

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/31/2026
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess and complete a daily skin assessments for one of two sampled residents (Resident 2) who was assessed to be at high risk for developing pressure injury (PI-a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, shear, and/or friction, or a combination of these factors) from 2/11/2026 to 2/16/2026 in accordance with the facility's policy and procedures. These deficient practices may result into Resident 2's worsening of current PI and or developing new PI. Findings:During a review of Resident 2's admission Record, the admission Record indicated the facility initially admitted Resident 2 on 7/1/2024 and readmitted on [DATE] with diagnoses that included but not limited to type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), PI stage 4 (most severe stage of skin and tissue breakdown, meaning there is full-thickness skin and tissue loss with directly exposed or palpable muscle, tendon, ligament, cartilage, or bone) of the sacral (the lower back region located directly above the tailbone and between the hip bones), and type 2 DM with foot ulcer (an open sore or skin break on the foot that happens to people with DM). During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool) dated 7/9/2026, the MDS indicated Resident 2 had severely impaired cognitive (ability to think, read, learn, remember, reason, express thoughts, and make decisions) skills for daily decision making. The MDS indicated Resident 2 required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with upper body dressing. The MDS indicated Resident 2 required substantial/maximal assistance (Helper does more than half the effort) with eating, oral and personal hygiene, and rolling left and right. The MDS also indicated Resident 2 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of two or more helpers is required for resident to complete the activity) with toileting hygiene shower/bathing self, lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 2 was at risk for developing PIs, had unhealed PI, and had diabetic foot ulcers. During a concurrent interview and record review on 7/30/2026 at 2:33 PM with Treatment Nurse 1 (TN 1), Resident 2's Care Plan initiated 10/7/2024 focused on risk for development of skin breakdown or pressure sore (PI), was reviewed. TN 1 stated the interventions included observing the resident's skin for redness, circulatory problems, and skin check every shift. During a concurrent interview and record review on 7/30/2026 at 2:36 PM with TN 1, Resident 1's Situation Background, Assessment, and Recommendation (SBAR-a structured communication tool used to share clear, concise information quickly in healthcare for patient handoffs and critical updates) dated 2/18/2026, was reviewed. TN 1 stated the SBAR dated 2/18/2026 indicated non blanchable redness (red or discolored area of skin that does not turn white when pressed. This sign usually shows that blood flow to the tissue is hurt and early skin damage has begun) to bilateral (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056063	Facility ID: 056063 If continuation sheet Page 1 of 2

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(both) heels. TN 1 stated there were no reports from Certified Nurse's Assistants (CNAs) or Licensed Vocational Nurses (LVNs) of any skin abnormalities for Resident 2 before 2/18/2026. During an interview on 7/30/2026 at 4:34 PM with Wound Care Nurse Practitioner (WCNP), WCNP stated there is a risk for developing non-blanchable redness when residents have diabetes, poor circulation, and not being turned for long periods of time and can even deteriorate. WCNP also stated for residents that cannot move and with poor nutrition, these residents are at very high risk for developing PI or a lower stage PI to become worse and therefore the skin assessment or check should have been done daily. WCNP stated, a non-blanchable redness on the heel will not develop overnight and Resident 2's daily skin check should have been done to ensure to capture early signs of skin impairment During a concurrent interview and record review on 7/30/2026 at 3:57 PM with the DON, the Daily Body Check Report worksheet from 2/11/2026 to 2/16/2026 were reviewed. The DON confirmed there were no records of Daily Body Check reports done on 2/11/2026 to 2/16/2026. The DON stated that if there were no records of the Daily Body Check Report Worksheet, no assessment or skin checks were done. During a concurrent interview and record review on 7/30/2026 at 4:05 PM with the DON, the facility's Policy and Procedure (P&P) titled Wound Prevention: Skin and Wound Management, undated, was reviewed. The DON stated the P&P indicated the purpose of the program is to assist the facility in the care, services and documentation related to the occurrence, treatment, and prevention of pressure (PI) as well as, non-pressure related wounds. The DON stated the P&P also indicated weekly skin checks will be conducted by the licensed nurse and documented in the resident's electronic medical record; daily, during routine care, the CNA will observe the resident's skin and when abnormalities are noted, this will be communicated to the licensed nurse. The DON stated the policy was not followed as the Daily Body Check Report Worksheet for 2/11/2026 to 2/16/2026 were not completed or performed as indicated in the P&P and the resident's care plan. The DON stated if daily body check were not performed, skin impairments or injuries may be missed and by the time the impairment/injuries are discovered, the skin impairment/injuries may already be worse and treatment and services are already delayed.		