STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056063	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Infinity Care of East Los Angeles	101 S Fickett Street Los Angeles, CA 90033

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2) were free from physical abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish), when Resident 1 allegedly grabbed Resident 2 by the neck and shook Resident 2 on 2/23/2025. This deficient practice resulted in Resident 1 had a scratch to left side of the neck and had the potential to negatively affect Resident 1's comfort and psychosocial (having to do with the mental, emotional, social, and spiritual effects of a disease) well-being which can lead to hospitalization and/ or death. Findings: During a review of Resident 1's Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included psychosis (a mental health condition characterized by a loss of contact with reality), encephalopathy (a medical condition characterized by a general dysfunction of the brain) and acute kidney failure (a sudden loss of kidney function). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 5/15/2024, the MDS indicated Resident 1's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 1 required setup or clean-up assistance (helper sets up or cleans up) with eating, oral hygiene and personal hygiene. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues; resident completes activity) with toileting hygiene, shower/bath, upper body dressing, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 1 is independent with lying to sitting on side of bed, sit to stand, walk 10 feet (unit of measurement), walk 50 feet with two turns, and walk 50 feet. During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 2/23/2025, timed 8:20 AM, documented by LVN 1, indicated a situation of alleged minor altercation. The SBAR indicated Resident 1 is confused. The SBAR indicated while LVN 1 is walking down the hall, she heard loud voices coming from Resident 1 and 2's room. The SBAR also indicated LVN 1 observed Resident 1 was standing next to his bed and Resident 2 is sitting on his bed. Resident 1 stated I grabbed him (Resident 2) and I shook him. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing Problems) and difficulty in walking. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 2 required supervision or touching assistance with eating, oral hygiene, toileting hygiene, shower/bath, upper body dressing, lower body dressing, and putting on/taking off footwear and personal hygiene. The MDS indicated Resident 2 required supervision or touching assistance with walk 10 feet, walk 50 feet with two turns, and walk 50 feet. During a review of Resident 2's SBAR dated 2/23/2025, timed 8:13 AM, documented by LVN 1, indicated a situation of alleged minor altercation with resident (Resident 1), and Resident 2 was noted with scratch to left side of neck. The SBAR indicated Resident 2 is alert and oriented to person, time, and place. The SBAR indicated Resident 2 stated He (Resident 1) grabbed me. During a review of Resident 2's Skin only evaluation, dated 2/23/2025, timed 9:31 AM, indicated a skin issue of left neck scratch, measured 5 centimeters (cm, unit of measurement) in length by width of 0.1 cm. During a review of Resident 2's order summary report, dated 2/28/2025, timed 11:20 AM, indicated a treatment order to left side of neck, cleanse with normal saline and pat dry, apply triple antibiotic to area and leave open to air daily for 5 days, with order date of 2/23/2025. During an observation on 2/28/2025 at 8 AM with Resident 2, in Resident 2's room, Resident 2 was observed sitting in bed, and Resident 2 refused to be interviewed when asked about the incident with Resident 1. During an interview on 2/28/2025 at 1:05 PM with Certified Nurse Assistant (CNA) 1, CNA 1 stated, on 2/23/2025 morning, around 7 AM, CNA 1 was passing breakfast trays when he heard Licensed Vocational Nurse (LVN) 1 asked assistance in Resident 1 and 2's room. During an interview on 2/28/2025 at 12:50 PM with LVN 2, LVN 2 stated he was working on the second floor on 2/23/2025 and LVN 2 was informed the alleged physical abuse of Resident 1 and Resident 2. LVN 2 stated LVN 1 was the first staff who heard the altercation and who went to Resident 1 and 2's room to check what was going on. During a concurrent observation in Resident 2's room and interview on 2/28/2025 at 2 PM with Resident 2, a scratch on the resident's neck was observed. Resident 2 stated that his previous roommate (Resident 1), grabbed him by the neck (unable to recall when), and that is how he obtained the left neck scratch. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Director of Nursing (DON) on 2/28/2025 at 4:45 PM, the DON stated she was made aware on 2/23/2025 by LVN 1 that there was a resident-to-resident altercation between Resident 1 and Resident 2 in their room. The DON stated she went to Resident 2's room, where the alleged incident happened, and the DON observed Resident 2 in bed, with a scratch on Resident 2's left neck. The DON stated Resident 2 claimed that Resident 1 tried to choke him, and that Resident 1 end up obtaining a scratch in his left side of the neck. During a review of the facility's Policy and Procedure (P&P), titled Abuse prevention and reporting, dated 8/1/2007, indicated the facility shall uphold resident's right to be free from any form of verbal (use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability), sexual (non-consensual sexual contact of any type with a resident), physical, and mental abuse, corporal punishment (physical punishment), and involuntary seclusion (forced confinement of a person in a room or area). The P&P also indicated the facility shall establish system to prevent patient abuse including those practices and omissions, neglect (the failure of the facility, its employees or service providers to provide goods and services to a resident) and misappropriation of property (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent) that if left unchecked, may lead to abuse. The P&P also indicated residents shall not be subjected to abuse by anyone, including, but not limited to, facility staff; other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 46087 Based on observation, interview and record review, facility failed to ensure wander guard (used to keep track of patients) was checked for functionality and expiration date according with the facility's policy and procedure (P&P) titled Wander Guard, for one of two sampled resident (Resident 1) who was cognitively (ability to think and reason) impaired and displayed behaviors of wandering (walking around aimlessly without a fixed plan) in the facility. This deficient practice placed Resident 1 at risk for eloping (a patient who is incapable of adequately protecting himself, and who departs the health care facility unsupervised and undetected) with the potential of being exposed to severe environmental conditions including excessive cold, possible motor vehicle accident, medical complications including malnutrition (health problems that may arise due to lack of nutrients [substances found in food necessary for the body to function normally]), dehydration (abnormally low fluid levels in the body), and death. Findings: During a review of Resident 1's Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included psychosis (a mental health condition characterized by a loss of contact with reality), encephalopathy (a medical condition characterized by a general dysfunction of the brain) and acute kidney failure (a sudden loss of kidney function). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 1's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 1 required setup or clean-up assistance (helper sets up or cleans up) with eating, oral hygiene and personal hygiene. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues; resident completes activity) with toileting hygiene, shower/bath, upper body dressing, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 1 is independent with lying to sitting on side of bed, sit to stand, walk 10 feet (unit of measurement), walk 50 feet with two turns, and walk 50 feet. During a review of Resident 1's order summary dated [DATE], timed 11:04 AM, indicated the following orders: Place wander guard (used to keep track of patients) to right arm and check placement every (q) shift for elopement risk with order date of [DATE]. Check function of wander guard with transmitter q shift/ change battery as needed every shift for operational with order date of [DATE]. During a concurrent observation and interview on [DATE] at 10:55 AM, with Resident 1, in Resident 1's room, Resident 1 asked surveyor to remove the band that is placed on his left ankle. Resident 1 showed surveyor the wander guard that is attached to his left ankle. Resident 1 stated he does not know what it is for, and Resident 1 wants it removed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation in Resident 1's room and interview on [DATE] at 2:12 PM, with Licensed Vocational Nurse (LVN) 3, LVN 3 checked Resident 1's wander guard that is attached to Resident 1's ankle. LVN 3 read the numbers printed in Resident 1's wander guard, and LVN 3 stated the numbers are 072024. LVN 3 stated there is another set of numbers with some letters that reads ,d+[DATE]i. LVN 3 stated he did not know what these numbers and letters mean in the wander guard. During an interview on [DATE] at 2:17 PM with Director of Staff Development (DSD), the DSD stated she initially applied wander guard to Resident 1 yesterday ([DATE]) in Resident 1's right wrist. The DSD stated she did not and should have checked the expiration of the wander guard before applying it to the reisdent. During an interview on [DATE] at 2:25 PM with Facility's Administrator (ADM), the ADM stated that as long as the wander guard alarmed when staff tested the wander guard before applying to Resident 1 yesterday, then it should be okay to use. During an interview on [DATE] at 3:34 PM with Registered Nurse (RN) 1, RN 1 stated using an expired wander guard might compromise the use of it, and residents who used it might end up eloping because the alarm might not sound to alert the staff that resident with wander guard is already near the door where the exit alarm receiver (devices that receive signals from alarms on emergency exit doors, triggering an alarm when an unauthorized exit is attempted) is located. During an interview on [DATE] at 4:46 PM with RN 2, RN 2 stated Resident 1 removed his wander guard that is placed on his right wrist, evening of [DATE]. RN 2 stated she did not document that it was removed, and she reapplied the wander guard in Resident 1's left ankle before she ended her shift at 11 PM. RN 2 stated that she did not and should have inspected for the functionality of the wander guard before applying to Resident 1's left ankle. RN 2 stated she did not know that the expiration date is printed in the wander guard. During an interview on [DATE] at 5:03 PM with the Director of Nursing (DON), the DON stated expired medical supplies like wander guard should not be used to any residents and should be dispose properly. The DON also stated expired wander guard is not guaranteed that it is going to work to prevent elopement. During a review of Facility's undated Policy and Procedure (P&P), titled Resident Elopement, indicated the facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. It also indicated policy interpretation and implementation as follows: The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. During a review of Facility's P&P, titled Wander Guard, dated [DATE], indicated it is the policy of this facility to preserve and maintain resident's safety, by instituting measures to monitor and prevent resident from opportunities of wandering away from the facility. The procedure indicated the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility shall use Wander Guard as primary measure of monitoring and preventing residents from wandering away from the facility. Wander Guards shall only be used if prescribed by a physician. Licensed nurse shall be responsible for including in the resident's plan of care, use of wander guard for resident's safety. Licensed nurse shall be responsible for care and use of wander guard, following manufacturer's recommendations. During a review of user guide, titled Code Alert, Wander Management Transmitters, dated ,d+[DATE], indicated each transmitter is stamped with a warranty expiration date. This date indicates the date the warranty on that transmitter expires. If the warranty period has expired, discard the transmitter immediately. The user guide indicated using a transmitter beyond the printed expiration date can result in system failure and/or elopement. The user guide indicated test all transmitters prior to use to verify proper operation. This includes every time that the band is replaced. Failure to test the transmitters before use can result in system failure and/or an elopement.