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	06/11/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received reasonable accommodation of needs for two (2) of 2 sampled residents (Residents 12 and 92) reviewed for environment/call devices by failing to ensure:Resident 12's call light (a visible and audible alarm activated by a call button) was within reach and was functioning.Resident 92's call light was within reach. This deficient practice had the potential to result in the delay or inability for Residents 12 and 92 to obtain necessary care and services, which could negatively affect the residents' overall wellbeing. Findings: 1. During a review of Resident 12's admission Record, the admission record indicated Resident 12 was admitted to the facility on [DATE], with the diagnoses including but not limited to absence of right leg above knee, pressure ulcer (an injury that breaks down the skin and underlying tissue) of sacral region (bone at the end of the spine) stage four (pressure injury is very deep, reaching into muscle and bone and causing extensive damage), and type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel). During a record review of Resident 12's Minimum Data Set (MDS, a resident assessment and tool), dated 4/16/2026, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were intact. The MDS indicated Resident 12 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with toileting hygiene, lower body dressing, and chair/bed-to-chair transfer. During a concurrent observation in Resident 12's room and interview on 6/8/2026 at 8:18 AM, Resident 12 was observed lying in bed with the call light wrapped around the right-hand side rail (metal or plastic bars installed along the sides of a bed) and dangling close to the floor. Resident 12's breakfast tray was placed on a bedside table near the wall at the foot of the bed. Resident 12 stated he wanted to eat but could not reach his breakfast tray. Resident 12 also stated he could not reach his call light to call for assistance. Resident 12 stated his call light did not work and has not worked since he was admitted to the facility (on 1/1/2026). During a concurrent observation in Resident 12's room and interview on 6/8/2026 at 8:20 AM with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 12 stated he could not reach his call light. CNA 2 stated Resident 12's call light was hanging from the side rail. CNA 2 pressed Resident 12's call light and noted that the light Infront of the resident's door did not turn on. CNA 2 stated when the call light is pressed, the light in front of the door should turn on. (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	06/11/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/2026 at 1:19 PM with the Director of Nursing (DON), the DON stated the call light should be kept within reach and should function properly so the resident could call staff for assistance. The DON stated call lights are used to prevent episodes of incontinence, prevent falls, and provide assistance to residents when they are in pain. 2. During a review of Resident 92's admission Record, the admission Record indicated Resident 92 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease (CKD- is a long-term condition where the kidneys are damaged and slowly lose their ability to filter waste and excess fluid from the blood), cirrhosis of the liver (the permanent scarring of the liver caused by long-term, continuous damage), and anxiety (mental disorder involves persistent and excessive worry that can interfere with daily activities). During a review of Resident 92's Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) Care Plan, initiated 9/30/2025, the Care Plan indicated a goal for Resident 92's needs to be met and anticipated daily. The staff intervention included maintaining a call light within easy reach. During a review of Resident 92's MDS, dated [DATE], the MDS indicated Resident 92 had intact cognitive skills for daily decision making. The MDS also indicated Resident 92 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathing self and supervision or touching assistance (helper provides verbal cues and/or touching steadying and/or contact guard assistance as resident completes activity) with eating and oral hygiene. During a concurrent observation in Resident 92's room and interview on 6/8/2026 at 11:26 AM, Resident 92's call light cord was observed hanging on the back of Resident 92's bed and out of reach. Resident 92 stated she could not reach the call light cord. During an interview on 6/11/2026 at 10:26 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 92's call light should always be accessible for the resident to contact staff and get help in case she needs assistance with anything including food, bathroom assistance. LVN 1 also stated if Resident 92 does not have access to a call light, staff will not be able to know if she needs anything and would be unaware of her needs. During a review of the facility's P&P titled Call System, Residents, revised 9/2022, the P&P indicated residents are provided with a means to call staff directly for assistance, from his/her bed, from toileting/bathing facilities and from the floor through a communication system that directly calls a staff member or a centralized workstation. The P&P also indicated the resident call system will always remain functional.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a safe, sanitary and homelike environment for three (3) of five (5) sampled residents (Residents 47, 48 and 92), in the environment task, by failing to ensure: 1. Resident 47's bathroom sink was not leaking, and the ceiling light above the bathroom sink was functioning.2. Resident 92's ceiling was clean and free of dirt.3. Resident 48's bed was maintained in a safe condition.These failures had the potential to negatively affect Resident 47, 48, and 92's quality of life and psychosocial well-being.Findings: 1. During a review of Resident 47's admission Record indicated Resident 47 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses other encephalopathy (a group of conditions that cause brain dysfunction, such as confusion, memory loss and personality changes), dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), and muscle weakness (a reduced ability of one or more muscles to generate force, making it harder to perform tasks that require strength) During a review of the Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 4/25/2026, it indicated Resident 47 had had moderate impairment (decisions poor, cues/supervision required) for cognitive skills (the mental processes that allow people to think, learn, and solve problems) for daily decision making. It also indicated, Resident 47 required partial or moderate assistant, (helper does less than half the effort) with the toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated, Resident 47 needed supervision or touching assistance (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene, and Resident 47 needed setup or clean-up assistance (helpers sets up or cleans up, resident completes activity) for eating. During an observation of Resident 47's room on 6/9/2026 at 1:39 PM, Resident 47's bathroom sink was observed to have a white linen underneath the sink with yellow water mark and water stain that shows sign of water leaking to the bottom of the sink. In addition, there was no light bulbs on the ceiling light above the bathroom sink. During a concurrent observation and interview on 6/9/2026 at 1:42 PM with Resident 47 in her room, Resident 47 stated she told the staff and the supervisor about the water leak from the resident's bathroom sink and there was no light on top of the bathroom sink(unable to recall since when), and no one ever come to fix it. Resident 47 stated she stopped complaining and she used the bathroom sink since that is the only sink the resident could use. During a concurrent observation and interview on 6/10/2026 at 2:55 PM with Infection Preventionist Nurse (IPN) in Resident 47's room, IPN stated the white sheet under the bathroom sink was not supposed to be left underneath the sink to absorb leaking water from the sink. IPN also stated the ceiling light needed light bulbs, so the resident has a light when using the bathroom sink. IPN stated this was not a home-like environment for Resident 47. During an interview with Interim Maintenance Director (IMD) on 6/11/2026 at 9:46 AM, IMD stated Resident 47's leaking sink in the bathroom should have been repaired and it was not supposed to have a water leak. IMD also stated, the ceiling light needs light bulbs so the resident can use it. IMD 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	06/11/2026

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	this is not a homelike environment to Resident 47. IMD stated the residents like it when everything in their room is fixed and homelike. During a review of the facility's P&P titled, Homelike Environment revised on February 2021, the P&P indicated the following residents are provided with a safe, clean, comfortable and homelike environment. The P&P also indicated the facility staff, and management will maximize characteristics that reflect a personalized, homelike setting including a clean, sanitary and orderly environment. In addition, the P&P indicated comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable and homelike environment and the lighting design emphasizes sufficient general lighting in resident-use areas. A review of the facility's P&P titled, Maintenance Service, revised on 1/29/2026, indicated, maintenance service shall be provided to all areas of the building, grounds, and equipment. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of the maintenance personnel include but are not limited to: maintaining the building in good repair and free from hazards. 2. During a review of Resident 92's admission Record, the admission Record indicated Resident 92 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease (CKD- is a long-term condition where the kidneys are damaged and slowly lose their ability to filter waste and excess fluid from the blood), cirrhosis of the liver (the permanent scarring of the liver caused by long-term, continuous damage) and anxiety (mental disorder involves persistent and excessive worry that can interfere with daily activities). During a review of Resident 92's MDS dated [DATE], the MDS indicated Resident 92 had intact cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 92 was substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathing self and supervision or touching assistance (helper provides verbal cues and/or touching steadying and/or contact guard assistance as resident completes activity) with eating and oral hygiene. During an observation on 6/8/2026 at 11:26 AM, at Resident 92's bedside, a splatter of brown spots was observed on the ceiling above Resident 92's bed. During a concurrent observation and interview on 6/11/2026 at 10:43 AM with Housekeeping Supervisor (HS), at Resident 92's bedside, a splatter of brown spots was observed on the ceiling above Resident 92's bed. HS stated there were brown spots on the ceiling located above Resident 92's bed and HS was not sure if it was food or stool but should not be there. HS stated it was important to ensure Resident 92's environment was clean and not dirty because that is what was good for the resident. HS further added the facility is supposed to make sure every resident had a safe, clean and homelike environment. During a review of the facility's policy titled Quality of Life- Homelike Environment, revised 5/2017, the policy indicated residents are provided with a safe, clean, comfortable and homelike environment. The policy also indicated the facility staff, and management will maximize characteristics that reflect (continued on next page)

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	056063	A. Building B. Wing	06/11/2026

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a personalized, homelike setting including a clean, sanitary and orderly environment. 3. During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was admitted to the facility on [DATE] with diagnoses that included epilepsy (a chronic disorder of the brain characterized by recurrent brief episodes of involuntary movement that may involve a part of the body or the entire body, and are sometimes accompanied by loss of consciousness), cerebral infarction (a life-threatening medical emergency that occurs when a blood clot or plaque blocks an artery supplying blood to the brain), fracture (a complete or partial break) of the right femur (thigh bone), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 48's MDS dated [DATE], the MDS indicated Resident 48 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 48 was dependent (helper does all effort to complete activity) with oral, toileting, and personal hygiene, eating, dressing and transfers. During an observation on 6/8/2026 at 8:36 AM at Resident 48's bedside, a black box, powered on with multiple cords, was seen under Resident 48's bed, with a white plastic bag wrapped around it and tied to the bed frame. During a concurrent observation and interview on 6/11/2026 at 9:59 AM with Licensed Vocational Nurse 1 (LVN 1), at Resident 48's bedside, the same observation from 6/8/2026 of black box, powered on with multiple cords, was seen under Resident 48's bed, with a white plastic bag wrapped around it and tied to the bed frame was observed. LVN 1 stated the black box under Resident 48's bed was the main control for the bed's movements going up and down, including the head of the bed. LVN 1 stated the control was tied to the bed frame with a plastic bag and it should not be. LVN 1 further stated this should not have been done because it causes electrical hazards and is dangerous for Resident 48. During an interview on 6/11/2026 at 10:34 AM with IMD and the Maintenance Assistant (MA), IMD stated the black box tied to Resident 48's bed with a plastic bag was the bed's motor. Both IMD and MA stated the motor should not have been tied to the bed and was unsafe for Resident 48. The IMD further stated the motor had a broken part that would allow it to be properly and safely connected to bed frame and should have been replaced instead of tied to the bed. IMD stated if the motor was to drop and break, Resident 48 would be stuck in the bed and whatever position the bed was in. During a review of the facility's policy and procedure (P&P) titled, Hazardous Areas, Devices and Equipment, (undated), the P&P indicated all hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. The P&P also indicated environmental hazards to include devices and equipment that are improperly used or poorly maintained. During a review of the facility's P&P titled, Assistive Devices and Equipment, dated 1/21/2026, the policy indicated that the facility would maintain and supervise the use of assistive devices and equipment for residents. The P&P also indicated that defective devices are discarded or repaired.

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	056063	A. Building B. Wing	06/11/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive, resident-centered care plan (integrated health care services delivered in a setting and manner that is responsive to individuals and their goals, values, and preferences, in a system that supports good provider-resident communication and empowers individuals receiving care and providers to make effective care plans together) was developed for two (2) of 2 sampled residents (Residents 3 and 74) reviewed under care planning as indicated on the facility's policy:Resident 3 did not have a care plan for Restorative Nursing Assistant (RNA) services (provided by certified nursing assistants [CNAs] who specialize in rehabilitation and restorative care for residents with limited mobility).Resident 74 did not have a care plan to address the resident's behavior of removing, throwing the resident's clothes off and preferring to be naked. These deficient practices have the potential for a delay in the necessary care and services for Residents 3 and 74, which could cause harm and complications resulting in negatively affecting the residents' overall wellbeing. Findings: 1. During a review of Resident 3's admission Record, the admission record indicated Resident 3 was admitted to the facility on [DATE], with the diagnoses including but not limited to unspecified fracture (break in the bone) of left calcaneus (large bone forming the heel), acute osteomyelitis (infection of bones) of the left ankle and foot, and heart failure (a lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen). During a record review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 4/13/2026, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 3 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with toileting hygiene, lower body dressing, lying to sitting on side of bed, and sitting to standing. During a record review of Resident 1's Physician Order Summary Report, dated 4/20/2026, the order indicated RNA to provide active assisted range of motion (AAROM, a type of therapeutic exercise used in physical therapy and rehabilitation to improve joint flexibility, muscular strength, and joint mobility) to bilateral upper extremities (BUE, both arms from shoulder to hands) and bilateral lower extremities (BLE, both legs from hip to foot) every day five times a week or as tolerated, one time a day every Monday, Tuesday, Wednesday, Thursday, and Friday. A review of Resident 3's care plan dated from 4/20/2026 to 6/11/2026, it did not indicate a care plan for Resident 3's RNA services. During a current interview and record review on 6/11/2026 at 8:44 AM with Licensed Vocational Nurse 1 (LVN 1) of Resident 3's care plans dated from 4/20/2026 to 6/11/2026, LVN 1 stated Resident 3 did not have a care plan for the resident's RNA services and the resident should have a care plan for RNA services since the resident was receiving RNA services. During an interview on 6/11/2026 at 10:53 AM with Minimum Data Set Nurse (MDSN), MDSN stated once Resident 3 was started with RNA services the licensed nurse should have updated the care plan (continued on next page)

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	056063	A. Building B. Wing	06/11/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to include the RNA services. During an interview on 6/11/2026 at 1:53 PM with the Director of Nursing (DON), the DON stated Resident 3 should have RNA services included in her care plan. The DON stated RNA services were performed to maintain the resident's functionality and prevent any decline in her range of motion. During a review of the facility's P&P titled, Restorative Nursing Services, revised 7/2017, the P&P indicated restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care. 2. During a review of Resident 74's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD; a chronic inflammatory lung disease that causes obstructed airflow from the lungs), cirrhosis (scarring) of liver and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 74's MDS dated [DATE], the MDS indicated Resident 74 had intact cognitive (ability to think and process information) ability. The MDS indicated Resident 74 was dependent for toileting hygiene, showering, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 74 required maximal assistance (helper does more than half the effort) for eating, oral hygiene and upper body dressing. During an observation on 6/8/2026 at 10:12 AM, Resident 74 was observed sleeping on his bed naked and without a blanket. During a concurrent observation and interview on 6/8/2026 at 10:16 AM with LV 3, Resident 74 was observed sleeping on the resident's bed naked and without blanket. LVN 3 stated Resident 74 is sleeping naked and the resident refuses to wear clothes. LVN 3 stated Resident 74 throws his diaper and blankets off. During a concurrent record review and interview on 6/8/2026 at 10:18 AM with LVN 3, Resident 74's CP history dated 4/9/2026 to 6/8/2026 was reviewed. LVN 3 stated Resident 74 does not have a CP for the resident behavior of removing, throwing clothes off and preferring to be naked. LVN 3 stated Resident 74 should have a CP to address the resident's behavior of taking clothes off and preferring to be naked. LVN 3 stated if there is no CP, interventions are not monitored and the behavior may worsen. During a concurrent interview and record review on 6/11/2026 at 12:11 PM with the Director of Nursing (DON), the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, was reviewed. The P&P indicated: A comprehensive, person-centered CP that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Reflects currently recognized standards of practice for problem areas and conditions. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. (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	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The DON stated that the policy indicated, a resident should have a CP that has measurable objectives and goals to address the resident's needs and behaviors. The DON stated, a behavior of not wearing clothes should have a CP to address possible underlying issues and try to resolve them.

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	056063	A. Building B. Wing	06/11/2026

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents receive proper treatment and/or assistive devices to maintain vision and/or hearing abilities for two (2) of 2 sampled residents (Residents 6 and 51) reviewed for vision/hearing to ensure:Resident 6 receive a proper assistive device to maintain hearing and have a comprehensive person-centered care plan to address the resident's hearing loss. The medical doctor (MD) for Resident 51 was informed of the resident's missed ophthalmology (the specialized field of medicine that focuses on the health of the eye appointment) to ensure alternative ophthalmology care, services and/or appointments were provided to maintain the resident's vision health. These deficient practices may result in Resident 6 not being able to hear adequately and resulted in a delay in care and services, with the potential for worsening or untreated vision problems for Resident 51. Findings: 1. During a review of Resident 6's admission Record, the admission record indicated Resident 6 was admitted to the facility on [DATE], with the diagnoses including but not limited to sensorineural hearing loss (damage to the inner ear or auditory nerve [sensory fibers that conduct impulses from the organs of hearing to the brain] that affects sound perception), glaucoma (damage to optic nerve causing vision loss or blindness), and acute pulmonary edema (an abnormal accumulation of fluid in the lungs, making it hard to breathe). During a record review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 3/6/2026, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was moderately impaired. The MDS indicated Resident 6's ability to hear was highly impaired (absence of useful hearing). The MDS also indicated Resident 6 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, upper and lower body dressing, lying to sitting on side of bed, and chair/bed to chair transfer. During a review of Resident 6's Social History & Initial Assessment, dated 3/3/2026, the assessment indicated the resident has hearing difficulty. The assessment also indicated Resident 6 liked listening to music and watching television. During a review of Resident 6's Hearing Aid Delivery Report, dated 3/24/2026, the report indicated the facility received Resident 6's right and left hearing aids (a small, electronic device worn in or behind the ear that amplifies sound). During an interview on 6/8/2026 at 3:35 PM with Resident 6 in the resident's room, Resident 6 stated she cannot hear and wanted to communicate via writing, using a notebook and black marker. During an interview on 6/10/2026 at 10:50 AM with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated Resident 6 used a notebook and markers while communicating with staff. CNA 3 stated he had been taking care of Resident 6 routinely for three to four months and Resident 6 was hard of hearing. During a concurrent interview and record review on 6/10/2026 at 2:03 PM with Director of Social Service (DSS), Resident 6's Hearing Aid Delivery Report dated 3/24/2026 was reviewed. DSS stated staff had to talk really loud when talking to Resident 6 and she recommended that Resident 6 receive (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	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hearing aids. DSS stated Resident 6's hearing aids were delivered to the facility on 3/24/2026 but it was not given to Resident 6 and education was not provided to Resident 6 on how to use it. DSS stated staff should have given Resident 6 the resident's hearing aids and should have educated Resident 6 on how to operate the hearing aids. DSS stated Resident 6 should be using the hearing aids daily since it was delivered last 3/24/2026. During a follow up interview on 6/10/2026 at 2:16 PM with CNA 3, CNA 3 stated Resident 6 did not have any hearing aids. During an interview on 6/10/2026 at 2:36 PM with Registered Nursing Supervisor 2 (RNS 2), RNS 2 stated she communicated with Resident 6 by getting close to Resident 6's right side, pulling down RN 2's facemask, and speaking louder. During an interview on 6/10/2026 at 3:44 PM in Resident 6's room, Resident 6 stated she did not have a hearing aid since she was admitted at the facility. Resident 6 stated she was never given a hearing aid and really needed a hearing aid. During an interview on 6/11/2026 at 8:02 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 6 was hard of hearing. LVN 1 stated he (LVN 1) communicated with Resident 6 by talking and using his (LVN 1) hands gestures. LVN 1 stated hearing aids would be beneficial for Resident 6. LVN 1 stated he was not aware if Resident 6 had any hearing aid. During a concurrent interview and observation on 6/11/2026 at 8:08 AM with LVN 1 in the storage room, Resident 6's box of hearing aid was located on the shelf. LVN 1 stated Resident 6 had a right and left hearing aids which were placed in a box and stored in the storage room. LVN 1 stated Resident 6 should be given the resident's hearing aids so that the resident could hear and make it easier for the resident to communicate with staff and other residents. During a concurrent interview and record review on 6/11/2026 at 8:10 AM with LVN 1, Resident 6's Social Service History & Initial assessment dated [DATE], Hearing Aid Delivery Report dated 3/24/2026, and Care Plans dated from 8/25/2025 to 6/11/2026 were reviewed. LVN 1 stated Resident 6 had hearing difficulties since admission to the facility. LVN 1 stated Resident 6's preference is music and since the resident was hard of hearing this could affect the resident. LVN 1 stated Resident 6's hearing aids were delivered on 3/24/2026 and it was not given to Resident 6 so the resident did not have her hearing aids for almost three months. LVN 1 also stated there were no hearing aids included in Resident 6's care plan. LVN 1 stated Resident 6's hearing aids should be included in the resident's care plan since it was one of the interventions staff should be providing to Resident 6. LVN 1 stated including Resident 6's hearing aids into the care plan would inform the nurses Resident 6 had hearing aids so that staff could offer the hearing aids for Resident 6 to use. During an interview on 6/11/2026 at 10:53 AM with Minimum Data Set Nurse (MDSN), MDSN stated the resident's care plan should be updated to include the need of Resident 6 to use hearing aid as soon as the facility received the ordered hearing aids for Resident 6. MDSN stated the hearing aid availability needed to be communicated with staff in order to clearly inform the nurses what Resident 6's needs were. During an interview on 6/11/2026 at 1:47 PM with the Director of Nursing (DON), the DON stated the hearing aids should be labeled with the resident's name and given to the resident as soon as the hearing aid was delivered to the facility. The DON stated it was important for residents to use their (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	06/11/2026

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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hearing aids so the residents could hear what was going on and communicate effectively. The DON also stated when residents had hearing aids, the hearing aids should be updated in the care plan to allow staff to be aware the resident had a hearing deficient and know how to communicate effectively with the resident. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, the P&P indicated the comprehensive, person-centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial (combined influence of psychological factors and the surrounding social environment on physical, emotional, and/or mental wellness) well-being. During a review of the facility's P&P titled, Hearing Impaired Resident, Care of, revised 2/2018, the P&P indicated staff will assist hearing impaired residents to maintain effective communication with clinicians, caregivers, other residents and visitors. 2. During a review of Resident 51's admission Record, the admission Record indicated Resident 51 was readmitted to the facility on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dry eye syndrome (a chronic condition where the eyes do not produce enough tears, or the tears evaporate too quickly), fibromyalgia (a chronic disorder characterized by widespread musculoskeletal pain, profound fatigue, sleep disturbances, and cognitive issues) and dementia (a progressive state of decline in mental abilities). During a review of Resident 51's Dry Eyes, Risk for Impaired Visual Acuity care plan, revised 5/18/2025, the care plan indicated for ophthalmology and optometry examinations as needed to monitor progressive vision changes/loss. During a review of Resident 51's Ophthalmology Chart Note, dated 2/3/2026, the Ophthalmology Note indicated Resident 51 with significant dry eye syndrome and to return in three (3) to four (4) months for a follow up. During a review of Resident 51's Order Listing Report, dated 2/3/2026, the Order Listing Report indicated an order for a follow up appointment with Ophthalmologist 1 (a medical doctor [MD] who specializes in comprehensive eye and vision care) on 6/2/2026 at 9:45 AM. During a review of Resident 51's MDS dated [DATE], the MDS indicated Resident 51 had adequate vision (sees fine detail) with corrective lenses (contacts, glasses or magnifying glass). The MDS indicated Resident 51 had intact cognitive skills for daily decision making. The MDS also indicated Resident 51 required setup or clean up assistance (helper sets up or cleans up; resident completes activity) with eating and oral hygiene and partial/moderate assistance (helper does less than half the effort) with toileting hygiene, and shower/bathing self. During an interview on 6/8/2026 at 12:21 PM with Resident 51, Resident 51 stated she is having trouble with her vision and had an ophthalmology appointment on 6/2/2026 and has been going to Ophthalmologist 1 for at least 30- 40 years, and needed this appointment. Resident 51 stated she was told her appointment was cancelled due to her insurance but was not told anything else of the next plan. During a concurrent interview and record review on 6/10/2026 at 2:19 PM with Registered Nurse 1 (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	06/11/2026

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(RN 1), Resident 51's medical chart was reviewed from 2/3/2026 through 6/10/2026. The medical chart did not indicate a reason for Resident 51's missed ophthalmology appointment on 6/2/2026 and that Resident 51's MD was notified of the missed appointment. RN 1 stated there was no documentation including a progress note or MD notification regarding Resident 51's missed ophthalmology appointment on 6/2/2026. During an interview on 6/10/2026 at 2:25 PM with Social Services Assistant (SSA), the SSA stated Resident 51 had an ophthalmology appointment on 6/2/2026, that was cancelled due to the resident's medical insurance that is now pending approval. SSA stated he informed Resident 51 of the cancelled appointment but did not inform any other staff or documented it in the resident's medical records or any notes about the cancelled appointment. During an interview on 6/10/2026 at 2:40 PM with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated there should have been a progress note completed when Resident 51 missed her ophthalmology appointment that indicated the resident's MD was informed and any new orders for treatment and care. LVN 5 further stated it was important to make sure that Resident 51 vision care is provided, and the MD is informed to prevent the resident's eyesight from worsening and ensure the resident receives the care she needs. During an interview on 6/11/2026 at 1:02 PM with the (DON, the DON stated the MD should have been notified of Resident 51's missed ophthalmology appointment on or after 6/2/2026 because MD could have arranged an alternate plan of care to address Resident 51's eyes/vision concern. The DON further stated it was important to follow up and notify Resident 51's MD after the missed appointment to prevent a delay in services, because a delay can cause negative outcomes like eye pain or even worsened eyesight. During a review of the facility's policy titled Visually Impaired Resident, Care of, dated 3/2021, the policy indicated it was the facility's responsibility to assist the resident and representatives in locating available resources, scheduling appointments and arranging transportation to obtain needed services.

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	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor the intake and output for two (2) of three (3) sampled residents (Residents 3 and 34) reviewed for dialysis (a lifesaving treatment for residents with kidney failure) treatment in accordance with the resident's care plan and the facility's policy and procedure (P&P). This deficient practice had the potential for Residents 3 and 34 to have fluid overload (harmful amount of fluid in the body) which could cause complications such as swelling, high blood pressure, shortness of breath, and pulmonary edema (an accumulation of fluid in the lungs) or fluid deficit (condition where fluid output exceeds the fluid intake) which could cause complications such as low blood pressure, electrolyte imbalances (occurs when levels of essential minerals in the body are too high or too low disrupting normal bodily functions), reduced dialysis efficiency, or cardiac arrest (sudden and unexpected cessation of heart function causing the heart to stop pumping blood to the brain and other vital organs). Findings: 1. During a review of Resident 3's admission Record, the admission record indicated Resident 3 was admitted to the facility on [DATE], with diagnoses including but not limited to end stage renal disease (advanced stage kidney failure), heart failure (a lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), and dependence on renal (relating to the kidneys) dialysis. During a record review of Resident 3's Order Summary Report, dated 3/28/2026, the report indicated hemodialysis (medical procedure that filters the blood of waste products when the kidneys are not able to) on Monday, Wednesday, and Friday. During a record review of Resident 3's Care Plan, dated 3/28/2026, the Care Plan indicated Resident 3 has end stage renal disease with hemodialysis. The care plan interventions were to monitor intake and output every shift and monitor access area for redness, pain, signs and symptoms of infection, presence and absence of bruit (abnormal whooshing or swishing sound heart with a stethoscope over an arteriovenous fistula [AV, abnormal connection or link between an artery and a vein that allows blood to flow directly from one vessel to the other bypassing the normal capillary network] or shunt [a surgically created connection between an artery and a vein that provides long-term access for hemodialysis]), bleeding and notify physician at once. During a record review of Resident 3's Care Plan, dated 3/28/2026, the Care Plan indicated Resident 3 was at risk for dehydration (medical condition in which the body loses more fluids than it takes in, leading to an insufficient amount of water and essential electrolytes needed to perform vital functions) or potential fluid deficit related to weakness, use of laxative (medicine that loosens the bowels and encourages bowel movements), diabetes mellites (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), and end stage renal disease. The care plan interventions were to monitor and document intake and output as per facility policy and monitor vital signs as ordered/per protocol and record and to notify physician of significant abnormalities. During a record review of Resident 3's Minimum Data Set (MDS, a resident assessment and tool), dated 4/13/2026, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 3 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, lying to sitting on side of bed, and chair/bed to chair transfer. The MDS also indicated Resident 3 received dialysis. During a record review of Resident 3's Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) and medical records for the months of May 2026 and June 2026, there was no documented evidence that Resident 3's intake and output were monitored. During an interview on 6/11/2026 at 8:49 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated dialysis residents should be placed on intake and output monitoring when admitted to the facility. LVN 1 stated monitoring intake and output was done to prevent fluid overload. During a concurrent interview and record review on 6/11/2026 at 9 AM with LVN 1, Resident 3's physician order, care (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	06/11/2026

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plans, and MAR were reviewed. LVN 1 stated there was no order for intake and output monitoring. LVN 1 stated the admitting nurse should ask the physician for intake and output monitoring when the resident was admitted to the facility to ensure that this is done every shift. LVN 1 stated the care plan indicated to monitor the fluid intake every shift since Resident 3 had end stage renal disease with dialysis. LVN 1 stated monitoring of intake and output was documented done on the MAR. LVN 1 stated there was no intake and output monitoring documented in the MAR. 2. During a review of Resident 34's admission Record, the admission record indicated Resident 34 was admitted to the facility on [DATE], with diagnoses including but not limited to type 2 diabetes mellitus with diabetic chronic kidney disease (damage to the kidney's filtering system resulting from diabetes), acute on chronic diastolic congestive heart failure (a long term condition where the heart's left ventricle becomes stiff and cannot fill properly, leading to reduced blood flow despite normal pumping strength), end stage renal disease, and dependence on renal dialysis. During a record review of Resident 34's Care Plan, dated 3/30/2026, the Care Plan indicated Resident 3 has end stage renal disease with hemodialysis. The care plan interventions were to monitor intake and output every shift and monitor access area for redness, pain, signs and symptoms of infection, presence and absence of bruit, bleeding and to notify physician at once. During a record review of Resident 34's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was intact. The MDS indicated Resident 34 required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, upper and lower body dressing, lying to sitting on side of bed, and sitting to standing. The MDS also indicated Resident 34 received dialysis. During a record review of Resident 34's Order Summary Report, dated 3/31/2026, the report indicated hemodialysis on Monday, Wednesday, and Friday. During a record review of Resident 34's Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) and medical records for the months of May 2026 and June 2026, there was no documented evidence that Resident 34's intake and output were monitored. During a concurrent interview and record review on 6/11/2026 at 9:12 AM with LVN 1, Resident 34's physician order, care plans, and MAR were reviewed. LVN 1 stated Resident 34's care plan for end stage renal disease indicated to monitor for intake and output. LVN 1 stated there was no documentation that Resident 34's intake and output was monitored. LVN 1 stated if monitoring was done, this should have been documented in the MAR. LVN 1 stated when a dialysis resident is admitted to the facility, the admitting nurse should include all orders pertaining to dialysis such as fluid restriction, intake and output monitoring, medications, and the time and day for dialysis treatment. LVN 1 stated it was important to monitor intake and output of fluids for dialysis residents since their kidneys are not working effectively. LVN 1 stated when there is too much fluid, it could result in the residents experiencing fluid overload which causes edema and difficulty in breathing. LVN 1 stated when residents do not have enough fluids, this could cause a fluid deficit which leads to dehydration, low blood pressure, muscle cramping, and an electrolyte imbalance. During an interview on 6/11/2026 at 1:31 PM with the Director of Nursing (DON), the DON stated dialysis residents should have an order for intake and output monitoring along with a care plan. The DON stated it was important to monitor the residents' intake and output to avoid fluid overload since the residents' kidneys could not filter out the fluid. The DON also stated fluid overload could affect the residents' blood pressure, could go into shock (when the body is not getting enough blood flow, so organs do not get the oxygen they need, and it becomes lifeˆthreatening) and may also result in resident needing extra dialysis treatments. During a follow up interview on 6/11/2026 at 2:34 PM, the DON stated there should be an order to monitor the intake and output. The DON stated the intake and output monitoring should be documented on the MAR to ensure that monitoring was done. During a review of the facility's P&P titled, End-Stage Renal Disease, Care of a Resident with, revised 9/2010, the P&P indicated residents with end-stage renal disease (ESRD) will be care for according to currently recognized standards of care. Agreements between this facility and the contracted ESRD (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	06/11/2026

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility will include all aspects of how the resident's care will be managed, including how the care plan will be developed and implemented. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. During a record review of the facility's P&P titled, Intake, Measuring and Recording, revised 10/2010, the P&P indicated to review the resident's care plan to assess for any special needs of the resident. The information should be recorded in the resident's medical record: the date and time the resident's fluid intake was measured and recorded. During a record review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, the P&P indicated the comprehensive, person-centered care plan will reflect treatment goals, timetables, and objectives in measurable outcomes. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes and relevant clinical decision making.

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	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to take timely action on a Medication Regimen Review (MRR, also known as a Drug Regimen Review-is a structured, comprehensive evaluation of all medications a resident is taking, conducted typically by a pharmacist to ensure medications are appropriate, safe, effective, and used correctly) irregularity (includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences, as well as the identification of conditions that may warrant initiation of medication therapy) for two (2) of five (5) sampled residents (Resident 36 and Resident 51) reviewed for unnecessary medications by failing to ensure:Resident 36's Depakote level (refers to the measured concentration of valproic acid (the active ingredient in Depakote) in the blood, used to ensure the dose is effective yet safe. It helps verify the medication is working as intended without causing toxicity.) monitoring order was obtained from the physician.The physician addressed Resident 51's dose frequency for the use of Ativan (Lorazepam, prescription medication used to treat anxiety disorders [refers to a condition characterized by excessive, persistent, and uncontrollable worry or fear about everyday situations, accompanied by physical and cognitive symptoms that interfere with normal functioning).These deficient practices increased Residents 36 and 51's risk to experience adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to their medication therapy, potentially leading to impairment or decline in their mental, functional, and psychosocial wellbeing. Findings: 1. During a review of Resident 36's admission Record, the admission Record indicated Resident 36 was initially admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. Resident 36's diagnoses included paranoid schizophrenia (a chronic mental health condition marked primarily by intense, irrational suspicions [paranoia], persecutory delusions [false beliefs that are not based in reality], and auditory hallucinations [experiencing sensations that aren't real, most commonly hearing voices]), unspecified anxiety disorder, and chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe) During a review of Resident 36's Minimum Data Set (MDS, resident assessment tool), dated 4/12/2026, the MDS indicated Resident 36 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 36 needed substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self. Resident 36 needed partial or moderate assistance, (helper does less than half the effort) with lower body dressing, putting on/ taking off footwear, and personal hygiene. Resident 36 needed supervision or touching assistance (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene and upper body dressing. During a review of Resident 36's MRR, dated 5/11/2026, the MRR indicated a recommendation to monitor the Depakote (divalproex sodium, a prescription medication used as a mood stabilizer, anticonvulsant, and vascular headache suppressant) level in the blood stream. During a concurrent interview and record review on 6/11/2026 at 8:55 AM with the Director of Staff Development (DSD), Resident 36's MRR, dated 5/11/2026, and medical records were reviewed. The (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	06/11/2026

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DSD stated Resident 36's MRR, dated 5/11/2026, indicated a recommendation to monitor Resident 36's Depakote level. DSD stated there was no current monitoring for Depakote level. DSD stated it is very important to monitor Resident 36's Depakote level to ensure the dose stays safe and effective. During a concurrent interview and record review on 6/10/2026 at 4:55 AM with the Director of Nursing (DON), Resident 36's MRR dated 5/11/2026 was reviewed. The DON stated it is very important to follow up with the instructions indicated on the MRR to monitor Resident 36's Depakote level to prevent serious side effects, such as severe drowsiness, confusion, or organ damage like liver toxicity to Resident 36. 2. During a review of Resident 51's admission Record, the admission Record indicated Resident 51 was readmitted to the facility on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dry eye syndrome (a chronic condition where the eyes do not produce enough tears, or the tears evaporate too quickly) , fibromyalgia (a chronic disorder characterized by widespread musculoskeletal pain, profound fatigue, sleep disturbances, and cognitive issues), and dementia (a progressive state of decline in mental abilities). During a review of Resident 51's Diagnosis of Anxiety care plan, revised 2/6/2025, the care plan indicated interventions included were for pharmacist to conduct a MRR and to follow up on recommendations with the medical doctor (MD). During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 had adequate vision (sees fine detail) with corrective lenses (contacts, glasses or magnifying glass). The MDS indicated Resident 51 had intact cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 51 required setup or clean up assistance (helper sets up or cleans up; resident completes activity) with eating and oral hygiene and partial/moderate assistance (helper does less than half the effort) with toileting hygiene, and shower/bathing self. The MDS also indicated Resident 51 was receiving an antianxiety medication (a medication used to anxiety). During a review of the facility's Consultant Pharmacist's MRR, dated 4/12/2026 and 4/13/2026, the MRR indicated to inform the medical doctor (MD) and or psychiatrist if routine order for Ativan (Lorazepam, prescription medication used to treat anxiety disorders) is clinically indicated instead of renewing every 14 days, if Resident 51 is asking [in need of] frequently. During a review of Resident 51's Medication Administration Records (MARs - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 4/1/2026 to 4/31/2026, 5/1/2026 to 5/30/2026 and 6/1/2026 to 6/10/2026), the MARs indicated lorazepam (Ativan) oral tablet 0.5 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) give 1 tablet by mouth every six (6) hours as needed for anxiety for 30 days; manifested by persistent feeling of panic (pacing heart rate). The MARs also indicated Lorazepam 0.5 mg was administered to Resident 51 on the following: 4/1/2026 to 4/31/2026, except on 4/4/2026, 4/22/2026, 4/24/2026 and 4/29/2026. 5/1/2026 to 5/30/2026, except on 5/9/2026, 5/24/2026 and 5/27/2026. (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	06/11/2026

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/1/2026 to 6/10/2026. During a concurrent interview and record review on 6/11/2026 at 12:33 PM with the Director of Nursing (DON), Resident 51's physical and electronic medical records, dated 4/12/2026 through 6/11/2026, were reviewed. The medical records failed to indicate that Resident 51's physician and/or psychiatrist were informed of the MRR report. There was no written response from the physician or psychiatrist if a routine order for lorazepam was clinically indicated. The DON stated it was important to follow up with the pharmacist's recommendations for Resident 51's well-being, to ensure the goal to administer the lowest prescribed dose and for continuity of care. During a review of the facility's policy and procedure (P&P) titled, Medication Regimen Reviews, revised 2/2025, the MRR indicated: A licensed pharmacist reviews the medication regimen of each resident at least monthly. The purpose of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record. Upon receiving the MRR report from the pharmacist, the attending physician reviews and responds to the report. The physician documents in the resident's medical record that the pharmacist's recommendations have been reviewed and what (if any) actions were taken to address them.

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	06/11/2026

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

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor the signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) for two (2) of 2 sampled residents (Residents 34 and 57) reviewed for insulin (a natural hormone that turns food into energy and manages your blood sugar level, can be produced by the body or given artificially via medication). This deficient practice had the potential for Residents 34 and 57 to experience episodes of hypoglycemia and hyperglycemia without proper monitoring while receiving insulin which could result in harm, hospitalization, and diabetic coma (a life-threatening state of unconsciousness caused by extremely high or low blood sugar levels). Findings: 1. During a review of Resident 34's admission Record, the admission record indicated Resident 34 was admitted to the facility on [DATE], with diagnoses including but not limited to type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel) with diabetic chronic kidney disease (damage to the kidney's filtering system resulting from diabetes), acute on chronic diastolic congestive heart failure (a long term condition where the heart's left ventricle becomes stiff and cannot fill properly, leading to reduced blood flow despite normal pumping strength), and end stage renal disease (advanced stage kidney failure). During a record review of Resident 34's Care Plan, dated 3/30/2026, the Care Plan indicated Resident 34 had diabetes mellitus and was at risk for hypoglycemia or hyperglycemia. The care indicated, interventions were to observe for polyuria (abnormally large volumes of dilute urine), polydipsia (excessive or uncontrollable thirst), polyphagia (excessive or extreme hunger), change in level of consciousness, blurred vision, profuse sweating, irritability, tremors and notify medical doctor if noted. During a record review of Resident 34's Minimum Data Set (MDS, a resident assessment and tool), dated 4/6/2026, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 34 required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, upper and lower body dressing, lying- to- sitting on side of bed, and sitting- to- standing. The MDS also indicated Resident 34 received six insulin injections during the last seven (7) days or since admission/entry if less than 7 days. During a record review of Resident 34's Order Summary Report, dated 5/6/2026, Novolog FlexPen (pre-filled, rapid acting insulin pen used to control blood sugar in residents with diabetes) subcutaneous (SQ, a shot that delivers medicine into the fatty tissue layer just under the skin, above the muscle, using a short, small needle for slow, steady absorption) solution pen-injector 100 unit/milliliter (ml, unit of volume) (Insulin Aspart): Inject as per sliding scale. During a record review of Resident 34's Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) for the months of May 2026 and June 2026, there was no monitoring for signs and symptoms of hypoglycemia and hyperglycemia. During a concurrent interview and record review on 6/11/2026 at 8:19 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 34's Order Summary, Care Plans, and MAR dated from 5/1/2026 to 6/11/2026 were reviewed. The forms did not indicate Resident1 was monitored for signs and symptoms of hypoglycemia and hyperglycemia. LVN 1 stated Resident 34 received insulin since the resident had diabetes. LVN 1 stated, when residents receive an order for insulin, the license nurse should ask the doctor for orders for monitoring of signs and symptoms of hypoglycemia and hyperglycemia. LVN 1 stated there was no monitoring done for May 2026 and June 2026 for Resident 34 while the resident was receiving insulin. LVN 1 stated the care plan indicated to observe the resident for signs and symptoms of hypoglycemia and hyperglycemia and it was not done. LVN 1 stated monitoring for signs and symptoms of hypoglycemia and hyperglycemia was important to prevent anything bad from happening to the residents. LVN 1 stated signs and symptoms of hypoglycemia were altered level of consciousness, (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	06/11/2026

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sweating excessive and signs and symptoms of hyperglycemia were polydipsia, polyphagia, polyuria which could lead to diabetic ketoacidosis (DKA, a serious and potentially life-threatening complication of diabetes that occurs when the body lacks sufficient insulin leading to high blood sugar and the production of ketones [acids that can accumulate in the blood resulting in dangerous levels]) and Resident 34 was not observed and monitored for these signs and symptoms from 5/1/2026 to present. 2. During a review of Resident 57's admission Record, the admission record indicated Resident 57 was admitted to the facility on [DATE], with diagnoses including but not limited to type 2 diabetes mellitus with foot ulcer (an open wound that fails to heal properly), chronic obstructive pulmonary disease (COPD, disease that causes obstructed airflow from the lungs), and neuralgia (nerve pain) and neuritis (inflammation of nerves usually causing pain and loss of function). During a record review of Resident 57's Order Summary Report for the month of June 2026 indicated as follows:9/24/2025: Caution for risk of hypoglycemia monitor for signs and symptoms of hypoglycemia i.e.: confusion, dizziness, feeling shaky, irritability, hunger, pale skin, sweating, trembling, weakness, anxiety, headache, poor coordination, coma, server case and for fall. 9/24/2025: Trulicity (injectable type 2 diabetes medication that helps release insulin when blood glucose rises at mealtime) 4.5 mg/0.5 ml pen injection 0.5 mg subcutaneous every week every Wednesday for diabetes.9/24/2025: Novlin R (short-acting insulin used to help control blood sugar) injection solution (Insulin Regular (Human)): Inject as per sliding scale. During a record review of Resident 57's Care Plan, dated 9/26/2025, the Care Plan indicated Resident 57 has diabetes mellitus and was at risk for hypoglycemia, hyperglycemia, visual impairments, pain, wounds and poor wound healing. The care plan interventions for staff were to caution for risk of hypoglycemia monitor for signs and symptoms of hypoglycemia i.e. confusion, dizziness, feeling shaky, irritability, hunger, pale skin, [NAME], trembling, weakness, anxiety, headache, poor coordination, coma, sever case and for fall. The care plan also indicated intervention to administer Glucagon (an injectable medication used primarily for the emergency treatment of severe hypoglycemia in residents with diabetes) subcutaneous solution inject 1 mg subcutaneously every 24 hours as needed for severe hypoglycemia; and observe for polyuria, polydipsia, change in level of conscious, blurred vision, profuse [NAME], irritability, tremors and notify medical doctor (MD) if noted. During a record review of Resident 57's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making were intact. The MDS indicated Resident 57 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for toileting hygiene, upper and lower body dressing, and sit to lying. The MDS also indicated Resident 57 received 7 insulin injections during the last seven 7 days or since admission/entry if less than 7 days. During a record review of Resident 57's MAR for the months of May 2026 and June 2026, there was no monitoring for signs and symptoms of hypoglycemia and hyperglycemia. During a concurrent interview and record review on 6/11/2026 at 8:37 AM with LVN 1, Resident 57's order summary report for the month of June 2026, MAR for the month of May and June 2026 were reviewed. LVN 1 stated Resident 57 had a diagnosis of type 2 diabetes mellitus and the resident had a physician order for monitoring the signs and symptoms of hypoglycemia. LVN 1 stated Resident 57's care plan indicated to monitor the signs and symptoms of hypoglycemia and hyperglycemia, but there was no monitoring and documentation in the MAR for signs and symptoms of hypoglycemia and hyperglycemia for the months of May 2026 and June 2026. During an interview on 6/11/2026 at 1:36 PM with the Director of Nursing (DON), the DON stated when residents had orders for insulin there should be monitoring done for hypoglycemia and hyperglycemia. The DON stated documentation on the MAR would indicate that monitoring was being done. The DON stated both hypoglycemia and hyperglycemia could result in resident's serious illness and/ or death. During a record review of the facility's policy and procedure (P&P) titled, Insulin Administration, revised 9/2014, the P&P indicated notify the physician if the resident has signs and symptoms of hypoglycemia that are not resolved by following the facility protocol for hypoglycemia management. During a record review of the facility's P&P titled, Diabetes - (continued on next page)

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	056063	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical Protocol, dated 1/21/2026, the P&P indicated the staff, and provider will monitor for and manage hypoglycemia appropriately. The P&P indicated for hyperglycemia the staff will notify the practitioner as soon as possible when the resident has two or more blood glucose readings higher than 250 mg/deciliter (dL, unit of volume) within a 24-hour period accompanied by a new medical problem or a change in condition or functional status.

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	056063	A. Building B. Wing	06/11/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were properly labeled and stored per facility policy and procedure (P&P) by failing to ensure:1. One eye drop bottle was stored in the refrigerator and not in Medication Cart A.This deficient practice had the potential for harm to residents due to the potential loss of strength of the drugs, and the potential for the residents to receive ineffective drug dosages. 2. One insulin pen had a pharmacy label to indicate the drug name, dose, and expiration date.This deficient practice had the potential for the residents to receive the wrong formulation of the medication and be administered to the wrong resident. 3. Two boxes of apple juice were not stored in the medication refrigerator in Medication Storage Room A.This deficient practice had the potential for cross contamination of hazardous materials with the medications, and for the potential for the residents of receiving contaminated medications. 4. Two medication cups with opened unidentified medication tablets were stored in Medication Cart B.This deficient practice had the potential for increased risk of medication errors, theft, and contamination. 5. Three expired medications were discarded and not stored in Medication Cart B.This deficient practice had the potential for harm to residents due to the potential loss of strength of the drugs, and the potential for the residents to receive ineffective drug dosages. Findings: During a concurrent interview and observation of Medication Cart A on 6/11/2026 at 11:24 AM with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated the Xalatan Solution (medication for the treatment of high eye pressure) 0.005% eye drop was placed inside a plastic zip lock bag, which was labeled to refrigerate. LVN 6 stated the eye drop was unopened and was supposed to be kept in the refrigerator inside the medication room until it was opened. LVN 6 also stated there was also an insulin pen stored in Medication Cart A that was not properly labelled. LVN 6 stated the insulin pen only contained a resident's last name written in permanent marker. LVN 6 stated the resident's last name was not adequate for identification when using an insulin pen and should contain the first and last name of the resident and the medication. LVN 6 stated the insulin pen should have a pharmacy label to include the resident's name, drug name, dose, and expiration date. During a concurrent interview and observation on 6/11/2026 at 11:50 AM with LVN 1 in Medication Storage Room A, LVN 1 stated there were two (2) boxes of apple juice in the medication room refrigerator. LVN 1 stated the 2 boxes of apple juice should be kept in the break room refrigerator and not stored in the medication room refrigerator. During a concurrent interview and observation of Medication Cart B on 6/11/2026 at 12:05 PM with LVN 1, LVN 1 stated there were 2 cups with opened unidentified medication tablets stored in Medication Cart B. LVN 1 stated one medication cup, labeled Room A, had a total of 3 opened unidentified medication tablets. There was another medication cup labeled Room B which had a total of 3.5 medications. LVN 1 stated Medication Cart B also had expired medications of Glucagon (an emergency medication for very low blood sugar) one (1) milligram with expiration date of 3/2026, Elder Tonic Liquid Multivitamin/Mineral Supplement with expiration date of 1/2026, and Iron Supplement Liquid with expiration date of 5/2026. LVN 1 stated the opened medication tablets in the medication cups should not have been stored in the medication cart if the residents refused to take it. LVN 1 further stated the medications should have been discarded because this could result in losing the medications and forgetting to give the medications. LVN 1 stated expired medications if administered could result in the residents not getting the therapeutic effect. LVN 1 stated the Glucagon is used when a resident experiences severe hypoglycemia (low blood sugar) and used in an emergency. LVN added since the Glucagon was expired, the medication might now work or be effective when administered. During an interview on 6/11/2026 at 1:24 PM with the Director of Nursing (DON), the DON stated the insulin pens should include the resident's name, name of the medication, the dosage of the medication, and the expiration date so licensed nurses know who the (continued on next page)

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	056063	A. Building B. Wing	06/11/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication belonged to. The DON stated if the medication indicated it should be refrigerated, the medication should stay in the refrigerator instead of room temperature since it could impact the integrity of the medication. The DON also stated apple juice should not be stored in the medication refrigerator because it could result in cross contamination. The DON stated medications were not supposed to be left in medication cups with the resident's room numbers. The DON stated prepared medications that were not administered should have been destroyed. The DON stated leaving resident medications in medication cups could lead to an inability to identify the medications and increase the risk of them spilling out of the cups. The DON also stated expired medications should be discarded because if they are not, a licensed nurse might accidentally administer them to residents, which could result in a negative outcome and reduced medication effectiveness. During a record review of the facility's P&P, revised 2/2023, the P&P indicated the facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Medication and biologicals are stored in the packaging containers or other dispensing systems in which they are received. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly. The medication label includes, at a minimum:Medication name (generic and/or brand);Prescribed dose;Strength;Expiration date, when applicable;Resident's name;Route of administration; andAppropriate instructions and precautions.If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items. Only the dispensing pharmacy may label or alter the label on a medication container or package.

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	06/11/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with its policy and procedure (P&P) by:Failing to ensure staff put on gloves before taking cooked food's temperatureTo sanitize the food thermometer with an alcohol swab before using it to check the cooked food's temperature.Failing to ensure staff keep the kitchen floor dry and ensure water was not leaking from the kitchen floor. These deficient practices had the potential to result in food born illness (any sickness that is caused by the consumption of foods or beverages that are contaminated with certain infectious or noninfectious agents) to 96 residents. During a concurrent observation and interview on 6/10/2026 at 11:45 AM in the facility kitchen during tray line assembly, observed [NAME] 1 did not sanitize the food thermometer before taking temperature of pureed vegetables and [NAME] 1 was not wearing gloves. [NAME] 1 stated it is important to put gloves on and sanitize the food thermometer before using it to take the temperature of cooked food on the tray line to prevent cross-contamination (physical, unintentional transfer of harmful bacteria, viruses, or allergens from one surface, person, or food item to another), stopping germs and pathogens on the skin from transferring directly to the meals being served to residents. During a concurrent observation and interview on 6/10/2026 at 12:15 PM in the facility kitchen with Dietary Service Supervisor (DSS), observed kitchen floor near the sink area was wet and a small amount of water was leaking from the kitchen floor near the exit area. DSS stated kitchen floor should be kept dry to prevent slip-and-fall injuries and inhibit the growth of dangerous bacteria or mold. DSS also stated it is very important for [NAME] 1 to wear gloves and sanitize the food thermometer with an alcohol swab before [NAME] 1 was check the food temperature. to prevent physical, unintentional transfer of harmful bacteria, viruses, or allergens from one surface, person, or food item to another. During a review of the facility's Policy and Procedure (P&P) titled, Food Preparation and Service, revised November 2022, the P&P indicated, food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices.Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.When verifying food temperatures, staff use a thermometer which is both clean, sanitized, and calibrated to ensure accuracy.Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use. During a review of the facility's P&P titled, Cleaning and Disinfection of Environmental Surfaces -Infection Control, revised 1/21/2026, was reviewed. The P&P indicated housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled.

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	056063	A. Building B. Wing	06/11/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed in accordance with the facility's policy by failing to ensure:1. A trash bag containing soiled gauze with bodily fluids and wipes with the resident's bowel movement were not placed on top of Resident 5's bed, next to the resident's left leg during dressing change. This deficient practice had the potential to contaminate clean items and can place Resident 5 at risk for infection. 2. All facility linens and resident gowns were stored appropriately to maintain infection control.This deficient practice exposed the linens and resident gowns to environmental contamination, including dust, dirt, airborne particles, insects, moisture, and microorganisms resulting to unsanitary linens and gowns which are not safe for resident use.3. The facility completed infection surveillance (a continuous, systematic process of collecting, analyzing, and interpreting health data to monitor and control the spread of infections) from 2/1/2026 through 6/9/2026.4. Registered Nurse 1 (RN 1) performed hand hygiene (cleaning hands with the use of alcohol-based hand rubs containing 60%-95% alcohol or hand washing with soap and water) while touching food containers during the process of residents' lunch meal tray distribution on 6/11/2026.5. Certified Nurse Assistant 5 (CNA 5) wore gown while providing high contact care (routine, hands-on activities requiring prolonged close contact between a staff member and a resident) to Resident 9. These deficient practices have the potential to increase the risk of disease transmission, cross-contamination (the unintentional transfer of harmful bacteria, viruses, or allergens from one surface, object, to another), and severe occupational illness to other residents and staff in the facility. Findings: 1. During a review of Resident 5's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included heart failure, type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and unstageable (a full-thickness pressure injury where the base of the ulcer is obscured by dead skin or a dark, dry scab, making it impossible to determine the depth of the tissue damage) pressure ulcer of sacrum (lower end of the spinal area at the base of the spine). During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) dated 3/10/2026, the MDS indicated Resident 1 was severely impaired cognitive (ability to think and process information) ability. The MDS indicated Resident 5 was dependent (helper does all the effort) for eating, oral hygiene, toileting hygiene, showering, upper/lower body dressing, putting on/taking off footwear, personal hygiene and rolling left and right. The MDS indicated Resident 3 was at risk of developing new pressure ulcers and had two (2) unstageable pressure ulcers. The MDS indicated Resident 5's pressure ulcer treatments included a pressure reducing device for bed. During a record review of Resident 5's Order Summary Report dated 6/1/2026, the Order Summary Report indicated Resident 5 will have sacral pressure ulcer cleaned every day and have Santyl (a medication that helps treat pressure ulcers) ointment applied. During a concurrent observation and interview on 6/10/2026 at 8:48 AM with Licensed Vocational Nurse (LVN) 2, a trash bag containing soiled gauze from wound care and wipes with the resident's bowel movement were observed on top of Resident 5's bed next to Resident 5's left leg. LVN 2 stated that the trash bag should not have been placed on the Resident 5's bed because it puts the resident at (continued on next page)

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	056063	A. Building B. Wing	06/11/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	risk of getting an infection. During a concurrent observation and interview on 6/10/2026 at 8:50 AM with Certified Nursing Assistant (CNA) 1, Resident 5's left leg was observed touching the trash bag that was placed on top of his bed. CNA 1 stated that Resident 5's left leg touched the trash bag. CNA 1 stated the trash bag should not have been placed on top of the bed because the trash is dirty and it puts the resident at risk of infection. During a concurrent interview and record review on 6/10/2026 at 9:10 AM with the Infection Prevention Nurse (IPN), the facility's P&P titled, Infection Prevention and Control Program, dated 1/29/2026 was reviewed. The P&P indicated: An infection prevention and control program is established and maintained to provide a safe and sanitary environment and to help prevent the spread of infections. Important facets of infection prevention include educating staff and ensuring that they adhere to proper techniques and procedures. The IPN stated that the policy indicated that residents are to be provided with a sanitary environment to prevent the spread of infections. The IPN stated that a trash bag should not be placed on top of a resident's bed while doing a dressing change because it puts the resident at risk of infection. 2. During an observation on 6/8/2026 at 8:43 AM in Room A, a pile of folded white towels and bed linens were observed stored on top of the resident's closet. During an observation on 6/8/2026 at 8:43 AM in the bathroom of Room A, a used white towel was observed on top of the toilet. During a concurrent observation in the laundry area, which was located in a separate building outside the facility, and interview on 6/9/2026 at 1:15 PM with the Housekeeping Supervisor (HS), a linen cart with folded resident gowns was observed outside the laundry area (in an area with no overhead cover). The linen cart was uncovered exposing the resident gowns to the environment. The HS stated the gowns in the linen cart were clean, waiting to go into the facility. The HS stated since the linen cart was outside, it should have been covered, and the gowns should have been placed inside a bag to maintain infection control and prevent contamination of the clean gowns from dust or dirt. During a continued interview on 6/9/2026 at 1:20 PM with the HS, the HS stated per facility policy, clean linen should be stored inside the linen carts, and not on top of the resident's closets to prevent contamination from dust or dirt. The HS further stated any clean gowns or linen found on top of the residents' closets should be considered dirty and should not be used. During an interview on 6/10/2026 at 9:01 AM with the IPN, the IPN stated clean linens are to be stored in linen carts and not on top of resident closets to prevent debris from contaminating them. The IPN also stated clean linens that are stored outside the building should be placed inside a bag and covered to prevent contamination from the environment. The IPN stated that not storing clean linens appropriately can put the residents at risk if they or staff use the contaminated linen believing it was still clean. The IPN further stated according to facility protocol, used (dirty) linens are to be removed and placed into a bag after use and not left in the resident areas to prevent contamination from a resident using or reusing the dirty linen. (continued on next page)

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	056063	A. Building B. Wing	06/11/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Laundry and Linen, dated 1/29/2026, the P&P indicated: The purpose of the P&P was to provide a process for the safe and aseptic handling, washing and storage of linen. All soiled linen must be placed directly into a covered laundry hamper. Clean linen will remain hygienically clean (free of pathogens in sufficient number to cause human illness) through measures designed to protect it from environmental contamination, such as covering linen carts. 3. During a concurrent interview and record review on 6/9/2026 at 2:27 PM with the IPN, the facility's infection control binder was reviewed. The binder failed to show any completed infection surveillance documentation from 2/1/2026 through 6/9/2026. The IPN stated the facility did not and should have an infection surveillance from 2/1/2026 through 6/9/2026. The IPN stated infection surveillance was not done because there were no infection surveillance logs, trackers, mapping, and reports. The IPN stated there were residents who received antibiotics from 3/2026 to 6/2026. The IPN further stated it was important to ensure that infection surveillance was being carried out per facility policy to keep residents, visitors and staff safe. The IPN stated the infection surveillance will assist the facility to know if there are infection control issues including widespread infections. The IPN also stated that infection surveillance is done to prevent the spread of infections and determine infection trends. During a review of the facility's P&P titled, Surveillance for Infections, dated 1/21/2026, the P&P indicated: The Infected Preventionist will conduct ongoing surveillance for healthcare-associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventative interventions. The purpose of surveillance of infections is to identify both individual cases and trends of HAIs and epidemiologically significant organisms to guide appropriate interventions and to prevent future infections. Infections that will be included in routine surveillance include those with evidence of transmissibility in a healthcare environment, available processes and procedures that prevent or reduce the spread of infection, clinically significant morbidity or mortality associated with infection and pathogens associated with serious outbreaks. The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. Targeted surveillance will be done: Daily (as indicated): Record detailed information about the resident and infection on an individual report form. Monthly: Collect information from individual resident infection reports and enter line listing infections (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	06/11/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by resident for the entire month). Monthly: Summarize monthly data for each nursing unit by site and pathogen (any organism or agent—such as a virus, bacterium, fungus, or parasite—that can produce disease in a host). Monthly/Quarterly: Identify predominant pathogens or sites of infection among residents in the facility or in particular units by recording them month to month and observing trends. Monthly/Quarterly: Compare incidence of current infections to previous data to identify trends and patterns, using an average infection rate over previous time period as the baseline. During an observation in the 2nd^floor hallway on 6/9/2026 from 12:15 p.m. to 12:23 p.m., and interview with Registered Nurse 1 (RN 1), RN 1 was observed touching her surgical face mask and hair with her bare hands while also touching and opening the lids of the food containers on the 2nd^floor meal cart. RN 1 did not perform hand hygiene after touching her hair and/or mask. RN 1 stated she was opening the food containers to check for correct food textures for the residents and stated she did not perform hand hygiene between touching her hair and/or mask and handling the food containers but should have. RN 1 stated it was important to perform hand hygiene to prevent or reduce the spread of bacteria to residents. During an interview on 6/11/2026 at 1:02 PM with the DON, the DON stated it was important for staff to follow the infection control and prevention measures to make sure they are decreasing the risk of spreading bacteria and infection to residents, visitors and staff. During a review of the facility's P&P titled, Infection Prevention and Control Program (IPCP), dated 1/29/2026, the P&P indicated an IPCP is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 5. During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 9's diagnoses included encounter for attention to gastrostomy (a medical appointment for routine maintenance, evaluation, or troubleshooting of a feeding tube [G-tube, a medical device used to safely deliver liquid nutrition, hydration, and medications directly into the stomach or small intestine) and dysphagia oropharyngeal phase (difficulty moving food and liquids from the mouth into the throat and esophagus). During a review of Resident 9's Minimum Data Set (MDS, resident assessment tool), dated 9/23/2026, the MDS indicated Resident 9 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 9 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with toileting hygiene, lower body dressing, putting on/ taking off footwear. Resident 9 needed substantial/maximal assistance (helper does more than half the effort) with shower/bathe self and personal hygiene. Resident 9 needed partial or moderate assistance, (helper does less than half the effort) with oral hygiene and upper body dressing. During a review of the Physician's Order (PO), dated 1/20/2026, the PO indicated Resident 9 is on enhanced barrier precautions (EBP, an infection control strategy implemented in nursing homes to (continued on next page)

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	056063	A. Building B. Wing	06/11/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prevent the spread of multidrug-resistant organisms [bacteria and other germs that have evolved to resist multiple classes of antimicrobial drugs]) for his G-tube (a medical device inserted directly through the abdomen into the stomach. It provides a direct route to deliver food, liquids, and medications for individuals who cannot eat or swallow safely by mouth). During a concurrent observation and interview on 6/9/2026 at 8:45 AM in Resident 9's room, CNA 5 was observed changing Resident 9's diaper and gown. CNA 5 was observed without an isolation gown. CNA 5 stated he should have worn a gown while rendering care to Resident 9 to prevent the transmission of bacteria and germs to other residents in the facility. During a concurrent interview and record review on 6/9/2026 at 9:15 AM with Infection Preventionist Nurse (IPN), Resident 9's PO, dated 1/20/2026, was reviewed. IPN stated Resident 9's PO indicated Resident 9 was on enhanced barrier precautions and that it requires healthcare staff to wear gowns and gloves during high-contact resident care activities, such as changing diaper and gown, and during shower care. IPN also stated that it was very important for CNA5 to wear a gown during high-contact care activities to prevent the spread of multidrug-resistant organisms (bacteria and other germs that have mutated to survive the medications designed to kill them). IPN stated the facility does not have a specific policy on EBP that will also include the use of PPE. IPN stated the facility uses the Multidrug-Resistant Organisms policy as a guide for their EBP. During a review of the facility's Policy and Procedure (P&P) titled, Multidrug-Resistant Organisms, revised on August 2019, the P&P indicated Appropriate precautions are taken when caring for individuals known or suspected to have infection with a multidrug-resistant organism. Environmental surfaces and medical equipment, especially those in close proximity to the resident, may be contaminated, don gowns and gloves before or upon entry to the resident's room or cubicle.

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	056063	A. Building B. Wing	06/11/2026

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to educate and offer the pneumococcal vaccine (a medical injection that protects against the bacteria Streptococcus pneumoniae, [a bacterium that colonizes the respiratory tract causing serious infections, including Pneumonia {PNA, lung infection}) and/or influenza (flu, a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs) vaccine (an annual vaccine that helps protect the body from the influenza virus) to four (4) of five (5) sampled residents (Residents 48, 14, 3, and 34), reviewed for infection prevention, control, and immunizations (process of protecting a person from a disease by giving a vaccine that helps the body build immunity) upon admission and when appropriate, as indicated in the facility's policy. These deficient practices have the potential to increase Residents 48, 14, 3, and 34 risk of infection such as PNA, bacteremia (infection of the blood), meningitis (infection of the tissue covering the brain and spinal cord), influenza, and suffer from severe complications, hospitalization, and death. Findings:1. During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was admitted to the facility on [DATE] with diagnoses that included gastroesophageal reflux disease (GERD - chronic digestive disease where the contents of the stomach refluxes and irritates the esophagus) protein-calorie malnutrition (a condition resulting from inadequate intake of protein and calories), dysphagia (difficulty swallowing), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 48's Minimum Data Set (MDS - a resident assessment tool), dated 5/15/2026, the MDS indicated Resident 48 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 48 was dependent (helper does all effort to complete activity) with oral, toileting, and personal hygiene, eating, dressing and transfers. During a concurrent interview and record review on 6/9/2026 at 2:30 PM with the Infection Preventionist Nurse (IPN), Resident 48's electronic medical chart, from 8/5/2025 to 6/9/2026 was reviewed. Resident 48's electronic chart failed to indicate Resident 48's immunization history. There was no documented evidence that Resident 48/Responsible Party was educated and offered the influenza and pneumococcal vaccines. The IPN stated there was no documentation that education was provided, or the vaccines were offered per facility policy. During a concurrent interview and record review on 6/9/2026 at 4:35 PM with the IPN, Resident 48's physical medical chart, from 8/5/2025 to 6/9/2026 was reviewed. Resident 48's physical medical chart failed to indicate that Resident 48/Responsible Party was educated and offered the influenza and pneumococcal vaccines. The IPN stated there was no declination, consent or documentation that vaccine education was provided and they should have been in the medical chart and documented if done. 2. During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was admitted to the facility on [DATE] with diagnoses that included PNA, chronic respiratory failure (an ongoing condition where the lungs cannot effectively take in enough oxygen or remove enough carbon dioxide from your bloodstream), and major depressive disorder (MDD - a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14 with severely impaired cognitive skills for daily decision making. The MDS also indicated Resident 2 was dependent with toileting, bathing, and lower body dressing, Resident 14 required partial/moderate assistance (helper does less than half the effort) with oral hygiene and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating. During a review of Resident 14's Immunization History Report, the Immunization History Report indicated Resident 14's most recent influenza vaccine was administered on 10/11/2024, Resident 14's Immunization History Report did not have a documented evidence that pneumococcal vaccine was administered or that Resident 24 (continued on next page)

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	056063	A. Building B. Wing	06/11/2026

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refused it. During a concurrent interview and record review on 6/9/2026 at 2:35 PM with the IPN, Resident 14's electronic medical chart from 12/1/2025 to 6/9/2026 was reviewed. Resident 14's electronic chart failed to indicate that Resident 14/Responsible Party was educated and offered the influenza and pneumococcal vaccines. The IPN stated there was no documentation that education was provided or the vaccines were offered. During a concurrent interview and record review on 6/9/2026 at 4:23 PM with the IPN, Resident 14's physical medical chart, from 12/1/2025 to 6/9/2026 was reviewed. Resident 14's physical medical chart failed to indicate that Resident 14/Responsible party was educated and offered the influenza and pneumococcal vaccines. The IPN stated there was no declination, consent or documentation that vaccine education was provided and they should have been in the medical chart and documented if done. 3. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] with diagnoses that included end stage renal disease (ESRD- irreversible kidney failure), heart failure (a condition where the heart muscle becomes too weak or stiff to pump enough oxygen-rich blood to meet the body's needs), and type 2 DM. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had intact cognitive skills for daily decision making. The MDS also indicated Resident 3 was dependent with toileting, bathing, and lower body dressing and supervision or touching assistance with eating. During a review of Resident 3's Immunization History Report, the Immunization History Report indicated Resident 3 was administered with influenza vaccine on 9/30/2023, and no documented history of pneumococcal vaccination administrations or refusals. During a concurrent interview and record review on 6/9/2026 at 2:42 PM with the IPN, Resident 3's electronic medical chart from 3/28/2026 to 6/9/2026 was reviewed. Resident 3's electronic medical chart failed to indicate that Resident 3 was educated and offered the influenza and pneumococcal vaccines. The IPN stated there was no documentation that education was provided, or the vaccines were offered per facility policy. During a concurrent interview and record review on 6/9/2026 at 4:54 PM with the IPN, Resident 3's physical medical chart, from 3/28/2026 to 6/9/2026 was reviewed. Resident 3's physical medical chart failed to indicate that Resident 3 was educated and offered the influenza and pneumococcal vaccines. The IPN stated there was no declination, consent or documentation that vaccine education was provided and they should have been in the medical chart and documented if done. 4. During a review of Resident 34's admission Record, the admission Record indicated Resident 34 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure (a serious condition that happens when the lungs cannot get enough oxygen into the blood or remove enough carbon), chronic pulmonary edema (the slow, long-term accumulation of excess fluid in the lungs' air sacs, making it progressively difficult to breathe) and chronic kidney disease (CKD- a long-term condition where the kidneys are damaged and slowly lose their ability to filter waste and excess fluid from the blood). During a review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34 had intact cognitive skills for daily decision making. The MDS also indicated Resident 34 required substantial/maximal assistance (helper does more than half the effort needed to complete the activity) with oral, toileting and personal hygiene, dressing and set up or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. During a review of Resident 34's Immunization History Report, the Immunization History Report indicated Resident 34's most recent influenza vaccine was administered on 10/2/2024, and the pneumococcal vaccine on 10/1/2024. During a concurrent interview and record review on 6/9/2026 at 2:46 PM with the IPN, Resident 34's electronic medical chart, from 3/30/2026 to 6/9/2026 was reviewed. Resident 34's electronic chart failed to indicate that Resident 34 was educated and offered the influenza vaccine. The IPN stated there was no documentation that education was provided, or the influenza vaccine was offered per facility policy. During a concurrent interview and record review on 6/9/2026 at 4:57 PM with the IPN, Resident 34's physical medical chart, from 3/30/2026 to 6/9/2026 was reviewed. Resident 34's physical medical chart failed to indicate that Resident 34 was educated and offered the influenza and pneumococcal vaccines. The IPN stated there was no declination, consent (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	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or documentation that vaccine education was provided and they should have been in the medical chart and documented if done. During an interview on 6/10/2026 at 9:00 AM with the IPN, the IPN stated it was important to ensure vaccines are offered and given to residents to ensure patient safety, prevent the spread of contagious agents, and to lessen the severity of symptoms if Residents were to get sick. The IPN further stated it was important to ensure the vaccine information statements (VIS- an information sheet produced by the Centers for Disease Control and Prevention [CDC] that explains the benefits and risks of a specific vaccine) was provided to the residents and responsible parties to ensure they are making an informed decision when they give their consent or decline the vaccines. During an interview on 6/11/2026 at 12:53 PM with the Director of Nursing (DON), the DON stated vaccinations are given to decrease outbreaks and the spread of communicable diseases (illness caused by pathogens [bacteria, viruses, fungi, or parasites] that spreads from one person another), to prevent the residents from being more at risk to illness, and to ensure the safety of residents, visitors and staff. The DON stated it was important to provide the VIS to residents to ensure residents and RPs understand when deciding to accept or decline the vaccines. During a review of the facility's Policy and Procedure (P&P) titled, Pneumococcal Vaccine, dated 1/21/2026, the P&P indicated all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The P&P also indicated prior to, upon admission, or within five (5) working days, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, offered the vaccine series within 30 days of admission to the facility. The P&P indicated if a resident refuses, appropriate information will be documented in the resident's medical record indicating the date of refusal, and if administered, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record. During a review of the facility's P&P titled, Influenza, Prevention and Control of Seasonal, dated 1/21/2026, the P&P indicated the facility follows current guidelines and recommendations for the prevention and control of seasonal influenza. The P&P indicated the Infection Preventionist organizes and oversees an annual influenza vaccine campaign and that all residents are offered the vaccine prior to the onset of the influenza season. During a review of the facility's P&P titled, Vaccination of Residents, dated 1/21/2026, the P&P indicated:All residents are offered recommended vaccines unless the vaccine id medically contraindicated or the resident has already been vaccinated.Upon admission residents are evaluated for current vaccination status and when indicated, residents are offered recommended vaccines.Prior to receiving vaccinations, the resident or legal representative is provided with information and education regarding the risks, benefits, and potential side effects of the vaccinations.The resident (or representative) is provided with the most current vaccine information statement (VIS) prior to vaccine administration.Provision of information, education and the VIS are documented in the resident's medical record.The resident (or representative) has the right to refuse vaccines, and the date and reason for refusal are documented in the resident's medical record.Administration of vaccines are made in accordance with current advisory Committee on Immunization Practices (ACIP) and CDC recommendations at the time.

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	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to ensure Resident 96's foley bag (the external collection pouch attached to a thin, sterile tube inserted into the bladder to drain urine) was covered with a dignity bag for one (1) of two (2) sampled residents (Residents 96) reviewed for dignity. This deficient practice may compromise Resident 96 's psychological well-being, social interaction, personal privacy and dignity.Findings:During a review of Resident 96's admission Record, the admission Record indicated Resident 96 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 96's diagnoses included type 2 diabetes mellitus (high blood sugar in the bloodstream), neuromuscular dysfunction of bladder unspecified (refers to a condition occurs when brain, spinal cord, or nerve issues disrupt the signals between the brain and bladder, leading to poor control, leakage, or incomplete emptying), and presence of urogenital implants (a medical device has been surgically placed in the urinary or reproductive organs to support or restore their function). During a review of Resident 96's Minimum Data Set (MDS, resident assessment tool), dated 5/14/2026, the MDS indicated Resident 96 had no impairment for cognitive skills (the mental processes that allow people to think, learn, and solve problems) for daily decision making. The MDS indicated Resident 96 required partial or moderate assistance, (helper does less than half the effort) with the toileting hygiene, lower body dressing, and putting on/taking off footwear. Resident 96 needed supervision or touching assistance (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene, upper body dressing and personal hygiene. Resident 96 needed setup or clean-up assistance (helpers sets up or cleans up, resident completes activity) for eating. The MDS also indicated Resident 96 use of foley (urinary indwelling catheter) to drain the bladder and collect urine. During a concurrent observation and interview on 6/9/2026 at 4:16 PM with Certified Nursing Assistant 4 (CNA 4) in front of Resident 96's room, Resident 96 was observed sitting in the wheelchair. Resident 96 had a urinary bag (a medical device that attaches to a catheter to collect urine) that was not covered with a dignity bag hanging on the left side of Resident 96's wheelchair. CNA 4 stated Resident 96's urinary bag was supposed to be covered with a dignity bag to provide privacy and dignity to the resident. During an interview on 6/9/2026 at 4:37 PM with Director of Staffing Development (DSD), the DSD stated it is very important to cover Resident 96's urinary bag with a dignity bag to maintain privacy, independence, and dignity. During a review of the facility's Policy and Procedure (P&P) titled, Dignity, reviewed 1/21/2026, the P & P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with respect at all times. It also indicated demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example:helping the resident to keep urinary catheter bags covered.

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	056063	A. Building B. Wing	06/11/2026

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three (3) of 3 sampled residents (Residents 57, 72 and 103) who were discharged from Medicare Part A (a type of insurance that covers skilled nursing home stays) coverage in the last six (6) months received a Notice of Medicare Non-Coverage (NOMNC; form that notifies someone when their Medicare Part A benefits will expire and allows them to file an appeal) before their Medicare Part A coverage ended. This deficient practice had the potential to result in resident and/ or resident's responsible party not being able to exercise their right to file an appeal. Findings: During a review of Resident 72's Census and Rates (CR) report I(undated), it indicated, the resident's last covered day for Medicare Part A Skilled Services was [DATE]. During a review of Resident 103's CR (undated), the report indicated the resident's last covered day for Medicare Part A Skilled Services was [DATE]. During a review of Resident 57's CR (undated), the report indicated the resident's last covered day for Medicare Part A Skilled Services was [DATE]. During an interview on [DATE] at 8:05 AM with Resident 57, Resident 57 stated the facility did not notify him of his Medicare Part A benefits were about to expire before the expiry date on [DATE]. During an interview on [DATE] at 8:13 AM with Resident 72, Resident 72 stated the facility did not notify him of his Medicare Part A benefits were about to expire before the expiry date on [DATE]. During a concurrent interview and record review on [DATE] at 9:06 AM with the facility's Business Office Manager (BOM), Residents 72, 103 and 57's CR were reviewed. The BOM stated that Residents 72, 103 and 57 all had their Medicare Part A benefits expired but the resident's did not receive a NOMNC or any notification that their benefits would expire. During a concurrent interview and record review on [DATE] at 9:13 AM with the BOM, the facility's P&P titled, Medicare Advance Beneficiary and Medicare Non- Coverage Notices, review date on [DATE] was reviewed. The P&P indicated:A resident (who is a Medicare beneficiary) is informed in advance and in writing when Medicare payment denial or change is likely.Written notices of the likelihood of Medicare payment denial are provided to the resident far enough in advance of an event so that the beneficiary can make a rational, informed decision without undue pressure. BOM stated the policy indicated that residents will be notified in advance and in writing when their Medicare benefits will expire but there is no evidence that Residents 57, 72 and 103 were notified before their Medicare benefits expired. Bon stated the facility should have notified the residents to ensure the residents can make informed decisions and the residents will not be billed for services they do not want and to allow the residents or resident representative to file an appeal.

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	06/11/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an ordered orthopedic (ortho- the branch of medicine focused on the diagnosis, treatment, prevention, and rehabilitation of the musculoskeletal system) appointment was scheduled for (1) of 31 sampled residents (Resident 48) per physician's order. This failure resulted in a delayed evaluation, services and care related to Resident 48's left hip pain.Findings:During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was admitted to the facility on [DATE] with diagnoses that included left hip arthritis (a disease that causes damage in your joints), pain in left hip, and chronic kidney disease (CKD - longstanding disease of the kidneys leading to renal failure). During a review of Resident 48's Order Summary Report, an order dated 4/1/2026 on the Order Summary Report indicated to make an appointment [for] left hip pain with Orthopedic Doctor 1 (OD 1); will need transportation wheelchair with return. During a review of Resident 48's Pain Consultation Physician's Note, dated 4/13/2026, the Physician's Note indicated Resident 48 reported muscle stiffness, tenderness and worsening pain on the left hip. The Physician's Note indicated a plan to send to OD 1 for a possible left hip replacement (a surgical procedure where an orthopedic surgeon removes a damaged or worn-out hip joint and replaces it with an artificial implant). During a review of Resident 48's Authorization Request Form, dated 4/13/2026, the Authorization Request Form indicated an urgent request was submitted for an appointment with OD 1.During a review of Resident 48's Minimum Data Set (MDS- a resident assessment tool), dated 5/2/2026, the MDS indicated Resident 84 had intact cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 48 required setup or clean up assistance (helper sets up or cleans up; resident completes activity) with eating, supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene and substantial/maximal assistance (helper does more than half the effort) with toileting hygiene and shower/bathing self. During an interview on 6/8/2026 at 8:19 AM with Resident 48, Resident 48 stated he needed a hip replacement due to his medical condition (left hip pain/ arthritis), and was told he would have an appointment for an evaluation, but the facility had not scheduled a follow up appointment nor provided any further information since his last appointment with his doctor. During an interview on 6/11/2026 at 10:13 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 48 was admitted to the facility with hip pain and has severe arthritis, in which the resident sees a pain specialist for. LVN 1 stated as of 6/11/2026, LVN 1 did not know the status of Resident 48's pending appointment with OD 1 or if it has been scheduled. LVN 1 stated the Social Services Department would have called to arrange an appointment. LVN 1 stated he has not followed up with anyone since the order for the ortho appointment was given on 4/1/2026 and that LVN 1 should have made a follow up. LVN 1 stated licensed nurses should have followed up after the order was placed, so that Resident 48 would have a confirmed appointment. LVN 1 further stated, without any follow up regarding the ordered appointment with OD 1, Resident 48 could be negatively affected because the appointment was to evaluate for hip replacement surgery and a delayed appointment would delay treatment and the needed surgery. LVN 1 further stated Resident 48 could have experienced severe pain, decreased quality of life due to the delayed appointment and services. During an interview on 6/11/2026 at 11:01 AM with Registered Nurse 3 (RN 3), RN 3 stated she did not know the status of Resident 48's ordered ortho appointment with OD 1, because the social services department were supposed to follow up and handle the scheduling of the appointment. During an interview on 6/11/2026 at 11:03 AM with Social Services Assistant (SSA), SSA stated there was an authorization request submitted for Resident 48's ortho appointment on 4/13/2026, and the facility did not follow up for the status of the approval from the day it was submitted until 6/11/2026. During multiple interviews on 6/11/2026 at 11:06 AM, and 12:00 PM with Admissions Coordinator (AC), AC stated she submitted an authorization request form (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	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Resident 48's ortho appointment on 4/13/2026 but had not followed up with an approval status prior to today, 6/11/2026. AC stated it had been two (2) months with no follow up on the approval status. AC stated after calling for an approval status on 6/11/2026 after realizing no follow up was done, Resident 48 had been approved for an appointment with OD 1 since 5/15/2026, but the facility was unaware of the resident's approval status. AC further stated this caused a delay of scheduling for Resident 48 from 5/15/2026 to 6/11/2026 and the facility staff should have followed up sooner to allow Resident 48 to have continued care which could have also helped with the resident's hip pain. During an interview on 6/11/2026 at 1:02 PM with the Director of Nursing (DON), the DON stated nursing, social services and the business office staff should have all followed up with Resident 48's ordered appointment with OD 1, sooner than 6/11/2026. The DON further stated it was important to follow up with orders and appointment authorizations to prevent a delay of services, and that a delay in services could have negatively affected Resident 48 with a decline in health and/or increased in pain. During a review of the facility's Policy and Procedure (P&P) titled, Referral, Social Services, revised 12/2008, the P&P indicated social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician.

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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 ensure the low air loss mattress (LALM, designed to distribute the resident's body weight over a broad surface area and help prevent skin breakdown) for one (1) of 1 sampled residents (Resident 5) reviewed for pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) was at the correct settings in accordance with the facility's policy and procedure (P&P) and physician's order. On 6/8/2026, Resident 5, who weighed 159 pounds (lbs, unit of measurement for weight) LALM setting was set at 180 lbs. This deficient practice placed Resident 5 at risk for deterioration of the resident's current pressure ulcer.Findings: During a review of Resident 5's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included heart failure, type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and unstageable (a full-thickness pressure injury where the base of the ulcer is obscured by dead skin or a dark, dry scab, making it impossible to determine the depth of the tissue damage) pressure ulcer of sacrum (lower end of the spinal area at the base of the spine). During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) dated 3/10/2026, the MDS indicated Resident 1 had severely impaired cognitive (ability to think and process information) ability. The MDS indicated Resident 5 was dependent (helper does all the effort) for eating, oral hygiene, toileting hygiene, showering, upper/lower body dressing, putting on/taking off footwear, personal hygiene and rolling left and right. The MDS indicated Resident 3 was at risk of developing new pressure ulcers and has two (2) unstageable pressure ulcers. The MDS indicated Resident 5's pressure ulcer treatments included a pressure reducing device for bed. During a concurrent observation and interview on 6/8/2026 at 9:52 AM in Resident 5's room, Resident 5's LALM was observed set at 180 lbs. Resident 5 stated the bed feels uncomfortable. During a concurrent observation in Resident 5's room and interview on 6/8/2026 at 9:56 AM with Licensed Vocational Nurse (LVN) 1, Resident 5's LALM was observed to be set at 180 lbs. LVN 1 stated Resident 3's LALM was set at 180 lbs., but it should be set to 159 lbs. LVN 1 stated if the LALM is set to a higher weight it adds more pressure and can make Resident 5's pressure ulcer get worse. During a concurrent interview and record review on 6/8/2026 at 10:00 AM with LVN 1, Resident 5's weight record dated 6/4/2026 was reviewed. Resident 5's weight record indicated Resident 5 weighed 159 lbs. on 6/4/2026. LVN 1 stated Resident 5's most recent weight is 159 lbs. During a concurrent interview and record review on 6/8/2026 at 10:02 AM with LVN 1, Resident 5's Order Summary Report dated 4/23/2026 was reviewed. The Order Summary Report indicated that Resident 5 may have a LALM for wound management set at resident's current weight. LVN 1 stated the order is to set the LALM at resident's current weight, but it was not set at the resident's current weight. During a concurrent interview and record review on 6/11/2026 at 12:00 PM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Support Surface Guidelines, revised 9/2013 was reviewed. The P&P indicated:The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices at risk of skin breakdown.Redistributing support surface is to provide pressure relief or reduction.Elements of support surfaces that are critical to pressure ulcer prevention and general safety include pressure redistribution.The DON stated the policy indicated that support surfaces are meant to redistribute pressure but if a LALM is not set correctly, it does not redistribute pressure but adds more pressure to a wound. The DON stated this can possibly cause the resident's wound to worsen. During a concurrent interview and record review on 6/11/2026 at 12:09 PM with the DON, Resident 5's LALM manufacture's guidelines manual (Brand 1 Manual) was reviewed. The Brand 1 Manual indicated:Brand 1 LALM is indicated for the prevention and treatment of any and all pressure ulcers when used in conjunction with a comprehensive pressure ulcer management program.Determine the patient's weight and set the control knob to that weight setting on the control unit.The DON stated Brand 1 Manual indicated that the LALM must be set the same as the resident's weight.

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	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to obtain weekly weights from 2/17/2026 through 3/17/2026 and record the fluid intake every shift from 6/1/2026 to 6/11/2026 for one (1) of 1 sampled resident (Resident 48), reviewed for nutrition care area, per the physician's order and care plan. These failures had the potential for Resident 48 to receive inadequate care and interventions to prevent weight loss.Findings:During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was admitted to the facility on [DATE] with diagnoses that included gastroesophageal reflux disease (GERD - chronic digestive disease where the contents of the stomach refluxes and irritates the esophagus) protein-calorie malnutrition (a condition resulting from inadequate intake of protein and calories), dysphagia (difficulty swallowing) and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 48's Order Summary Report, the Order Summary Report indicated weekly weights times four (4) [weeks], active on 2/17/2026. During a review of Resident 48's Weight Summary, (undated), the Weight Summary indicated a weight of 154 pounds on 2/2/2025 with a 10 percent weight loss from the resident's weight of 172 pounds on 8/6/2025. The weight summary failed to indicate the completion of weekly weights from 2/17/2026 through 3/17/2026. During a review of Resident 48's At Increased Nutritional Risk.Weight Loss care plan, revised 2/17/2026, the care plan indicated the intervention to monitor and record intake at mealtimes and between meals. The care plan also indicated for staff to monitor and record fluid intake every shift at meals and activities. During a review of Resident 48's Minimum Data Set (MDS resident assessment tool), dated 5/15/2026, the MDS indicated Resident 48 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 48 was dependent (helper does all effort to complete activity) with oral, toileting, and personal hygiene, eating, dressing and transfers. During a concurrent interview and record review on 6/11/2026 at 10:03 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 48's medical records including the paper chart, electronic chart and Certified Nursing Assistant (CNA) Daily Charting Form, dated 2/17/2026 through 6/11/2026 were reviewed. The records did not indicate completed weekly weights from 2/17/2026 to 3/17/2026 and recorded fluid intake amounts for each meal and between meals from 6/1/2026 to 6/11/2026. LVN 1 stated there were no weekly weights done for Resident 48 from 2/17/2026 to 3/17/2026 after being ordered by the physician and there was no fluid intake monitored and recorded with every meal and/or between meals indicated the Resident 48's care plan and both should have been done. LVN 1 stated Resident 48's weights should have been taken weekly for monitoring per physician's order so staff can see how much the resident's weighs each week to ensure the resident is not losing too much weight and make any needed adjustments [to the resident's care]. During an interview on 6/11/2026 at 1:09 PM with the Director of Nursing, the DON stated Resident 48's fluid intake should have been monitored and recorded every mealtime and in between meals to ensure the resident was receiving adequate hydration. The DON also stated Resident 48's weekly weights should have been done from 2/17/2026 to 3/17/2026 so staff would know if the current weight loss prevention interventions were effective or not. During a review of the facility's policy and procedure (P&P) titled, Weight Assessment and Intervention, dated 3/2022, the P&P indicated:Residents are weighed upon admission and at intervals established by the interdisciplinary team (IDT- a coordinated group of healthcare professionals.Weights are recorded in each unit's weight record chart and in the individual's medical record. During a review of the facility's P&P titled, Nutrition (Impaired)/Unplanned Weight Loss- Clinical Protocol, (undated), the P&P indicated:Nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time.The physician will authorize the appropriate interventions, as indicated. The physician and staff will monitor nutritional status, an individual's response to interventions, and possible complications of such interventions.

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	056063	A. Building B. Wing	06/11/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the physician's order for one of five sampled residents (Resident 68) observed during medication administration by failing to ensure the resident rinsed his mouth after receiving Budesonide Inhalation Suspension (an inhaled corticosteroid [class of drugs that reduce inflammation and immune system activity] medication for the maintenance treatment of asthma [a chronic condition that affects the airways in the lungs and makes it harder to breathe]) as indicated on the facility's policy. This deficient practice had the potential for an increased risk of oral thrush (fungal infection in the mouth), throat irritation, and increased systemic absorption of the medication.Findings: During a review of Resident 68's admission Record, the admission record indicated Resident 68 was admitted to the facility on [DATE], with the diagnoses including but not limited to chronic obstruction pulmonary disease (COPD, disease that causes obstructed airflow from the lungs) with acute exacerbation (sudden worsening of COPD symptoms), pneumonia (lung inflammation caused by bacterial or viral infection), emphysema (a chronic lung condition that causes shortness of breath due to damage to the air sacs in the lungs), and respiratory disorders. During a record review of Resident 68's Care Plan, dated 12/4/2024, the Care Plan indicated Resident 68 was at risk for shortness of breath (SOB), respiratory illness/distress secondary to diagnosis of COPD, emphysema, wheezing (a high-pitched, lung sound produced by airflow through an abnormally narrowed or compressed airway), dyspnea (difficulty breathing), and history of acute respiratory failure (the lungs failed to exchange gas effectively) with hypoxia (lack of oxygen in the tissues to sustain bodily function). The nursing staff interventions were to administer Budesonide Suspension 0.5 milligram (mg - unit of measurement)/two (2) milliliter (ml - unit of volume): 2 ml inhale orally two times a day for SOB/wheezing, rinse mouth post use, give medications as ordered by physician, and to monitor/document side effects and effectiveness of the medication. During a record review of Resident 68's Minimum Data Set (MDS, a resident assessment and tool), dated 3/16/2026, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were intact. The MDS indicated Resident 68 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for toileting hygiene, upper and lower body dressing, and chair/bed to chair transfer. During a record review of Resident 68's Order Summary Report, dated 6/3/2026, the Order Summary indicated Budesonide Inhalation Nebulization (a device for breathing mist treatment) Solution 2.5 mg: 2 ml, inhale orally two times a day for SOB/wheezing, rinse mouth post use. During an observation on 6/10/2026 at 8:22 AM in Resident 68's room, Licensed Vocational Nurse 1 (LVN 1) administered Budesonide Inhalation Solution to Resident 68 via nebulizer mask (a drug delivery device used to deliver drugs in the form of inhalation into the lungs). During a concurrent observation in Resident 68's room and interview on 6/10/2026 at 9:13 AM with Licensed Vocational Nurse 1 (LVN 1) returned to check on Resident 68's Budesonide Inhalation Solution. LVN 1 returned the nebulizer mask to the bag and exited Resident 68's room without having Resident 68 rinse his mouth. LVN 1 stated he was completed with Resident 68's Budesonide Inhalation Solution administration. LVN 1 stated after administering the Budesonide Inhalation Solution to Resident 68, LVN 1 should have Resident 68 rinsed his mouth with water and did not have instructed Resident 68 to rinse his mouth after the Budesonides Inhalation Solution administration. LVN 1 stated the order indicated to rinse Resident 68's mouth after administration. LVN 1 stated rinsing the mouth after the Budesonide Inhalation Solution administration would remove the medication residue. During an interview on 6/11/2026 at 1:22 PM with the Director of Nursing (DON), the DON stated the resident's mouth should be rinsed after the administration of Budesonide Inhalation Solution to prevent infection in the mouth such as oral thrust and any other complications (continued on next page)

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	056063	A. Building B. Wing	06/11/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that could result from the medication. During a record review of the facility's Policy and Procedure (P&P) titled, Administering Medications, revised 4/2019, the P&P indicated medications are administered in accordance with the prescriber orders.

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	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the food preferences for one (1) of 1 sampled resident (Resident 80), reviewed for food care area, were honored as requested.This failure resulted in a violation of Resident 80's right to have preferred food choices, with the potential for decreased food intake, inadequate nutrition, and weight loss. Findings:During a review of Resident 80's admission Record, the admission Record indicated Resident 80 was admitted to the facility on [DATE] with diagnoses that included cellulitis (a skin infection that causes swelling and redness) of the right lower limb, heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), neuralgia (severe, shock-like nerve pain caused by irritation), and neuritis (nerve inflammation). During a review of Resident 80's Physician's Order, dated 3/30/2026, the Physician's Orders indicated a no added salt (NAS) diet, regular texture, regular/thin liquids and to add 16 ounces of fluids (only water or orange juice) and a bowl of fruit with meals. During a review of Resident 80's Increased Nutritional Risk care plan, initiated 3/31/2026, the care plan indicated for staff to offer alternatives within the recommended dietary guidelines to accommodate Resident 80's tastes and preferences. During a review of Resident 80's Potential for Significant Weight Change care plan, initiated 3/31/2026, the care plan indicated for staff to obtain food preferences from resident of family if resident unable to express and adhere to food preferences as able. During a review of Resident 80's Minimum Data Set (MDS - a resident assessment tool), dated 4/6/2026, the MDS indicated Resident 80 with intact cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 80 required setup or clean-up assistance (helper sets up or cleans up and resident completes activity) with eating and substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bath self and dressing. During a review of Resident 80's Nutrition/Dietary Note, dated 5/4/2026, the Nutrition/Dietary Note indicated Resident 80 requests no rice, no pasta, no juices except orange juice, and likes sandwiches and salads. During a concurrent observation in Resident 80's room, interview, and record review on 6/10/2026 at 12:40 PM with Resident 80's lunch meal tray was observed with broccoli, garlic bread and tofu. Resident 80's Lunch Tray Card (an identifier placed on a resident's meal tray that lists their physician-ordered diet, and food preferences), dated 6/10/2026, was reviewed. The Lunch Tray Card indicated Resident 80's preferred likes were salads with peas, corn, and chicken. Resident 80 stated she did not want her lunch tray and should have received a chicken salad. Resident 80 stated she wanted to eat healthier because of her heart condition and that is why she requested salads at every lunch. During a concurrent interview and record review on 6/10/2026 at 3:51 PM with the Dietary Supervisor (DS), Resident 80's electronic Dietary Profile, (undated) was reviewed. The Dietary Profile indicated salads with peas, corn and chicken for lunch. The DS stated the facility had salads available for lunch on 6/10/2026, and Resident 80 should have received a salad for her lunch in accordance with her diet profile and preference. The DS further stated it was important to honor Resident 80's food preferences because it was her right and staff were there to support the residents' preferences. The DS also stated if food preferences were not honored, the residents could get upset, be unhappy with their food and could lose weight. During a concurrent interview and record review interview on 6/11/2026 at 9:13 AM with the Registered Dietitian and DS, the facility's Policy & Procedure (P&P) titled, Resident/Patient Food Preferences, dated 2018, was reviewed. The P&P indicated the Director of Food and Nutrition Services, or designee will visit the resident to determine food preferences and the resident's food preferences should be placed on the profile card and identified on the tray card. The RD stated the resident's food preferences as indicated on the profile card and identified on the resident's tray card, should be honored by providing the resident food in accordance with his/her preference. The RD (continued on next page)

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	056063	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further stated it was important to honor the residents' food preferences for better quality of life, that residents receive joy and happiness from food and if they do not like it, it could negatively affect them. The RD stated residents may not be able to control a lot of things that may be happening, but food choices are something they can control, so honoring their preferences means respecting their dignity and rights.

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	06/11/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete medical records for one (1) of three (3) sampled Residents (Resident 2), when Resident 2's Notice of Proposed Transfer/Discharge (an official, written document that must be issued before moving a resident to another location or discharging them) did not indicate a reason for the resident's transfer/discharge. This failure resulted in an incomplete notice of transfer/discharge within Resident 2's medical record. Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was readmitted to the facility on [DATE] with diagnoses that included adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), dementia (a progressive state of decline in mental abilities) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 2's discharge Minimum Data Set (MDS - a resident assessment tool), dated 5/11/2026, the MDS indicated Resident 2 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 2 was dependent (helper does all the effort) with oral, toileting and personal hygiene, bathing and dressing. The MDS also indicated Resident 2 had a feeding tube (a flexible medical device used to deliver liquid nutrition and medications directly into the stomach or small intestine). During a review of Resident 2's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 5/11/2026, the SBAR indicated Resident 2 had dislodged gastrostomy (opening (called a stoma) is used to insert a specialized feeding tube) tube. The SBAR also indicated for Resident 2 to be transferred to the hospital via 911 for further evaluation and management. During a review of Resident 2's Discharge summary, dated [DATE], the Discharge Summary indicated Resident was discharged to general acute care hospital (GACH) 1 for dislodged tube. During a concurrent interview and record review on 6/10/2026 at 2:35 PM with Registered Nurse Supervisor 1 (RNS), Resident 2's Notice of Proposed Transfer/Discharge (an official, written document that must be issued before moving a resident to another location or discharging them), dated 5/11/2026 was reviewed. The Notice of Proposed Transfer/Discharge did not indicate a selection for the reason the transfer/discharge was done. RNS 1 stated Resident 2's Notice of Proposed Transfer/Discharge was not documented completely, and that a transfer/discharge reason should have been indicated on the notice, but it was not. RNS 1 stated it was important to ensure this document was filled out completely so that the family and/or the resident know why they were transferred to GACH 1 and to maintain accurate and complete records. During an interview on 6/11/2026 at 12:52 PM with the Director of Nursing (DON), the DON stated all medical records must be complete and accurate. During a review of the facility's Policy & Procedure (P&P) titled, Charting and Documentation, revised 7/2017, the P&P indicated all services provided to the resident, progress toward the care plan goals, or changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record and that documentation in the medical record will be objective, complete and accurate.

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	06/11/2026

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to educate and offer the Covid-19 (a highly contagious respiratory illness caused by the SARS-CoV-2 virus) vaccine to one (1) of five (5) sampled residents (Resident 48) reviewed for infection prevention, control, and immunizations (process of protecting a person from a disease by giving a vaccine that helps the body build immunity) as indicated in the facility's policy.This failure had the potential for Resident 48 (or resident's responsible party [RP]) to accept or decline the Covid-19 vaccine without the proper understanding of risks and benefits to make an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), placed the residents at a higher risk of acquiring Covid-19 and increased risk of transmission to other residents in the facility.Findings: During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was admitted to the facility on [DATE] with diagnoses that included gastroesophageal reflux disease (GERD - chronic digestive disease where the contents of the stomach refluxes and irritates the esophagus) protein-calorie malnutrition (a condition resulting from inadequate intake of protein and calories), dysphagia (difficulty swallowing), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 48's Minimum Data Set (MDS - a resident assessment tool), dated 5/15/2026, the MDS indicated Resident 48 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 48 was dependent (helper does all effort to complete activity) with oral, toileting, and personal hygiene, eating, dressing and transfers.During a concurrent interview and record review on 6/9/2026 at 2:30 PM with the Infection Preventionist Nurse (IPN), Resident 48's electronic medical chart, from 8/5/2025 to 6/9/2026 was reviewed. Resident 48's electronic chart failed to indicate that Resident 48/Responsible Party was educated and offered the Covid-19 vaccine. The IPN stated there was no documentation that education was provided, or that the vaccine was offered During an interview on 6/10/2026 at 9:00 AM with the IPN, the IPN stated it was important to ensure vaccines are offered and given to residents to ensure patient safety, prevent the spread of contagious agents, and to lessen the severity of symptoms if Residents were to get sick. The IPN further stated it was important to ensure the vaccine information statements (VIS- an information sheet produced by the Centers for Disease Control and Prevention [CDC] that explains the benefits and risks of a specific vaccine) were provided to the residents and responsible parties, to ensure they are making an informed decision when they give their consent or decline the vaccines. per facility policy. During a concurrent interview and record review on 6/9/2026 at 4:35 PM with the IPN, Resident 48's physical medical chart, from 8/5/2025 to 6/9/2026 was reviewed. Resident 48's physical medical chart failed to indicate that Resident 48/Responsible Party was educated and offered the Covid-19 vaccine. The IPN stated there was no declination, consent or documentation that vaccine education was provided and they should have been in the medical chart and documented if done. During an interview on 6/11/2026 at 12:53 PM with the Director of Nursing (DON), the DON stated vaccinations are given to decrease outbreaks and the spread of communicable diseases (illness caused by pathogens [bacteria, viruses, fungi, or parasites] that spreads from one person another), to prevent the residents from being more at risk with exposure to illness and to ensure the safety of residents, visitors and staff. The DON stated it was important to provide the VIS to residents to ensure they understand when deciding to accept or decline the vaccines. During a review of the facility's P&P titled, Coronavirus Disease (COVID-19) - Vaccination of Residents, dated 1/21/2026, the P&P indicated residents are offered the vaccine unless the immunization is medically contraindicated or the resident is fully vaccinated. The P&P (continued on next page)

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	056063	A. Building B. Wing	06/11/2026

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Infinity Care of East Los Angeles	101 S Fickett Street Los Angeles, CA 90033

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the resident (or representative) is provided with the most current VIS prior to the vaccine, and the resident's medical record will include documentation that indicates the provided education and each dose of COVID-19 vaccine administered. During a review of the facility's P&P titled, Vaccination of Residents, dated 1/21/2026, the P&P indicated:All residents are offered recommended vaccines unless the vaccine is medically contraindicated or the resident has already been vaccinated.Upon admission residents are evaluated for current vaccination status and when indicated, residents are offered recommended vaccines.Prior to receiving vaccinations, the resident or legal representative is provided with information and education regarding the risks, benefits, and potential side effects of the vaccinations.The resident (or representative) is provided with the most current vaccine information statement (VIS) prior to vaccine administration.Provision of information, education and the VIS are documented in the resident's medical record.The resident (or representative) has the right to refuse vaccines, and the date and reason for refusal are documented in the resident's medical record.Administration of vaccines are made in accordance with current advisory Committee on Immunization Practices (ACIP) and CDC recommendations at the time.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation and interview, the facility failed to ensure the facility's air conditioner was maintained in safe operating condition in accordance with the facility's policy and procedure (P&P) titled Maintenance Service. The air conditioner has water leaking on the floor in a high traffic area near the nursing station. This deficient practice had the potential to create a fall risk hazard for residents walking by the nursing station. Findings:During a concurrent observation and interview on 6/8/2026 at 10:03 AM with Licensed Vocational Nurse (LVN) 1, the facility's air conditioning (AC) unit was observed leaking water into the floor in front of the nursing station and in an area that residents walk by. LVN 1 stated water is leaking from the AC and there is no wet floor sign on the puddle of water created from the leaking AC. LVN 1 stated a resident can fall if there are no wet floor sign and the resident step on the puddle of water unknowingly. During a concurrent observation and interview on 6/8/2026 at 10:07 AM with Administrator (ADM) the facility's leaking AC near the nursing station was observed. ADM stated the AC is dripping water on the floor and needs to get it fixed. During a concurrent observation and interview on 6/8/2026 at 10:08 AM the with Director of Staff Development (DSD) the facility's leaking AC near the nursing station was observed. DSD stated there is no wet floor sign near the puddle of water that has dripped on the floor from the AC. DSD stated wet floor signs alert residents of a wet floor so they will not trip. DSD stated that residents can fall if they do not see the puddle of water on the floor. During a concurrent interview and record review on 6/11/2026 at 11:11 AM with the facility's Interim Maintenance Director (IMD), the facility's P&P titled, Maintenance Services, last reviewed on 1/29/2026 was reviewed. The P&P indicated:Maintenance services shall be provided to all areas of the building, grounds and equipment.The Maintenance Department is responsible for maintaining the building, ground and equipment in a safe and operable manner at all times.Functions of maintenance personnel include but are not limited to maintaining the building in good repair and free from hazards.IMD stated he saw the water leaking on the floor from the AC and it is a safety hazard because there was no wet floor sign on it and someone walking by would not be aware of it and could fall. IMD stated the facility's P&P indicated that the equipment should be in safe and operable manner.