

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/11/2025
NAME OF PROVIDER OR SUPPLIER Infinity Care of East Los Angeles		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect one of three sampled residents (Resident 1) right to be free from sexual abuse (non-consensual [without the person's permission] touching of one person for the sexual gratification of another) on 5/6/2025 by failing to ensure:</p> <ol style="list-style-type: none"> Resident 1 was protected from sexual abuse by Resident 3. On 5/6/2025, while Resident 1 was sitting on her wheelchair along the hallway in front of Room A, Resident 3 touched Resident 1 on her inner thigh and later Resident 3 was witnessed touching Resident 1's upper back by placing his hands inside Resident 1's shirt. Resident 1 was protected from further abuse by Resident 3 when facility staff did not separate Resident 1 from Resident 3. On 5/6/2025, Resident 1 and Resident 3 attended the same recreational group activity in the Activities Room. Further abuse was to Resident 1 and other residents in the facility from Resident 3 when the facility failed to address Resident 3's behavior of touching his private part (a person's external sexual organs or genitals) during group activities in the Activity Room. <p>These deficient practices resulted in Resident 1 experiencing sexual abuse, expressed feeling scared and not feeling safe in the facility since the incident occurred with Resident 3 on 5/6/2025.</p> <p>On 5/8/2025 at 6:31 PM, the California Department of Public Health (CDPH) called an Immediate Jeopardy situation (IJ, a situation in which the facility's noncompliance [not following rules] with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Resident) due to the facility's failure to protect Resident 1 from sexual abuse.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility submitted an acceptable IJ Removal Plan (action to correct the deficient practice), to CDPH on 5/11/2025 at 5:20 PM. The IJ was removed on 5/11/2025, after the surveyor verified and confirmed the facility implemented the facility's IJ Removal Plan (a detailed plan to address the IJ findings) while onsite by observation, interview, and record review. The IJ was removed in the presence of the Administrator Consultant (ADMC) and the Director of Staff Development (DSD).</p> <p>The acceptable IJ Removal Plan included the following information:</p> <p>1)</p> <p>Resident 3 was transferred to General Acute Care Hospital (GACH) for psychiatric (relating to mental illness) evaluation on 5/8/2025 at 10:51 PM. The attending physician issued the order for transfer at 5/8/2025, at 7:09 PM.</p> <p>2)</p> <p>Resident 3 was on one-on-one watch on 5/8/2025 until transportation arrived for pickup.</p> <p>3)</p> <p>On 5/8/2025 at 7:14 PM, Psychiatrist Physician Assistant (PPA- a licensed healthcare professional who practices medicine under the supervision of a physician, specializing in the diagnosis and treatment of mental illness) evaluated Resident 1 for psychological support and emotional distress. On 5/8/2025 at 7:11 PM, the PPA evaluated Resident 3 as well for psychosocial support (the provision of emotional, social, and mental health assistance to individuals or groups experiencing challenges) and emotional distress.</p> <p>4)</p> <p>The Psychologist (mental health professional who specializes in the study of the mind and behavior) vendor came to the facility on 5/9/2025 at 10:04 AM to evaluate Resident 1 for psychosocial distress (the emotional, social, and/or spiritual discomfort an individual experiences when overwhelmed by stressful situations, particularly those that impact their quality of life) related to the recent case of sexual abuse. According to the psychologist's notes for Resident 1, the psychologist notes indicated, The recent incident of alleged sexual misconduct appears to be managed by the facility's safety protocols. On 5/10/2025 at 8:26 AM, Resident 1 was transferred to GACH for psychiatry (psych) evaluation, per the attending physician's order. According to the psychologist notes for Resident 2, the psychologist notes indicated, patient is currently stable and not experiencing significant psychological distress related to the reported incident.</p> <p>5)</p> <p>72 Hours SBAR (Situation, Background, Assessment, Recommendation - a structured communication tool used to improve clean and efficient communication, especially in critical situations or when transferring information between health-care professionals) initiated for Resident 1 on 5/8/2025, including assessment of emotional distress.</p> <p>6)</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>(Late) Report of SOC-341 (Report of Suspected Dependent Adult/Elder Abuse form- a mandated form used to document reports of suspected elder and dependent adult abuse) was completed on 5/8/2025 and faxed to the LTC (long-term care) Ombudsman (a designated official who advocates for the rights and well-being of residents in long-term care facilities) on 5/8/2025 at 10:05 PM and faxed to CDPH on 5/8/2025 at 10 PM for the incident of sexual abuse experienced by Resident 1. The local police department came to the facility to follow up on the telephonic report on 5/9/2025 at 9:40 AM for the incident of sexual abuse to Resident 1.</p> <p>7)</p> <p>On 5/8/2025, 5/9/2025, and 5/10/2025, the DSD in-serviced all staff for abuse prevention, reporting, and investigation.</p> <p>8)</p> <p>On 5/10/2025, ADMC in-serviced the following staff: 7 AM - 3 PM Licensed Nurses and Department Heads regarding Abuse Prevention, Investigation, and Reporting with emphasis placed on the importance of staff knowing how to report telephonically to CDPH, LTC Ombudsman, Local PD and how to complete and fax the SOC-341 form to CDPH and LTC Ombudsman.</p> <p>9)</p> <p>On 5/10/2025, ADMC in-serviced the following staff: 3 PM to 11 PM Licensed Nurses regarding Abuse Prevention, Investigation, and Reporting with emphasis placed on the importance of staff knowing how to report telephonically to CDPH, LTC Ombudsman, Local PD and how to complete and fax the SOC-341 form to CDPH and LTC Ombudsman.</p> <p>10)</p> <p>On 5/10/2025, the ADM (Administrator) attended an approved training course for abuse prevention and reporting. Training course is approved by the [NAME] (National Association of Long Term Care Administrator Boards- the authority for leadership core competencies in long term care) for 1 hour ([NAME] Approval- #2862013-1.05-3574-DL) and administered via: https://ltctrainer.com/product/elder-abuse-1011.cfm, the training course was completed by the Administrator on 5/10/2025. On 5/10/2025, the ADMC gave a one-on-one in-service to the ADM regarding F600 and F607.</p> <p>11)</p> <p>Beginning 5/10/2025, Daily Room Rounds sheets will include questions such as: Do you feel safe? and Are you getting along with your roommate? and Do you feel safe in all areas of the facility, such as hallways, elevator, activities room, rehab room, and dining areas?</p> <p>12)</p> <p>The incident of sexual abuse experienced by Resident 1 was care planned by the MDS Nurse on 5/8/2025.</p> <p>13)</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The incident of physical abuse experienced by Resident 2 was care planned by the MDS Nurse on 5/8/2025.</p> <p>14)</p> <p>If Resident 3 is readmitted to the facility, the resident can have in-room activities to ensure other residents are not subjected to unwanted touching or view of the resident touching himself.</p> <p>15)</p> <p>The daily resident census for 5/9/2025 was surveyed by Social Services Director (SSD- a person responsible for ensuring the resident's social, emotional, and physical needs are met in the facility) and assistants to ensure that no other residents experienced abuse at the hands of Resident 3 during their stay in the facility. The answers of the residents (from the daily census) will be documented.</p> <p>16)</p> <p>The Medical Director (MD) was called and visited the facility on 5/9/2025, and discussed solutions regarding the deficient practices (an action, error, or lack of action on the part of the facility that leads not non-compliance with a regulatory requirement or standard).</p> <p>17)</p> <p>Facility appointed temporarily an Abuse Coordinator on 5/10/2025, in consultation with the ADMC. The new Abuse Coordinator will be Business Office Manager (BOM). An alternate abuse coordinator will be made available in the event the Business Office Manager is unavailable. The alternate abuse coordinator will be: Central Supply Director (CSD). The ADMC in-serviced the new Abuse Coordinator and the alternate Abuse Coordinator regarding the role of an abuse coordinator. Please see attached the acknowledgement letter. The in-coming Director of Nursing (DON) who will start on 5/12/2025 will be the new Abuse coordinator. The ADMC will in-service the incoming DON regarding the role of Abuse Coordinator and the F-Tag 600 and F-Tag 607 starting tomorrow, 5/12/2025. Please see attached application and offer letter for the DON that will start on 5/12/2025.</p> <p>18)</p> <p>Beginning 5/10/2025, while the facility is not in compliance with F600 and F607, ADMC will be employed as an ADMC to oversee the current facility ADM and give guidance on implementation of the immediate Plan of Action (POA) to ensure total compliance is achieved.</p> <p>19)</p> <p>On 5/10/2025 at 4 PM, the ADMC in consultation with the President of the facility, suspended the assigned facility ADM for 5 days. If the conditions of counseling are not met further disciplinary actions up to termination are recommended.</p> <p>20)</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 5/11/2025, the ADMC recommended to the President and Chief Executive Officer (CEO) to terminate the ADM and to start looking for a new ADM. The CEO agreed with the recommendation and will start looking for a new candidate as soon as possible. The CEO expects to hire a qualified candidate within 30 days.</p> <p>21)</p> <p>The in-coming DON will serve as the interim Nursing Home ADM while the current ADM is on suspension. The ADMC will provide oversight to the interim ADM and the abuse coordinator regarding F-Tag 600 starting on 5/12/2025. Once the facility hires a new ADM, the new ADM will be the Abuse Coordinator.</p> <p>Cross reference F607, F684, and F842</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record, it indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included other recurrent depressive disorder (persistent sadness and loss of interest in activities, affecting thoughts, behaviors, feelings, and well-being), schizophrenia (a mental illness that can affect thoughts, moods, and behavior), and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).</p> <p>During a review of Resident 1's History and Physical Examination (H&P), dated 4/30/2024, the H&P indicated Resident 1 could make needs known but could not make medical decisions due to cognitive (mental action or process of acquiring knowledge and understanding) decline.</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/3/2025, the MDS indicated Resident 1 was assessed having moderately impaired cognitive skills (decisions poor; cues/supervision required) for daily decision making. Resident 1 required partial/moderate assistance (helper does more than half the effort) with upper body dressing, personal hygiene, sit to stand, and chair/bed-to-chair transfer. Resident 1 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, and lower body dressing.</p> <p>During a review of Resident 1's Recreational Group Participation Record (a record that indicates resident participation in a recreational activity or event), dated 5/2025, the record indicated Resident 1 participated in activities in the Activity Room from 5/1/2025 to 5/8/2025.</p> <p>During a review of Resident 1's Care Plan Report, dated 10/31/2024, the care plan indicated Resident 1 had a history (hx) and episodes of verbalizing, I don't want to live anymore (no suicidal ideation plan verbalized) and was a potential/at risk for injury to self. Resident 1's care plan interventions indicated the following:</p> <p>Psychology (study of human mind and its functions especially those affecting behavior in a given context) consult and treatment (tx) as/if indicated</p> <p>SSD for psychosocial support</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/8/2025, at 10:59 AM, with Charge Nurse 1 (CN 1) and the DON, CN 1 stated, on 5/6/2025, at around 1 PM, Resident 1 and Resident 3 were sitting on their wheelchairs and were placed next to each other in the hallway in front of Room A. CN 1 stated Resident 1 and Resident 3 were waiting to be taken to the Activity Room. CN 1 stated she was sitting in the nurse's station and when she stood up, observed Resident 3 touch Resident 1 on her inner thigh. CN 1 stated she called Resident 3's name and observed Housekeeping Staff (HKS) pull Resident 3's wheelchair away from Resident 1 and parked it on the opposite side of the hallway. CN 1 stated Resident 3 wheeled his wheelchair to Resident 1 and rubbed her back from behind. CN 1 stated she walked towards Resident 1 and Resident 3 and wheeled Resident 3 to the nurse's station. CN 1 stated Resident 3 denied touching Resident 1 when she asked him why he touched her. CN 1 stated Resident 1 stated she did not feel comfortable being touched by Resident 3 after the incident happened. CN 1 stated Restorative Nursing Assistant 1(RNA 1) and HKS also witnessed the incident. CN 1 stated Activities Assistant (AA) arrived and brought Resident 1 and Resident 3 to the activity room. CN 1 stated she followed Resident 1 and Resident 3 upstairs (in the activity room) and informed AA that Resident 1 and Resident 3 were not allowed to sit next to each other in the activity room. CN 1 stated AA informed her the Resident 3 was always placed away from the female residents in the activity room because of past incidences where Resident 3 had been touchy. CN 1 stated she did not know what AA meant by touchy and did not ask AA.</p> <p>During a concurrent observation and interview on 5/8/2025, at 11:32 AM, with Resident 1, Resident 1 was sitting on her wheelchair outside of her room. Resident 1 was alone and was rocking back and forth during the interview. Resident 1 stated that a couple of days ago Resident 3 touched her and pointed to her scapular (the flat triangular bone located on the back of the upper body) area when asked where she was touched. Resident 1 stated the incident</p> <p>occurred in the hallway close to the nurse's station while waiting to go to the activity room. Resident 1 stated she told Resident 3 to stop touching her and to leave her alone. Resident 1 stated she did not feel safe in the facility because she was raped (a type of sexual assault involving sexual intercourse, or other forms of sexual penetration, carried out against a person without their consent) before when she was living in the streets. Resident 1 stated only CN 1 talked to her about the incident since it happened. Resident 1 stated she was taken to the Activity room after the incident (Resident 3 inappropriately touching Resident 1 on 5/6/2026) happened. Resident 1 stated</p> <p>Resident 3 was also taken to the Activity room after the incident happened. Resident 1 stated she felt scared that Resident 3 was in the same room as her and felt like there was nothing she could do about it.</p> <p>During an interview on 5/8/2025, at 12:05 PM, with RNA 1, RNA 1 stated on 5/6/2025, she observed Resident 3 wheel his wheelchair towards Resident 1 and touch her inner thigh. RNA 1 stated she called Resident 3's name to get his attention. RNA 1 stated she did not stop Resident 3 from touching Resident 1 because she was pushing another resident towards the nurse's station. RNA 1 stated Resident 3 had a history of verbally abusing and talking about female body parts to the Certified Nursing Assistants (CNA). RNA 1 stated she reported the incident to CN 1. RNA 1 stated it was important to separate the residents to make them feel safe when there is suspected abuse. RNA 1 stated she spoke to Resident 1 after the incident. RNA 1 stated Resident 1 stated she felt scared because the incident with Resident 3 reminded her of what happened in the past.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/8/2025, at 1:50 PM, with HKS, HKS stated on 5/6/2025, she was cleaning Room A and saw Resident 1 and Resident 3 next to each other in the hallway. HKS stated she observed Resident 3 touch Resident 1's inner thigh on her way out of Room A. HKS stated she told Resident 3 not to touch Resident 1 and immediately pulled his wheelchair to the other side of the hallway. HKS stated she walked to the nurse's station and informed CN 1 about the incident. HKS stated while reporting to CN 1 she saw Resident 3 wheel himself back to Resident 1's wheelchair. HKS stated she observed Resident 3 place his hand inside Resident 1's shirt and touched Resident 1's upper back. HKS stated Resident 1 looked scared during the incident and rocked back and forth in her wheelchair. HKS stated Resident 3 always speaks dirty (use sexually explicit language) whenever a female staff enters his room.</p> <p>During a concurrent interview and record review on 5/8/2025, at 2:23 PM with the Minimum Data Set Nurse (MDSN), MDSN stated no documentation in Resident 1's chart about the incident on 5/6/2025 between Resident 1 and Resident 3. MDSN stated there was no documentation in Resident 3's chart about the incident on 5/6/2025 between Resident 1 and Resident 3. MDSN stated Resident 1 and Resident 3 documentation should have included an SBAR, progress note, care plan, and a 72-hour monitoring (a period of increased observation and assessment after a suspected incident of abuse or neglect, lasting 72 hours). MDSN stated no documentation was found in the charts that indicated Resident 1 and Resident 3's physicians and responsible parties were notified about the incident. MDSN stated it was important to notify the physician about sexual abuse so Resident 1 and Resident 3 could get the proper and necessary treatment or evaluation. MDSN stated Resident 1 and Resident 3 should have been separated and not attend activities at the same time and the same day.</p> <p>During an interview on 5/8/2025, at 3:23 PM, with AA, AA stated Resident 3 always rubbed his private part over Resident 3 clothes in the Activity room. AA stated when Resident 3 rubs his private part it looked like he was masturbating (stimulate one's own genitals for sexual pleasure). AA stated Resident 3 also liked looking at female residents and blow air kisses (to purse the lips as if kissing someone without making contact) at them. AA stated Resident 3's behavior made the female residents in the Activity room uncomfortable, so she would move Resident 3 away from the female residents and cover Resident 3 private area with a towel. AA stated Resident 3 would get mad every time AA told him to stop rubbing his private area. AA stated she reported Resident 3's behavior to the Activities Director (AD) and CNA 2. AA stated AD informed AA that AD would talk to Resident 3 about his behavior. AA stated she did not know if AD informed the DON or ADM about Resident 3's behavior.</p> <p>During the same interview on 5/8/2025, at 3:23 PM with AA, AA stated Resident 1 and Resident 3 arrived separately in the Activity room on 5/6/2025, at around 1 PM. AA stated CN 1 followed Resident 1 and Resident 3 to the Activity room and informed AA both residents needed to be seated away from each other but did not tell her why.</p> <p>During an observation in Resident 1's room on 5/8/2025 at 5:32 PM, the DON was observed asking Resident 1 if she felt safe in the facility. Resident 1 informed the DON she did not really feel safe in the facility because of what Resident 3 did to her. Resident 1 informed the DON that Resident 1 had a history of being raped before being admitted at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/8/2025, at 6:14 PM, with the ADM, the ADM stated the alleged sexual abuse between Resident 1 and Resident 3 happened on 5/6/2025. ADM stated there was no documentation that an assessment, monitoring or development of a care plan was done for Resident 1 and Resident 3 after the incident. The ADM stated facility staff should have assessed, monitored, and developed a care plan about the abuse incident between Resident 1 and Resident 3.</p> <p>During a concurrent interview and record review with AA on 5/9/2025, at 11:36 AM, Resident 1 and Resident 3's Recreational Group Participation Record, dated 5/2025 were reviewed. AA stated on 5/6/2025 Resident 1 and Resident 3 were both in the Activity room to watch a movie. AA stated she would not have had Resident 1 and Resident 3 in the Activity room at the same time if she knew about the incident in front of Room A.</p> <p>During an interview on 5/9/2025, at 11:54 AM, with AD, AD stated Resident 3 sat by the Medical Records (MR) room with a towel on his lap whenever he came to the Activity room. AD stated AA informed him about Resident 3 rubbing his private area around four months ago. AD stated he told Resident 3 to stop rubbing his private area as soon as he learned about it because there were female residents also went to the Activity room. AD stated Resident 3 told him he was just scratching his private area because he had a rash when AD told him to stop. AD stated he informed an unknown licensed nurse to check on Resident 3's rash. AD did not inform the ADM about Resident 3's behavior in the Activity room.</p> <p>During an interview on 5/9/2025, at 12:05 PM, with the Medical Record Director (MRD), the MRD stated Resident 1 and Resident 3 should not have been placed in the same room after the suspected abuse incident. MRD stated facility staff should have reported and documented Resident 3's behavior so that everyone was aware of his behavior. MRD stated facility staff could protect and prevent abuse from Resident 3 if everyone was aware of his behavior.</p> <p>During an interview on 5/9/2025, at 1:55 PM, Licensed Vocational Nurse 1 (LVN 1) stated Resident 2 touching Resident 1 on Resident 1's inner thigh and back without her consent was considered sexual abuse. LVN 1 denied knowing about the incident but stated Resident 1 and Resident 3 should not have been placed in the Activity room after the incident because Resident 1 can re-live the trauma that she experienced from being touched by Resident 3. LVN 1 stated trauma can be repeated in the presence of the abuser. LVN 1 stated it was also possible that Resident 3 can abuse Resident 1 again by being in the same room as her. LVN 1 stated the facility staff who observed the sexual abuse should have assessed the resident, written an SBAR, documented what was seen in the progress notes, and monitored the resident for 72 hours. LVN 1 stated the physician should have been notified of the incident. LVN 1 stated the SSD should have talked to Resident 1 to assess her psychosocial status after the incident. LVN 1 stated a care plan should have been developed for Resident 1 and Resident 3 to address resident-centered interventions to care for a resident who experienced abuse and prevent abuse.</p> <p>During a follow- up interview on 5/9/2025, at 2:25 PM, CN1 stated she did not write an SBAR or a care plan regarding the inappropriate touching of Resident 3 towards Resident 1. CN 1 stated it was important to write a care plan for abuse to know what interventions are needed to prevent another abuse incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a concurrent follow up interview and record review on 5/9/2025, at 2:54 PM, with MDSN, MDSN stated Resident 3 did not have a progress note, interdisciplinary team meeting (IDT- a group of healthcare professionals from different disciplines who collaborate to provide comprehensive and coordinated care for a resident), or care plan indicating his behavior of touching himself inappropriately in the Activity room.</p> <p>During an interview on 5/9/2025, at 3:23 PM, with the MD, MD stated the facility did not inform him that Resident 1 was the victim of Resident 3's inappropriate behavior on 5/6/2025. The MD stated Resident 3's inappropriate behavior towards Resident 1 should have been reported to the police and CDPH. The MD stated Resident 1 and Resident 3 should not have been placed in the Activity room at the same time. The MD stated Resident 1 seeing Resident 3 in the same room can physically and emotionally affect her since she was alert and oriented. The MD stated the facility's policy and procedure (P&P) for abuse prevention and reporting was not followed.</p> <p>During an interview on 5/9/2025, at 4:47 PM, with SSD, SSD stated she was informed by an unknownstaff that Resident 3 touched Resident 1's thigh and upper back on 5/6/2025. SSD stated the ADM was informed of the incident but believed it was not considered abuse because Resident 1 was wearing pants and Resident 3 just touched her thigh. SSD stated she did not assess or talk to Resident 1 after the incident. SSD stated Resident 1 and Resident 3 should not have been placed in the Activity room together at the same time to ensure Resident 1's safety. SSD stated she should have advocated for Resident 1's safety in the facility.</p> <p>During an interview on 5/10/2025, at 11:53 AM with the ADM, in the presence of the ADMC, the ADM stated he was informed by several staff that Resident 3 had a history of inappropriately touching females at a different facility. The ADM stated CN 1 informed him on 5/6/2025 that Resident 3 touched Resident 1's inner thigh and upper back in the hallway. The ADM stated if Resident 3 touched Resident 1 on her inner thigh and upper back without Resident 1's consent then it was considered abuse. The ADM stated the facility staff did not follow the process for abuse involving Resident 1 and Resident 3. The ADM stated it was important for facility staff to prevent further interactions and incidents between Resident 1 and Resident 3. The ADM stated Resident 1 or Resident 3 should have been moved to a different floor in the facility to prevent them from seeing each other. The ADM also stated Resident 1 and Resident 3 should not have attended activities at the same time in the Activity room on 5/6/2025. The ADM stated there was potential harm to Resident 1's physical and emotional health because the memories from her previous rape can come back after the incident with Resident 3. The ADM stated the facility staff did not follow the facility's goal for Resident 1 which was to provide proper care, keep her safe and free from abuse, and take care of her emotional and physical well-being. The ADM stated he was the abuse coordinator in the facility. The ADM stated the responsibility of the abuse coordinator was to ensure abuse is prevented and investigated. The ADM stated the facility's P&P for abuse prevention was not followed.</p> <p>During a review of the facility's P&P, titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 03/2025, the P&P indicated the following:</p> <p>Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including but not necessarily limited to other residents.</p> <p>Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems.</p> <p>Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.</p> <p>Protect residents from any further harm during investigations.</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their policy and procedure (P&P) for abuse (the willful infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm) prevention, reporting, and investigation for two of three sampled residents (Resident 1 and Resident 2) by failing to:</p> <ol style="list-style-type: none"> 1. <p>Report physical abuse (any intentional act causing injury or trauma to another person) by Resident 3 to Resident 2 within two hours from when the Activities Assistant (AA) witnessed Resident 3 punching (strike with a fist) Resident 2 on the chest while waiting inside the elevator on 4/15/2025. There was no documented evidence that the facility reported the incident to State Survey agency (SA or California Department of Public Health [CDPH]- a governmental body or institution established by a state government to perform specific functions or responsibilities like enforcing laws), Ombudsman (a designated official who advocates for the rights and well-being of residents in long-term care facilities), and law enforcement from 4/15/2025 to 5/8/2025.</p> 2. <p>Investigate and provide documentation of investigation of Resident 3's physical abuse to Resident 2.</p> 3. <p>Protect Resident 1 and other residents in the facility from further abuse and/or another abuse by Resident 3 when the facility did not report to SA, Ombudsman, and law enforcement when Charge Nurse 1 (CN 1), Restorative Nursing Assistant 1 (RNA 1), and Housekeeping Staff (HKS) witnessed Resident 3 touch Resident 1's inner thigh and inside the resident's shirt touching Resident 1's upper back.</p> 4. <p>Investigate and provide documentation of investigation of the sexual abuse (non-consensual touching of one person for the sexual gratification of another) incident by Resident 3 towards Resident 1 on 5/6/2025.</p> <p>These deficient practices resulted in Resident 2 experiencing physical abuse from Resident 3 on 4/15/2025 and Resident 1 experiencing sexual abuse from Resident 3 on 5/6/2025. It also placed other residents in the facility potential for physical and sexual abuse from Resident 3 due to Resident 3's inappropriate behavior. On 5/8/2025, Resident 1 expressed feeling scared and did not feel safe in the facility since the incident occurred with Resident 3. Resident 2 was placed at risk for physical and/or psychosocial (having to do with the spiritual, emotional, social, and mental aspects of a person's life) effects such as experiencing fear.</p> <p>(continued on next page)</p> 		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 5/8/2025 at 6:36 PM, the California Department of Public Health (CDPH) called an Immediate Jeopardy situation (IJ, a situation in which the facility's noncompliance [not following rules] with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Resident) with regards to the facility's failure to implement their policy and procedure for abuse prevention, reporting and investigation for Resident 1 and Resident 2.</p> <p>The facility submitted an acceptable IJ Removal Plan (action to correct the deficient practice), to CDPH on 5/11/2025 at 5:21 PM. The IJ was removed on 5/11/2025, after the surveyor verified and confirmed the facility implemented the facility's IJ Removal Plan (a detailed plan to address the IJ findings) while onsite by observation, interview, and record review. The IJ was removed in the presence of the Administrator Consultant (ADMC) and the Director of Staff Development (DSD).</p> <p>The acceptable IJ Removal Plan included the following information:</p> <p>1)</p> <p>Resident 3 was transferred to General Acute Care Hospital (GACH) for psychiatric (relating to mental illness) evaluation on 5/8/2025 at 10:51 PM. The attending physician issued the order for transfer at 5/8/2025, at 7:09 PM.</p> <p>2)</p> <p>Resident 3 was on one-on-one watch on 5/8/2025 until transportation arrived for pickup. An order was obtained from the physician, and a log was used by the staff to document.</p> <p>3)</p> <p>On 5/8/2025 at 7:14 PM, Psychiatrist Physician Assistant (PPA- a licensed healthcare professional who practices medicine under the supervision of a physician, specializing in the diagnosis and treatment of mental illness) evaluated Resident 1 for psychological support and emotional distress. On 5/8/2025 at 7:40 PM, the PPA evaluated Resident 2 for psychological support and emotional distress. On 5/8/2025 at 7:11 PM, the PPA evaluated Resident 3 as well for psychosocial support (the provision of emotional, social, and mental health assistance to individuals or groups experiencing challenges) and emotional distress.</p> <p>4)</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Psychologist (mental health professional who specializes in the study of the mind and behavior) vendor came to the facility on 5/9/2025 at 10:04 AM to evaluate Resident 1 for psychosocial distress (the emotional, social, and/or spiritual discomfort an individual experiences when overwhelmed by stressful situations, particularly those that impact their quality of life) related to the recent case of sexual abuse. The Psychologist vendor came to the facility on 5/9/2025 at 10:59 AM to evaluate Resident 2 for psychosocial distress related to the recent case of physical abuse. According to the psychologist's notes for Resident 1, the psychologist notes indicated, The recent incident of alleged sexual misconduct appears to be managed by the facility's safety protocols. On 5/10/2025 at 8:26 AM, Resident 1 was transferred to GACH for psychiatry (psych) evaluation, per the attending physician's order. According to the psychologist notes for Resident 2, the psychologist notes indicated, patient is currently stable and not experiencing significant psychological distress related to the reported incident.</p> <p>5)</p> <p>72 Hours SBAR (Situation, Background, Assessment, Recommendation - a structured communication tool used to improve clean and efficient communication, especially in critical situations or when transferring information between health-care professionals) initiated for Resident 1 on 5/8/2025, including assessment of emotional distress.</p> <p>6)</p> <p>72 Hours SBAR initiated for Resident 2 on 5/8/2025, including assessment of emotional distress.</p> <p>7)</p> <p>(Late) Report of SOC-341 (Report of Suspected Dependent Adult/Elder Abuse form- a mandated form used to document reports of suspected elder and dependent adult abuse) was completed on 5/8/2025 and faxed to the LTC (long-term care) Ombudsman (a designated official who advocates for the rights and well-being of residents in long-term care facilities) on 5/8/2025 at 10:05 PM and faxed to CDPH on 5/8/2025 at 10 PM for the incident of sexual abuse experienced by Resident 1. The local police department came to the facility to follow up on the telephonic report on 5/9/2025 at 9:40 AM for the incident of sexual abuse to Resident 1.</p> <p>8)</p> <p>(Late) Report of SOC-341 was completed on 5/8/2025 and faxed to LTC Ombudsman on 5/8/2025 at 9:38 PM and faxed to CDPH on 5/8/2025 at 9:40 PM for the incident of physical abuse experienced by Resident 2. Local Police Dept. came to the facility to follow up on the telephonic report on 5/9/2025 at 9:40AM for the incident of physical abuse to Resident 2.</p> <p>9)</p> <p>On 5/8/2025, 5/9/2025, and 5/10/2025, the DSD in-serviced all staff for abuse prevention, reporting, and investigation.</p> <p>10)</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 5/10/2025, ADMC in-serviced the following staff: 7 AM - 3 PM Licensed Nurses and Department Heads regarding Abuse Prevention, Investigation, and Reporting with emphasis placed on the importance of staff knowing how to report telephonically to CDPH, LTC Ombudsman, Local PD and how to complete and fax the SOC-341 form to CDPH and LTC Ombudsman.</p> <p>11)</p> <p>On 5/10/2025, ADMC in-serviced the following staff: 3 PM to 11 PM Licensed Nurses regarding Abuse Prevention, Investigation, and Reporting with emphasis placed on the importance of staff knowing how to report telephonically to CDPH, LTC Ombudsman, Local PD and how to complete and fax the SOC-341 form to CDPH and LTC Ombudsman.</p> <p>12)</p> <p>On 5/10/2025, the ADM attended an approved training course for abuse prevention and reporting. Training course is approved by the [NAME] (National Association of Long Term Care Administrator Boards- the authority for leadership core competencies in long term care) for 1 hour ([NAME] Approval- #A-DL) and administered via Website Address A, the training course was completed by the Administrator on 5/10/2025. On 5/10/2025, the ADMC gave a one-on-one in- service to the ADM regarding F600 and F607.</p> <p>13)</p> <p>Beginning 5/10/2025, Daily Room Rounds sheets will include questions such as: Do you feel safe? and Are you getting along with your roommate? and Do you feel safe in all areas of the facility, such as hallways, elevator, activities room, rehab room, and dining areas?</p> <p>14)</p> <p>The incident of sexual abuse experienced by Resident 1 was care planned by the MDS Nurse on 5/8/2025.</p> <p>15)</p> <p>The incident of physical abuse experienced by Resident 2 was care planned by the MDS Nurse on 5/8/2025.</p> <p>16)</p> <p>If Resident 3 is readmitted to the facility, the resident can have in-room activities to ensure other residents are not subjected to unwanted touching or view of the resident touching himself.</p> <p>17)</p> <p>The daily resident census for 5/9/2025 was surveyed by Social Services Director (SSD) and assistants to ensure that no other residents experienced abuse at the hands of Resident 3 during their stay in the facility. The answers of the residents will be documented.</p> <p>18)</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Evaluation of the Abuse Prevention Program will be discussed with the board of physicians in the monthly Quality Assessment (QA- the specification of standards for quality of service and outcomes, and systems throughout the organization for assuring that care is maintained at acceptable levels in relation to those standards)/Utilization Review (UR-a process that evaluates the appropriateness and necessity of healthcare services, treatments, and procedures) meeting with emphasis on all cases of abuse being reported within 2 hours. The abuse log will be reviewed in the monthly QA/UR meeting to ensure all cases of abuse are documented for their given month.</p> <p>19)</p> <p>Interviews were conducted on 5/9/2025 with Resident 1 and associated witness as part of the facility's sexual abuse investigation.</p> <p>20)</p> <p>Interviews were conducted on 5/9/2025 with Resident 2 and associated witness as part of the facility's physical abuse investigation.</p> <p>21)</p> <p>The Medical Director (MD) was called and visited the facility on 5/9/2025 and discussed solutions regarding the deficient practices (an action, error, or lack of action on the part of the facility that leads not non-compliance with a regulatory requirement or standard).</p> <p>22)</p> <p>Facility appointed temporarily an Abuse Coordinator on 5/10/2025, in consultation with the ADMC. The new Abuse Coordinator will be Business Office Manager (BOM). An alternate abuse coordinator will be made available in the event the Business Office Manager is unavailable. The alternate abuse coordinator will be: Central Supply Director (CSD). The ADMC in-serviced the new Abuse Coordinator and the alternate Abuse Coordinator regarding the role of an abuse coordinator. Please see attached the acknowledgement letter. The in-coming Director of Nursing (DON) who will start on 5/12/2025 will be the new Abuse coordinator. The ADMC will in-service the incoming DON regarding the role of Abuse Coordinator and the F-Tag 600 and F-Tag 607 starting tomorrow, 5/12/2025. Please see attached application and offer letter for the DON that will start on 5/12/2025.</p> <p>23)</p> <p>Beginning 5/10/2025, while the facility is not in compliance with F600 and F607, ADMC will be employed as an ADMC to oversee the current facility ADM and give guidance on implementation of the immediate Plan of Action (POA) to ensure total compliance is achieved.</p> <p>24)</p> <p>On 5/10/25 at 4:00pm, the ADMC, in consultation with the President of the facility, suspended the assigned facility administrator for 5 days. If the conditions of counseling are not met further disciplinary actions up to termination are recommended.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>25)</p> <p>On 5/11/2025, the ADMC recommended to the President and Chief Executive Officer (CEO) to terminate the ADM and to start looking for a new ADM. The CEO agreed with the recommendation and will start looking for a new candidate as soon as possible. The CEO expects to hire a qualified candidate within 30 days.</p> <p>26)</p> <p>The in-coming DON who will start on 5/12/2025 will serve as the interim Nursing Home ADM, while the current ADM is on suspension. The ADMC will provide oversight to the interim NH ADM/DON regarding F607 starting on 5/12/25. Once the facility hired a new ADM, the new ADM will be the Abuse Coordinator.</p> <p>Cross reference F600, F684, and F842</p> <p>Findings:</p> <p>1.</p> <p>During a review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included other recurrent depressive disorder (persistent sadness and loss of interest in activities, affecting thoughts, behaviors, feelings, and well-being), schizophrenia (a mental illness that can affect thoughts, moods, and behavior), and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).</p> <p>During a review of Resident 1's History and Physical Examination (H&P), dated 4/30/2024, the H&P indicated Resident 1 could make needs known but could not make medical decisions due to cognitive (mental action of process of acquiring knowledge and understanding) decline.</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/3/2025, the MDS indicated Resident 1 was assessed having moderately impaired cognitive skills for daily decision making. Resident 1 required partial/moderate assistance (helper does more than half the effort) with upper body dressing, personal hygiene, sit to stand, and chair/bed-to-chair transfer. Resident 1 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, and lower body dressing.</p> <p>During a review of Resident 1's Care Plan Report, dated 10/31/2024, the care plan indicated Resident 1 had a history (hx) and episodes of verbalizing, I don't want to live anymore (no suicidal ideation plan verbalized) and was a potential/at risk for injury to self. Resident 1's care plan interventions indicated the following:</p> <p>Psychology (study of human mind and its functions especially those affecting behavior in a given context) consult and treatment (tx) as/if indicated</p> <p>Social Services Director (SSD) for psychosocial support</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Stay with Resident if Resident shows signs and symptoms of sadness, notify physician (MD) of change in condition (COC)</p> <p>During a review of Resident 1's Diagnostic Evaluation (Psychology) report, dated 5/9/2025, the report indicated the following:</p> <p>Resident 1 was referred following an allegation that another male Resident touched her inner thigh and rubbed her back on 5/6/2025.</p> <p>The referral also includes a review of her current risk statements, which include recurrent declarations of I want to die.</p> <p>Observed engaging in repetitive rocking behavior, which may be indicated of internal distress (state of unease or discomfort experienced within oneself often stemming from thoughts, feelings and experiences rather than outside factors) or an anxiety (an emotional state characterized by feelings of unease such as worry or fear that can range from mild to severe)-regulating mechanism.</p> <p>2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing, bilateral (affecting both sides) primary osteoarthritis (a progressive disorder of the joints, caused by gradual loss of cartilage) of knee, and other specified polyneuropathies (damage to multiple nerves typically affecting both sides of the body and often starting in the hands and feet).</p> <p>During a review of Resident 2's MDS indicated Resident 2 was assessed having intact memory and cognitive skills for daily decision making. Resident 2 required set up or clean up assistance with oral/personal hygiene, upper/lower body dressing, and eating. Resident 2 was independent with toileting hygiene, sit to lying, sit to stand, and toilet transfer. Resident 2 required supervision or touching assistance with walking 150 ft.</p> <p>3. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia (a progressive state of decline in mental abilities), recurrent depressive disorder, and specified anxiety disorder.</p> <p>During a review of Resident 3's H&P, dated 3/22/2025, the H&P indicated Resident 3 had a fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 was assessed having moderately impaired cognitive skills for daily decision making. Resident 3 required supervision or touching assistance with oral hygiene, upper body dressing, sit to stand, chair/bed-to-chair transfer, and toilet transfer. Resident 3 was independent with wheeling his manual wheelchair at least 50 feet (ft- unit of measurement) and make two turns and 150 ft in a corridor or similar space.</p> <p>During an observation on 5/8/2025, at 10:58 AM, Resident 3 was observed sitting in his room watching television. Resident 3's room was located on the same floor as Resident 1. Resident 3 refused to be interviewed.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/8/2025, at 10:59 AM, with Charge Nurse 1 (CN 1), in the presence of the DON, CN 1 stated on 5/6/2025, at around 1 PM, Resident 1 and Resident 3 were sitting on their wheelchairs and were placed next to each other in the hallway in front of Room A. CN 1 stated Resident 1 and Resident 3 were waiting to be taken to the Activity Room. CN 1 stated she was sitting in the nurse's station and when she stood up, observed Resident 3 touch Resident 1 on her inner thigh. CN 1 stated she called Resident 3's name and observed Housekeeping Staff (HKS) pull Resident 3's wheelchair away from Resident 1 and parked it on the opposite side of the hallway. CN 1 stated Resident 3 wheeled his wheelchair to Resident 1 and rubbed her back from behind. CN 1 stated she walked towards Resident 1 and Resident 3 and wheeled Resident 3 to the nurse's station. CN 1 stated Resident 3 denied touching Resident 1 when she asked him why he touched her. CN 1 stated Resident 1 stated she did not feel comfortable being touched by Resident 3 after the incident happened. CN 1 stated Restorative Nursing Assistant 1(RNA 1) HKS also witnessed the incident. CN 1 stated Activities Assistant (AA) arrived and brought Resident 1 and Resident 3 to the activity room. CN 1 stated she followed Resident 1 and Resident 3 to the Activity room and informed AA that Resident 1 and Resident 3 were not allowed to sit next to each in the activity room. CN 1 stated AA informed her that Resident 3 was always placed away from the female residents in the activity room because of past incidences where Resident 3 had been touchy. CN 1 stated she did not know what AA meant by touchy and did not ask AA.</p> <p>During the same interview with CN 1 on 5/8/2025, at 10:59 AM, CN 1 stated AA was aware of the incident between Resident 1 and 3 that happened on 5/6/2025, and did not report Resident 3's inappropriate behavior to the ADM. CN 1 stated she was a mandated reporter (a person who is required by law to report suspected cases of abuse and neglect to the authorities) and reported the incident between Resident 1 and 3 to the ADM five minutes after she left the activity room. CN 1 stated the ADM told her he was not going to report the incident to CDPH. CN 1 stated the process in the facility regarding abuse was to report the abuse to the abuse coordinator immediately. CN 1 stated the facility's abuse coordinator was the ADM. CN 1 stated abuse should be reported to CDPH, LTC Ombudsman, and the police within 2 hours from when the abuse was witnessed/suspected, or the allegation was made.</p> <p>During the same interview on 5/8/2025, at 11:10 AM, with CN 1 and the DON, CN 1 stated on 4/15/2025, Resident 3 punched Resident 2 on the chest while Residents 3, 2 and AA were in the elevator. CN 1 stated Resident 3 stated he punched Resident 2 in retaliation to a prior incident when Resident 2 got upset at Resident 3 for walking between Resident 2 and another resident in the facility. The DON stated Resident 3 had a history of causing problems with other residents at a different facility.</p> <p>During a concurrent observation and interview on 5/8/2025, at 11:32 AM, with Resident 1, Resident 1 was sitting on her wheelchair outside of her room. Resident 1 was alone and was rocked back and forth during the interview. Resident 1 stated that a couple of days ago Resident 3 touched her and pointed to her scapular (the flat triangular bone located on the back of the upper body) area when asked where she was touched. Resident 1 stated the incident occurred in the hallway close to the nurse's station while waiting to go to the activity room. Resident 1 stated she told Resident 3 to stop touching her and to leave her alone. Resident 1 stated she did not feel safe in the facility because she was raped (a type of sexual assault involving sexual intercourse, or other forms of sexual penetration, carried out against a person without their consent) before when she was living in the streets. Resident 1 stated only CN 1 talked to her about the incident since it happened. Resident 1 stated she was brought to the Activity room after the incident happened. Resident 1 stated Resident was also brought to the Activity room after the incident happened. Resident 1 stated she felt scared that Resident 3 was in the same room as her but felt like there was nothing she could do about it.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/8/2025, at 12:05 PM, with RNA 1, RNA 1 stated on 5/6/2025, she observed Resident 3 wheel his wheelchair towards Resident 1 and touch her inner thigh. RNA 1 stated she called Resident 3's name to get his attention. RNA 1 stated she did not stop Resident 3 from touching Resident 1 because she was pushing another resident towards the nurse's station. RNA 1 stated Resident 3 had a history of verbally abusing and talking about female body parts to the Certified Nursing Assistants (CNA). RNA 1 stated she spoke to Resident 1 after the incident and Resident 1 stated she felt scared because the incident with Resident 3 reminded her of what happened in the past. RNA 1 stated she was a mandated reporter and reported the incident to CN 1 but RNA 1 was not sure what happened after. RNA 1 stated abuse should be reported to CDPH, LTC Ombudsman, and the police right away or within two hours from when it happened. RNA 1 stated it was important to investigate and report the abuse to CDPH to ensure the safety of the residents. RNA 1 stated the ADM never interviewed RNA 1 about what she witnessed between Resident 1 and 3.</p> <p>During an interview on 5/8/2025, at 12:39 PM with CNA 1, CNA 1 stated about a month ago Resident 2, and Resident 3 had a fight in the elevator.</p> <p>During an interview on 5/8/2025, at 1:50 PM, with HKS, HKS stated on 5/6/2025, she was cleaning Room A and saw Resident 1 and 3 sitting next to each other in the hallway. HKS stated she observed Resident 3 touch Resident 1's inner thigh as she walked out of Room A. HKS stated she told Resident 3 not to touch Resident 1 and immediately pulled his wheelchair on the other side of the hallway. HKS stated she walked to the nurse's station and informed CN 1 about the incident. HKS stated she saw Resident 3 wheel himself back to Resident 1's wheelchair and observed Resident 3 place his hand inside Resident 1's shirt and touched Resident 1's upper back. HKS stated Resident 1 looked scared during the incident and rocked back and forth in her wheelchair. HKS stated Resident 3 always spoke dirty (use sexually explicit language) whenever a female staff enters Resident 3's room.</p> <p>During a concurrent interview and record review on 5/8/2025, at 2:25 PM with the Minimum Data Set Nurse (MDSN), MDSN stated on 5/6/2025, an unknown CNA reported to CN 1 that Resident 3 touched Resident 1 inappropriately on Resident 1's inner thigh and upper back. MDSN stated on 5/6/2025, CN 1 informed the ADM regarding the incident between Resident 1 and Resident 3. MDSN stated that inappropriate touching was considered sexual abuse. MDSN stated abuse allegations should have been investigated by the ADM who was the facility's abuse coordinator. MDSN stated abuse allegations should be reported immediately or within two hours to CDPH, LTC Ombudsman, and the police. MDSN stated the ADM was the person responsible in the facility for reporting abuse to the SAs. MDSN stated she did not know if the ADM reported the incident between Resident 1 and 3 to the SAs. MDSN stated the incident between Resident 1 and Resident 3 should have been investigated by the ADM. MDSN stated she did not know if the ADM reported and investigated the incident between Resident 1 and Resident 3 that happened on 5/6/2025. MDSN stated she has not seen the police in the facility to investigate the incident between Resident 1 and Resident 3. MDSN stated Resident 1 and Resident 3 did not have an investigation report or a copy of the faxed SOC 341 (State of California's form used to report elderly abuse) about the incident on 5/6/2025 in the residents' charts.</p> <p>During the same concurrent interview and record review on 5/8/2025, at 2:25 PM, with the MDSN, MDSN stated she has not seen the police in the facility to investigate the physical abuse between Resident 2 and Resident 3 that happened on 4/15/2025. MDSN stated Resident 2 and 3 did not have an investigation report or a copy of the faxed SOC 341 about the physical abuse on 4/15/2025 in their charts.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview, on 5/8/2025, at 3 PM, with AA, AA stated approximately 4 weeks ago (around April) she was inside the elevator in the Activity room with Resident 2 and Resident 3. AA turned her back away from Resident 2 and Resident 3 to operate the elevator when she heard a noise. AA stated she turned around and saw Resident 3 punching Resident 2 at least three times on Resident 2's chest. AA stated Resident 2 attempted to punch Resident 3 back but could not reach him because of the resident's walker. AA stated she stood between Resident 2 and Resident 3 to stop them from punching each other. AA stated she reported the physical abuse immediately to Licensed Vocational Nurse 1 (LVN 1). AA stated the Activities Director (AD) and Medical Record Director (MRD) witnessed and assisted AA in separating Resident 2 and Resident 3 in the elevator. AA stated abuse needed to be reported immediately to the ADM. AA stated she reported the physical abuse to LVN 1 but not to the ADM. AA stated after the incident, the ADM met with the DON, MDSN, Resident 2 and Resident 3 in the ADM's office. AA stated she did not know if the ADM reported the physical abuse to CDPH, ombudsman and/or the police after the meeting. AA stated all facility staff are mandated reporters.</p> <p>During an interview, on 5/8/2025, at 4:56 PM, with Resident 2, Resident 2 stated Resident 3 punched him on his right chest in the elevator last month (unable to recall when) and the incident took place inside the elevator. Resident 2 stated Resident 3 was his roommate before, but they never got along. Resident 2 stated Resident 3 always got mad and yelled at him for waking up early and making noise. Resident 2 stated Resident 3 was a problematic resident and did not want to have anything to do with him.</p> <p>During an interview, on 5/8/2025, at 6:14 PM, with the ADM, in the presence of the DON, the ADM stated the alleged sexual abuse between Resident 1 and Resident 3 happened on 5/6/2025. ADM stated he did not investigate the incident that took place on 5/6/2025 between Resident 1 and Resident 3. The ADM stated he did not report the incident between Resident 1 and Resident 3 to CDPH, police, and LTC Ombudsman.</p> <p>During the same interview, on 5/8/2025, at 6:14 PM, with the ADM, in the presence of the DON, the ADM stated he was informed on 4/15/2025 that Resident 2 and Resident 3 had an altercation in the elevator after attending activities. The ADM stated Resident 3 punched Resident 2 for an unknown reason. The ADM stated he did not report the altercation between Resident 2 and Resident 3 to CDPH, LTC Ombudsman, and the police. The ADM stated he did not have an investigation report about the altercation between Resident 2 and Resident 3.</p> <p>During an interview, on 5/9/2025, at 12:05 PM, with MRD and Medical Records Assistant (MRA), MRD stated on 4/15/2025, she heard AA yell ayuda (help) in the Activity room elevator. MRD stated she and MRD ran to the elevator and saw Resident 3 trying to punch Resident 2. MRD stated she pulled Resident 3 out of the elevator and AA proceeded to take Resident 2 to his room. MRD stated she reported the altercation to LVN 1, SSD, and the DSD. MRD stated she did not report the incident to the ADM because he was not available. MRD stated abuse should be reported by all facility staff immediately or within 2 hours to CDPH, LTC Ombudsman, and police. MRD and MRA both stated they knew how to call the police and the LTC Ombudsman but stated they did not know how to report to CDPH. MRD and MRA both stated they did not know what an SOC 341 was and how to fill out a SOC 341 form. MRD stated it was important to report and investigate abuse for the safety of the residents in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview, on 5/9/2025, at 1:55 PM, with LVN 1, LVN 1 stated on 4/15/2025, AA notified him about the incident in the elevator between Resident 2 and Resident 3. LVN 1 stated the incident between Resident 2 and Resident 3 should have been reported to CDPH, the police and Ombudsman. LVN 1 stated the DON, and the ADM should fill out and send the SOC 341 form to CDPH for all alleged/witnessed abuse. LVN 1 stated he did not know if the ADM reported the altercation between Resident 2 and 3 to CDPH. LVN 1 stated he never saw the police come to the facility to investigate the altercation between Resident 2 and Resident 3. LVN 1 stated he did not know if the ADM investigated the incident between Resident 2 and Resident 3.</p> <p>During the same interview, on 5/9/2025, at 1:55 PM, with LVN 1, LVN 1 denied any knowledge about the incident that took place on 5/6/2025 between Resident 1 and Resident 3. LVN 1 stated the investigation should have included interviews from the witnesses, Resident 1, and Resident 3. LVN 1 stated it was the responsibility of the abuse coordinator to investigate abuse once it was reported. LVN 1[TRUNCATED]</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to ensure three of three sampled residents (Resident 1, 2 and 3) received treatment and care in accordance with professional standards of practice by failing to:</p> <ol style="list-style-type: none"> 1. <ol style="list-style-type: none"> a. Assess and monitor Resident 1's physical, emotional, and mental status after a change in condition on 5/6/2025 when she was inappropriately touched on her inner thigh and upper back by Resident 3. b. Develop a resident-centered care plan for Resident 1 addressing an incident on 5/6/2025 after Resident 1 was inappropriately touched on her inner thigh and upper back by Resident 3 c. Inform the physician after Resident 1 was inappropriately touched on her inner thigh and upper back by Resident 3. <p>Thes deficient practices resulted in failure in the delivery of necessary services and care and Resident 1 feeling unsafe and scared in the facility and had the potential to cause harmful physical and/or psychosocial effect, injury and/or death for Resident 1.</p> 2. <ol style="list-style-type: none"> a. Assess and monitor Resident 2's physical and emotional status after a change in condition on 4/15/2025 when he was punched in the chest at least three times in the elevator by Resident 3. b . Develop a resident-centered care plan for Resident 2 addressing getting punched on 4/15/2025 on the chest at least three times in the elevator by Resident 3. c. Inform the physician after Resident 2 was punched at least three times on the chest by Resident 3 on 4/15/2025. <p>These deficient practices resulted in failure in the delivery of necessary services and care and had the potential to cause harmful physical and/or psychosocial effect, injury and/or death for Resident 2.</p> 3. <ol style="list-style-type: none"> a. Assess and monitor Resident 3 after inappropriately touching Resident 1 on Resident 1's inner thigh and upper back on 5/6/2025 and punching Resident 3 in the elevator on 4/15/2025. b. Develop a Resident-centered care plan addressing Resident 3's inappropriate behavior towards Resident 1 on 5/6/2025 and physical aggression towards Resident 2 on 4/15/2025. c. Inform the physician after Resident 3 inappropriately touched Resident 1 on 5/6/2025 and punched Resident 2 in the elevator on 4/15/2025. <p>(continued on next page)</p> 		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>These deficient practices resulted in failure in the delivery of necessary services and care had the potential to place other residents in the facility at risk for experiencing physical and sexual abuse by Resident 3's due to his unaddressed inappropriate and aggressive behavior.</p> <p>Cross reference F600, F607, and F842</p> <p>Findings</p> <p>1. During a review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included other recurrent depressive disorder (persistent sadness and loss of interest in activities, affecting thoughts, behaviors, feelings, and well-being), schizophrenia (a mental illness that can affect thoughts, moods, and behavior), and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).</p> <p>During a review of Resident 1's History and Physical Examination (H&P), dated 4/30/2024, the H&P indicated Resident 1 could make needs known but could not make medical decisions due to cognitive (mental action of process of acquiring knowledge and understanding) decline.</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/3/2025, the MDS indicated Resident 1 was assessed having moderately impaired cognitive skills for daily decision making. Resident 1 required partial/moderate assistance (helper does more than half the effort) with upper body dressing, personal hygiene, sit to stand, and chair/bed-to-chair transfer. Resident 1 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, and lower body dressing.</p> <p>During an interview on 5/8/2025, at 10:59 AM, with Charge Nurse 1 (CN 1), CN 1 stated, on 5/6/2025, at around 1 PM, Resident 1 and Resident 3 sat next to each other in their wheelchairs in front of Room A. CN 1 stated she observed Resident 3 touch Resident 1 on Resident 1's inner thigh. CN 1 stated she called Resident 3's name and observed Housekeeping Staff (HKS) pull Resident 3's wheelchair away from Resident 1 and parked it on the opposite side of the hallway. CN 1 stated Resident 3 wheeled his wheelchair back to Resident 1 and rubbed her back from behind. CN 1 stated she asked Resident 1 if she felt comfortable about what happened and Resident 1 stated she did not feel comfortable being touched by Resident 3.</p> <p>During a concurrent observation and interview on 5/8/2025, at 11:32 AM, with Resident 1, Resident 1 sat on her wheelchair outside her room. Resident 1 was alone and rocked back and forth during the interview. Resident 1 stated that a couple of days ago Resident 3 touched her and pointed to her scapular (the flat triangular bone located on the back of the upper body) area when asked where she was touched. Resident 1 stated the incident occurred in the hallway close to the nurse's station while waiting to go to the activity room. Resident 1 stated she told Resident 3 to stop touching her and to leave her alone. Resident 1 stated she was scared and did not feel safe in the facility because she was raped (a type of sexual assault involving sexual intercourse, or other forms of sexual penetration, carried out against a person without their consent) before when she was living in the streets. Resident 1 stated only CN 1 talked to her about the incident since it happened.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 5/8/2025, at 2:23 PM with the Minimum Data Set Nurse (MDSN), Resident 1's medical records dated from 5/6/2025 to 5/8/2025 were reviewed. MDSN stated there was no documentation in Resident 1's chart about the incident on 5/6/2025 between Resident 1 and Resident 3. MDSN stated Resident 1's documentation should have included an SBAR (Situation, Background, Assessment, Recommendation - a structured communication tool used to improve clear and efficient communication, especially in critical situations or when transferring information between health-care professionals), progress note (a written record that documents a resident's medical status, treatment progress, and any changes in their condition over time), care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs), and monitoring (a period of increased observation and assessment after an incident like suspected abuse or neglect). MDSN stated there was also no documentation in Resident 1's chart that indicated Resident 1's physician was notified about the incident. MDSN stated it was important to notify the physician about the alleged sexual abuse so Resident 1 could get the proper and necessary treatment or evaluation.</p> <p>During a follow-up interview on 5/9/2025, at 2:25 PM, CN1 stated she did not write an SBAR or a care plan regarding the inappropriate touching of Resident 3 towards Resident 1. CN 1 stated it was important to write a care plan for abuse to know what interventions are needed to meet the goal of the problem.</p> <p>2 During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing, bilateral (affecting both sides) primary osteoarthritis (a progressive disorder of the joints, caused by gradual loss of cartilage) of knee, and other specified polyneuropathies (damage to multiple nerves typically affecting both sides of the body and often starting in the hands and feet).</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was assessed having intact memory and cognitive skills for daily decision making. Resident 2 required set up or clean up assistance with oral/personal hygiene, upper/lower body dressing, and eating. Resident 2 was independent with toileting hygiene, sit to lying, sit to stand, and toilet transfer. Resident 2 required supervision or touching assistance with walking 150 ft.</p> <p>During an interview on 5/8/2025, at 11:10 AM, with CN 1, CN 1 stated on 4/15/2025, Resident 3 punched Resident 2 in the chest inside the elevator. CN 1 stated Resident 3 punched Resident 2 in retaliation to a prior incident when Resident 2 got upset at Resident 3 for walking between him and another resident in the facility. CN 1 stated Activity Assistant (AA) was in the elevator with Resident 2 and Resident 3 when the altercation happened.</p> <p>During a concurrent interview and record review on 5/8/2025, at 2:23 PM with MDSN, Resident 2's medical records dated from 4/15/2025 to 5/8/2025 were reviewed. The MDSN stated there was no documentation in Resident 2's chart about the incident of physical abuse by Resident 3 towards Resident 2 on 4/15/2025 between Resident 2 and Resident 3. MDSN stated Resident 2's documentation should have included an SBAR, progress note, care plan, and monitoring after the incident. MDSN stated there was also no documentation in Resident 2's medical chart that indicated Resident 2's physician was notified that Resident was punched in the chest. MDSN stated it was important to notify the physician about the physical abuse so Resident 2 could get the proper and necessary treatment or evaluation.</p> <p>(continued on next page)</p>		

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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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview, on 5/8/2025, at 4:56 PM, with Resident 2, Resident 2 stated Resident 3 punched him on his right chest in the elevator last month.</p> <p>During an interview, on 5/9/2025, at 1:55 PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated on 4/15/2025, AA notified him that there was an incident in the Activity room elevator (located in the third floor) between Resident 2 3. LVN 1 stated he did not assess or document what he witnessed in the elevator. LVN 1 stated an SBAR should have been created to document what happened. LVN 1 stated Resident 2 should have been assessed for injuries and his well-being should have been monitored for 72 hours after the incident. LVN 1 stated Resident 2's physician should have been notified. LVN 1 stated the facility staff who initiated the SBAR should also create a care plan addressing the incident with goals and specific interventions for the Resident. LVN 1 stated a care plan should have interventions like assessment, medications, and monitoring.</p> <p>3. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnosis that included unspecified dementia (a progressive state of decline in mental abilities), recurrent depressive disorder, and specified anxiety disorder.</p> <p>During a review of Resident 3's H&P, dated 3/22/2025, the H&P indicated Resident 3 had a fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 was assessed having moderately impaired cognitive skills for daily decision making. Resident 3 required supervision or touching assistance with oral hygiene, upper body dressing, sit to stand, chair/bed-to-chair transfer, and toilet transfer. Resident 3 was independent with wheeling his manual wheelchair at least 50 feet (ft- unit of measurement) and make two turns and 150 ft in a corridor or similar space.</p> <p>During a concurrent interview and record review on 5/8/2025, at 2:23 PM with MDSN, Resident 3's medical records dated from 4/15/2025 to 5/8/2025 were reviewed. MDSN stated there was no documentation in Resident 3's chart about the incident on 5/6/2025 between Resident 3 and Resident 1. MDSN stated Resident 3 documentation should have included an SBAR, progress note, care plan, and monitoring. MDSN stated there was also no documentation in the chart that indicated Resident 3's physician was notified that Resident 3 punched Resident 2 last 4/15/2025 and that Resident 3 inappropriately touched Resident 1 on 5/6/2025. MDSN stated it was important to notify the physician about Resident 3's physical abuse and inappropriate behavior so that they can get the proper and necessary treatment or evaluation.</p> <p>During an interview, on 5/8/2025, at 6:14 PM, with the Administrator (ADM), the ADM stated Resident 1 did not have an SBAR and progress note that described the incident between Resident 1 and Resident 3. The ADM stated Resident 1 did not have a care plan to address the inappropriate touching and what interventions need to be taken for Resident 1. The ADM stated Resident 1's physical and emotional status was not monitored after being inappropriately touched by Resident 3.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/9/2025, at 3:23 PM, with the Medical Director (MD), the MD stated the facility did not inform him that Resident 1 was the victim of Resident 3's inappropriate behavior on 5/6/2025. The MD stated Resident 1 and Resident 3 should not have been placed in the Activity room at the same time. The MD stated Resident 1 seeing Resident 3 in the same room can physically and emotionally affect her since she was alert and oriented. The MD stated the facility's policy and procedure (P&P) for change of condition and abuse prevention and reporting was not followed.</p> <p>During an observation in the SSD's office and interview, on 5/9/2025, at 4:47 PM, with SSD, SSD stated she did not visit and assess Resident 1's psychosocial well- being after the she was inappropriately touched by Resident 3 on 5/6/2025 because the incident was not reported to CDPH. SSD stated she did not assess Resident 2's psychosocial well- being after the physical altercation in the elevator with Resident 3 on 4/15/2025. SSD stated that an IDT (IDT- a group of healthcare professionals from different disciplines who collaborate to provide comprehensive and coordinated care for a patient) meeting was done after the physical altercation between Resident 2 and Resident 3 but could not remember who was a part of the meeting or when the meeting took place. SSD was not able to provide documented evidence of the IDT meeting. SSD stated the physician for Residents 1, 2, and 3 should have been notified after each incident to find out if they needed to be transferred to the hospital for further evaluation. SSD stated it was important to assess and monitor Residents 1, 2, and 3 after each incident to make sure they feel safe and their secure. SSD stated it was important to assure the residents that their needs are being met in the facility.</p> <p>During an interview, on 5/9/2025, at 7:29 PM, with the Director of Nursing (DON), the DON stated she did not know why there was no documented evidence that Residents 1, 2, and 3 were assessed and monitored after their incidents. The DON stated the inappropriate touching, and physical abuse should have been care planned by the licensed nurse who was in charge the day the incidents took place. The DON stated inappropriate touching and getting punched on the chest are considered a change in the Resident's condition. The DON stated the licensed nurses should have documented, assessed, monitored, and notified the physician regarding the incidents with Resident 1, 2, and 3.</p> <p>During a follow up interview, on 5/10/2025, at 11:53 AM, with the ADM, the ADM stated he spoke to MD on 5/6/2025 but could not remember if he informed MD that Resident 3 inappropriately touched Resident 1 on her inner thigh and back. The ADM stated that in abuse cases, as soon as the residents are separated and safe it was the responsibility of the licensed nurse in charge to write and SBAR, create a care plan specific to the incident, call the physician, and monitor the resident. The ADM stated facility staff did not follow the Abuse Program policy for Resident's 1, 2 and 3.</p> <p>During a review of the facility's P&P, titled, Change in a Resident's Condition or Status, revised on 3/2024, the P&P indicated the following:</p> <p>Our facility promptly notifies the resident, his or her attending physician, and the Resident representative or changes in the resident's medical/mental condition and/or status (example: changes in level of care, Resident rights)</p> <p>The nurse will notify the resident's attending physician or physician on call when there has been and accident of incident involving the resident and significant change in the resident's physical/emotional/mental condition</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff, requires interdisciplinary review and/or revision to the care plan</p> <p>Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example information prompted by the Interact SBAR Communication Form.</p> <p>Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.</p> <p>The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status</p> <p>During a review of the facility's P&P, titled, Charting and Documentation, revised on 3/2025, the P&P indicated the following:</p> <p>All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care</p> <p>The following information is to be documented in the resident's medical record: changes in the resident's condition and events, incidents or accidents involving the Resident</p> <p>During a review of the facility's P&P, titled, Care Plans, Comprehensive Person-Centered, revised on 3/2024, the P&P indicated the following:</p> <p>A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.</p> <p>The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.</p> <p>The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>During a review of the facility's P&P, titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 03/2025, the P&P indicated the facility will establish and maintain a culture of compassion and caring for all Residents and particularly those with behavioral, cognitive, or emotional problems.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to maintain an accurately documented medical records for two of three sampled residents (Resident 1 and Resident 3) when:</p> <ol style="list-style-type: none"> 1. Charge Nurse 1 (CN 1) initiated Resident 3's SBAR (Situation, Background, Assessment, Recommendation - a structured communication tool used to improve clean and efficient communication, especially in critical situations or when transferring information between health-care professionals) that indicated Resident 3 inappropriately touched a staff (unknown) instead of Resident 1. 2. Minimum Data Set (MDS - a resident assessment tool) Nurse (MDSN) developed a care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives and time frames to meet a resident's [NAME], nursing, and mental and psychosocial needs) that indicated Resident 3 had inappropriate behavior with female staff/Certified Nurse Assistant (CNA) instead of Resident 1 <p>This deficient practice resulted in failure in the delivery of necessary services and care for Resident 1 and Resident 3 and had the potential to place other residents in the facility at risk for experiencing physical (any intentional act causing injury or trauma to another person by way of bodily contact) and sexual abuse (non-consensual [without the person's permission] touching of one person for the sexual gratification of another) by Resident 3's due to his unaddressed inappropriate and aggressive behavior.</p> <p>Cross reference F600, F607 and F684</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included other recurrent depressive disorder (persistent sadness and loss of interest in activities, affecting thoughts, behaviors, feelings, and well-being), schizophrenia (a mental illness that can affect thoughts, moods, and behavior), and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).</p> <p>During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 was assessed as having moderately impaired (decisions poor; cues/supervision required) cognitive skills for daily decision making. Resident 1 required partial/moderate assistance (helper does more than half the effort) with upper body dressing, personal hygiene, sit to stand, and chair/bed-to-chair transfer. Resident 1 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, and lower body dressing.</p> <p>During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnosis that included unspecified dementia (a progressive state of decline in mental abilities), recurrent depressive disorder, and specified anxiety disorder.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 was assessed having moderately impaired cognitive skills for daily decision making. Resident 3 required supervision or touching assistance with oral hygiene, upper body dressing, sit to stand, chair/bed-to-chair transfer, and toilet transfer. Resident 3 was independent with wheeling his manual wheelchair at least 50 feet (ft- unit of measurement) and make two turns and 150 ft in a corridor or similar space.</p> <p>During an interview on 5/8/2025, at 10:59 AM, with Charge Nurse 1 (CN 1) and the Director of Nursing (DON), CN 1 stated, on 5/6/2025, at around 1 PM, Resident 1 and Resident 3 were sitting on their wheelchairs and were placed next to each other in the hallway in front of Room A. CN 1 stated Resident 1 and Resident 3 were waiting to be taken to the Activity Room. CN 1 stated she was sitting in the nurse's station and when she stood up, observed Resident 3 touch Resident 1 on her inner thigh. CN 1 stated she called Resident 3's name and observed Housekeeping Staff (HKS) pull Resident 3's wheelchair away from Resident 1 and parked it on the opposite side of the hallway. CN 1 stated Resident 3 wheeled his wheelchair to Resident 1 and rubbed her back from behind. CN 1 stated she walked towards Resident 1 and Resident 3 and wheeled Resident 3 to the nurse's station. CN 1 stated Resident 1 stated she did not feel comfortable being touched by Resident 3 after the incident happened.</p> <p>During a concurrent observation and interview on 5/8/2025, at 11:32 AM, with Resident 1, Resident 1 was sitting on her wheelchair outside of her room. Resident 1 was alone and rocked back and forth during the interview. Resident 1 stated that a couple of days ago Resident 3 touched her and pointed to her scapular (the flat triangular bone located on the back of the upper body) area when asked where she was touched. Resident 1 stated the incident occurred in the hallway close to the nurse's station while waiting to go to the activity room. Resident 1 stated she told Resident 3 to stop touching her and to leave her alone. Resident 1 stated she did not feel safe in the facility because she was raped (a type of sexual assault involving sexual intercourse, or other forms of sexual penetration, carried out against a person without their consent) before when she was living in the streets. Resident 1 stated only CN 1 talked to her about the incident since it happened.</p> <p>During an interview on 5/9/2025, at 1:55 PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated facility staff who witnessed the sexual abuse was responsible for initiating an SBAR and the care plan for the resident. LVN 1 stated it was important that the information on the SBAR and care plan was accurate.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview with CN 1 and record review, on 5/9/2025, at 2:25 PM, Resident 3's SBAR, dated 5/6/2025 was reviewed. CN 1 stated on 5/6/2025, before 3 PM, CN 1 was called to the DON's office for a meeting by the Administrator (ADM). CN 1 stated when she arrived at the DON's office the ADM, MDSN, Social Services Director (SSD), and Director of Staffing Development (DSD) were there. CN 1 stated the ADM told CN 1 to initiate an SBAR and indicate that Resident 3 had inappropriate behavior with staff since the ADM did not plan on reporting the incident between Resident 1 and 3 to the California Department of Public Health (CDPH- a governmental body or institution established by a state government to perform specific functions or responsibilities like enforcing laws). CN 1 stated she disagreed with the ADM and told the ADM that was not what happened. CN 1 stated she reminded the ADM that Resident 1 was inappropriately touched Resident 3 and not the staff. CN 1 stated the ADM wanted CN 1 to document Resident 3's behavior problems towards staff to justify Resident 3's need to get evaluated by a psychiatrist (psych, medical director who specializes in diagnosis, treatment, and prevention of mental, emotional, and behavioral disorder) and transferred out of the facility without getting Resident 1 involved. CN 1 stated, on 5/7/2025, she initiated Resident 3's SBAR and indicated Resident 3 had inappropriate behavior with female staff and was trying to touch CNAs inappropriately.</p> <p>During a concurrent interview and record review on 5/9/2025, at 2:54 PM, with MDSN, Resident 3's care plan for inappropriate behavior was reviewed. MDSN stated on 5/6/2025, Resident 3 touched Resident 1's inner thigh and upper back in the hallway. MDSN stated the ADM called a meeting in his office to discuss what to do with Resident 3. MDSN stated the ADM wanted to get a psych consult for Resident 3 but needed a reason why a consultation was necessary. MDSN stated the ADM met with MDSN and CN 1 in the DON's office. MDSN stated that during the meeting, the ADM stated he wanted CN 1 to document that Resident 3's inappropriate behavior was towards female staff and not Resident 1. MDSN stated CN 1 did not want to follow what the ADM was asking CN 1 to do. MDSN stated she could not understand why the ADM wanted to indicate that female staff was inappropriately touched and not Resident 1. MDSN 1 stated CN 1 documented on the SBAR that Resident 3 inappropriately touched female staff on 5/7/2025. MDSN stated she wrote Resident 3's care plan that indicated Resident 3 had inappropriate behavior and was touching female staff on 5/7/2025 after CN 1 asked for her help. MDSN stated that what she documented on Resident 3's care plan did not match what actually happened. MDSN stated she did not indicate in the care plan that it was Resident 1 who was touched inappropriately. MDSN stated CN 1 was guided by the ADM to write the SBAR a certain way. MDSN stated all facility staff are responsible for documenting what actually happened.</p> <p>During an interview on 5/9/2025, at 4:47 PM, with SSD, SSD stated she was in the DON's office when the ADM met with CN 1 and MDSN. SSD stated the ADM asked CN 1 to document on the SBAR that Resident 3 inappropriately touched staff and not Resident 1. SSD stated that as a result of CN 1's inaccurate documentation, she was not able to assess Resident 1 after the incident with Resident 3. SSD stated that if SSD documented the incident between Resident 1 and Resident 3 then CN 1's documentation on the SBAR will not match with SSD's documentation. SSD stated it was not right that what happened to Resident 1 was not documented because it was not advocating for Resident 1.</p> <p>During an interview, on 5/9/2025, at 7:29 PM, with the DON, the DON stated it was important for facility staff to accurately document what occurred to the residents in the facility. The DON stated facility staff were not allowed to falsify any documentation.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised on 3/2024, the P&P indicated, Documentation in the medical record will be objective (not opinionate or speculative), complete, and accurate.</p> <p>During a review of the facility's P&P titled, Administrator, revised on 3/2024, the P&P indicated, The Administrator is responsible for, but not limited to implementing established Resident care policies, personnel policies, safety and security policies, and other operational policies and procedures necessary to remain in compliance with current laws, regulations, and guidelines governing long-term care facilities.</p>		