11/2/2022 at 3 PM, LVN 1 stated she did not come to the facility for any reason on 9/30/2022 as she was working at her other job that day and she did not have any kind of remote access to the electronic health record to be able to sign for records from another location. LVN 1 stated she did not complete any of the treatment shown as incomplete on MRA's second version of the TAR Audit Report, dated 9/26/2022 and if any records were signed as complete on days she was not here, it was not her signing the records. A review of LVN 1's Employee Timecard Report, dated 11/2/2022, indicated LVN 1 did not clock in to work at the facility on 9/30/2022. A review of the facility's nursing schedule for the week on 9/24 to 9/30/2022 indicated LVN 1 was not scheduled to work on 9/30/22. A review of the facility Nurse Staffing Assignment & Sign-In Sheet for the 3rd Floor, dated 9/30/2022, indicated LVN 1 did not sign in to work as a treatment nurse or any other nursing responsibilities on that day. (continued on next page)

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	12/12/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/2/2022 at 3:17 PM, the MRA stated she removed records from the initial TAR Audit Report dated 9/26/2022 because she checked back on 10/5/2022 and saw that they were marked green in the electronic health record and considered them as done. The MRA stated she cannot explain how 14 treatment records for Residents 1, 2, 3, 4, and 5 were signed as completed by LVN 1 on 9/30/2022 when LVN 1 was not working or was not present in the facility on that day. The MRA stated she failed to determine whether the treatments marked done in the TAR on 9/30/2022 from 9/25/2022 accurately reflected care delivered to Residents 1, 2, 3, 4, and 5. The MRA stated she will have to be more careful when performing her audits to ensure staff were not documenting treatments as completed without actually performing the treatment per the prescriber's orders. The MRA stated if treatments were marked as completed in the electronic health record without having actually been performed, it could result in resident harm such as their wounds getting worse from lack of treatment. During an interview on 11/2/2022 at 3:45 PM, the Director of Nursing (DON) stated the facility nurses did not have any form of remote access to sign records offsite. The DON stated the only way for any nursing staff to make entries into the electronic health record was to be onsite at the facility and she could not explain how LVN 1 signed 14 treatment records as complete for Residents 1, 2, 3, 4, and 5 on 9/30/2022 when she was not working or present at the facility that day. A review of the facility's policy titled, Charting and Documentation, revised 7/2017, indicated the following information was to be documented in the resident medical record: .Treatments or services performed . Documentation in the medical record will be objective (not opinionated or speculative), completed and accurate. A review of the facility's policy titled, Legal Health Record, Revised 3/9/2021, indicated documentation in the legal health record will follow these basic rules: All entries will include date and time as appropriate and will be signed . Document a LATE ENTRY as soon as possible, if required: . There was no time limit for writing a late entry however, the more time that passes the less reliable the entry becomes from a legal/regulatory standpoint. If the late entry was used to document an omission, validate the source of additional information as much as possible.