STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055977	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kennedy Care Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record review, the facility failed to implement a comprehensive care plan that met the care/services based on the resident's individual assessed needs for one of two sampled residents (Resident 4) by failing to ensure that a comprehensive (CP) was developed after Resident 2 had a change of condition for dislodgment of nephrostomy tube (a thin, flexible tube inserted into the kidney through the skin to drain urine directly into a collection bag). This deficient practice had the potential to result negative impact on residents ' health and safety, as well as the quality of care and services received. Findings: A review of the Admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including displacement of nephrostomy catheter (it can occur when the tube falls out or becomes mispositioned, which can lead to decreased or absent urine output), and fibromyalgia (a condition that causes pain all over the body, sleep problems, fatigue, and often emotional and mental distress). A review of the Minimum Data Set (MDS - resident assessment tool) dated 11/7/2024, indicated Resident 4 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were mildly impaired. The MDS indicated Resident 4 required total dependent from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 4 ' s Order Summary Report, dated 6/14/2024, Left and Right flank (the areas around the sides of your body from your upper abdomen to your back) nephrostomy drainage: monitor for change in urine character. A review of Resident 4 ' s SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) indicaterd the following: i. dated 5/9/2024 indicated, noted that L (left) flank Nephrostomy tube had been dislodge from site. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ii. Dated 5/20/2024 indicated, Resident (4) is noted with blood in left nephrostomy drainage bag. iii. Dated 5/28/2024 indicated, Minimal output to bilateral nephrostomy. iv. Dated 6/9/2024 indicated, Resident is noted with right nephrostomy tube dislodge. v. Dated 12/7/2024 indicated, Hematuria (the presence of red blood cells in the urine) noted on R (right) nephrostomy drainage bag, foul odor noted on the site. A review of Resident 4 ' s electronic health record and paper health record indicated, there was no care plan developed and revised with a goal and interventions on change of condition for Resident 4 ' s nephrostomy tube. During a record review and interview with Registered Nurse 1 (RN 1) on 1/3/2025 at 1:48 p.m., RN 1 stated, there should be a care plan when Resident 4 had displacement of nephrostomy tube and was sent out to GACH 1 on several incidents. RN 1 stated, CP should be in place so that staff are all on the same page when doing interventions for the care of nephrostomy tube. During a review of the facility ' s policy and procedure (P&P) titled, Care Plans, Comprehensive Person-centered, reviewed on 4/14/2024, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview and record review, the facility failed to ensure a resident's peripheral catheter (is a thin tube inserted into a vein for therapeutic purposes such as administration of medications, fluids and/or blood products) dressing was labeled and documented as indicated in the facility policy for one out of two sampled resident (Resident 2). This deficient practice had the potential to place residents at risk for developing infections at the IV site. Findings: A review of the Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including polymyositis with myopathy (refers to a condition where polymyositis, an inflammatory muscle disease, is accompanied by muscle weakness, dysphagia (difficulty swallowing) and cerebral atherosclerosis (build-up of fats, cholesterol, and other substance in and on the arterial walls). A review of the Minimum Data Set (MDS - resident assessment tool) dated 12/23/2024, indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. A review of Resident 2's Order Summary Report, dated 1/2/2025 indicated, establish IV line. During an observation of Resident 2 on 1/3/2025 at 10:47 a.m. with Licensed Vocational Nurse 1, observed Resident 1 ' s PIV line with no date on the transparent dressing. The IV catheter site. During an interview with Registered Nurse 1 (RN 1) on 1/3/2024 at 11:02 a.m., RN 1 stated, the PIV line and dressing should be labeled when it was inserted so that they know when it is due to be changed. RN 1 stated, PIV line should be changed every three days. During a review of the facility's policy and procedure (P&P) titled, Peripheral IV Dressing Changes, revised 5/2022, the P&P indicated, Change the dressing at the time of catheter site rotation (every 72 to 96 hours) or immediately upon observing that the integrity of the dressing has been compromised . Label dressing with date, time, and initials.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 43454 Based on observation, interview and record review, the facility failed to ensure that a Director of Nursing (DON) works onsite for at least 8 consecutive hours a day from 11/2024 to 1/3/2025. This deficient practice had the potential for facility ' s inability to manage and oversee nursing services provided to the residents. Findings: During an interview with Registered Nurse 1 (RN 1) on 1/3/2025 at 3:17 p.m., RN 1 stated, the DON has been out of sick leave since November 2024. RN 1 stated, there is no DON interim since the DON has been out. RN 1 stated, she does now know who the clinical consultant in the facility and had not seen any and there is no managing the nursing services. During a concurrent interview and record review of the DON ' s timesheet record with Medical Record Director (MRD) as of 1/3/2024, the MRD stated, the DON does not have any timesheet record available. During an interview with Administrator-in-Training on 1/3/2025 at 3:39 p.m., AIT stated, the DON has been out on leave since November 2024. AIT stated, there is no DON interim in the facility, and they did not send any fax notification to the State Agency regarding DON interim who will be in place of the DON ' s absence. A review of facility ' s job description titled, Director of Nursing, prepared on 7/2018 indicated, The DON is a registered nurse who oversees and supervises the care of all the residents . Essential Duties include: overall management of the entire nursing department and staffing levels, develop and implement nursing policies and procedures and ensure compliance, responsible for ensuring resident safety and that all residents are treated with utmost respect.