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	09/12/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the residents' privacy and dignity by failing to ensure the indwelling urinary catheter (a soft hollow tube which is passed into the bladder to drain urine, for persons who cannot empty their bladder in the usual way) drainage bag was always covered for one of three sampled residents (Resident 1).This deficient practice had the potential to affect Resident 1's sense of self-worth and self-esteem.During a review of Resident 1's admission Record, it indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including toxic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), obstructive and reflux uropathy (a condition in which the flow of urine is blocked and urine flows backward from your bladder into your kidneys) and depression (a mood disorder that causes persistent feeling of sadness and loss of interest). During a review of the Minimum Data Set (MDS - resident assessment tool) dated 6/20/2025, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 required maximal assistance 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). The MDS also indicated Resident 1 has an indwelling urinary catheter. During a review of Resident 1's Order Summary Report, dated 6/13/2025, it indicated that physician ordered, Indwelling urinary catheter is in privacy bag and catheter leg strap/leg bag on at all times. During a review of Resident 1's Care Plan (CP) for bladder: at risk for complications with urinary system related to complaints of dysuria (refers to pain or discomfort during urination), complaints or urinary frequency, indwelling catheter, dated 5/22/2025 and revised on 9/2/2025, the CP indicated an intervention that included, privacy cover to catheter bag as indicated to promote dignity. During an observation of Resident 1 on 9/11/2025 at 9:22 a.m., observed Resident 1's indwelling urinary catheter with no privacy bag. Resident 1 had two other roommates in the same room. During an interview with Treatment Nurse 1 (TXN 1) on 9/11/2025 at 9:24 a.m., TXN stated and confirmed, Resident 1's urinary catheter does not have any privacy bag, and it is being exposed to other residents, visitors and staff. During an interview with Director of Nursing (DON) on 9/11/2025 at 1:12 p.m., DON stated, urinary catheter should be covered with privacy bag for resident's dignity. DON stated, they need to educate residents and resident's family members the importance of privacy in resident's foley catheter collection bag. During a review of facility's policy and procedure (P&P), titled, Urinary Catheters approved on 8/18/2021, the P&P indicated preventative measures for controlling common infections are critical component of the overall plan of care for residents with a urinary catheter. During a review of facility's P&P titled, Dignity, reviewed date 4/2025, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on interview and record review the facility failed to ensure residents' information was not sent to the personal cell phones of facility staff members. This deficient practice had the potential for unauthorized release of residents' information to the public. During an interview on 9/11/25 at 9:06 a.m., restorative nursing assistant (RNA 1, a certified nursing assistant (CNA) with specialized training in rehabilitation skills) stated she received text messages on her personal cellphone from the rehabilitation department regarding residents who would need to be on the RNA program. RNA 1 stated the text messages would include the name of the residents and their room number. During an interview on 9/11/25 at 10:18 a.m. the physical therapist (PT) stated when a resident needs to be on the RNA program, a group text message would be sent to the director of rehabilitation, the physical therapist, occupational therapist, director of staff development and the RNA. The PT stated the text messages would include the name of the residents, their room number and the specific RNA program. The PT stated the purpose of the text message was for the group to know that there is an RNA program for the resident. During an interview on 9/11/25 at 10:26 a.m., certified nursing assistant (CNA 2) stated she receive text messages on her personal cellphone that would include the name of the resident, the care they would need and their room number. During an interview on 9/11/25 at 1:16 p.m. , the director of nursing (DON) stated .personal phones should not be used when the patients (residents) name and room number are included. DON further stated don't transmit resident information to staff personal phone. DON stated this is due to the Health Insurance Portability and Accountability Act (HIPAA, establishes standards to protect people's medical records and other protected health information). During a review of the facility's policy and procedures (P&P) titled Telephones, Employee Use of reviewed on 4/25, the P&P indicated cell phones may be used for personal calls and text messaging when the employee is on meal and break periods. Employee cell phones remain off and/or silent during all other work hours. During a review of the facility's P&P titled Compliance Risks - Privacy, Security and Breach Notifications reviewed on 4/25, the P&P indicated the facility complies with the laws governing privacy, security, and breach notification of protected health information set forth in the Health Insurance Portability and Accountability Act (HIPAA) and other privacy and security rules. The same Policy indicated personnel are trained in the policies and practices that protect the privacy, confidentiality and security of resident-identifiable information throughout the facility.

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F 0684 Level of Harm - Minimal harm or potential for 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** Based on interview and record reviews, the facility failed to ensure resident received treatment and care in accordance with professional standards of practice for one of three sampled residents, (Resident 1) by failing to follow and implement physician's order and when Resident 1's blood pressure was elevated according to facility's policy and procedure titled, Changes in Resident's Condition or Status.This deficient practice placed Resident 1 in delayed intervention to provide treatment for urinary tract infection (UTI- an infection in the bladder/urinary tract) as required per facility's policy and procedure upon changes in condition.During a review of Resident 1's admission Record, it indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including toxic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), obstructive and reflux uropathy (a condition in which the flow of urine is blocked and urine flows backward from your bladder into your kidneys) and depression (a mood disorder that causes persistent feeling of sadness and loss of interest). During a review of the Minimum Data Set (MDS - resident assessment tool) dated 6/20/2025, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 required maximal assistance 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). The MDS also indicated Resident 1 has an indwelling urinary catheter (a soft hollow tube which is passed into the bladder to drain urine, for persons who cannot empty their bladder in the usual way). During a review of Resident 1's Care Plan (CP) for indwelling catheter: urinary retention: dated 6/16/2025 and revised on 9/2/2025, the CP indicated a goal of, (Resident 1) will show no signs and symptoms (s/sx) of urinary infection. During a concurrent interview and record review with Director of Nursing (DON) on 9/11/2025 at 12:42 p.m., DON stated, on 8/23/2025, Resident 1 complained of pain and weakness and staff notified the Medical Doctor 1 (MD 1). DON stated, she interviewed Registered Nurse 1 (RN 1) and found out that MD 1 ordered for a urine sample to be collected and to test for UTI, but it was not carried out by RN 1. DON reviewed Resident 1's medical record and stated the order for urine sample was not entered in Resident 1's medical record, and there was no change of condition documentation completed on 8/23/2025 when Resident 1 complained of pain and weakness. DON stated the urine sample order for Resident 1 was missed and delayed for two days. DON stated, Resident 1 had a delay in the care and treatment. During a review of facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, reviewed date 4/2025, the P&P indicated, The nurse will notify the resident's attending physician or physician on call when there has been a(an): i. specific instruction to notify the physician of changes in the resident's condition. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. During a review of facility's P&P titled, Urinary Tract Infection/Bacteriuria - Clinical Protocol, review date April 2025, the P&P indicated, The physician will order appropriate treatment for verified or suspected UTIs and/or urosepsis based on a pertinent assessment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff follow physician's order and facility's policy with wearing personal protective equipment (PPE-a barrier precaution which includes the use of gloves, gown, mask, face shield, when anticipating coming in contact with blood, body fluids or other communicable toxins or agents) when providing care to one of three sampled residents (Resident 2) who was on an enhanced barrier precaution (utilized to prevent the spread of multi-drug resistant organisms) room. This deficient practice placed residents at a higher risk of acquiring and transmitting infections to other residents, staff and visitors in the facility.During a review of Resident 2's admission Record, it indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including sepsis (a life-threatening blood infection), urinary tract infection (UTI- an infection in the bladder/urinary tract), and chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure). During a review of the Minimum Data Set (MDS - resident assessment tool) dated 9/5/2025, indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 2 required maximal assistance 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). During a review of Resident 2's Order Summary Report (OSR) dated 8/31/2025, the OSR indicated, physician ordered, Enhanced Barrier Precautions during high contact resident care activities. During a concurrent interview and observation with Licensed Vocational Nurse 2 (LVN 2) on 9/11/2025 at 9:56 a.m., LVN 2 was observed inside Resident 2's room and changing Resident 2's incontinent brief while Resident 2 was lying on her side. LVN 2 stated, I'm changing the resident right now. LVN 2 was observed not wearing complete PPE while providing close contact care to Resident 2. During a follow-up interview with LVN 3 on 9/11/2025 at 9:50 a.m., LVN 3 stated, Resident 2 asked to be checked if her incontinent brief was wet, so she went ahead and checked Resident 2's incontinent brief. LVN 3 stated, she was not wearing the full PPE because she was in and out of the room and forgot to put a complete PPE back on. When asked what type of transmission-based precaution Resident 2 was on, LVN 3 stated, I think she was on droplet precaution (safety measures used to stop the spread of germs that travel in the small, wet drops that come from a person's mouth or nose when they cough, sneeze, or talk). During an interview with Director of Nursing (DON) on 9/11/2025 at 1:12 p.m., DON stated, residents who are on enhanced barrier precautions, staff must wear full PPE which included gowns, gloves, goggles or face shield if needed when dealing with body fluids. DON stated, if staff do not wear full PPE while providing close contact care, it puts others at risk of infection. DON further stated, Resident 2 was on an enhanced barrier precaution, not droplet precaution for transmission-based precaution. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, revised on 4/2025, the P&P indicated, Enhanced Barrier Precautions (EBP) are utilized to prevent the spread of multi-drug resistance organisms (MDROs - bacteria that are resistant to more than one antibiotic and can cause serious infections) to residents. EBP refer to infection prevention and control interventions designed to reduce the transmission of MDROs during high contact resident care activities. Examples of high contact resident care activities requiring the use of gown or gloves for EBPs include: dressing, bathing/showering, providing hygiene or grooming, changing briefs or assisting with toileting, transferring, providing bed mobility, changing linens, prolonged, high-contact with items in the resident's room, with resident's equipment or with resident's clothing or skin, device care or use and wound care.