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	08/28/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. (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

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	08/28/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow its Resident Rights policy for two (2) of 2 sampled residents (Residents 1 and 2) when they did not accommodate their request to be roomed together as a married couple. This failure had the potential to negatively affect Residents 1 and 2's psychosocial wellbeing. 1. During a review of Resident 1's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of atherosclerosis (the buildup of fats, cholesterol and other substances in and on the artery [a blood vessel that carries oxygen-rich blood from the heart to the rest of the body] walls) of aorta (the largest artery in the body) and cardiomegaly (an enlarged heart). During a review of Resident 1'S Minimum Data Set (MDS - a resident assessment tool), dated 8/9/2025, the MDS indicated the resident had an intact cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 1 needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with personal hygiene and eating and was independent with upper and lower body dressing (the ability to dress and undress above and below the waist), putting on/taking off footwear, transfers (how resident moves to and from bed, chair, wheelchair, standing position) and walking 150 feet. 2. During a review of Resident 2's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of dementia (a progressive state of decline in mental abilities), without behavioral disturbance (a problematic pattern of behavior that interferes with a person's ability to function in daily life), psychotic disturbance (a state of losing touch with reality, characterized by symptoms of delusions [false beliefs] and hallucinations [seeing or hearing things that are not there]), mood disturbance (a significant, disruptive change in a person's emotional state that goes beyond everyday fluctuations and impacts their mood, thoughts and behavior) and anxiety (a state of intense fear, worry, and unease) and hearing loss (a partial or total inability to hear sounds). Resident 2's admission Record also indicated that her responsible party was Resident 1. During a review of Resident 2'S MDS, dated [DATE], the MDS indicated the resident was moderately impaired with cognitive skills for daily decision making. Resident 2 needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with personal hygiene, upper and lower body dressing, and putting on/taking off footwear. Resident 2 needed setup or clean-up assistance with eating and walking 150 feet and was independent with transfers. During a review of Resident 1's Situation, Background, Assessment and Recommendation (SBAR; a communication framework for providing essential patient information in a structured way) Documentation, dated 8/15/2025, Resident 1's SBAR Documentation indicated Resident 1 was in the room with his spouse (Resident 2) when Resident 2 yelled and threw paper at him and Resident 1 stated, Can you guys get her out of the room? The residents were immediately separated. During an interview on 8/28/2025 at 9:48 AM with Resident 1, Resident 1 stated on 8/15/2025, while he was in his room sitting down coloring and doing crossword puzzles, his spouse (Resident 2) who also shares the same room, got mad at him due to frustration and started screaming for not paying attention to her. Resident 1 stated his wife (Resident 2) had been together for 80 years and are normally always happy and like all couples, have their arguments. Resident 1 stated he spoke briefly to Licensed Vocational Nurse 1 (LVN 1) but does not believe that he asked her to remove Resident 2 from their room. Resident 1 also stated that when they removed Resident 2 from their room, he only thought they were separating them for a short time like a time-out. During the same interview on 8/28/2025 at 9:48 AM with Resident 1, Resident 1 stated that he had been separated from Resident 2 for about 2 or three (3) weeks now. Resident 1 stated the facility staff never explained to him that he would be separated from Resident 2 for this long and only thought the separation would be brief. Resident 1 stated that if he had known they were going to move Resident 2 out of their room, he would have begged them to leave Resident 2 in their room. Resident 1 also stated that he has told multiple staff members, including LVN 1, that he would like Resident 2 to come back to their room. Resident 1 further stated he felt bad that Resident 2 was in another room and felt lonely and abandoned and just wanted her to be back in the same room with him. During an interview on 8/28/2025 at 10:01 AM with LVN 1, LVN 1 stated on 8/15/2025 she was sitting at the nurses' station when Resident 1 came up to her to ask to remove Resident 2 from their room. LVN 1 stated Resident 1 told her Resident 2 was screaming and throwing paper at him. LVN 1 stated she felt Resident 1 and Resident 2 were just having an argument between spouses and did not feel like it was verbal abuse (the