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	01/23/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect one (1) of six (6) sampled residents (Resident 1) right to be free from sexual abuse (non-consensual [without the person's permission] sexual contact of any type with a resident who does not wish to engage in sexual activity or may not have the capacity to consent) when Resident 2 was observed playing with Resident 1's private part on 1/10/2026. This failure resulted in Resident 1 being sexually abused by Resident 2 on 1/10/2026 and had the potential to result in Resident 1 experiencing negative psychosocial effects (a person's mental, emotional, social and spiritual health and hopelessness) based on the reasonable person concept (refers to a tool to assist the survey team's assessment of the severity level of negative, or potentially negative, psychosocial outcome [psychosocial effects] of the deficiency may have had on a reasonable person in the resident's position), due to Resident 1's severely impaired cognitive skills (never/rarely made decisions). An individual subjected to abuse may have psychological (mental or emotional) effects including the feelings of hopelessness (a feeling or state of despair or lack of hope), helplessness (the belief that there is nothing that anyone can do to improve a bad situation), and humiliation (the feeling of being ashamed or losing respect for yourself). *Cross referenced w/ F609Findings:1. 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 dementia (a progressive state of decline in mental abilities) and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 1'S Minimum Data Set (MDS - a resident assessment tool), dated 12/8/2025, the MDS indicated the resident was severely impaired with cognitive skills for daily decision making. Resident 1 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity, or the assistance of two (2) or more helpers is required for the resident to complete the activity) with tub/shower transfers (the ability to get in and out of a tub/shower). Resident 1 needed substantial/maximal assistance (helper does more than half the effort) with lower body dressing (the ability to dress and undress below the waist) and putting on/taking off footwear. Resident 1 needed partial/moderate assistance (helper does less than half the effort) with upper body dressing (the ability to dress and undress above the waist) and personal hygiene. Resident 1 also needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with chair/bed-to-chair transfers, rolling left and right in bed, going from sitting to lying down in bed and with eating. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR; a standardized communication tool used in healthcare to provide concise, relevant information during critical situations) Documentation dated 1/10/2026, timed at 5:30 PM, Resident 1's SBAR documentation indicated Certified Nursing Assistant 1 (CNA 1) reported that while Resident 1 was lying in bed, his roommate Resident 2 approached him and played with his (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	01/23/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	(Resident 1) private part. CNA 1 moved Resident 2 right away from Resident 1 and reported the incident to Registered Nurse 1 (RN 1). RN 1 interviewed Resident 1 and Resident 1 was only able to state his name. During a review of Resident 1's Care Plan dated 1/10/2026, Resident 1's Care Plan indicated Resident 1 experienced unwanted touching behavior.During a review of Resident 1's Care Plan dated 1/13/2026, Resident 1's Care Plan indicated Resident 1 was at risk for emotional/psychological distress due to possible unwanted touching behavior by another resident.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 and polyneuropathies (a condition involving widespread damage to many peripheral nerves - those outside the brain and spinal cord). During a review of Resident 2'S MDS, dated [DATE], the MDS indicated the resident was severely impaired with cognitive skills for daily decision making. Resident 2 needed partial/moderate assistance with chair/bed-to-chair transfers, upper and lower body dressing, putting on/taking off footwear and personal hygiene. Resident 2 needed supervision or touching assistance with rolling left and right in bed and going from lying down to sitting on the side of the bed. Resident 2 also needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. During a review of Resident 2's SBAR documentation dated 1/10/2026, timed at 5:44 PM, Resident 2's SBAR documentation indicated on 1/10/2026 CNA 1 had reported that Resident 2 was seen playing with Resident 1's private part. CNA 1 stopped Resident 2 and reported to RN 1. RN 1 interviewed Resident 2 and Resident 2 did not remember what happened.During a review of Resident 2's Care Plan dated 1/10/2026, Resident 2's Care Plan indicated possible unwanted touching behavior.During a review of Resident 2's Physician (MD) Order from 1/10/2026 at 6:53 PM, Resident 2's MD Order indicated to transfer Resident 2 to general acute care hospital (GACH) for escalating dementia.During a review of Resident 2's MD Order from 1/10/2026 at 6:58 PM, Resident 2's MD Order indicated to place Resident 2 on one-on-one (1:1; direct monitoring) until ambulance arrives.During a concurrent review of the Admission/Transfer/Discharge (ATD) log for 1/2026, and interview with the Director of Staff Development (DSD) on 1/22/2026 at 10:30 AM, the DSD stated according to the ATD log, Resident 2 was picked up by an ambulance on 1/10/2026 at 10 PM. During an observation in Resident 1's room and interview on 1/22/2026 at 1PM, Resident 1 was lying in bed. Resident 1 was asked about the alleged sexual abuse that occurred on 1/10/2026; however, Resident 1 was only able to state his name. During a concurrent review of the 1:1 Monitoring log and interview with the Director of Nursing (DON) on 1/22/2026 at 2 PM, the DON stated the log indicated Resident 2 had a 1:1 supervision from 5:30 PM to 10 PM on 1/10/2026. The DON further stated CNA1 stayed with Resident 1 until 7 PM, after which another CNA provided 1:1 supervision from 7 PM to 10 PM, until Resident 1 was picked up by ambulance for transfer to GACH. During an interview on 1/23/2026 at 1:21 PM, CNA 1 stated on 1/10/2026 at around 5:15 PM, she was passing out dinner trays when she went to assist Resident 1 with dinner. CNA 1 stated as she opened the curtains, she witnessed Resident 2 on his knees on the left side of Resident 1's bed and was touching Resident 1's private parts with both his hands while Resident 1's diaper was open. CNA 1 stated she immediately put the dinner tray down right outside the resident's room and went back to Resident 2 who was still touching Resident 1's private parts for a duration of approximately 10 seconds from when CNA1 observed him when she first entered the resident's room. CNA1 stated she grabbed Resident 2's left arm and helped him crawl back to bed since Resident 2 was unable to walk. CNA 1 stated she then went out and grabbed a linen cart and placed it between Resident 1 and Resident 2's bed to prevent Resident 2 from crawling back to Resident 1. CNA 1 stated she reported the incident to RN 1 who was at the nurses' statio and when she returned to Resident 1 and 2's room, Resident 2 was still in bed. CNA 1 stated (continued on next page)

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	01/23/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	she then started assisting Resident 1 with his dinner.During an interview on 1/23/2026 at 2:32 PM with the DON, the DON stated Resident 1 was severely impaired in cognitive skills for daily decision making and did not have the ability to consent to sexual activity with Resident 2. 3. During a review of Resident 3's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of acute respiratory failure (when the lungs suddenly cannot get enough oxygen into the blood or remove enough carbon dioxide making it a life-threatening emergency) with hypoxia (a dangerous condition where the body tissues and organs do not receive enough oxygen to function properly) and heart failure (when the heart cannot pump enough oxygen-rich blood to meet the body's needs). During a review of Resident 3'S MDS, dated [DATE], the MDS indicated the resident had intact cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 3 needed supervision or touching assistance with walking 150 feet, chair/bed-to-chair transfers, going from sitting to standing, upper and lower body dressing, putting on/taking off footwear, personal hygiene and eating. During an interview on 1/22/2026 at 1:25 PM with Resident 3, Resident 3 stated as he was walking down the hallway, he witnessed Resident 2 lowering Resident 1's diaper and touching Resident 1's buttock while in Residents 1 and 2's room. Resident 3 stated he does not remember the date and time when this incident happened. Resident 3 stated he reported what he saw to an unidentified staff member. During an interview with the DSD on 1/22/2026 at 10:30 AM, the DSD stated the facility investigated Resident 3's report of alleged sexual abuse by Resident 2 but was unable to identify the staff member to whom Resident 3 claimed to have reported the sexual abuse. The DSD stated the facility was unable to substantiate Resident 3's allegation. During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program, revised 6/2/2025, the P&P indicated, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment (the use of physical force intended to cause pain or discomfort as a way to discipline or correct behavior), involuntary seclusion (separation of a resident from others against their will or without their consent, often by confining them to a room or specific area), verbal, mental, sexual or physical abuse, and physical or chemical restraint (use of medication to control a person's behavior or restrict their freedom of movement, when the drug is not required to treat a medical condition) not required to treat the resident's symptoms. The P&P also indicated:As part of the resident abuse prevention, the administration will:Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual.Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents.Identify and assess all possible incidents of abuse;Investigate and report any allegations of abuse within timeframes as required by federal requirements.

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	01/23/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report to the state agency (California Department of Public Health- CDPH, where state law provides for jurisdiction in long-term care facilities) an allegation of sexual abuse (non-consensual [without the person's permission] sexual contact of any type with a resident who does not wish to engage in sexual activity or may not have the capacity to consent) within two (2) hours after the allegation was made and the results of the investigation within five (5) working days of the incident for one (1) of six (6) sampled residents (Resident 1).This deficient practice had the potential to place Resident 1 at risk for further abuse and/or under reporting from the facility.Cross referenced with F600Findings:1. 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 dementia (a progressive state of decline in mental abilities) and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 1'S Minimum Data Set (MDS - a resident assessment tool), dated 12/8/2025, the MDS indicated the resident was severely impaired with cognitive skills for daily decision making. Resident 1 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of two (2) or more helpers is required for the resident to complete the activity) with tub/shower transfers (the ability to get in and out of a tub/shower). Resident 1 needed substantial/maximal assistance (helper does more than half the effort) with lower body dressing (the ability to dress and undress below the waist) and putting on/taking off footwear. Resident 1 needed partial/moderate assistance (helper does less than half the effort) with upper body dressing (the ability to dress and undress above the waist) and personal hygiene. Resident 1 also needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with chair/bed-to-chair transfers, rolling left and right in bed, going from sitting to lying down in bed and with eating. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR; a standardized communication tool used in healthcare to provide concise, relevant information during critical situations) Documentation dated 1/10/2026, timed at 5:30 PM, Resident 1's SBAR documentation indicated Certified Nursing Assistant 1 (CNA 1) reported that while Resident 1 was lying in bed, his roommate Resident 2 approached him and played with his private part. CNA 1 moved Resident 2 right away from Resident 1 and reported the incident to Registered Nurse 1 (RN 1). A message was left to the resident's physician and family representative and the authorities (police department) and ombudsman (advocates for residents of nursing homes, board and care homes and assisted living facilities) were contacted. 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 and polyneuropathies (a condition involving widespread damage to many peripheral nerves - those outside the brain and spinal cord). During a review of Resident 2'S MDS, dated [DATE], the MDS indicated the resident was severely impaired with cognitive skills for daily decision making. Resident 2 needed partial/moderate assistance with chair/bed-to-chair transfers, upper and lower body dressing, putting on/taking off footwear and personal hygiene. Resident 2 needed supervision or touching assistance with rolling left and right in bed and going from lying down to sitting on the side of the bed. Resident 2 also needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. During a review of Resident 2's SBAR documentation dated 1/10/2026, timed at 5:44 PM, Resident 2's SBAR documentation indicated on 1/10/2026 CNA 1 had reported that Resident 2 was seen playing with Resident (continued on next page)

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	01/23/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1's private part. CNA 1 stopped Resident 2 and reported to RN 1. RN 1 interviewed Resident 2 and Resident 2 did not remember what happened.3. During a review of Resident 3's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of acute respiratory failure (when the lungs suddenly cannot get enough oxygen into the blood or remove enough carbon dioxide making it a life-threatening emergency) with hypoxia (a dangerous condition where the body tissues and organs do not receive enough oxygen to function properly) and heart failure (when the heart cannot pump enough oxygen-rich blood to meet the body's needs). During a review of Resident 3'S MDS, dated [DATE], the MDS indicated the resident had intact cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 3 needed supervision or touching assistance with walking 150 feet, chair/bed-to-chair transfers, going from sitting to standing, upper and lower body dressing, putting on/taking off footwear, personal hygiene and eating.During an interview on 1/22/2026 at 1:25 PM with Resident 3, Resident 3 stated as he was walking down the hallway, he witnessed Resident 2 lowering Resident 1's diaper and touching Resident 1's buttock while in Residents 1 and 2's room. Resident 3 stated he does not remember the date and time when this incident happened. Resident 3 stated he reported what he saw to an unidentified staff member.During an interview on 1/22/2026 at 2:20 PM with the Director of Nursing (DON), the DON stated she was made aware of an incident that took place on 1/10/2025 where Resident 1 was inappropriately touched by Resident 2. The DON stated she was made aware by RN 1 and that the incident was reported to the police and the ombudsman. The DON stated per the facility's policy, CDPH was not informed because of the All Facilities Letter 24-09 (AFL; a letter from the Center for Health Care Quality [CHCQ], Licensing and Certification [L&C] Program to health facilities that are licensed or certified by L&C).During an interview on 1/22/2026 at 4:00 PM with RN 1, RN 1 stated she was notified about the incident involving Resident 1 and 2 by CNA 1 on 1/10/2026. RN 1 stated as CNA 1 was passing dinner trays she went to assist Resident 1 with dinner and when she opened the curtain, she witnessed Resident 2 playing with Resident 1's private part. RN 1 stated she reported the incident to the physician, the DON, and the Administrator (ADM) and was then instructed by the ADM to report the incident to LAPD and the ombudsman and to not call CDPH since both residents had a diagnosis of dementia. During an interview on 1/22/2026 at 4:30 PM with ADM, ADM stated the incident between Resident 1 and 2 from 1/10/2026 was reported to him within 2 hours and they only reported it to the police department and the ombudsman following AFL 24-09 which indicated that they would not have to report to CDPH since neither resident sustained any injuries and both residents had a history of dementia.During an interview on 1/23/2026 at 1:21 PM with CNA 1, CNA 1 stated on 1/10/2026 at around 5:15 PM, she was passing out dinner trays when she went to assist Resident 1 with dinner. CNA 1 stated as she opened the curtains, she witnessed Resident 2 on his knees on the left side of Resident 1's bed and touching Resident 1's private parts with both his hands. CNA 1 stated she immediately went to put the dinner tray down and went back to Resident 2 who was still touching Resident 1's private parts for approximately 10 seconds CNA1 stated she grabbed Resident 2's left arm and helped him crawl back to bed since Resident 2 was unable to walk. CNA 1 stated she then went out and grabbed a linen cart and placed it between Resident 1 and Resident 2's bed to prevent Resident 2 from crawling back to Resident 1. CNA 1 stated she reported the incident to RN 1.During a concurrent interview and record review on 1/23/2026 at 2:15 PM with ADM, AFL 24-09 dated 2/28/2024 was reviewed. AFL 24-09 indicated, Facilities are responsible for following all applicable laws. The California Department of Public Health's failure to expressly notify facilities of statutory or regulatory requirements does not relieve facilities of their responsibility to comply with all laws and regulations. Facilities should refer to (continued on next page)

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	01/23/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the full text of all applicable sections of the Health and Safety Code (a set of legal regulations, statutes, or standards designed to protect public well-being, safety, and health) and Title 22 (a set of California regulations that establish minimum health, safety, and operational standards for community care facilities) of the California Code of Regulations. ADM stated they did not report the incident to CDPH due to a misinterpretation of AFL 24-09. During the same concurrent interview and record review on 1/23/2026 at 2:15 PM with ADM, the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting, revised 6/2/2025, the P&P indicated: All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator or his/her designee, to the following persons or agencies: For incidents involving resident-on-resident abuse that did not result in bodily harm where the alleged abuser is a resident diagnosed with dementia, the facility is required to notify the Ombudsman and Local Enforcement in writing within 24 hours (AFL-24-09)A. The State licensing/certification agency responsible for surveying/licensing the facility.ADM stated that after reviewing the Centers for Medicare and Medicaid Services (CMS, a U.S. federal agency within the department of Health and Human [NAME] that sets quality standards for healthcare facilities) State Operations Manual (SOM; a federal guide that provides instructions and policies and procedures for state survey agencies to monitor and enforce regulations in healthcare facilities participating in Medicare/Medicaid) dated 8/8/2024, the ADM stated now understands the incident should have been reported to CDPH and that they will need to review and revise their abuse reporting policy.During an interview on 1/23/2026 at 2:32 PM with the DON, the DON stated after reviewing the SOM dated 8/8/2024, the incident should have also been reported to CDPH since the regulatory text indicated the alleged sexual abuse as a reportable offense since Resident 1 did not have any capacity to consent to being touched by Resident 2. During the same concurrent interview and record review on 1/23/2026 at 2:32 PM with the DON, the facility's P&P titled, Abuse Investigation and Reporting, revised 6/2/2025 was reviewed. The P&P indicated: All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator or his/her designee, to the following persons or agencies: For incidents involving resident-on-resident abuse that did not result in bodily harm where the alleged abuser is a resident diagnosed with Dementia, the facility is required to notify the Ombudsman and Local Enforcement in writing within 24 hours (AFL-24-09)A. The State licensing/certification agency responsible for surveying/licensing the facility.The DON stated they will need to review the policy and should revise it to remove the AFL. During an interview on 1/23/2026 at 4:16 PM with the DON, the DON stated the incident that happened between Resident 1 and 2 on 1/10/2026 was not reported to CDPH and should have been reported to CDPH within 2 hours and per their facility policy, a 5 day incident report should have also been sent to CDPH to ensure there is no harm to Resident 1 and because it is a regulatory requirement.During a review of the facility's P&P titled, Abuse Prevention Program, revised 6/2/2025, the P&P indicated, As part of the resident abuse prevention, the administration will: iv. Investigate and report any allegations of abuse within timeframes as required by federal requirements.During a review of the facility's P&P titled, Abuse Investigation and Reporting, revised 6/2/2025, the P&P indicated:b. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than:The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with the written report of the findings of the investigation within five (5) working days of the occurrence of the incident.

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	01/23/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility (Facility 1) failed to ensure one (1) of six (6) sampled residents (Resident 2) was admitted to the resident's previous bed (Bed AA) that was on bed hold (holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization) from 1/10/2026 to 1/14/2026. This failure resulted in discharge of Resident 2 from general acute care hospital (GACH) to another Skilled Nursing Facility (SNF) 2 on 1/14/2025 and violates the right of Resident 2 to return to his previous bed that was reserved for the resident. Findings: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) and polyneuropathies (a condition involving widespread damage to many peripheral nerves - those outside the brain and spinal cord).During a review of Resident 2'S Minimum Data Set (MDS - a resident assessment tool), dated 12/14/2025, the MDS indicated the resident was severely impaired (never/rarely made decisions) with cognitive skills for daily decision making. The MDS also indicated Resident 2 needed partial/moderate assistance (helper does less than half the effort) with chair/bed-to-chair transfers, upper and lower body dressing, putting on/taking off footwear and personal hygiene. In addition, it indicated 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 rolling left and right in bed and going from lying down to sitting on the side of the bed.During a review of Resident 2's Physician (MD) Order from 1/10/2026 at 6:53 PM, Resident 2's MD Order indicated to transfer Resident 2 to GACH for escalating (the worsening of symptoms) dementia.During an interview on 1/23/2026 at 2:15 PM with the Administrator (ADM), ADM stated Resident 2 was transferred from GACH to SNF 2. ADM stated he had asked if they could find alternative placement for Resident 2 due to an isolated incident of sexual abuse (non-consensual [without the person's permission] sexual contact of any type with a resident who does not wish to engage in sexual activity or may not have the capacity to consent) that happened involving Resident 2 on 1/10/2026. ADM further stated he did not want the incident to happen again and that SNF 2 was more appropriate to care for Resident 2 than they were.During an interview on 1/23/2026 at 3:26 PM with ADM, ADM stated he does not believe the skilled nursing facility Resident 2 was transferred to is a locked facility.During an interview on 1/23/2026 at 3:35 PM with the Admissions Director (AD) of SNF 2 (current SNF Resident 2 is residing at), AD stated SNF 2 is not a locked facility and that the inquiry for Resident 2 to be transferred over to them came from Resident 2's previous SNF (Facility 1) and coordinated by the Facility 1's Marketer (MK). AD stated they were not given a reason why Resident 2 was being transferred over to them but stated Facility 1 had just asked if SNF 2 could take the resident for now and stated that Resident 2 was transferred to them from GACH on 1/14/2026. During an interview on 1/23/2026 at 3:39 PM with GACH's Case Manager (CM), CM stated the request for Resident 2's to be transferred to SNF 2 was not a request from the resident nor Resident 2's family representative. CM stated Facility 1's MK had informed CM that the building was undergoing remodeling due to water damage from the rain so the facility cannot admit Resident 2 and the resident needed to be transferred to another facility short term due to Resident 2's room needing to undergo remodeling. CM stated according to Facility 1's MK, Resident 2's family representative was notified and aware of the transfer.During a review of Resident 2's GACH Interdisciplinary Note dated 1/14/2026 at 3:47 PM, Resident 2's GACH Interdisciplinary Note indicated according to Facility 1 there is a problem at the facility and Resident 2 will be sent to Facility (continued on next page)

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	01/23/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1's sister facility which is SNF 2 temporarily and per MK Resident 2's family was made aware of the transfer and that the transfer will be temporary due to building under construction due to rain damage. During an observation on 1/23/2026 at 3:56 PM in room [ROOM NUMBER], there was no observation of any remodeling or maintenance being done in the room.During an interview on 1/23/2026 at 3:58 with Maintenance Supervisor (MS), MS stated the only current work that needs to be done for the building is for rooms [ROOM NUMBERS] where they are changing the drywall due to leak damage and that there is no work that needs to be done in room [ROOM NUMBER].During an interview on 1/2/2026 at 4:10 PM with MK, MK stated she was told by her management director to send a referral for Resident 2 to go to their sister facility SNF 2 due to Resident 2 exhibiting some sort of behavior (not identified). MK stated she was not sure if the transfer was temporary or not and that she does know if Facility 1 is having some type of remodeling but is not sure if it is happening in Resident 2's previous room or not.During an interview on 1/23/2026 at 4:16 PM with Facility 1's Director of Nursing (DON), the DON stated Resident 2 was on a 7 day bed hold and if Resident 2 was able to return to the facility within 7 days, it would be his right to come back. The DON further stated that she was not made aware of the reason why Resident 2 was transferred to another SNF.During an interview on 1/23/2026 at 4:45 PM with the DON, the DON stated it is Resident 2's right to return to the facility because it is Resident 2's home and stated Resident 2 was previously in room [ROOM NUMBER]. The DON stated she only knows that rooms [ROOM NUMBERS] are currently undergoing work. The DON also stated she was not aware that Facility 2, where Resident 2 was transferred, was not a locked facility, and stated SNF 2 should have also been made aware by MK of Resident 2's behavior prior to accepting the resident. The DON further stated on 1/14/2026, when Resident 2 was transferred to SNF 2, she was not notified and therefore could not confirm whether a bed was available for Resident 2 to be admitted back to Facility 1. During an interview on 1/23/2026 at 5:03 PM with the DON, the DON stated Resident 2 being discharged from GACH on 1/14/2026 would have been within Resident 2's bed hold and should have been able to come back to the facility on that day in the same room (room [ROOM NUMBER]) and bed (Bed AA) the resident was previously residing in. The DON stated she is not sure if the transfer to SNF 2 is temporary but stated if Resident 2 returned to Facility 1, she would have placed him back on 1:1 monitoring if there had been no other room available other than Resident 2's previous room. During a review of the facility's policy and procedure titled Bed-Holds and Returns,, review date on 6/2/2025, the policy indicated the resident who seek to return to the facility within the bed hold period defined in the state plan are allowed to return to the resident's previous room, if available. The policy also indicated, following a hospitalization, reisdent whom staff are concerned about permitting to return to the facility due to the resident's clinical/ behavioral condition at the time of transfer are evaluated based on the resident's current condition, not the resident's condition when originally transferred.