POC accepted 3/8/23, 36395, HFEN

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	C 02/08/2023

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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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a Facility Reported Incident (FRI). Facility Reported Incident Number: CA00819585 Representing the Department: Health Facilities Evaluator Nurse: 36395 The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was identified for the Facility Reported Incident: CA00819585 (Refer to Ftag 600).	F 000	**Case #: CA00819585** **Date of Survey Completed: 2/8/203** This plan of correction constitutes the licensee's written credible allegation of compliance. Preparation and/or execution for this plan of correction does not constitute an admission of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is submitted as part of the statutory requirements set forth in the Code of Federal Regulations, Title 42, Section 489.13; State Operations Manual, Section 2612; and California Health and Safety Code, Section 1280 and the facility does not waive its right to contest or pursue an appeal of the deficiency as allowed under Federal and State Law. **F-600 Free from Abuse and Neglect CFR(s): 483.12 (a)(1)**	
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** 1. Resident 1 was discharged on 2/3/2023 to another skilled nursing facility for continuity of care. 2. Resident 2 was evaluated by Social Services for any psychosocial and emotional disturbance/ distress. No psychosocial and emotional disturbance/ distress. 3. Resident 3 was evaluated by Social Services for any psychosocial and emotional disturbance/ distress. No psychosocial and emotional disturbance/ distress.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2-22-23

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.

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F 600	Continued From page 1 by: Based observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse and misappropriation of property (deliberate misplacement, exploitation, wrongful, temporary, or permanent use of a resident's belongings without the resident's consent) by Resident 1 for two of three sampled residents (Resident 2 and Resident 3). Resident 1 hit Resident 3 with a cane, and Resident 1 took Resident 2 and Resident 3's personal property for his own use and without permission. As a result, on 1/5/2023, Resident 1 was transferred to the general acute hospital (GACH 1) for a psychiatric evaluation (medical doctor that specializes in the diagnosis and treatment of mental illness). Resident 3 developed a bruise in the inner bicep (large muscle of the arm) measuring eight centimeters (cm) by four cm. Resident 3 stated he felt scared and had severe pain in both arms and shoulder requiring Tylenol (pain medication). Resident 2 stated he felt anxious and upset when he saw Resident 1 with his personal property. Findings: A review of the Admission Record indicated Resident 1 was admitted to the facility on 11/1/2022 with diagnoses including toxic encephalopathy (brain disorder caused by exposure to toxic substances) and muscle weakness. A review of the History and Physical dated 11/1/2022 indicated Resident 1 could make needs known but could not make medical	F 600	4. Director of Staff Development (DSD)/ Director of Nursing (DON)/ Clinical Resource Consultant / Designee conducted a series of in-service/ training and reeducation to nursing staff (CNAs/ LVNs/ RNs) on 2/15/2023 about residents rights to be free from abuse, neglect, misappropriation of property and exploitation , staff's responsibility to protect residents rights, as well as the facility's policy and procedure regarding abuse investigation, reporting and prevention, emphasis on importance of reporting and preventing misappropriation of personal property, in accordance to the regulations. 5. Administrator/ Designee provided a series of in-service/ training and reeducation to Department Managers and non-nursing personnel on 2/15/23 about residents rights to be free from abuse, neglect, misappropriation of property and exploitation , staff's responsibility to protect residents rights, as well as the facility's policy and procedure regarding abuse investigation, reporting and prevention, emphasis on importance of reporting and preventing misappropriation of personal property, in accordance to the regulations.	

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F 600	Continued From page 2 decisions. A review of the Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 11/5/2022 indicated Resident 1 was oriented to year, month, and day. Resident 1 needed set up help (performs activity once the materials are provided) with eating and one-person physical assistance with bed mobility, transfer, dressing, toilet use, personal, hygiene, and bathing. The MDS indicated Resident 1 had no behavioral symptoms (hitting, scratching, or threatening). A review of the Care Plan initiated on 12/2/2022 indicated Resident 1 spoke another language other than English. The Care Plan indicated the language barrier may appear to limit effective communication that may result in decline of psychosocial (the interrelation of social factors and individual thought and behavior) well-being under the new environment. The Care Plan goal indicated Resident 1 would maintain stable mood and behavior. The interventions included to observe Resident 1 for any changes in mood, behavior, and psychosocial well-being. According to a review of the Nurses Notes dated 1/5/2023, at 5:25 a.m., Resident 1 and Resident 3 had an altercation (a noisy argument or disagreement). The Nurses Notes indicated Resident 1 used his cane and hit Resident 3. The Notes indicated during an assessment Resident 1 had no injury, was anxious and continuously talking. Resident 1 calmed down and gave up his cane without resistance. Resident 1 refused to talk about the incident and was moved to another unit.	F 600	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** • On 2/9/23 Social Service Director/ Designee conducted an interview of all residents residing on the 1st floor/ unit of the facility who are identified to be alert/ oriented and interviewable – to see if they have had witnessed or experience another resident who willfully took another person's personal property while in the facility. • No other resident was affected and all residents interviewed stated they felt safe, and their needs were met timely by the facility staff. • All active residents including residents newly admitted residents have the potential to be affected by this deficient practice. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur;** 1. Administrator/ Designee will schedule a room/ area rounds 7x/week x 2 weeks, then 5x/week x 2 weeks then 3x/week assigning at least 10 Residents to Interdisciplinary Team (IDT) and Department Heads members and will randomly interview alert/ oriented/ interviewable assigned residents and their assigned nursing staff to check if they have had witnessed or experience other resident(s) who willfully took his/her or another person's personal property while in the facility. Incident(s) will be reported to the facility's Abuse Prevention Coordinator (Administrator) immediately for further investigation.	

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F 600	Continued From page 3 A review of the Nurses Notes dated 1/5/2023 at 7:55 a.m., indicated Resident 3 "verbalized he was hit on his back and both hands many times," by Resident 1 while Resident 3 was trying to get the food that Resident 1 took from him. The Nurses Notes indicated Resident 3 did not have open wound, skin tears or discolorations. Resident 3 complained of pain on his arms rated at five out of 10 (using the pain scale, one to three for mild pain, four to six, moderate pain and seven to 10 severe pain) and was given Tylenol (pain medication). Resident 1's primary physician and Nurse Practitioner (NP) was notified. A review of the Interdisciplinary Team Meeting (IDT, team of health professionals from different disciplines who work together to address resident's needs) notes dated 1/5/2023 at 11:34 a.m., indicated Resident 1 took Resident 3's food. Resident 1 used his cane and hit Resident 3 when Resident 3 tried to take his food back. Resident 1 was alert and oriented. The IDT Notes indicated the police department and Resident 1's primary physician was notified. The primary physician gave an order to transfer Resident 1 to the general acute hospital (GACH 1) for psychiatric (medical doctor that specializes in the diagnosis and treatment of mental illness) evaluation. A review of the IDT notes dated 1/5/2023 at 12:20 p.m., indicated Resident 3's physician gave an order to continue to monitor Resident 3 for side effects to the arms and back for 72 hours and to notify the physician if there were any changes. According to a review of the Admission Record, Resident 3 was admitted to the facility on 7/31/2022 with diagnoses including hypertension	F 600	2. The facility's Abuse Prevention Coordinator (Administrator) will meet with the members of the Resident Council committee monthly to review and/or discuss any facility care related issues, and to provide the committee action plans required. 3. Director of Staff Development (DSD)/ Director of Nursing (DON)/ Clinical Resource Consultant / Designee will provide a series of in-service/ training and reeducation to nursing staff (CNAs/ LVNs/ RNs) about residents rights to be free from abuse, neglect, misappropriation of property and exploitation , staff's responsibility to protect residents rights, as well as the facility's policy and procedure regarding abuse investigation, reporting and prevention, emphasis on importance of reporting and preventing misappropriation of personal property, in accordance to the regulations. This in-service/ training and re-education will be conducted monthly x 6 months then annually and as needed thereafter. 4. Administrator/ Designee provided a series of in-service/ training and reeducation to Department Managers and non-nursing personnel on 2/15/23 about residents' rights to be free from abuse, neglect, misappropriation of property and exploitation, staff's responsibility to protect residents' rights, as well as the facility's policy and procedure regarding abuse investigation reporting and prevention, emphasis on importance of reporting and preventing misappropriation of personal property, in accordance to the regulations. This in-service/ training and re-education will be conducted monthly x 6 months then annually and as needed thereafter.	

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F 600	Continued From page 4 (high blood pressure) and generalized muscle weakness. A review of the MDS dated 11/4/2022 indicated Resident 3 was oriented to year and month. Resident 3 needed set up help with bed mobility, transfer, dressing, eating, toilet use and one-person physical assistance with personal hygiene and bathing. A review of the Physician Progress Notes dated 1/13/2023, indicated skin assessments after the altercation between Resident 1 and Resident 3 did not record any bruising or discoloration. The Progress Notes indicated Resident 3's bruise may have been deeper initially and surfaced over time. The Physician Progress Notes indicated, "However, given the altercation and size of the bruise, will order x-ray to confirm no damage to bone." During an observation on 1/13/2023 at 9:15 a.m., Resident 3's right inner bicep (arm) had a bruise. During a concurrent interview, Resident 3 stated on 1/5/2023 at around 5 a.m., while he was sleeping, his roommate, Resident 1 "stole his snacks, peanuts and fruits." Resident 3 stated when he woke up, he saw his food on Resident 1's bed. Resident 3 stated he went to get his food and Resident 1 became angry and hit him on the arms, shoulder, back and his head with the cane. Resident 3 stated after Resident 1 hit him he was "in so much pain," and staff gave him Tylenol which helped ease the pain. Resident 3 stated the bruise in the inner bicep was due to Resident 1 hitting him with the cane. Resident 3 stated he felt better and safe when Resident 1 was moved to another room right after the incident. During an interview on 1/13/2023 at 9:30 a.m., Resident 2 stated on 12/31/2022 during the	F 600	**How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** • Findings from room rounds reports and resident council minutes will be presented to QA Committee monthly for further resolution and recommendations for the first 3 months, then quarterly thereafter if no negative trends are found. • This correction will be monitored by the Administrator /Designee for continuous compliance. **Completion Date: 3/8/2023**	3/8/2023

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F 600	Continued From page 5	F 600		

morning, his bathrobe was missing from his closet. Resident 2 stated when he looked across the room, he saw Resident 1, his roommate, wearing his bathrobe. Resident 2 further stated Resident 1 came to his bedside, looked through his belongings and took his box of tissue paper without his permission. Resident 2 stated he informed Certified Nursing Assistant (CNA) 1 that Resident 1 was bothering him and wearing his bathrobe. Resident 2 stated he felt upset and anxious.

A review of the Admission Record indicated Resident 2 was admitted to the facility on 10/5/2022 with diagnoses including depression and low back pain. A review of the History and Physical, dated 10/5/2022 indicated Resident 2 had the capacity to understand and make decisions. A review of the MDS dated 10/22/2022 indicated Resident 2 was oriented to year, month, and day.

During an interview on 1/13/2023 at 10:21 a.m., CNA 1 stated Resident 2 did inform her that Resident 1 took his bathrobe. CNA 1 stated she asked Resident 1 for the bathrobe and gave it back to Resident 2. CNA 1 further stated Resident 1 would go from one bed to the other when his roommates were not in the room. CNA 1 stated she saw items like a comb in Resident 1's closet that did not belong to him. CNA 1 stated she re-directed Resident 1, informed Registered Nurse Supervisor (RNS) 2 and the licensed vocational nurse (LVN 1).

During an interview on 1/13/2023 at 11:09 a.m., RNS 1 stated Resident 3 was assessed every shift after the altercation. RNS 1 stated this morning during breakfast, CNA 1 reported that

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F 600	Continued From page 6	F 600		

Resident 3 had a bruise in the right inner bicep.

During an interview on 1/13/2023 at 11:59 a.m., LVN 1 stated she was not aware that Resident 1 was taking belongings from his roommates. LVN 1 stated if she had known she would notify the physician and redirect Resident 1.

On 1/13/2023 at 12:46 p.m., during an interview, RNS 2 stated she was not aware that Resident 1 was going through the belongings of his roommates and if she had known they would do a room change, notify the physician and focus on the resident's behavior.

During an interview on 1/13/2023 at 2:42 p.m., LVN 2 stated CNA 1 informed him about Resident 3's right inner bicep bruise this morning. LVN 2 stated Resident 3's bruise measured eight cm by four cm.

During an interview on 1/13/2023, at 2:57 p.m., the director of nursing (DON) stated she was not aware Resident 1 took Resident 2's bathrobe or that Resident 1 took personal property from his roommates. The DON stated if she had known, Resident 1 would need to be redirected and monitor his whereabouts. The DON stated if Resident 1 was getting personal belongings from other roommates, an altercation could happen.

A review of the facility policy titled, "Resident Rights," revised on 8/2022, indicated residents have the right to be free from abuse, neglect, misappropriation of property and exploitation. The policy indicated residents have the right to retain and use personal possessions to the maximum extent that space and safety permit. The policy indicated the residents will be supported by the

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F 600	Continued From page 7 facility in exercising his or her rights. A review of the facility policy titled, "Abuse Prevention Program," dated 12/1/2022, indicated the policy was to promote an environment free from any form of resident abuse, neglect, misappropriation of resident property, exploitation and/or mistreatment.	F 600		