

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  09/12/2025
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility did not provide the necessary care and services for 1 of 2 sample residents (Resident 1) who had a fall by failing to:1. Ensure Resident 1's fall assessment was accurate and complete.2. Ensure Resident 1's fall was thoroughly investigated by interviewing the roommate. 3. Ensure Resident 1's Care Plan was resident centered.4. Ensure Resident 1's Minimum Data Set (MDS) was accurate to reflect the resident needs for Activities of Daily Living (ADL - activities such as bathing, dressing and toileting a person performs daily).5. Ensure LVN 1 reported and monitored Resident 1 after a suspected fall.6. Ensure Resident 1's fall was monitored and documented on 8/31/2025 11pm to 7am shift, 9/1/2025 3pm to 11pm shift and 11pm to 7am shift, 9/2/2025 3pm to 11am shift and 11pm to 7am shift.This deficient practice has the potential for Resident 1 to have further falls which could result to harm, hospitalization, and/or death.Findings:1. During a review of Resident 1's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE], and was readmitted on [DATE] with the following, but not limited to, diagnoses of Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), muscle weakness, dry eye syndrome (eye is dry and sensitive to light), dementia (a progressive state of decline in mental abilities), difficulty in waking, history of falling and hypertension (HTN-high blood pressure).During a review of Resident 1's Physician Orders, dated 11/21/2024, the Physician Orders indicated clonidine hydrochloride (antihypertensive medication) oral tablet 0.1 milligrams (mg) as needed for systolic (pressure in arteries when heart pumps blood throughout body) greater than 160.During a review of Resident 1's Care Plan with focus on diagnosis of dementia, dated 12/3/2024, the Care Plan indicated staff are to perform ADLs every shift.During a review of Resident 1's Care Plan with focus on Resident 1 at risk for decline in ADLs secondary but not limited to Parkinson's Disease with dyskinesia, cataracts and dementia, dated 3/5/2025, the Care Plan indicated to assist with ADL to the extent necessary for safety and comfort. During a review of Resident 1's MDS, dated [DATE], the MDS indicated the resident is severely impaired in cognitive (the ability to think and understand) skills for daily decision making.During a review of Resident 1's Fall Risk Assessment, dated 6/5/2025, the assessment indicated only the age category was marked.During a concurrent interview and record review on 9/12/2025 at 11:45AM, Resident 1's Fall Risk Assessment, dated 6/5/2025, was reviewed. The DON stated the Fall Risk Assessment was not accurate and was incomplete because vision and cognitive should have been marked.During a concurrent interview and record review on 9/12/2025 at 12:13PM, Resident 1's Fall Risk Assessment, dated 6/5/2025 and 9/5/2025, were reviewed. The DON stated the fall risk assessments are inaccurate and the assessments should have included the resident's antihypertensive medication, unsteady gait, visual due to cataracts, and altered awareness should have been marked which places the resident at a high risk for falls.During a review of the facility's P&amp;P titled Charting and Documentation, revised 3/2024, the P&amp;P indicated documentation in the medical record will be objective, complete and accurate. 2. During a review of Resident 2's (Resident 1's roommate) admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following but not limited to diagnosis of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 2's History and Physical (H&amp;P), dated 9/10/2024, the H&amp;P indicated the resident has the capacity to understand and make decisions.During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident is independent in cognitive skills for daily decision making.During an interview on 9/11/2025 at 10:53AM while in Resident 1 and Resident 2's room, Resident 2 was observed lying on her left side in bed and facing Resident 1's bed, when Resident 2 stated she observed Resident 1 having a fall at the end of 8/2025. Resident 2 also stated Resident 1 slipped from her bed and fell on her buttocks.During an interview on 9/11/2025 at 11:10AM, Resident 1 stated she fell from her bed a few weeks ago. Resident 1 also stated her roommate witnessed her fall.During a concurrent interview and record review on 9/12/2025 at 11:40AM, Resident 1's Skin Incident and Investigation Report, dated 9/1/2025, was reviewed. DON stated she did not but should have had an interview with Resident 2. The DON also stated she did not do a thorough investigation.During an interview on 9/12/2025 at 12 PM, the DON stated she forgot to interview Resident 2 when she did her investigation. The DON also stated interviewing Resident 2 would help clarify if the resident had an alleged fall or an actual fall During a review of the facility's P&amp;P titled Assessing Falls and Their</p>		