

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 09/15/2025
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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policy and procedure to ensure the personal fund for one (1) of two (2) sampled residents (Resident 1) was not overcharged. This deficient practice resulted in Resident 1 being overcharged in the share of cost for 11/2024. Findings: During a review of Resident 1's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of dementia (a progressive state of decline in mental abilities), glaucoma (a group of eye diseases that damage the optic nerve, which carries visual information from the eye to the brain) and bilateral hearing loss. During a review of Resident 1's Eligibility Response, dated 11/1/2024, the Eligibility Response indicated the residents spend down total obligation/share of cost is \$1,133.00. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/8/2025, the MDS indicated the resident is severely impaired (never/rarely made decisions) in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated that the resident is dependent (helper does all of the effort. Residents does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on /taking off footwear and personal hygiene. During a review of Resident 1's ledger, dated 1/11/2022 to 7/11/2025, the ledger indicated Resident 1 was charged \$1,133.00 on 10/2024 and \$1,867.00 on 11/2024. During a review of the facility's Resident Trust Account, dated 3/20/2025, the Resident Trust Account indicated Resident 1 was charged \$3000.00 in total for 10/2024 and 11/2024. During a concurrent interview and record review on 9/15/2025 at 12:38PM, Resident 1's ledger, dated 1/11/2022 to 7/11/2025, and Resident 1's Eligibility Response, dated 11/1/2024, was reviewed. The Finance Manager (FM) stated the ledger indicated Resident 1 was charged \$1,867.00 on 11/2024 but the ledger indicated Resident 1's share of cost should be \$1,133.00; therefore, Resident 1 was overcharged \$734. During a concurrent interview and record review on 9/15/2025 at 1:31PM, Resident 1's finance documents, dated 11/2024, were reviewed. The FM stated there were no documents indicating why there was an overcharge of \$734. During a review of the facility's Policy and Procedure (P&P) titled Conveyance of Resident Funds, revised 3/2024, the P&P indicated should any over-charge occur regarding a resident's funds, those overcharged resident funds should be returned to the resident, the resident representative, or to the resident's estate. During a review of the facility's P&P titled Medicare Advance Beneficiary and Medicare Non-Coverage Notices, revised 3/2024, the P&P indicated residents are informed in advance when changes will occur to their bills.</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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