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	02/17/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure adequate supervision and security measures by failing to:Protect one of four sampled residents (Resident 1), from misappropriation (the unauthorized, improper, or unlawful use of funds or other property for purposes other than that for which intended) of property and personal belongings.Document and list inventory of Resident 1's personal belongings upon admission according to facility's policy and procedures (P&P) titled, Personal Property.These deficient practices resulted in the theft of Resident 1's mobile phone by an unhoused individual (HL 1) while Resident 1 was in the facility.Findings:During a review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), malignant neoplasm of the endocrine pancreas (a rare type of cancer that starts as a growth of cells in the pancreas), muscle weakness (weakening, shrinking, and loss of muscle) and difficulty in walking.During a review of the Minimum Data Set (MDS - resident assessment tool) dated 1/10/2026, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 1 required moderate assistance to total dependence 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 that Resident 1 experienced mood symptoms such as little interest or pleasure in doing things, feeling down, depressed or hopeless and trouble falling or staying asleep, or sleeping too much during half or more of the days, with totaling severity score of 10 (indicates moderate to severe symptoms of depression).During a review of Resident 1's medical record, as of 2/17/2026, there was no personal inventory list that was documented and inventoried during Resident 1's stay in the facility. During an interview with Medical Record Director (MRD) on 2/17/2026 at 12:28 p.m., MRD stated and confirmed that Resident 1's personal belongings were not inventoried and documented in Resident 1's medical records.During an interview with Resident 1's Family Member (R1FM) on 2/17/2026 at 11:06 a.m., R1FM stated, in the morning of 1/9/2026, an unhoused individual entered the facility without facility's staff knowledge, stayed and slept in one of the beds where Resident 1 was staying. R1FM stated, Resident 1 pressed the call light multiple times upon discovering HL1 was sleeping in the same room as hers and acted strange, but no staff answered her call light for a while. R1FM further stated, Resident 1 felt terrified of the incident and felt unsafe while in the facility. R1FM stated, they discovered in the morning that Resident 1's mobile phone was missing and reported it to the facility staff.During an interview with Licensed Vocational Nurse 1 (LVN 1) on 2/17/2026 at 12:09 p.m., LVN 1 stated, she noticed HL1 was in Resident 1's same room early morning of 1/9/2026 but they didn't have a resident assigned in that bed. LVN 1 asked HL1 what he was doing in the facility, where HL1 stated, he checked in while holding and showing her a mobile phone. LVN 1 stated, HL1 looked like a homeless person and was carrying (continued on next page)

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 02/17/2026
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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	a plastic bag that looked like a grocery bag. LVN 1 escorted HL1 out from the facility upon realizing that he did not belong in the facility. LVN 1 stated, she did not document the incident and she did not report it to the management and staff. LVN 1 stated, she did not check upon Resident 1 and she did not assess Resident 1 if she was affected by the incident. LVN 1 stated, she does not know how long HL1 stayed in the room and what he did the entire time he was in the facility. LVN 1 stated, the Certified Nurse Assistant (CNA) assigned to Resident 1 also noticed HL1 in the same room and thought that there was a new resident assigned to that bed. LVN 1 further stated, they have issues with the front door of the facility where it doesn't completely close all the way and locked from the outside upon entering the door.During an interview with Director of Nursing (DON) on 2/17/2026 at 12:48 p.m., DON stated, she was made aware of the incident that happened on 1/9/2026 by the Administrator (ADM) that a person (HL1), with no business to be in the facility, gained access to the facility without staff's knowledge and stayed in one of the bed where Resident 1 was admitted to. DON stated, they investigated the incident and they found out that the front door was broken and was not completely closing and locking upon opening. DON stated, it was also reported to them that Resident 1's mobile phone went missing after HL1 gained access to the facility. DON stated, they investigated the incident and was able to retrieve back the mobile phone but it was broken when it was returned to the facility.During a follow-up interview and concurrent record review with DON on 2/17/2026 at 1:01 p.m., DON reviewed Resident 1's medical record and stated, there was no documentation of the incident that happened with Resident 1 and HL1 and no documentation if any assessment was completed with Resident 1 after the incident. DON further stated, there was no documentation of Resident 1's personal belongings inventory upon admission. DON stated, there should be documentation of the incident to validate and support what the staff did during the incident.During a review of facility's P&P titled, Personal Property, reviewed date 4/2025, the P&P indicated, Resident belongings are treated with respect by facility staff, regardless of perceived value.The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary. The facility promptly investigated any complaints of misappropriation or mistreatment of resident property. During a review of facility's P&P titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, review date 4/2025, the P&P indicated, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives:Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident propertyInvestigate and report any allegations within timeframes required by federal requirements.During a review of facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, review date 4/2025, the P&P indicated, All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. The individual conducting the investigation as a minimum:. documents the investigation completely and thoroughly.

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 02/17/2026
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their policy regarding reporting of theft and misappropriation of property and to submit a conclusion report of investigation within five days or in accordance with state or federal law for one of four sampled residents (Resident 1). This resulted in a delay of an onsite inspection by the Department of Public Health to ensure the residents' allegation of theft and misappropriation of property was investigated which can also lead to a delay in prevention of further misappropriation of property and undetected type of abuse for all residents, staff and visitors in the facility. Cross Reference F602Findings: During a review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), malignant neoplasm of the endocrine pancreas (a rare type of cancer that starts as a growth of cells in the pancreas), muscle weakness (weakening, shrinking, and loss of muscle) and difficulty in walking.During a review of the Minimum Data Set (MDS - resident assessment tool) dated 1/10/2026, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 1 required moderate assistance to total dependence 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 that Resident 1 experienced mood symptoms such as little interest or pleasure in doing things, feeling down, depressed or hopeless and trouble falling or staying asleep, or sleeping too much during half or more of the days, with totaling severity score of 10 (indicates moderate to severe symptoms of depression).During a review of Resident 1's medical record, as of 2/17/2026, there was no personal inventory list that was documented and inventoried during Resident 1's stay in the facility. During an interview with Medical Record Director (MRD) on 2/17/2026 at 12:28 p.m., MRD stated and confirmed that Resident 1's personal belongings were not inventoried and documented in Resident 1's medical records.During an interview with Resident 1's Family Member (R1FM) on 2/17/2026 at 11:06 a.m., R1FM stated, in the morning of 1/9/2026, an unhoused individual entered the facility without facility's staff knowledge, stayed and slept in one of the beds where Resident 1 was staying. R1FM stated, Resident 1 pressed the call light multiple times upon discovering HL1 was sleeping in the same room as hers and acted strange, but no staff answered her call light for a while. R1FM further stated, Resident 1 felt terrified of the incident and felt unsafe while in the facility. R1FM stated they discovered in the morning that Resident 1's mobile phone was missing and reported it to the facility staff.During an interview with Licensed Vocational Nurse 1 (LVN 1) on 2/17/2026 at 12:09 p.m., LVN 1 stated, she noticed HL1 was in Resident 1's same room early morning of 1/9/2026 but they didn't have a resident assigned in that bed. LVN 1 asked HL1 what he was doing in the facility, where HL1 stated, he checked in while holding and showing her a mobile phone. LVN 1 stated, HL1 looked like a homeless person and was carrying a plastic bag that looked like a grocery bag. LVN 1 escorted HL1 out from the facility upon realizing that he did not belong in the facility. LVN 1 stated, she did not document the incident and she did not report it to the management and staff. LVN 1 stated, she did not check upon Resident 1 and she did not assess Resident 1 if she was affected by the incident. LVN 1 stated, she does not know how long HL1 stayed in the room and what he did the entire time he was in the facility. LVN 1 stated, the Certified Nurse Assistant (CNA) assigned to Resident 1 also noticed HL1 in the same room and thought that there was a new resident assigned to that bed. LVN 1 further stated, they have issues with the front door of the facility where it doesn't (continued on next page)

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 02/17/2026
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	completely close all the way and locked from the outside upon entering the door.During an interview with Director of Nursing (DON) on 2/17/2026 at 12:48 p.m., DON stated, she was made aware of the incident that happened on 1/9/2026 by the Administrator (ADM) that a person (HL1), with no business to be in the facility, gained access to the facility without staff's knowledge and stayed in one of the bed where Resident 1 was admitted to. DON stated, they investigated the incident and they found out that the front door was broken and was not completely closing and locking upon opening. DON stated, it was also reported to them that Resident 1's mobile phone went missing after HL1 gained access to the facility. DON stated, they investigated the incident and was able to retrieve back the mobile phone, but it was broken when it was returned to the facility. DON stated, this incident was not reported to the district office because it did not meet their criteria of reporting theft and misappropriation of property.During a follow-up interview and concurrent record review with DON on 2/17/2026 at 1:01 p.m., DON reviewed Resident 1's medical record and stated, there was no documentation of the incident that happened with Resident 1 and HL1 and no documentation if any assessment was completed with Resident 1 after the incident. DON stated, there should be documentation of the incident to validate and support what the staff did during the incident and ensure resident was safe after the incident.During an interview with Administrator (ADM) on 2/17/2026 at 1:16 p.m., ADM stated, an HL1 entered the facility without staff's knowledge and stole Resident 1's mobile phone on 1/9/2026. ADM stated, this incident was investigated internally and was reported to the Police due to the theft of Resident 1's mobile phone by an unknown person who gained access in the facility without staff's knowledge. ADM stated, there was an issue with their front entry door and it was not locking and closing completely. ADM stated, this incident was not reported to the state licensing/certification agency because it did not meet their criteria of reporting to the district office. When asked what the criteria are that the facility needs to report to the district office, ADM did not answer and looked on his mobile phone while being interviewed.During a review of facility's policy and procedures (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, review date 4/2025, the P&P indicated, All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility. Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury, or within 24 hours of allegation that does not involve abuse or result in serious bodily injury. Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone. Findings of all investigations are documented and reported. The individual conducting the investigation as a minimum:. documents the investigation completely and thoroughly. Follow-up Report: Within five business days of the incident, the administrator will provide a follow-up investigation report.During a review of facility's P&P titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, review date 4/2025, the P&P indicated, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives:- Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property- Investigate and report any allegations within timeframes required by federal requirements.

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 02/17/2026
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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 review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one of four sampled residents, (Resident 1) by failing to: Ensure Resident 1 was assessed and evaluated after an incident of theft and misappropriation of property by an unhoused individual (HL 1) who gained access to the facility without consent on 1/9/2026.Ensure a complete documentation of the incident was completed and documented according to facility's policy and procedure (P&P) titled, Charting and Documentation, and Abuse, Neglect, Exploitation and Misappropriation Prevention Program.These deficient practices placed Resident 1 in delayed intervention to provide treatment and care and to ensure safety of Resident 1 and possibly all other residents, staff and visitors in the facility.Findings:During a review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), malignant neoplasm of the endocrine pancreas (a rare type of cancer that starts as a growth of cells in the pancreas), muscle weakness (weakening, shrinking, and loss of muscle) and difficulty in walking.During a review of the Minimum Data Set (MDS - resident assessment tool) dated 1/10/2026, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 1 required moderate assistance to total dependence 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 that Resident 1 experienced mood symptoms such as little interest or pleasure in doing things, feeling down, depressed or hopeless and trouble falling or staying asleep, or sleeping too much during half or more of the days, with totaling severity score of 10 (indicates moderate to severe symptoms of depression).During an interview with Resident 1's Family Member (R1FM) on 2/17/2026 at 11:06 a.m., R1FM stated, in the morning of 1/9/2026, an unhoused individual entered the facility without facility's staff knowledge, stayed and slept in one of the beds where Resident 1 was staying. R1FM stated, Resident 1 pressed the call light multiple times upon discovering HL1 was sleeping in the same room as hers and acted strange, but no staff answered her call light for a while. R1FM stated they discovered in the morning that Resident 1's mobile phone was missing and reported it to the facility staff. R1FM further stated, Resident 1 felt terrified of the incident and felt unsafe while in the facility and R1FM and Resident 1 both requested the facility to transfer her to another facility.During an interview with Licensed Vocational Nurse 1 (LVN 1) on 2/17/2026 at 12:09 p.m., LVN 1 stated, she noticed HL1 was in Resident 1's same room early morning of 1/9/2026 but they didn't have a resident assigned in that bed. LVN 1 asked HL1 what he was doing in the facility, where HL1 stated, he checked in while holding and showing her a mobile phone. LVN 1 stated, HL1 looked like a homeless person and was carrying a plastic bag that looked like a grocery bag. LVN 1 escorted HL1 out from the facility upon realizing that he did not belong in the facility. LVN 1 stated, she did not document the incident and she did not report it to the management and staff. LVN 1 stated, she did not check upon Resident 1 and she did not assess Resident 1 if she was affected by the incident. LVN 1 stated, she does not know how long HL1 stayed in the room and what he did the entire time he was in the facility. LVN 1 further stated, they have issues with the front door of the facility where it doesn't completely close all the way and locked from the outside upon entering the door which is how HL1 gained access to the facility.During an interview with Director of Nursing (DON) on 2/17/2026 at 12:48 p.m., DON stated, she was made aware of the incident that happened on 1/9/2026 by the Administrator (ADM) that a person (continued on next page)

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 02/17/2026
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	(HL1), with no business to be in the facility, gained access to the facility without staff's knowledge and stayed in one of the bed where Resident 1 was admitted to. DON stated, they investigated the incident and they found out that the front door was broken and was not completely closing and locking upon opening. DON stated, it was also reported to them that Resident 1's mobile phone went missing after HL1 gained access to the facility.During a follow-up interview and concurrent record review with DON on 2/17/2026 at 1:01 p.m., DON reviewed Resident 1's medical record and stated, there was no documentation of the incident that happened with Resident 1 and HL1 and no documentation if any assessment was completed with Resident 1 after the incident. DON stated, there should be documentation of the incident to validate and support what the staff did during the incident and ensure resident was safe after the incident.During a review of facility's P&P titled, Charting and Documentation, review date 4/2025, the P&P indicated that, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facility communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Documentation of procedures and treatments will include care-specific details, including: the date and time the procedure/treatment was provided, the assessment date and/or any unusual findings obtained during the procedure/treatment.During a review of facility's P&P titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, review date 4/2025, the P&P indicated, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including,but not necessarily limited to:a. facility staff;b. other residents;c. consultants;d. volunteers;e. staff from other agencies;f. family members;g. legal representatives;h. friends;i. visitors; and/orj. any other individual.Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Investigate and report any allegations within timeframes required by federal requirements. Protect residents from any further harm during investigations.

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 02/17/2026
NAME OF PROVIDER OR SUPPLIER Kennedy Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 619 N. Fairfax Ave Los Angeles, CA 90036	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to maintain a safe, and functional environment for residents, staff and visitors by failing to ensure one of two entry doors in the facility was free from mechanical and/or electrical failure and in a safe operating condition.This deficient practice resulted to the theft of Resident 1's mobile phone by an unhoused individual (HL 1) who entered the facility without staff awareness on 1/9/2026, placing all residents, staff, and visitors at risk of avoidable abuse and misappropriation of property.Findings:During a review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), malignant neoplasm of the endocrine pancreas (a rare type of cancer that starts as a growth of cells in the pancreas), muscle weakness (weakening, shrinking, and loss of muscle) and difficulty in walking. During a review of the Minimum Data Set (MDS - resident assessment tool) dated 1/10/2026, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 1 required moderate assistance to total dependence 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 Vortex Industries, LLC (door service company), receipt dated 1/9/2026, the receipt indicated, Main entry door: performed inspection and found that the closer no longer had latching force and was not closing the door properly. Opened the valve up all the way and it was dead, the closing force was also not responding properly and wanted to slam with the valves barely opened.During an interview with Maintenance Director (MTD) on 2/17/2026 at 10:51 a.m., MTD stated that the front door of the facility was recently fixed by an outside vendor due to some error in the parts of the door, the magnet that holds the door to make sure that the door would close automatically was not working properly. MTD stated that the doors are checked frequently by maintenance staff to ensure that they are working properly. MTD stated that he does not have a maintenance log where he keeps documentation of door entrances maintenance check. During an interview with Resident 1's Family Member (R1FM) on 2/17/2026 at 11:06 a.m., R1FM stated, in the morning of 1/9/2026, an unhoused individual entered the facility without facility's staff knowledge, stayed and slept in one of the beds where Resident 1 was staying. R1FM stated, Resident 1 pressed the call light multiple times upon discovering HL1 was sleeping in the same room as hers and acted strange, but no staff answered her call light for a while. R1FM further stated, Resident 1 felt terrified of the incident and felt unsafe while in the facility. R1FM stated, they discovered in the morning that Resident 1's mobile phone was missing and reported it to the facility staff.During an interview with Licensed Vocational Nurse 1 (LVN 1) on 2/17/2026 at 12:09 p.m., LVN 1 stated, she noticed HL1 was in Resident 1's same room early morning of 1/9/2026 but they didn't have a resident assigned in that bed. LVN 1 asked HL1 what he was doing in the facility, where HL1 stated, he checked in while holding and showing her a mobile phone. LVN 1 stated, HL1 looked like a homeless person and was carrying a plastic bag that looked like a grocery bag. LVN 1 escorted HL1 out from the facility upon realizing that he did not belong in the facility. LVN 1 stated, she did not document the incident and she did not report it to the management and staff. LVN 1 further stated, they have issues with the front door of the facility where it doesn't completely close all the way and locked from the outside upon entering the door.During an interview with Administrator (ADM) on 2/17/2026 at 1:16 p.m., ADM stated, an HL1 entered the facility without staff's knowledge and stole Resident 1's mobile phone on 1/9/2026. ADM stated, an outside vendor was (continued on next page)

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 02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kennedy Care Center	619 N. Fairfax Ave Los Angeles, CA 90036

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	consulted to check their front entrance door. ADM stated, the outside vendor had to replace parts of the door because it was not working properly.During a review of facility's P&P titled, Maintenance Service, review date 4/2025, the P&P indicated that, Maintenance Service shall be provided to all areas of the building, grounds, and equipment. Functions of maintenance personnel include, but are not limited to: maintaining the building in good repair and free from hazards. The maintenance director is responsible for maintaining records/reports: inspection of building; work order request; maintenance schedules.