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	11/19/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to or failed to ensure the Physician Orders for Life-Sustaining Treatment (POLST-a form that gives seriously ill patients more control over their end-of-life care) form for one (1) of three (3) sampled residents (Resident 1) was accurately complete. This deficient practice had the potential to cause conflict in carrying out the resident's wishes for medical treatment and regarding the resident 1's health care decision. Findings:A review of Resident 1's admission Record, the admission Record indicated Resident 1 was readmitted to the facility on [DATE], with diagnoses that included type II diabetes mellitus (a condition in which the body cannot regulate blood sugar levels in the blood), metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the body, leading to a range of symptoms from confusion to coma), and cerebral infarction (is a condition that caused by a disruption of blood flow to the brain, leading to a lack of oxygen and glucose). A review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated [DATE], indicated Resident 1 had impaired cognitive skills (mental action or process of acquiring knowledge and understanding) in decision making. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does no of the effort to complete the activity) from staff for toileting hygiene, oral hygiene, and roll from lying on [NAME] to left and right side. During a concurrent interview and record review on [DATE] at 10:17 AM with Social Service Director (SSD), Resident 1's POLST dated [DATE] was reviewed. The POLST indicated a signature of Resident 1's wife and the signature under the physician/ nurse practitioner/ physician's assistant was left blank. SSD stated she met with the Resident 1's wife and nephew to complete Resident 1's POLST form. SSD stated she did not use the facility's Language Access Program (Oral and written language services used to provide individuals with limited English proficiency [LEP- an individual who does not speak English as their primary language and has a limited ability to read, speak, write, or understand English]) to assist Resident 1's wife completing the POLST form. SSD stated, SSD let Resident 1's nephew explain the CPR in Spanish to Resident 1's wife. SSD stated she was not sure if Resident 1's nephew correctly translated the medical terminology in the POLST form to Resident 1's wife, which resulted in Resident 1 and the resident's wife's wishes and needs were not accurately communicated to the staff and not accurately completed in the POLST form. During an interview on [DATE] at 11:09 AM with Director of Staff Development (DSD), DSD stated SSD should not meet with the family and complete The POLST without the presence of the physician, nurse practitioner, or physician assistant. DSD stated it is important to follow the facility's policy of how to complete POLST, so that emergency personnel know what treatments the patient/family want in the event of a medical emergency. During a telephone interview on [DATE] at 9:46 AM with Resident 1's wife. Resident 1's wife stated that she signed the POLST form which was filled out prior to the meeting with SSD on [DATE]. Resident 1's wife stated the form was written in English and she did not understand it. A review of the facility's POLST policy and procedure, dated [DATE], indicated POLST must be completed by a healthcare provider based on patient preferences and medical indications. The policy indicated to be valid a POLST form must be signed by a physician, or by a nurse (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and signed by the patient (resident) or decisionmaker. It also indicated if a translated form is used with patient or decisionmaker, attach it to the signed English POLST form. A review of the facility's policy and the procedure titled Translation and/or Interpretation of Facility Service, revised dated [DATE], it indicated the facility's language access program will ensure that individuals with limited English proficiency shall have meaningful access to information and services provided by the facility. The policy indicated competent oral translation of vital information (for example, Resident Rights, consent for treatment, etc.) that is not available in written translation, and non-vital information (public service information) should be provided in a timely manner and at no cost to the residents through the following means:A. a staff member who is trained and competent in the skill of interpreting,B. contracted interpreter services.C. telephone interpretation service.D. Interpreters and translators must be appropriately trained in medical terminology.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary treatment interventions for one of three sampled residents (Resident 1). Resident 1 was assessed to have stage II pressure ulcer (Stage 2 PU- a partial-thickness wound that damages the first two layers of skin-the epidermis [the thin, tough, outer layer of skin] and dermis[the thicker, middle layer located beneath]) on the resident's sacrum (a triangular bone in the lower back) on 11/7/2025 and the facility failed to provide wound treatment on 11/8/2025 to 11/10/2025. This failure may result in worsening of the PU and may lead to infection or Resident 1's hospitalization. Findings:A review of Resident 1's admission Record, the admission Record indicated Resident 1 was readmitted to the facility on [DATE], with diagnoses that included type II diabetes mellitus (a condition in which the body cannot regulate blood sugar levels in the blood), metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the body, leading to a range of symptoms from confusion to coma), and cerebral infarction (is a condition that caused by a disruption of blood flow to the brain, leading to a lack of oxygen and glucose). A review of Resident 1's Minimum Data Set (MDS- resident screening tool), dated 11/12/2025, indicated Resident 1 had impaired cognitive skills (mental action or process of acquiring knowledge and understanding) in decision making. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) from staff for toileting hygiene, oral hygiene, and roll from lying on [NAME] to left and right side. The MDS also indicated Resident 1 had one (1) stage 2 pressure ulcers that were present upon admission/entry or reentry. The MDS indicated facility would provide pressure injury (pressure ulcer) treatment to Resident 1. A review of Resident 1's Skin Re-assessment Check (SRC), dated 11/7/2025, the SRC indicated Resident 1 had a skin tear on left buttock and PU on the sacrum. A review of Resident 1's Care Plan for skin integrity related to open wound to sacrum and left buttock, initiated date on 11/10/2025, indicated to administer treatment as ordered, and treat left buttock and sacrum open wound by cleansing with normal saline (salt in water, used for cleaning wounds and medical equipment, and diluting medications), pat dry, apply Medi-honey (medical-grade wound dressing) to wound, cover with foam dressing every shift for wound treatment for 21 days. During a concurrent interview and record review on 11/18/2025 at 12:12 PM with the Director of Nursing (DON), Resident 1's Treatment Administration Record (TAR) dated from 11/1/2025 to 11/17/2025 was reviewed. The TAR indicated the wound treatment for the skin tear on left buttock and Stage 2 PU on the sacrum started on 11/11/2025 at 3:00 PM. The DON stated the facility staff should have placed a wound treatment order following the skin assessment on 11/7/2025 but did not. The DON stated Resident 1's skin tear on left buttock and Stage 2 PU on the sacrum were not treated from 11/8/2025 to 11/10/2025 and it could increase risk of serious health complications such as infection. During a concurrent interview on 11/18/25 at 1:19 PM with Director of Staff Development (DSD), Resident 1's TAR from 11/1/2025 to 11/17/2025 was reviewed. Resident 1's TAR indicated wound treatment for left buttock and sacrum were initiated on 11/11/2025. The DSD stated she did not see the wound treatment order for Resident 1'sleft buttock and sacral area. The DSD stated the DSD only provided wound treatment for Resident 1's gastrostomy tube site (GT- the opening in the abdomen where a GT is surgically placed to provide access to the stomach) on 11/8/2025, 11/9/2025, and 11/10/2025. The DSD stated there was no order for wound treatment for Resident 1's skin tear on the left buttock and St 2 PU on sacrum from 11/8/2025 to 11/10/2025 so there was no wound treatment provided. The DSD further stated that failure to treat wounds on time could lead to infection of the wound or delay the wound healing process. During an interview on 11/18/2025 at 3:06 PM with TXN 1, TXN 1 stated the admission nurse completed the baseline skin assessment for Resident 1. TXN 1 stated no TXN worked on the weekend and the wound treatment order for Resident 1's left buttock and sacral area was started on 11/11/2025. TXN 1 stated failure to treat PU could lead to prolonged discomfort, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infections, sepsis, and/ or death. During a review of the facility's Policy and Procedure (P&P) titled, Pressure Injury Risk Assessment, revised dated March 2020, the P&P indicated to provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries. The P&P also indicated the interventions for the PU must be based on current, and recognized standards of care. A review of the facility's P&P titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol, revised dated April 2018, the P&P indicated the staff and practitioner will examine the skin of newly admitted residents for evidence of exiting pressure ulcers or other skin conditions and order pertinent wound treatments, including pressure reduction surfaces, wound cleansing, and debridement approaches, dressings (occlusive, absorptive, etc.) and application of topical agents.