

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 11/20/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454</p> <p>Based on observation, interview and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect in full recognition of her individuality for five out of four sampled residents (Resident 1) by failing to ensure the staff was not standing over the Resident 61 while feeding and assisting her during a meal.</p> <p>This deficient practice had the potential to result in feelings of decreased self-esteem and self-worth for Resident 1.</p> <p>Findings:</p> <p>A review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including unspecified dementia (a progressive state of decline in mental abilities) and chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure).</p> <p>A review of the Minimum Data Set (MDS - a resident assessment tool) dated 11/1/2024, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was moderately impaired. The MDS indicated Resident 1 required moderate to maximal assistance from staffs for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a meal observation on 11/20/2024 at 12:45 p.m. in Resident 1's room, Resident 1 was observed on bed while Certified Nursing Assistant (CNA) 2 was standing over Resident 1's while feeding him lunch. Resident 1 was observed looking up at CNA 2 and requested to have his head of bed higher because he complained of neck pain.</p> <p>During an interview with CNA 2, on 11/20/2024 at 1:46 p.m., CNA 2 stated, when feeding resident, staff should be sitting down and feeding resident so that it is more comfortable for resident, and she could see his face. CNA 2 stated, there was no chair available, so she just stood over Resident 1.</p> <p>During an interview with Registered Nurse Supervisor (RN) 1, on 11/20/2024 at 12:58 p.m., RN 1 stated, staffs should be sitting down while feeding and assisting residents for their dignity. RN 1 stated, staff should find an available chair while feeding residents and they have enough chairs in 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
---	-------	-----------

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 11/20/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policies and procedures (P&P) titled Assistance with Meals, reviewed April 17, 2024, the P&P indicated, Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: not standing over residents while assisting them with meals.</p>