

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055977	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/22/2024
NAME OF PROVIDER OR SUPPLIER  Kennedy Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  619 N. Fairfax Ave Los Angeles, CA 90036	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455</b></p> <p>Based on observation, interview and record review, the follow it ' s Policy and procedure by failing to report an Unusual Occurrence (Resident elopement) within 24hrs to the State Survey Agency for one out of 3 sampled residents (Residents 1).</p> <p>This deficiency practice placed the health and safety of Resident 1 at risk of exposure to heat or cold exposure, dehydration, other medical complications and being struck by a motor vehicle.</p> <p>Findings:</p> <p>A review of Resident 1 ' s admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that include schizoaffective disorder (a chronic mental health condition characterized primarily by symptoms, such as hallucinations or delusions, and mood disorder), Post-Traumatic Stress Disorder (a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event), Major depressive disorder (a serious mental health condition that involves a persistent low mood, loss of interest in activities, and other symptoms that interfere with daily life), osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time.), muscle weakness and cardiomyopathy (a disease that affects the heart muscle, making it difficult for the heart to pump blood).</p> <p>A review of Resident 1 ' s history and physical (H&amp;P) indicated, Resident 1 was recently hospitalized due to psychiatric disorder with depression, suicidal ideation, hallucination, and anxiety. Resident 1 could make needs known but could not make medical decisions.</p> <p>A review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assesement tool) dated 7/1/2024, indicated the Resident 1 ' s mental cognition (skills for daily decision-making) was intact. Resident 1 independent for eating and oral hygiene and upper body dressing, toileting hygiene, shower/bathing self, and lower body dressing.</p> <p>A review of Resident 1 ' s facility progress notes dated 10/8/2024 indicated, on 7/3/2024 at 6:45am while Licensed Vocational Nurse (LVN1) was passing medication housekeeper (HK1) approached LVN1 stating she (HK1) met Resident 1 at the front facility entrance door around 6am and Resident 1 told HK1 he was leaving the facility.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/22/2024 at 12:50PM, Licensed Vocational Nurse (LVN1) stated on 7/3/2025 at 6:40am Housekeeping (HK1) asked LVN1 if it was okay to clean Resident 1 ' s room since he (Resident 1) had left the facility. LVN1 stated HK1 said she found Resident 1 by the facility front entrance with his belongings and had stated to HK1 as he walked out, he was leaving the facility. LVN1 stated she immediately started searching for Resident 1 because Resident 1 did not have authorization to leave the facility, LVN1 stated she searched for Resident 1 inside and outside the facility but could not find Resident 1.</p> <p>During an interview on 10/22/2024 at 1:10pm Housekeeping (HK1) stated as she walked into the facility to start her work shift at 6:00am, Resident 1 was at the facility entrance with his belongings, HK1 states she said, good morning to Resident 1 and asked him you ' re leaving, Resident 1 responded yes. HK1 states she proceeded to her workstation in the facility basement gathered her cleaning supplies and cart, came upstairs at 6:40am to ask LVN1 if she could clean Resident 1 ' s room since he had just left the facility. HK1 stated LVN1 panicked and stated to HK1 that Resident 1 did not have authorization to leave the facility and started running in the hallways while reaching out to other staff to assist her in finding Resident 1. HK1 stated she does not know if the nurses ever found Resident 1.</p> <p>During an interview on 10/22/2024 at 3:45pm the Director of Nursing (DON) stated upon admission to the facility on [DATE], Resident 1 was alert and oriented person, place, time, and event (a/a/ox4), was able to make decisions, DON stated Resident 1 was discharged from acute care with no suicidal ideation and had been started on psychiatric medications in the acute hospital, and continued in facility. DON stated Resident 1 signed all his admission paperwork including consent, was seen by psychiatric doctor in acute and had received a follow-up visit from the psychiatrist while in the facility. DON stated she received a call from LVN1 stating Resident 1 had left the facility without authorization to leave. DON stated LVN1 notified Resident 1 ' s doctor of Resident 1 ' s unauthorized leave and was given an order allowing Resident to leave against medical advice. DON stated, Resident 1 ' s unauthorized leave was documented as leaving against medical advice (AMA) and not an elopement from the facility.</p> <p>During a review of facility's policy and procedure (P&amp;P) titled Unusual Occurrence, dated 4/17/2024, the P&amp;P indicated. As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents , Policy further states, unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45455</p> <p>Based on interview and record review, the facility failed to provide monitoring and supervision for one of three sampled residents (Resident 1) by failing to ensure Resident 1 did not elope from the facility (leaving the facility premises safe area without the facility's knowledge and supervision).</p> <p>This deficiency practice placed the health and safety of Resident 1 at risk of exposure to heat or cold exposure, dehydration, other medical complications and death.</p> <p>Findings:</p> <p>A review of Resident 1's admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that include schizoaffective disorder (a chronic mental health condition characterized primarily by symptoms, such as hallucinations or delusions, and mood disorder), Post-Traumatic Stress Disorder (a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event), Major depressive disorder (a serious mental health condition that involves a persistent low mood, loss of interest in activities, and other symptoms that interfere with daily life), osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time.), muscle weakness and cardiomyopathy (a disease that affects the heart muscle, making it difficult for the heart to pump blood).</p> <p>A review of Resident 1's history and physical (H&amp;P) indicated, Resident 1 was recently hospitalized due to psychiatric disorder with depression, suicidal ideation, hallucination, and anxiety. Resident 1 could make needs known but could not make medical decisions.</p> <p>A review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/1/2024, indicated the Resident 1's mental cognition (skills for daily decision-making) was intact. Resident 1 independent for eating and oral hygiene and upper body dressing, toileting hygiene, shower/bathing self, and lower body dressing.</p> <p>A review of Resident 1's facility progress notes dated 10/8/2024 indicated, on 7/3/2024 at 6:45am while Licensed Vocational Nurse (LVN1) was passing medication housekeeper (HK1) approached LVN1 stating she (HK1) met Resident 1 at the front facility entrance door around 6am and Resident 1 told HK1 he was leaving the facility.</p> <p>During an interview on 10/22/2024 at 12:50PM, Licensed Vocational Nurse (LVN1), stated on 7/3/2025 at 6:40am Housekeeping (HK1) asked LVN1 if it was okay to clean Resident 1's room since he (Resident 1) had left the facility. LVN1 stated HK1 said she found Resident 1 by the facility front entrance with his belongings and had stated to HK1 as he walked out, he was leaving the facility. LVN1 stated she immediately started searching for Resident 1 because Resident 1 did not have authorization to leave the facility, LVN1 stated she searched for Resident 1 inside and outside the facility but could not find Resident 1.</p> <p>(continued on next page)</p>		

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