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	07/22/2024

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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455 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 his/her individuality for five of 18 sampled residents (Residents 27, 37, 50 61, and 81) by failing to: A. Ensure staff did not stand over Resident 61 while feeding and assisting the resident during a meal. Facility failed to ensure staff are not standing over resident while feeding for Resident 61 B. Assist Resident 27 with setting-up dinner tray on the resident's bedside table. C. Assist Resident 81 clean-up food crumbs on the resident's clothes and bed linen after the resident had finished eating dinner. D. Ensure staff did not speak in a language not understood by Residents 50 and 37 in accordance with the facility's employee handbook updated 6/2021. These deficient practice had the potential to result in feelings of decreased self-esteem and self-worth for Residents 27, 61 81, and Resident 50 and 37's primary language not being respected and had the potential to affect the resident's communication and understanding with the staff Findings: A. A review of Resident 27's Admission Record (Face Sheet) indicated Resident 27 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (a condition in which brain function is disturbed due to different diseases or toxins in the body), severe dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life.), schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), and hypertension (abnormally high blood pressure). A review of Resident 27's Minimum Data Set (MDS-a standardized assessment and care screening tool), dated 6/12/2024 indicated Resident 27's cognition (the mental ability to understand and make decisions of daily living) was moderately impaired, required set-up or clean up assistance with eating, the MDS indicated Resident 27 required substantial/maximal assistance for to move from a lying to sitting position on the bed and was non-ambulatory. (continued on next page)

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 - Some	A review of Resident 81's Admission Record indicated Resident 81 was originally admitted to the facility on [DATE] with diagnoses that included encephalopathy (a group of conditions that cause brain dysfunction), type 2 diabetes mellitus (A lifelong, chronic, metabolic disease characterized by elevated levels of blood glucose (or blood sugar)), cognitive communication deficit (difficulty paying attention to a conversation, staying on topic, remembering information, responding accurately, understanding, or following directions.), schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and hypertension (high blood pressure) A review of Resident 81's MDS, dated [DATE] indicated Resident 81's cognition was severely impaired and required supervision and touching assistance with eating. The MDS indicated Resident 81 required substantial/maximal assistance with upper and lower body dressing and the resident was non-ambulatory (did not walk). During an initial tour observation and concurrent interview on 07/19/24 at 7:10 PM, Resident 81 was observed awake in bed with left-over food crumbs on the resident's t-shirt and bed linens. Resident 81 stated he finished eating dinner at 6 pm and had that a staff member (unidentified) picked his dinner tray picked up by staff. During an interview with certified nurse assistant 5 (CNA 5) on 7/19/2024 at 7:43 PM, CNA 5 stated leaving food on t-shirt and linen is a dignity issue. CNA 5 stated Resident is supposed to be cleaned up and not left with food crumbs on his linens and t-shirt. During a tour observation and concurrent interview with Resident 27 on 7/20/24 at 12:55 PM, Resident 27 was observed lying flat in bed, raising, and lowering his head while attempting to eat the lunch meal that was placed directly in-front of him on a bedside table that was slightly elevated above the resident's head. Resident 27 was holding a cup of water in the right hand. Resident 27's right hand was observed with tremors (shaking) as the resident was trying to place the cup of water on the bedside table. During an interview with Licensed Vocational Nurse 6 (LVN 6) on 7/20/2024 at 1:05 PM, LVN 6 stated, Resident 27 was at risk of aspirating (choking) his food to the lungs while eating and lying flat in bed. LVN 6 further stated aspirating food to the lungs good lead to pneumonia which would result in unnecessary hospitalization , poor outcomes and even death. During an interview with the Director of Nursing (DON) ON 7/21/2024 at 8:30 PM, the DON stated all residents should be provided with care and cleaned before and after meals. The DON stated leaving resident with food on their clothes and linens is a dignity issue. Staff must ensure there is no spillage of food on Residents clothes and/or linen because this could lead resident to looking dirty and unclean and/or unkempt. The DON further stated, all Residents head of bed must be raised when eating to prevent aspiration of food which could result in unnecessary hospitalization and poor outcomes for the Resident. A review of the facility's policy and procedures (P&P) titled Assistance with meals dated 4/17/2024, indicated, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident . Facility staff will serve resident trays and will help residents who require assistance with eating. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled Dignity, dated 4/17/2024, indicated, each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being . when assisting with care, residents are supported in exercising their rights. For example, residents are provided with a dignified dining experience. 43454 B. A review of Resident 61's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including unspecified sequelae of cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue), type two diabetes mellitus (DM-high blood sugar) and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy). A review of Resident 61's MDS, dated [DATE], indicated Resident 61's cognitive skills for daily decision-making were severely impaired and required supervision to maximal assistance from staff for activities of daily living (ADLs- eating, oral hygiene, toileting hygiene, personal hygiene, repositioning from wit to lying, sit to stand and chair/bed-to-chair transfer). During a meal observation on 7/20/2024 at 1 p.m. in Resident 61's room, Resident 61 was observed sitting on a wheelchair while Certified Nursing Assistant 3 (CNA 3) was standing over Resident 61's while feeding the resident lunch. Resident 61 was observed refusing to eat while CNA 3 insisted on trying to feed Resident 61. During an interview with CNA 3 on 7/20/2024 at 1:03 p.m., CNA 3 stated, when feeding resident, staff should be sitting down and feeding resident on an eye to eye level so that resident's don't feel inferior while being fed. CNA 3 stated, she could not find a chair and was trying to squat while feeding Resident 61 and stated, it is okay to squat while feeding residents. During an interview with Registered Nurse Supervisor 1 (RNS 1) on 7/20/2024 at 1:09 p.m., RNS 1 stated, staff should be sitting down while feeding and assisting residents while feeding and squatting is not acceptable. Staff should find an available chair while feeding residents. A review of the facility's policy and procedures (P&P) titled Assistance with Meals, reviewed 4/17/2024 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. 44252 C. During a review of Resident 50's Admission Record, dated 7/21/24, indicated Resident 50 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus type two (a condition were your body has trouble controlling the level of sugar in the blood), end stage renal disease (ESRD, the stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life) with dependance on dialysis (treatment that helps your body remove extra fluid and waste products from your blood), generalized muscle weakness, ad reduced mobility. The same admission record further indicated the resident's primary language as English. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 50's MDS, dated [DATE], the MDS indicated, Resident 50 had intact cognition. The same MDS indicated Resident 50 required partial/moderate assistance from staff for eating and oral hygiene, and was dependent on staff for toileting, bathing, dressing and personal hygiene, bed mobility and transfers. During a review of Resident 37's Admission Record, dated 7/21/24, indicated Resident 37 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus type two, ulcerative colitis (an inflammatory bowel disease causing irritation and ulcers in the lining of your large intestine), generalized muscle weakness, abnormal gait and mobility, and hypertensive (high blood pressure) heart failure (a condition in which the heart has trouble pumping blood thought the body). The same admission record further indicated the resident's primary language as English. During a review of Resident 37's History and Physical (H&P), dated 7/18/24, indicated, the resident had the capacity to understand and make decisions. During a review of Resident 37's MDS dated [DATE], indicated the resident required set up or clean-up assistance with eating, and was dependent on staff for toileting, bathing, dressing and personal hygiene, bed mobility and transfers. During an interview on 7/19/24 at 8:04 pm with Resident 50, the resident stated when staff come in her room, sometimes they were speaking in a language the resident did not understand. During an interview on 7/19/24 at 8:30 pm with Resident 37, the resident stated, it is difficult to communicate with some of the staff because they frequently speak a language he does not understand, and occasionally they do not understand what he is saying. During an interview on 7/21/24 at 8:44 pm with Director of Nursing (DON), the DON stated the expectation is that the staff speak English in the patient care area, unless the resident speaks a different language then that would be their preference. A review of the facility's employee handbook (updated June 2021), indicated, English-only rules, an English-only rule will be allowed only for the following . communications with residents, resident's families, coworkers or supervisors who only speak English . for cooperative work assignment to promote efficiency.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview, and record review, the facility failed to ensure the residents and/or responsible party (RP) was informed and consented in advance, of the risks and benefits of pneumonia (PNA-infection that inflames air sacs in one or both lungs and can be life-threatening to anyone but particularly to infants, children, and people over [AGE] years old) vaccines and immunization (a simple, safe, and effective way of protecting people against harmful diseases, before they come into contact) for one of five sampled residents (Resident 52). This deficient practice violated the resident's right to make an informed decision regarding the use of vaccinations and immunizations. Findings: A review of Resident 52's Admission Record, indicated Resident 26 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), dementia (loss of cognitive functioning-thinking remembering, and reasoning) in other diseases, and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). A review of Resident 52's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 4/8/2024, indicated Resident 52 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required maximal assistance to total dependent from staff with ADLs- eating, oral hygiene, toileting hygiene, shower/bathe, and personal hygiene. During a review of Resident 52's Immunization Report and a concurrent interview with the Infection Preventionist Nurse (IPN) on 7/21/2024 at 3:33 p.m , the record indicated Resident 52 received the pneumococcal vaccine in the facility on 10/26/202 and 2/1/2023. IPN reviewed Resident 52's medical record with the surveyor and was unable to find any informed consent that Resident 52 and/or responsible party signed prior to administering the vaccine. IPN stated, an informed consent should be in placed prior to administering the vaccine and an education should be provided regarding adverse reaction and it is residents' rights. During an interview with the Director of Nursing (DON) on 7/21/2024 at 9:05 p.m., the DON stated, residents should be offered immunizations if they are eligible and an informed consents are needed prior to administering any vaccines in the facility. A review the facility's policy and procedures (P&P) titled Pneumococcal Vaccine, revised 10/2023 indicated, Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine . Provision of such education is documented in the resident's medical record.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455 Based on observation, interview, and record review, the facility's interdisciplinary team (IDT-a coordinated group of experts from several different fields who work together) failed to ensure that a resident would not be allowed to keep medications at the bedside without a physician's order and/or without being assessed to determine if the resident is capable to self-administer medications for one of 18 sample residents (Resident 292). This deficient practice had a potential for resident 292 to self-medicate himself and delayed necessary health intervention. Findings: A review of Resident 292's Admission Record indicated Resident 292 was originally admitted to the facility on [DATE] with diagnoses that included Paraplegia (the inability to voluntarily move the lower parts of the body), Dorsalgia (low back pain, mid back pain or sciatic nerve related pain, that originate in muscles, nerves or joints), muscle weakness, immunodeficiency (The decreased ability of the body to fight infections and other diseases), Malignant neoplasm of prostate (a cancerous tumor in the gland of the male reproductive system), and type 2 diabetes (elevated levels of blood glucose (or blood sugar). A review of Resident 292's Minimum Data Set (MDS-a standardized assessment and care screening tool), dated 7/16/2024 indicated Resident 292's cognition ((the mental ability to understand and make decisions of daily living) was moderately impaired, was independent with eating, required partial/moderate assistance with upper body dressing and lower body dressing. The MDS indicated Resident 292 was non-ambulatory. During an initial tour observation and concurrent interview with Resident 292 on 7/20/24 at 8:27 AM, Resident 292's personal belonging was observed to have observed to have a bottle of Norco (controlled medication issued to relieve moderate to severe pain) 10-325 (unit dose), milligrams (mg-Unit of measure) x 29 pills, at the resident's bedside table. Resident 292 stated he was admitted to the facility on [DATE] and, came with the Norco from the hospital. During an interview with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated Resident 292 was not supposed to have the Norco at bedside unless Resident 292 had a self-administration order and had demonstrated the ability to safely self-administer the medication (Norco). LVN 5 further stated Resident 292 was at risk for overdose if he took the Norco without notifying the nurse. LVN 5 stated that a wandering Resident could gain access to the Norco, placing that resident at risk for overdose or an allergic reaction. During an interview with the Director of nursing (DON) on 7/21/2024 at 8:30 PM, the DON stated having the medication at bedside placed Resident 292 was at risk for overdose through self-administration of medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures (P&P) titled Self-Administration of medication, dated 10/2024 indicated, the interdisciplinary (IDT- a coordinated group of experts from several different fields who work together) assess each Resident's cognitive and physical abilities to determine whether self-administering medications is safe and appropriate for the Resident.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure residents' call light (a device used to notify the nurse that the resident needs assistance) were within reach for three out of 18 sampled residents (Resident 66, 192, and 51). This deficient practice had the potential to result in the residents not being able to summon staff for assistance for care and services as needed, which could lead to accidents such as falls with injuries for Residents 66, 91, and 51. Findings: 1. A review of Resident 66's Admission Record indicated resident was originally admitted to the facility on [DATE] and was readmitted on [DATE], with diagnosis including chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure), Alzheimer's disease (a progressing brain disorder that destroys memory and other important mental function), and dysphagia (difficulty swallowing food or liquid). A review of Resident 66's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 7/3/2024, indicated Resident 66 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required total dependence from staff for activities of daily living (ADL-eating, oral hygiene, toileting hygiene, personal hygiene). During a concurrent observation with Resident 66 on 7/19/2024 at 7:47 p.m., Resident 66 was observed lying in bed, eyes closed, unable to find Resident 66's call light in bed. During a concurrent observation and interview with Licensed Vocational Nurse 2 (LVN 2) on 7/19/2024 at 7:49 p.m., LVN 2 observed Resident 66's call light and found that the call light was not connected to Resident 66's bed. LVN 2 stated and confirmed that Resident 66's call light was not within the resident's reach, and this prevents her (Resident 66) from communicating her needs. LVN 2 further stated the call light should still be within the resident's reach. 2. A review of Resident 192's Admission Record indicated Resident 192 was admitted to the facility on [DATE], with diagnoses including dysphagia, malignant neoplasm of rectum (rectal cancer - a type of cancer that forms in the tissues of the rectum), and chronic kidney disease. A review of Resident 192's MDS dated [DATE], indicated Resident 192 had severely impaired cognition for daily decision-making and required maximal assistance from staff for ADL- oral hygiene and toileting hygiene, repositioning from sit to lying and lying to sitting on side of bed. A review of Resident 192's care plan (CP) for high risk for falls, initiated on 4/18/2024 indicated an intervention that included, Be sure her [Resident 192] call light is within reach and encourage the resident to use it for assistance as needed (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation with Resident 192 on 7/19/2024 at 7:44 p.m., Resident 192 was observed lying in bed, eyes closed, call light was on the floor away from Resident 192's reach. During a concurrent observation and interview with LVN 2 on 7/19/2024 at 7:47 p.m., LVN 2 observed Resident 192's call light on the floor, picked it up and put in Resident 192's reach. LVN 2 stated and confirmed, Resident 192's call light was not within her reach, which prevents her (Resident 192) from communicating her needs. During an interview with the Director of Nursing (DON) on 7/21/2024 AT 8:57 p.m., the DON stated call light should always be within residents' reach. A review of the facility's policy and procedures (P&P), titled, Answering the Call Light, reviewed on 4/17/2024, indicated, When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. Some residents may not be able to use their call light. Be sure you check these residents frequently. 45455 3. A review of the Resident 51's Admission Record indicated the facility admitted Resident 51 on 05/17/2019 with diagnoses cerebral infarction (stroke- damage to tissues in the brain), malignant neoplasm of the prostate (a cancerous tumor in the gland of the male reproductive system.), overactive bladder (has an urgent need to urinate multiple times per day and/or night), dysphagia (difficulty with swallowing) abnormality with gait and mobility (alterations in the way of walking) and hypertension (high blood pressure). A review of Resident 51's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 05/11/2024, indicated Resident 51 had severe cognitive impairment (The mental ability to make decisions of daily living), required partial/moderate assistance with eating and upper body dressing. The MDS indicated Resident 51 required substantial/maximal assistance with lower body dressing, toileting, and was non-ambulatory. During an initial tour observation on 7/19/24 at 7:07 PM, Resident 51 was observed lying on his bed, alert, and calm. Resident 51 did not have a call light (a way for patients to communication tool for Residents to alert their care providers when they need assistance) within reach. During an interview with Licensed Vocational Nurse 2 (LVN 2) on 07/19/24 at 7:16 PM, LVN 2 stated, a call light is a means of communication between Residents and staff. Not having a call light within reach is very risky, denies [Resident 51] the ability to communicate his needs because he has no way of getting anyone's attention. During an interview with the Director of Nursing (DON) on 7/21/2024 at 8:30 PM, the DON stated call light response is every staff's responsibility. The DON stated call lights must be accessible to all resident to communicate their needs to the staff. The DON stated failure to have an accessible call light could cause delay in care for assistance, could lead to poor outcomes and even unnecessary hospitalization . A review of the facility's policy and procedures (P&P) titled Answering the Call light dated 4/17/2024, indicated, when a resident is in bed , ensure call light is within easy reach of the resident.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record review, the facility failed to ensure residents were informed, offered or followed up regarding Advance Directive (ACHD - written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) in a timely manner for four of 18 sampled residents (Resident 61). This deficient practice had the potential to cause conflict with Resident 61's wishes regarding health care. Findings: A review of Resident 61's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including unspecified sequelae of cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue), type two diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy). A review of the Minimum Data Set (MDS-standardized screening and assessment tool for all residents of long-term care facilities), dated 5/2/2024, indicated Resident 61's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making were severely impaired and required supervision to maximal assistance from staff for activities of daily living (ADLs- eating, oral hygiene, toileting hygiene, personal hygiene, repositioning from wit to lying, sit to stand and chair/bed-to-chair transfer). A review of Resident 61's Physician Orders for Life Sustaining Treatment form (POLST-a medical order from a physician that aids people with serious illnesses more control over their own care by stating the type of treatment they want to receive) indicated, Resident does not have an ACHD. During a concurrent interview and record review with Social Services Director 2 (SSD 2) on 7/20/2024 at 3:32 p.m., Resident 61's medical records were reviewed. SSD 2 stated, Resident 61 does not have an ACHD and there was no indication if facility followed up with Resident 61 and/or if the responsible party was given information if they would like to create one. A review of Resident 61's Progress Notes, written by SSD 2, dated 7/21/2024 indicated, SSD 2 reached out to resident responsible party . explained and requested a copy of any legal documentation like Advance Directive . advance directive acknowledgment form for signature and clearance of advance directive. A review of the facility's policy and procedures (P&P) titled, Advance Directive, revised on 5/2024 indicated, A POLST paradigm form is not an advance directive . Prior to or upon admission of a resident, the social services director or designee inquiries of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview and record review, the facility failed to provide a safe, comfortable, and homelike environment for three out of 18 sampled residents (Resident 44, 74 and 59) by failing to: 1. Ensure residents' rooms were kept with comfortable sound levels maintained for two of three sampled residents (Resident 59 and 74). 2. Ensure the window blind, bedside drawer and electric wall plug were maintained and in functional working condition for one of three sampled resident (Resident 44). These deficient practices had the potential to negatively impact the resident's quality of life and placed Residents 59, 74, and 44 an increased level of discomfort and inability to sleep during the night. Findings: 1. During a review of Resident 59's Admission Record, dated 7/21/24, indicated Resident 59 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus type two, peripheral vascular disease (PVD, a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), generalized muscle weakness, difficulty walking, hear failure and lymphedema (Swelling, most often in an arm or leg, caused by a lymphatic system [a group of organs, vessels and tissues that protect you from infection and keep a healthy balance of fluids throughout your body] blockage). During a review of Resident 59's History and Physical (H&P), dated 6/13/24, indicated, the resident had the capacity to understand and make decisions. During a review of Resident 59's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool) dated 4/11/24, indicated the resident required set up or clean-up assistance with eating, and required maximal assistance from staff for toileting, bathing, dressing and personal hygiene, bed mobility and transfers. During an interview with Resident 59 on 7/19/24 at 8:30 pm, the resident stated, the facility is noisy and the staff make it even noisier, people slam the doors and the building shakes, making it hard to rest. During an interview with the Director of Nursing (DON) on 7/21/24 at 8:44 pm, the DON stated the noise level should be controlled and comfortable for the residents. A review of the facility's policy and procedures (P&P) Homelike Environment revised 2/2021, indicated, residents are provided with a safe, clean, comfortable and homelike environment . The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include . comfortable sound levels. (continued on next page)

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	055977	A. Building B. Wing	07/22/2024

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P, titled, Homelike Environment, reviewed on 4/17/2024, indicated, Residents are provided with a safe, clean and homelike environment, including a comfortable sound levels. 43261 2. A review of Resident 74's Admission Record indicated Resident 74 was originally admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses including cerebrovascular disease (condition that affect blood flow in the brain), diabetes mellitus (DM-a long term condition that affects the way the body processes blood sugar [glucose]) and generalized muscle weakness. A review of Resident 74's MDS dated [DATE], indicated Resident 74 had moderately intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and requiring supervision from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During an interview with Resident 74 on 7/19/2024 at 7:18 p.m., Resident 74 stated that the facility becomes noisy during after hours at night and because of the noise, Resident 74 was not able to sleep or rest. During an interview with the Director of Nursing (DON) on 7/21/2024 at 8:45 p.m., the DON stated that noise level should be reduce at all times especially during the evening time. 43454 3. A review of Resident 44's Admission Record indicated Resident 44 was admitted to the facility on [DATE] with diagnoses including Parkinsonism (an umbrella term that refers to brain conditions that cause slowed movements, rigidity [stiffness] and tremors), metabolic 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), and respiratory disorders, (or lung diseases, are pathological conditions affecting the organs and tissues that make gas exchange difficult). A review of Resident 44's MDS dated [DATE], MDS indicated Resident 44 had a moderately intact cognition for daily decision-making. During a concurrent interview with Resident 44's Caregiver 1 (CG 1) on 7/20/2024 at 2:43 p.m., CG 1 stated, the window chain is broken which caused the window to not fully closed and it gets extremely hot in the morning. The bedside drawer is also broken, and they must place it in a certain position or else. The drawers would open on its own and its unable to also fully closed. The electric wall plug does not work as well, and they (caregivers) are scared to use it because they may be some issues with the wiring. CG 1 further stated, the facility staff, are aware of these issues but have not seen them trying to fix these issues. During a concurrent interview and observation with the Maintenance Supervisor (MS) on 7/21/2024 at 9:41 a.m., the MS observed Resident 44's room and stated he was aware that the window chain, bedside drawer, and electric wall plug in Resident 44's room are broken and are not properly working. The MS stated, MS knew about the issues (aforementioned) in the past two weeks ago. The MS further stated, he needed to check the wiring of the electric wall plug and fix it immediately. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 7/21/2024 at 8:57 p.m., the DON stated, the facility supplies, and equipment should be in proper working condition, and they should be reasonably accommodating residents, if there are broken equipment, this may affect their preferences and comfortability. A review of the facility's P&P titled, Maintenance Service, reviewed 4/17/2024 indicated, Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel include, but are not limited to: maintaining the building in good repair and free from hazards.

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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 (CP) that met the care/services based on the resident's individual assessed needs for one of six sampled residents (Resident 16) by failing to ensure that a comprehensive CP was developed and implemented for Resident 16's low-air-loss (LAL - a mattress designed to prevent and treat pressure wounds) mattress. This deficient practice had the potential to result in a negative impact on residents' health and safety and the quality of care and services received increasing the risk for Resident 16 to develop pressure ulcers/injuries (injury to skin and underlying tissue resulting from prolonged pressure on the skin). Cross Reference F686 Findings: A review of Resident 16's Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including 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), type two diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), and chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe). A review of Resident 16's Miimum Data Set (MDS- a standardized assessment and care screening tool) dated 6/28/2024, indicated Resident 16 had severely impaired cognition and requiring maximal assistance to total dependence from staff for ADL-repositioning from sit to lying, sit to stand, rolling left and right. The MDS also indicated Resident 16 was at risk of developing pressure ulcers/injuries and was on a pressure reducing device for bed. A review of Resident 16's CP for high risk for developing pressure ulcer related to needs assistance with ADLs, initiated on 11/27/2023 indicated, Low air loss mattress for skin management. Set according to resident weight. A review of Resident 16's Order Summary Report (OSR), dated 9/8/2022 indicated a physician ordered, Low-air- for skin management. Monitor for proper functioning and settings per resident's weight. A review of Resident 16's Weight Summary Report, dated 7/16/2024 indicated, Resident 1's weighed 98 pounds (lbs. - unit of measurement). During an observation of Resident 16 on 7/19/2024 at 6:49 p.m., Resident 16 was in bed, lying on a LAL mattress with the LAL mattress knob set at 130. Resident 16 stated, the LAL mattress, feels just ok and feels firm. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with Licensed Vocational Nurse 2 (LVN 2) on 7/20/2024 at 6:50 p.m., Resident 16's LAL mattress was observed with a setting of 130. LVN 2 stated, the knob setting indicated the weight in lbs. and that the current LAL mattress setting for Resident 16's LAL mattress was incorrect. LVN 2 stated, the setting should be close to 98 lbs. which was Resident 16's current weight. A review of facility's policy and procedures (P&P), titled, Care Plans, Comprehensive Person-Centered reviewed on 4/17/2024 indicated, A comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455 Based on observation, interview, and record review, the facility failed to provide preventive care consistent with professional standards of practice to three of three sampled residents (Residents 1, 16, and 292), who was at risk for developing of pressure injuries (Damage to an area of the skin caused by constant pressure on the area for a long time), by failing to: 1. Ensure Resident 292 had bilateral heel protectors (devices that include foam or gel that are used to help prevent heel pressure ulcers) placed while in bed per physician's order (MD order). 2. Ensure the appropriate settings for the low air loss mattress (LALM-a mattress designed to prevent and treat pressure wounds) for Residents 1 and 16 according to MD's order and/or the facility's policy. These deficient practices placed Residents 1, 16, and 292 at risk of poor wound healing of the current pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) and development of new pressure injury/ies. Cross Reference F656 Findings: A review of Resident 292's Admission Record indicated Resident 292 was originally admitted to the facility on [DATE] with diagnoses that included Paraplegia (the inability to voluntarily move the lower parts of the body), Dorsalgia (low back pain, mid back pain or sciatic nerve related pain, that originate in muscles, nerves or joints), muscle weakness, immunodeficiency (The decreased ability of the body to fight infections and other diseases), Malignant neoplasm of prostate (a cancerous tumor in the gland of the male reproductive system), and type 2 diabetes (elevated levels of blood glucose (blood sugar)). A review of Resident 292's Minimum Data Set (MDS-a standardized assessment and care screening tool), dated 7/16/2024 indicated Resident 292's cognition ((the mental ability to understand and make decisions of daily living) was moderately impaired, was independent with eating, required partial/moderate assistance with upper body dressing and lower body dressing. The MDS indicated Resident 292 was non-ambulatory. Findings: During an initial tour observation and concurrent interview with Resident 292 on 7/20/24 at 8:27 AM, Resident 292 stated he had pressure sores (ulcer/injury) on bilateral (both) heels, he has been wearing waffle boots (heel protectors) but did not know where they were placed after they were moved yesterday evening (7/19/2024). Resident 292's bilateral heels were observed open to air and resting directly on his nursing home bed mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Treatment Nurse 1 (TXT1) on 7/20/2024 at 8:38 AM, TXT1 stated Resident 292, has wounds to bilateral heels. He is supposed to have waffle boots placed on his bilateral heels to promote wound healing and prevent worsening of the wounds. A review of Resident 292's medical record titled Progress Notes dated 7/10/2024, indicated, Resident 292 had a diabetic ulcer to the left heel measuring 5.0 cm Length (L) x 8.0 cm Width (W) x UTD cm Depth (D)., and right heel measuring 3.0 cm L x 3.0 cm W x (unstageable full thickness skin/tissue loss- Depth unknown (UTD) cm D. A review of Resident 292's medical record titled Order Summary Report, dated 7/21/2024, indicated an order to offload bilateral heel with heel protector at all times. A review of Resident 292's medical record titled care plan revised 7/17/2024, indicated Administer treatment as ordered. During an interview with the Director of nursing (DON) on 7/21/2024 at 8:30 PM, the DON stated offloading heels is important to promote healing, not following doctor's orders could delay healing of wounds. A review of the facility's policy and procedures titled Prevention of Pressure Ulcers dated, 04/2020 indicated, . provide support devices and assistance as needed. 43261 2a. A review of Resident 1's Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including 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), obesity (a disorder involving excessive body fat that increases the risk of health problems), and diabetes mellitus (DM-a long term condition that affects the way the body processes blood sugar [glucose]). A review of Resident 1's MDS dated [DATE], indicated Resident 1 had a severely impaired cognition (ability to think and make decisions) and requiring maximal assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene).MDS also indicated Resident 9 was admitted with a stage four (4) pressure ulcer. A review of Resident 1's Order Summary Report (OSR), dated 9/10/2023, the OSR indicated that Resident 1 has an order for pressure reducing mattress. A review of Resident 1's Weight Summary Report (WSR), dated 7/9/2024, the WSR indicated Resident 1 weighed 178 pounds (lbs - unit of measurement). During a concurrent observation and interview with Licensed Vocational Nurse 7 (LVN 7) on 7/19/2024 at 7:48 p.m., Resident 1's LAL mattress was observed at a setting between 80 lbs. to 160 lbs. with a weight sticker posted in the LAL mattress machine, indicating 119 lbs. LVN 7 stated the LAL mattress should be set via weight or the comfort of the resident. LVN 7 also stated that Resident 1's LAL mattress setting should be between 160 lbs. to 240 lbs. since Resident 1 weighed 178 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 7/21/2024 at 1:27 p.m., the DON stated that the LAL common nursing practice for the LAL mattress setting should be based on resident's weight. The DON stated that since Resident 1 weighed 178 lbs., Resident 1's LAL mattress setting should be between 160 lbs. to 240 lbs. The DON also verified that Resident 1 was unable to state any discomfort. A review of facility's policy and procedures (P&P), titled, Beds, Special-Low Air Loss Therapy, reviewed on 4/2024, P&P indicated, the facility to utilize low air loss therapy under the direction of a physician's order and a company representative supplying the bed on an individual resident basis will adjust pressure settings of bed. 43454 2b. A review of Resident 16's Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses including encephalopathy, DM, and chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe). A review of Resident 16's MDS dated [DATE], indicated Resident 16 had severely impaired cognition and requiring maximal assistance to total dependence from staff for ADL-repositioning from sit to lying, sit to stand, rolling left and right. MDS also indicated Resident 16 is at risk of developing pressure ulcers/injuries (injury to skin and underlying tissue resulting from prolonged pressure on the skin) and Resident 16 is on pressure reducing device for bed. A review of Resident 16's care plan for high risk for developing pressure ulcer related to needs assistance with ADLs, initiated on 11/27/2023 indicated, Low air loss mattress for skin management. Set according to resident weight. A review of Resident 16's OSR, dated 9/8/2022 indicated physician ordered, Low-air-loss (LAL - a mattress designed to prevent and treat pressure wounds) for skin management. Monitor for proper functioning and settings per resident's weight. A review of facility's policy and procedure (P&P), titled, Beds, Special-Low Air Loss Therapy, reviewed on 4/2024, P&P indicated, the facility to utilize low air loss therapy under the direction of a physician's order and a company representative supplying the bed on an individual resident basis will adjust pressure settings of bed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure two of five sampled residents (Resident 61 and Resident 63), who were at high risk for fall and injuries and who required extensive assistance during repositioning according to the residents care plan. This failure had the potential to place Residents 61 and 63 at risk for falls or injury possible fracture (break in bone) while being transferred from wheelchair to the bed solely by Certified Nursing Assistant 3 (CNA 3). Findings: A. A review of Resident 61's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including unspecified sequelae of cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue), type two diabetes mellitus (DM-a long term condition that affects the way the body processes blood sugar [glucose]), and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy). A review of the Minimum Data Set (MDS-standardized screening and assessment tool), dated 5/2/2024, indicated Resident 61's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making were severely impaired and required moderate to maximal assistance from staff for activities of daily living (ADLs- repositioning from sit to lying, sit to stand and chair/bed-to-chair transfer). A review of Resident 61's Care Plan (CP) for high risk for falls and injuries related to history of falling, initiated on 11/1/2022, indicated, with interventions/task including: the resident needs a safe environment. A review of Resident 61's Physical Therapist (PT - a health specialist who evaluates and treats human body disorders) Treatment Notes, dated 7/10/2024 indicated, Resident 61 required maximal assists with two persons assist during transfers. During an observation on 7/20/2024 at 1:08 p.m. at Resident 61's room, Resident 61 was observed being transferred from a wheelchair to the bed by CNA 3, no other staff assisting CNA 3 was observed while Resident 61 was transferred to the bed. CNA 3 transferred Resident 61 by having Resident 61 draped both legs around CNA 3's waist and both arms wrapped around CNA 3's neck. B. A review of Resident 63's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including muscle weakness, acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), and contracture (a shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the MDS dated [DATE], indicated Resident 63's skills for daily decision-making were severely impaired and required total dependence from staff for ADLs- repositioning from sit to stand and chair/bed-to-chair transfer). A review of Resident 63's CP for falls: unwitnessed fall and is at risk for change in neurological status, injury, pain, recurring falls, initiated on 12/16/2023 indicated a goal that resident will not have any major injuries related to the occurrence of a fall. During an observation on 7/20/2024 at 1:12 p.m. at Resident 63's room, Resident 63 was observed being transferred from a wheelchair to the bed by CNA 3, no other staff assisting CNA 3 was observed while Resident 63 was transferred to the bed. CNA 3 transferred Resident 63 by having Resident 63 draped both legs around CNA 3's waist and both arms around CAN 3's neck. During an interview with CNA 3 on 7/20/2024 at 1:16 p.m., CNA 3 stated, she transferred both Resident 61 and Resident 63 on her own, and she did not need any assistance from other staff as it is okay to transfer both residents with one person assist. CNA 3 further stated and demonstrated that she had Resident 61 and Resident 63's arms wrap around her neck and both legs draped around her waist. During an interview with Registered Nurse Supervisor 1 (RNS 1) on 7/20/2024 at 1:17 p.m., RNS 1 stated, staff should use proper body alignment when transferring residents and should transfer residents who are at high risk for falls with two persons assist to prevent falls and injuries. RNS 1 stated, staff should not ask residents to drape both legs around staff's waist and both arm around their neck as this is not the proper body alignment when transferring residents. During an interview with the Director of Nursing (DON) on 7/21/2024 at 9:08 p.m., The DON stated, when transferring a resident from wheelchair to bed, staff have to slowly transfer residents using proper body alignment and use a two-person assists and/or mechanical lift if needed to prevent injury and accidents. A review of the facility's policy and procedures (P&P) titled, Repositioning, revised 5/2024 indicated, Repositioning the Resident in Bed: Check the care plan, assignment sheet or the communication system to determine resident's specific positioning needs including special equipment, resident level of participation and the number of staff required to complete the procedure. A review of the facility's P&P titled, Activities of Daily Living (ADL), Supporting, reviewed 4/17/2024, indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview and record review the facility failed to ensure the call lights were answered timely for three of six residents sampled (Residents 37, 50 and 59). This deficient practice resulted in a delay to services and care required by Residents 37, 50, and 59. Findings: A review of Resident 37's Admission Record, dated 7/21/24, indicated Resident 37 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus type two, ulcerative colitis (an inflammatory bowel disease causing irritation and ulcers in the lining of your large intestine), generalized muscle weakness, abnormal gait and mobility, and hypertensive (high blood pressure) heart failure (a condition in which the heart has trouble pumping blood thought the body). A review of Resident 37's History and Physical (H&P), dated 7/18/24, indicated, the resident has the capacity to understand and make decisions. A review of Resident 37's Minimum Data Set (MDS, a standardized assessment and screening tool), dated 6/5/24, indicated the resident required set up or clean-up assistance with eating, and was dependent on staff for toileting, bathing, dressing and personal hygiene, bed mobility and transfers. A review of Resident 50's Admission Record, dated 7/21/24, indicated Resident 50 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus type two (a condition were your body has trouble controlling the level of sugar in the blood), end stage renal disease (ESRD, the stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life) with dependance on dialysis (treatment that helps your body remove extra fluid and waste products from your blood), generalized muscle weakness, ad reduced mobility. A review of Resident 50's MDS, dated [DATE], the MDS indicated, Resident 50 had intact cognition (ability to think, understand and make daily decisions). The MDS indicated Resident 50 required partial/moderate assistance from staff for eating and oral hygiene, and was dependent on staff for toileting, bathing, dressing and personal hygiene, bed mobility and transfers. A review of Resident 59's Admission Record, dated 7/21/24, indicated Resident 59 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus type two, peripheral vascular disease (PVD, a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), generalized muscle weakness, difficulty walking, hear failure and lymphedema (Swelling, most often in an arm or leg, caused by a lymphatic system [a group of organs, vessels and tissues that protect you from infection and keep a healthy balance of fluids throughout your body] blockage). A review of Resident 59's H&P, dated 6/13/24, indicated, the resident had the capacity to understand and make decisions. (continued on next page)

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Kennedy Care Center	619 N. Fairfax Ave Los Angeles, CA 90036

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 59's MDS dated [DATE], indicated the resident required set up or clean-up assistance with eating, and required maximal assistance from staff for toileting, bathing, dressing and personal hygiene, bed mobility and transfers. During an interview with Resident 50 on 7/19/24 at 7:49 pm, the resident stated the call lights take a long time to be answered. Sometimes she has to wait for longer than 45 minutes to get help. The resident further stated all shift are affected by long wait times to get help. During an interview with Resident 59 on 7/19/24 at 8:30 pm, the resident stated the call lights take a long time to be answered if at all. Resident 59 stated that now the uses the TV by putting the volume all the way up and that seems to bring the staff in to help the resident. During an interview with Resident 37 on 7/20/24 at 8:41 am, the resident stated the staff take a long time to answer the call light and he needs help frequently throughout the day. Sometimes he will have to wait for the Certified Nursing Assistants (CNAs) to help him get cleaned up and then that can delay his physical therapy. Resident 37 stated they (facility) needs a better coordination. During an interview with Director of Nursing (DON) on 7/21/24 at 8:44 pm, the DON stated, the call lights should be answered as soon as possible and by everyone, no one should pass by a call light. They should step in and ask if the resident needs help. A review of the facility's policy and procedures Answering the Call Light, reviewed 4/17/24, indicated, the purpose of this procedure is to respond to the resident's requests and needs . Answer the resident's call as soon as possible.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 43261 Based on observation, interview and record review, the facility failed to post in a visible and prominent place daily; the actual hours worked by licensed and unlicensed nursing staffing directly responsible for resident care per shift for three of three sampled days (7/19/2024, 7/20/2024, and 7/21/2024). This deficient practice had the potential to prevent residents and visitors from knowing the accurate and final Direct Care Services Hours Per Patient Day (DHPPD) and had the potential to cause inadequate staffing. Findings: During an observation on 7/19/2024 at 9:19 p.m., located in the nurses' station, nurse staffing hours information dated 7/19/2024 was posted with missing actual nursing staffing hours. During an observation on 7/20/2024 at 9:45 a.m., located in the nurses' station, nurse staffing hours information dated 7/20/2024 was posted with missing actual nursing staffing hours. During an observation on 7/21/2024 at 9:52 a.m., located in the nurses' station, nurse staffing hours information dated 7/21/2024 was posted with missing actual nursing staffing hours. During an interview with the Director of Staff and Development (DSD) on 7/21/2024 at 9:54 a.m., the DSD stated DSD only post the projected hours, not the actual hours. The DSD stated, it was important to post the actual nursing hours to make sure that the required nursing hours are being followed and that they have the sufficient nursing staff working each shift. During an interview with the Director of Nursing (DON) on 7/21/2024 at 8:45 pm., The DON stated the nursing actual and projected hours should be posted on a daily basis. A review of facility's policy and procedure (P&P), titled, Posting Direct Care Daily Staffing Numbers reviewed 5/2024, indicated, the facility will post the following information within two hours of the beginning of each shift the following: i. Facility name ii. Current date iii. Resident census iv. Actual hours worked of all the licensed and unlicensed nursing staff directly responsible for resident care per shift. The P&P also indicated, the previous shift's forms are maintained with the current shift form for a total of 24 hours of staffing in a single location.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on interview and record review, the facility failed to ensure that two of five sampled residents (Residents 26 and 52) psychotropic (A drug or other substance that affects how the brain works and causes changes in mood) medication regimens were managed and monitored to promote or maintain the highest practicable mental, physical, and psychosocial well-being by failing to: 1. Ensure implementation of the facility's pharmacy recommendation for Resident 26's Risperdal (anti-psychotic medication) use. 2. Ensure the informed consents were in placed timely for Resident 52's physician's order for psychotropic medications. These deficient practices had the potential to place Resident 26 and 52 at risk of receiving unnecessary medications and/or overuse of medication and adverse consequences while using the medications. Findings: 1. A review of Resident 26's Admission Record, indicated Resident 26 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) and schizophrenia (a mental health problem that primarily affects a person's emotional state. A review of Resident 26's Minimum Data Set (MDS - a comprehensive standardized assessment and care screening tool), dated 6/25/2024, indicated Resident 26's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making was severely impaired and dependent from staff with activities of daily living (ADLs- eating, toileting hygiene, shower/bathe self, upper and lower body dressing, and personal hygiene). A review of Resident 26's Order Summary Report (OSR), dated 3/8/2024, indicated a physician order for a Risperdal 1 milligram (mg- unit of measurement) by mouth two times a day. A review of facility's Pharmacy Note to Attending Physician/Prescriber (PNAPP), dated 6/7/2024, PNAPP indicated, the medication must undergo a psychotropic drug regimen review with evaluation for dose reduction unless contraindicated. The PNAPP also indicated that Resident 26's attending physician agreed, documented and signed PNAPP that a dose adjustment will be done with physician (MD) order to discontinue Risperdal. During a concurrent interview and record review with the Director of Nursing (DON) on 7/21/2024 at 4:32 p.m. , Resident 26's progress notes and Medical Doctor (MD) order was reviewed, missing documentation and/or MD order to discontinue Risperdal medication. The DON stated that pharmacy recommendations must be checked and completed by the physician and nursing staff was supposed to verify and carry out physician's response. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's policy and procedures (P&P), titled, Medication Regimen Review, revised on 4/17/2024, indicated, the consultant pharmacist contacts the physician immediately to report and identified medication irregularities verbally and documents the notification and physician documents in the medical record that the irregularity has been reviewed and what action was taken to address it. A review of facility's P&P, titled, Tapering Medications and Gradual Drug Dose Reduction, revised on 4/17/2024, indicated, residents who use antipsychotic drugs shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. 43454 2. A review of Resident 52's Admission Record, indicated Resident 26 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including dementia (loss of cognitive functioning-thinking, remembering, and reasoning) in other diseases, schizophrenia and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). A review of Resident 52's dated 4/8/2024, indicated Resident 52's cognitive skills for daily decision-making was severely impaired and required maximal assistance to total dependent from staff with ADLs- eating, oral hygiene, toileting hygiene, shower/bathe, and personal hygiene. A review of Resident 52's OSR, dated 12/27/2023, indicated a physician order for the following: i. Escitalopram oral tablet 20 milligram (mg - unit of measurement) - give one tablet for depression manifested by (m/b) verbalization of sadness verified informed consent obtained by physician (MD). ii. Seroquel (an antipsychotic medication that treats several kinds of mental health conditions including schizophrenia and bipolar disorder) oral tablet 8.6 mg - give 1 tablet one tablet at bedtime for schizophrenia m/b outburst anger verified informed consent obtained by MD. A review of Resident 52's medical record with the Medical Record Director (MRD) on 7/21/2024 at 8:30 p.m., the MRD stated and indicated, there was no Informed Consent on 12/27/2023 for physician's order of Resident 52's escitalopram and Seroquel medications. During a concurrent interview with the DON on 7/21/2024 at 8:57 p.m., the DON stated, an informed consent should be in place and timely signed for all psychotropic medications. A review of facility's P&P titled, Psychoactive/Psychotropic Medication Use, revised on 7/2024 indicated, Prior to administration of a psychotropic medication, the prescribing clinician will obtain informed consent from the resident (or as appropriate, the resident representative), and document the consent in the medical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on observation, interview, and record review the facility failed to ensure Resident 29's Yupelri (Revefenacin-medication being given via inhalation [inhaling medication in the form of gas or vapor] used to help muscles around the airways of the lungs to relax) inhalation solution was stored properly per manufacturer's policy. This deficient practice had the potential to compromise the safety and effectiveness of medication, resulting in medication error when administered to Resident 29. Findings: A review of Resident 29's Admission Record, indicated Resident 29 was originally admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses including asthma (respiratory condition marked by spasms in the bronchi of the lungs, causing difficulty in breathing), pneumonia (PNA-infection that inflames air sacs in one or both lungs which may fill with fluid) and generalized muscle weakness. A review of Resident 29's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 5/5/2024, indicated Resident 29 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and requiring moderate assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). A review of Resident 29's Order Summary Report (OSR), dated 4/1/2023, indicated an order for Yupelri inhalation solution 175 microgram (mcg - unit of measurement) per three milliliter (ml - unit of measurement), to inhale 1 vial via nebulizer (inhalation machine) one time a day. During a concurrent observation and interview with Registered Nurse Supervisor 1 (RNS 1) on 7/20/2024 at 2:46 p.m., observed Resident 29's Yupelri box inside the medication fridge. RNS 1 stated RNS 1 was not aware that it should be in the fridge and will follow up with the pharmacist for storing medication. During an interview with Licensed Vocational Nurse 5 (LVN 5) on 7/20/2024 at 2:51 p.m., LVN 5 stated LVN 5 had put Yupelri medication in the fridge since it was supposed to be refrigerated until it is being used due to medication being in a liquid form. During an interview with the Director of Nursing (DON) on 7/21/2024 at 1:13 p.m., The DON stated that Yupelri was not supposed to be refrigerated and putting the medication in the fridge can affect the patency of the medication. A review of Yupelri's package inserts, undated, indicated, per manufacturer's policy, under storage and handling, to store medication at room temperature from 68-degree Fahrenheit to 77-degree Fahrenheit.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on observation, interview, and record review, the facility failed to provide palatable flood for two of six residents sampled (Residents 59 and 84). This failure resulted in bland, unpalatable food being served to the residents and surveyors. Findings: A review of Resident 59's Admission Record, dated 7/21/24, indicated Resident 59 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus type two, peripheral vascular disease (PVD - a disorder that involves the narrowing of peripheral blood vessels), generalized muscle weakness, difficulty walking, hear failure and lymphedema (tissue swelling). A review of Resident 59's History and Physical (H&P), dated 6/13/24, indicated, the resident had the capacity to understand and make decisions. A review of Resident 59's Minimum Data Set (MDS - A standardized assessment and care screening tool) dated 4/11/24, indicated the resident required set up or clean-up assistance with eating, and required maximal assistance from staff for toileting, bathing, dressing and personal hygiene, bed mobility and transfers. A review of Resident 84's Admission Record, dated 7/21/24, indicated Resident 84 was admitted to the facility on [DATE], with diagnoses including hypertension, generalized muscle weakness, anemia (low levels of healthy red blood cells to carry oxygen throughout your body), fibromyalgia (disorder characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory and mood issues) and abnormal posture. A review of Resident 84's H&P, dated 6/14/24, indicated, the resident had the capacity to understand and make decisions. A review of Resident 84's MDS dated [DATE], indicated the resident required set up or clean-up assistance with eating, and was dependent on staff for bed mobility, toileting, bathing, dressing and personal hygiene. During an interview on 7/19/24 at 8:04 pm with Resident 59, the resident stated overall the food could be better and there is no variety when she (Resident 59) asks for something different for the resident's sack lunch. During an observation on 7/20/24 at 10:10 am, Morning [NAME] (AMC) was observed frying hamburger patties, and not seasoning them. During a regular diet test tray evaluation on 7/20/24 at 12:35 pm by three surveyors, the test tray was noted to have a hamburger that was bland and had a soggy bottom bun, a peach pie that was smashed and potato salad that was also bland in taste. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/21/24 at 7:47 pm with Resident 84, the resident stated the food was bland, and needed seasoning. States she regularly had to add salt and sometimes cannot find the packet on her tray. A review of the facility's policy and procedures titled Resident Food Preferences, reviewed 4/17/24, indicated, Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident's or representative's consent. The resident has a right not to comply with therapeutic diets . if the resident refuses or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on observation, interview, and record review, the facility failed implement appropriate sanitation and food handling practices by failing to discard expired food stored in the resident's nutrition refrigerators. This deficient practice had the potential to result in unsafe food management. Findings: During an observation with concurrent interview on [DATE] at 10:38 a.m. with the Dietary Supervisor (DS), the facility's resident nutrition refrigerator was reviewed. There was one container of food labeled with a use by date of [DATE] and another with a brought in date of [DATE]. The DS stated those containers of food with past use by dates should have been thrown out, because it is past the use by date or 48 hours after the food was brought in. A review of the facility's policy and procedures (P&P), titled Foods Brought by Family/Visitors, reviewed [DATE], indicated, Food brought to facility by visitors and family is permitted . Family/visitors are asked to prepare and transport food using safe flood handling practices . Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that is clearly distinguishable from facility prepared food . Containers are labeled with the resident's name, the item and the use by date. The nursing staff will discard perishable foods on or before the use by date.

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F 0837 Level of Harm - Potential for minimal harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 45455 Based on observations, interviews, and record review the facility's governing body (individuals such as facility owner(s), Chief Executive Officer(s), or other individuals who are legally responsible to establish and implement policies regarding the management and operations of the facility) failed provide effective leadership oversight of processes and policies and procedures by failing to ensure the administrator was onsite and available via phone on a full-time basis. This deficienct practice had the potential to not meet/address direct the day-to day functions of the facility in accordance with current federal, state, and local standard, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care is provided to the residents. Findings: During an initial facility tour on 7/19/2024 at 8:30PM, the Administrator in Training (AIT) was observed present and working in the facility without the supervision of a licensed and qualified Administrator (ADM) on 7/19/2024 at 5:30pm. During a concurrent interview, the AIT stated, I am newly licensed Administrator and is scheduled to take over the daily operations of the facility on 8/1/2024. During an interview on 07/21/24 at 08:15 PM with the AIT, the AIT stated, AIT started to work at the facility on 7/1/2024. The AIT stated the facility's current ADM, will not be available during the recertification survey due to family issue. The AIT stated AIT is aware that the current licensed ADM should in the facility to follow/supervise the AIT. The AIT stated that the facility's current, Administrator is aware that the recertification survey is currently in process in the facility. A review of the AIT's employment offer letter dated 11/19/2023, indicated, the AIT started working at facility on 7/1/2024. A review of the facility's job description titled Administrator in Training (AIT) dated 03/2017, indicated, AIT reports to Administrator-preceptor, the roles, and responsibilities of the AIT . is a training position with direct oversight by a licensed precepting Administrator. The job description further states All Essential Duties and Responsibilities of this position (AIT) are under the direct supervision of the Preceptor (ADM). A review of the facility's job description titled Administrator (ADM), dated 12/2018, indicated, the primary purpose of your position is to direct the day-to day functions of the facility in accordance with current federal, state, and local standard, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be always provided to residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to: a. Ensure one of five sampled residents (Resident 66) who was on a transmission-based isolation for extended spectrum beta-lactamase (ESBL - an enzyme found in some strains of bacteria that can't be killed by many of the antibiotics that doctors use to treat infections) was placed into a private single room. b. Ensure staff wore appropriate Personal Protective Equipment (PPE- equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses, PPE may include respirators, gloves, overalls, boots, disposable gowns, and goggles) when providing care to one of four sampled residents (Resident 192) who is on a transmission-based precaution room. c. Ensure one of five sampled residents, (Resident 292), who had an active infection of Escherichia coli in urine (E. coli - bacteria that normally lives harmlessly in the human intestinal tract, but it can cause serious infections if it gets into the urinary tract) was placed into a contact precaution room according to facility's policy and procedures (P&P) and Centers of Disease Control and Prevention (CDC). These deficient practices placed increased the risk of acquiring and transmitting infections to other residents, staff and visitors in the facility. Findings: A review of facility's license, effective date 11/1/2023 indicated, the facility has a licensed bed capacity of 97 residents. 1a. A review of Resident 66's Admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses including chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure), Alzheimer's disease (a progressing brain disorder that destroys memory and other important mental function), and dysphagia (difficulty swallowing food or liquid). A review of Resident 66's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 7/3/2024, indicated Resident 66 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required total dependence from staff for activities of daily living (ADL-eating, oral hygiene, toileting hygiene, personal hygiene). A review of Resident 1's Physician Order Summary dated 7/13/2024, indicated a physician ordered, Contact Isolation (residents with known or suspected infections that represent an increased risk for contact transmission) every shift for ESBL in the urine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b. A review of Resident 192's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnosis including malignant neoplasm of rectum (rectal cancer - a type of cancer that forms in the tissues of the rectum), chronic kidney disease and respiratory disorders (a type of disease that affects the lungs and other parts of the respiratory system [nose, mouth, throat, voice box, windpipe and lungs]). A review of Resident 192's MDS dated [DATE], indicated Resident 192 had severely impaired cognition for daily decision-making and required maximal assistance from staff for ADL- oral hygiene and toileting hygiene, repositioning from sit to lying and lying to sitting on side of bed. A review of Resident 192's Order Summary Report as of 7/21/2024 indicated, there are no physician's order for transmission-based precaution. A review of facility's census indicated indicated that: On 7/19/2024, the facility had 85 residents with 12 empty beds, On 7/20/2024, the facility had 85 residents with 12 empty beds; and On 7/21/2024, the facility had 87 residents with 10 empty beds. During a concurrent observation and interview with Licensed Vocational Nurse 2 (LVN 2) on 7/19/2024 at 7:49 p.m., LVN 2 stated and confirmed Resident 66 was on contact isolation for ESBL and that Resident 66 sahred the same room with Resident 192. LVN 2 stated Resident 66 and Resident 192 were not on any contact isolation. During an observation on 7/19/2024, 7/20/2024, and 7/21/2024, Resident 66, who was on contact precaution isolation, was placed in a room shared with one other resident, Resident 192. During an interview with the Infection Preventionist Nurse (IPN) on 7/21/2024 at 3:38 p.m., the IPN stated, residents who are on contact precaution should be placed in a private room if there are room available in the facility. The IPN stated, the facility had empty rooms available on 7/19/2024, 7/20/2024, and 7/21/2024. The IPN stated, this place other residents at risk of contacting the infection. During an interview with the Director of Nursing (DON) on 7/21/2024 at 9:10 p.m., the DON stated residents on contact isolation should be placed in a private single room if the facility is able to accommodate them. The DON further stated, the facility had empty rooms available. The DON further stated, Resident 192, is being co-horted (share) with [Resident 66] who is on contact precaution isolation. A review of the facility's policy and procedures titled Isolation - Transmission-Based Precautions and Enhanced Barrier Precautions, reviewed on 4/17/2024 indicated, The individual on contact precautions is placed in a private room if possible. If a private room is not available, the infection preventionist will assess various risks associated with other resident placement options. (continued on next page)

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	07/22/2024

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 192's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including malignant neoplasm of rectum, chronic kidney disease and respiratory disorders A review of Resident 192's MDS dated [DATE], indicated Resident 192 had severely impaired cognition for daily decision-making and required maximal assistance from staff for ADL- oral hygiene and toileting hygiene, repositioning from sit to lying and lying to sitting on side of bed. During an observation of Resident 192 on 7/19/2024 at 6:25 p.m., Resident 192's room was observed with a signage of contact isolation room. Certified Nursing Assistant 4 (CNA 4) was observed feeding Resident 192 inside Resident 192's room and was not wearing any appropriate PPE. During an interview with CNA 4 on 7/19/2024 at 6:40 p.m., CNA 4 stated, she does not need to wear full PPE while assisting Resident 192 and/or going inside Resident 192. CNA 4 further stated, Resident 192's roommate (Resident 66), is the one with a contact precaution isolation order and I was told that I did not need to wear full PPE by other CNAs (unidentified) during hand-off reports. During an interview with LVN 2 on 7/19/2024 at 7:49 p.m., LVN 2 stated, staff need to wear full PPE before entering Resident 192 and Resident 66's room, because the whole room is a contact isolation room. During an interview with the IPN on 7/21/2024 at 3:38 p.m., the IPN stated, all staff should wear full PPE before entering a contact isolation room. The IPN stated, if they don't wear full PPE, if places risk of transmitting the infection to other residents, staff and visitors in the facility. 3. A review of Resident 292's Admission Record indicated resident was admitted to the facility on [DATE] with diagnoses including DM, respiratory disorders in diseases, and malignant neoplasm of prostate (prostate cancer - a disease in which malignant (cancer) cells form in the tissues of the prostate). A review of Resident 292'2 MDS dated [DATE], indicated Resident 292's cognitive skills for daily decision-making mildly impaired. A review of Resident 292's Lab Results Report, collected on 7/12/2024 indicated, Resident 292's urine culture (a test healthcare providers use to check for a UTI by seeing if bacteria or fungi can grow from a sample of urine) tested positive for e-coli. A review of Resident 292's Order Summary Report dated 7/15/2024 indicated, a physician ordered, macrobid (medication used to treat and prevent urinary tract infections) 100 milligrams (mg - unit of measurement) by mouth twice daily for Urinary Tract Infection (UTI). The Order Summary Report did not indicate Resident 292 had an order for contact isolation. During an observation of Resident 292 on 7/21/2024 at 4:05 p.m., Resident 292 was placed in a room shared with two other residents and Resident 292. There was no signage for contact precaution isolation posted outside the door. (continued on next page)

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	055977	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the IPN on 7/21/2024 at 5:33 p.m., the IPN stated, Resident 292, is on enhanced precaution room and not on any contact precaution room. The IPN stated, Resident 292 has an indwelling catheter (a device that drains urine (pee) from urinary bladder into a collection bag outside of the body when a person can't pass urine on their own or for various medical reasons) and incontinent for bowel and bladder. The IPN stated, there is difference between enhanced precaution room and contact precaution isolation. During an interview with DON on 7/21/2024 at 9:12 p.m., DON stated resident who have e-coli in urine does not need to be placed in a contact precaution room according to their policy. DON further stated, they have empty beds available in the facility. A review of the facility's policy and procedures titled Isolation - Transmission-Based Precautions and Enhanced Barrier Precautions, reviewed on 4/17/2024 indicated, Contact precautions are implemented for residents knows or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. A review of Centers of Disease Control and Prevention (CDC), Infection Control Guidelines titled, Type and Duration of Precautions Recommended for Selected Infections and Conditions, updated 9/2018 indicated, CDC recommends, for E. coli infection, residents should be placed under Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455 Based on observation, interview, and record review, the facility failed to provide at least 80 square feet (sq. ft. -unit of measure) per resident in one of 35 multiple resident bedrooms (room [ROOM NUMBER]) This deficient practice had the potential to result in inadequate useable living space for the residents and working space for the health caregivers. Findings: A review of the facility's Request for Room Size Waiver letter, dated 4/19/2024, submitted by the Administrator, indicated there is 1 room not meeting the 80 square feet requirement per resident according to federal regulation. The letter indicated that the the room size (room [ROOM NUMBER]) does not adversely affect any residents or any resident's special needs. The letter also indicated both ambulatory and non-ambulatory residents can freely move in the rooms without harm or impediment and there have been no grievances from residents, family members or staff regarding he room size of the room in question. A review of the undated Client Accommodations Analysis submitted by the facility indicated the following rooms with their corresponding measurements: Rooms # Total Sq. Ft Resident # Beds Floor Area Sq. Ft/Resident. room [ROOM NUMBER] 154 square feet 2 beds occupancy 77 square feet per resident The minimum square footage for a 2-bed room should be 160 sq. ft. per federal regulation. During the general observations of the residents' rooms from 7/19/2024 to 7/21/2024, the residents in room [ROOM NUMBER] had ample space to move freely inside the rooms. There were sufficient spaces to provide freedom of movement for the residents and for nursing staff to provide care to the residents. There was also sufficient space for beds, side tables and resident care equipment. During an interview with Certified Nurse Assistant 6 (CNA 6) on 07/21/24 4:23 PM, CNA 6 stated, room [ROOM NUMBER] feels small, when cleaning or changing Residents. CNA 6 stated CNA 6 must move the residents chair and bedside table out of the room to have enough space to do activities of daily living (ADLs). CNA 6 stated no Resident's or family have complained about the room size.