STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056063	A. Building B. Wing	05/31/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on interview and record review, the facility failed to ensure one (1) of 1 sampled resident (Resident 1), who has a diagnosis of nontraumatic (not caused by trauma or injury to the body) intracerebral hemorrhage (ICH, also known as hemorrhagic stroke [medical emergency where bleeding occurs within the brain tissue]) in brain stem (the lower part of the brain that connects to the spinal cord [a tube of tissue that carries nerve signals from the brain to the rest of the body]), assessed with severe cognitive impairment (ability to think, remember and reason) for daily decision making, and at risk for elopement (a resident who is incapable of adequately protecting himself, and who departs the health care facility unsupervised and undetected) was supervised to prevent injury and did not elope on 5/30/2025 between 8:40 AM to 9:30 AM by failing to: 1. Immediately reassess Resident 1, who was assessed as low risk for elopement on 5/8/2025, after Resident 1 was observed by Certified Nurse Assistant (CNA) 1 packing his belongings and verbalizing wanting to leave the facility on 5/30/2025 from 8:40 AM to 9:30 AM, in accordance with the facility's Resident Elopement Policy. 2. Implement interventions such as detailed monitoring plan to prevent elopement after Resident 1 was observed packing his belongings and verbalizing wanting to leave the facility on 5/30/2025 at around 8:40 AM in accordance with the facility's Resident Elopement Policy. 3. Supervise Resident 1 by ensuring the facility doors was being monitored to prevent Resident 1 from leaving the facility unsupervised, as instructed by the Director of Nursing (DON) after Resident 1 was observed packing his belongings and verbalizing wanting to leave the facility on 5/30/2025 at around 8:40 AM. These failures resulted in Resident 1 eloping from the facility on 5/30/2025 around 9:30 AM and had the potential to expose Resident 1 to harsh environmental conditions including excessive heat and or cold, the potential to be hit by a car as well as experiencing medical complications including malnutrition (a condition that occurs when a person does not consume enough nutrients or calories to meet their body's needs), dehydration (a condition that occurs when the body loses too much water and other fluids that it needs to work normally), heat stroke (a life-threatening condition where the body's temperature rises dangerously high), and death. Resident 1 returned to the facility on [DATE] at 3:45 PM (six [6] hours and 15 minutes after resident eloped), accompanied by an unidentified individual. (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/30/2025 at 6:26 PM, while onsite, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious harm, impairment, or death of a resident) due to the facility's failure to immediately supervise Resident 1 to prevent Resident 1's elopement from the facility. The surveyor notified the DON of the IJ situation on 5/30/2025 at 6:26 PM, due to the facility's failure to ensure Resident 1 was immediately supervised to prevent injury and did not elope on 5/30/2025 between 8:40 AM to 9:30 AM. On 5/31/2025 at 12:58 PM the facility submitted an acceptable IJ removal plan (IJRP). After verification of the IJRP implementation through observation, interview and record review, the IJ was removed in the presence of the DON. Following the removal of the IJ, noncompliance remained at a scope (refers to how widespread a deficiency is) and severity (no actual harm, with potential for more than minimal harm) of a D (isolated [one or a very limited number of residents are affected], actual harm, that is not immediate jeopardy). The IJ Removal Plan dated 5/31/2025, included the following: Part A 1. Resident 1 agreed to be transferred to the acute care hospital for further evaluation. The attending physician (MD 1) issued the order for transfer on 5/30/2025 at 7:50 PM. 2. Resident 1 will remain on 1 to 1 (1:1) supervision for safety until transportation arrives for pickup. An order was obtained by the physician, and a log was used by the staff to document. 3. The facility will implement on 5/30/2025, 24-hour monitoring immediately of the doors to strive and prevent harm to all our patients. 4. Resident 1 refused to be transferred to the General Acute Care Hospital (GACH) when transport arrived at 12:15 AM on 5/31/2025. 5. Received orders from MD 1 to apply a wander guard (a system that uses a wearable device such as a bracelet to monitor the movement of a resident residing within a nursing home by alerting caregivers if they exit the facility) to Resident 1 on 5/31/2025 at 8:00 AM. 6. Obtained informed consent from Resident 1's Responsible Party (RP) on 5/31/2025 at 8:10 AM. 7. Resident 1 continued to refuse the wander guard despite several attempts and education on safety. MD 1 and Resident 1's RP made aware. 8. Resident 1 will remain on 1:1 monitoring with a log for staff to document to ensure safety and continuous 24-hour monitoring of doors to prevent another incident reoccurring. 9. Resident 1's elopement assessment was updated to reflect Resident 1 being at high risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. Situation, Background, Assessment Recommendation (SBAR, a communication tool used by healthcare workers when there is a change of condition among the residents) documentation initiated on 5/31/2025 for Resident 1's and 72-hour SBAR documentation initiated. 11. Resident 1's care plan was updated with interventions implemented to prevent a repeat event. 12. Resident 1 spoke with a psychiatrist via (by) resident's telephone for evaluation for psychological support and emotional distress on 5/31/2025 at 10:45 AM. The psychiatrist ordered a follow-up with social services for discharge. Resident 1 was placed on psychological monitoring starting 5/30/2025. 13. Resident 1 will be seen by a psychologist on 5/31/2025 for evaluation for psychosocial distress related to the recent event of elopement. Part B 1. All residents have had an elopement risk evaluation assessment. All residents will be assessed upon admission, quarterly and in the event of a significant change with care plans updated. 2. Residents who are at high risk for elopement will be added to the quarterly Quality Assurance and Performance Improvement (QAPI, a data driven proactive approach to improvement used to ensure services are meeting quality standards) committee to identify other residents who have the potential to be affected. 3. Care plans will be updated for all 93 residents who are at low, moderate or high risk for elopement and will include strategies and interventions to maintain the residents' safety. 4. The facility has identified only one resident at high risk for elopement which is Resident 1. 5. The facility will put a system in place for residents who are identified as low to moderate elopement risk for frequent visual monitoring. Part C 1. The facility has put into place 24-hour door monitoring to ensure the deficient practice does not reoccur. 2. The facility employs a total of 58 staff members (Registered Nurses [RN], Licensed Vocational Nurses [LVN], and Certified Nursing Assistants [CNA]). The Director of Nursing (DON) and Director of Staff Development (DSD) in-serviced 25 staff members on 5/30/2025 and 5/31/2025 concerning the facility's policy to preserve and maintain resident safety by instituting measures to monitor and prevent resident from opportunities of wandering and eloping away from facility. DSD will in-service all licensed staff within 48-hours and before working assigned shift, staff will be in-serviced. As new hires come in, they will be educated and in-serviced on the elopement policy as well. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. The facility will place an elopement binder at each nursing station identifying which residents are at low, moderate, and high risk for elopement. Included in the binder will be policy and procedures related to elopement, face sheets with clear picture identifiers of residents at risk and protocols for the event of an elopement. 4. The facility will implement a system that when an employee observes a resident leaving the premises he/she should attempt to prevent the resident from leaving in a courteous manner, get help from staff immediately in the vicinity, instruct the charge nurse and or DON that the resident is attempting to leave or has left the premises. 5. The facility will implement a system that when a resident is missing, the facility will initiate the elopement/missing resident emergency procedure, initiate a search of the building and premises and notify the Administrator (ADM), the DON, the resident's responsible party, physician, law enforcement, ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and CDPH. 6. The facility will implement a system for when the resident who eloped is found, the DON and or charge nurse will examine the resident for injuries, contact the physician, report findings and conditions of the resident, notify the resident's responsible party, notify local law enforcement that the resident has been located, and initiate 72-hour SBAR documentation. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of nontraumatic intracerebral hemorrhage in brain stem and type two (2) diabetes mellitus (DM2, a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic chronic kidney disease (damage to the kidneys caused by long-standing high sugar levels leading to impaired kidney function and potentially kidney failure). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 5/14/2025, the MDS indicated the Resident 1 had severe impairment with cognitive skills for daily decision making. Resident 1 needed substantial/maximal assistance (helper does more than half the effort) with walking 10 feet. Resident 1 needed partial/moderate assistance (helper does less than half the effort) with transfers (how resident moves to and from bed, chair, wheelchair, standing position), personal hygiene, putting on/taking off footwear, upper and lower body dressing (the ability to dress and undress above and below the waist), and needed setup or clean-up assistance (helper sets up or cleans up, resident completes activity) with eating. During a review of Resident 1's Elopement Risk Evaluation, dated 5/8/2025, the Elopement Risk Evaluation indicated Resident 1 was evaluated as low risk for elopement. During a review of Resident 1's Health Status Note, dated 5/30/2025, timed at 11:42 AM, the Health Status Note indicated on 5/30/2025 at 8:45 AM (22 days from Resident 1's initial Elopement Risk Evaluation), The AD stated resident (Resident 1) voiced he would like to leave the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's SBAR documentation, dated 5/30/2025 at 2:19 PM, the SBAR documentation indicated Resident 1 left the building by walking without notifying anyone. The SBAR did not indicate the time Resident 1 left on 5/30/2025. During an interview on 5/30/2025 at 2:48 PM with the DON, the DON stated on the morning of 5/30/2025, she was informed by the AD that Resident 1 was packing his clothes and wanted to leave. The DON stated she called the Social Services Assistant (SSA) to speak with Resident 1 regarding Resident 1 wanting to leave. The DON then stated the SSA verified that Resident 1 wanted to leave and was going to call Resident 1's family so that Resident 1 could speak with them. The DON told the SSA to monitor the resident to monitor Resident 1 and ensure Resident 1 does not walk out of the facility's doors unsupervised. During the same interview on 5/30/2025 at 2:48 PM with the DON, the DON stated after the 9:30 AM meeting with all the facility department heads, CNA1 came up to all the department heads to ask if they have seen Resident 1. The DON stated she called a code silver (a signal used to alert staff of an older resident who has gone missing) and all staff started looking for Resident 1 around the facility premises and two blocks away from the building both on foot and by car. The DON stated that they had gone to the store across the street from the facility and the owner of the store had informed them that they saw Resident 1 walk out through the doors of the facility and walk towards the bus stop. The DON then stated around 11:45 AM, they received a call from a staff at Resident 1's previous residence (apartment) that Resident 1 was outside the apartment building. During the same interview on 5/30/2025 at 2:48 PM with the DON, the DON stated she had called 9-1-1 emergency response to go to Resident 1's previous residence to check on the resident. The DON stated after a while, paramedics told her that they could not force Resident 1 to go back to the hospital or facility since Resident 1 refused to leave his apartment. The DON then stated she called the Psychiatric Emergency Team (PET, a mobile team that provides crisis intervention and stabilization for individuals experiencing a mental health crisis) to go check on Resident 1 at his apartment. During the same interview on 5/30/2025 at 2:48 PM with the DON, the DON stated the doors of the facility is always to be monitored by the receptionist or another staff member. The DON added that if the facility staff monitoring the doors needs to step away or leave, she/he needs to be properly relieved by other staff, so the doors is continuously monitored to ensure residents do not walk out of the facility unsupervised. During an interview on 5/30/2025 at 3:54 PM with the DON, the DON stated Resident 1 returned to the facility at 3:45 PM on 5/30/2025 with an unknown individual. During an interview on 5/30/2025 at 4:01 PM with the DSD, the DSD stated a staff member should always be monitoring the door to help prevent resident elopement. DSD stated the receptionist normally comes in around 9:30 AM to 10 AM and works until 6 PM. DSD stated if the receptionist is not there to monitor the facility doors, another staff member should be assigned to monitor the door. During an interview on 5/30/2025 at 4:08 PM with AD, AD stated on 5/30/2025 around 8:50 AM to 9:05 AM while he was doing his rounds in the hallway, he passed CNA 1 who told him that Resident 1 wanted to leave the facility and was observed packing his belongings into a bag. AD stated he went straight to the DON to notify her of what Resident 1 was doing and the DON went to check on the situation right away. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/30/2025 at 4:13 PM with CNA 1, CNA 1 stated on 5/30/2025 around 8:40 AM, she observed Resident 1 gathering his belongings and asked him what he was doing. CNA 1 stated Resident 1 told her it was none of her business and she proceeded to inform AD of what she saw and continued with her assignment. CNA 1 then stated she noticed Resident 1 was gone (could not recall the exact time) after she went to follow-up after working with another resident. During an interview on 5/30/2025 at 4:22 PM with Resident 1, Resident 1 stated he left the faciity on the morning of 5/30/2025 because he needed to do some things at home and when he asked if he could leave, he was told no and so he left on his own. Resident 1 stated when the staff walked away from the doors, he stated he walked out of the building. Resident 1 then stated when he left the facility, he went to the bus stop and went to his apartment. Resident 1 stated that a friend of his picked him up from his apartment and brought him back to the facility. During an interview on 5/30/2025 at 4:31 PM with the DON, the DON stated residents who are high risk for elopement are the residents verbalizing wanting to leave or showing signs, such as packing their clothes. The DON stated interventions included are applying a wander guard (bracelets that residents wear, which is a tracking device to alert staff when a resident exits the facility), having a bed alarm (monitors resident's movement and alerts the staff when movement is detected) and a binder at the nurse's station to indicate who the high risk for elopement residents are. During the same interview with the DON on 5/30/2025 at 4:31 PM, a concurrent record review of Resident 1's elopement risk evaluation, dated 5/8/2025 was conducted. The DON stated the elopement risk evaluation indicated Resident 1 was assessed at low risk. The DON stated Resident 1's elopement risk should have been reassessed as soon as Resident 1 was observed packing his belongings and wanting to leave the facility, which could have increased Resident 1's risk of leaving the facility unsupervised. During an interview on 5/30/2025 at 4:37 PM with SSA, SSA stated around 8:45 AM to 8:50 AM, CNA 1 told him that Resident 1 was packing up his belongings and stated for CNA 1 to mind her own business. SSA stated the DON called him around 8:55 AM to also notify him of Resident 1 wanting to leave. DON instructed SSA to speak with Resident 1. SSA stated around 8:56 AM, he went to speak with Resident 1 to ask the resident why he was packing his belongings and Resident 1 told him it was none of his business. SSA stated around 9:05 AM, he gave the facility's cordless phone to Resident 1 so that he could speak with his family member. SSA then stated he left to go to the DON's office and was instructed by the DON to ensure the facility doors was monitored. SSA stated he went to the doors, but the receptionist was not there yet since she was running late. SSA stated there were staff (not specified) within the vicinity of the doors, but no one was specifically watching the doors. During an interview on 5/30/2025 at 5:09 PM with SSA, SSA stated on 5/30/2025 around 9:12 AM, he went to the facility front entrance, and no one was there, so he went to his office to grab his papers to get ready for the department head meeting which he attended at 9:34 AM. SSA stated once the meeting was over around 10 AM, CNA 1 approached all the department heads and asked if anyone had seen Resident 1 since he was not in his room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review of the facility's undated Policy and Procedure (P&P) titled, Resident Elopement and Resident 1's Care Plan dated 5/30/2025 on 5/30/2025 at 5:31 PM, the DON stated the P&P did not indicate that the facility's doors should be monitored. The DON stated the facility's doors being monitored for 24 hours and seven (7) days a week (24/7) should be included in the elopement policy to prevent residents from eloping. During the same interview on 5/30/2025 at 5:31 PM with the DON, the DON stated the facility doors should have been monitored as instructed which could have prevented Resident 1 from eloping. During a review of the facility's undated P&P titled, Resident Elopement, the P&P indicated, The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. Under policy interpretation and implementation, the P&P also indicated: A. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). B. The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. C. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Intervention to try to maintain safety, such as a detailed monitoring plan will be included.