DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Re-certification survey. Representing the Department of Public Health: [redacted] RN, HFEN [redacted] RN, HFEN [redacted] REHS, HFE I Total Resident Population: 94 Total Resident Sample Size: 19 Highest Scope and Severity: E	F 000	Plan of Correction Infinity Care of East Los Angeles makes every effort to comply with State and Federal regulations. Nothing in this plan of correction is an admission otherwise. Infinity Care of East Los Angeles has submitted this plan of correction to comply with the regulatory obligation and does not waive any objections contained therein. This Plan of Correction constitute Infinity Care of East LA's written credible allegation of compliance for the deficiencies noted.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164	• Inservice was provided to all staff regarding HIPPA, privacy and confidentiality of resident clinical record • DSD to ensure that all new hires are provided with orientation and training regarding privacy and confidentiality of all resident's clinical record and HIPPA components • Ongoing inservice provided by DSD to all staff every year and as needed	3/10/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director — 3/10/12

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINITY CARE OF EAST LOS ANGELES	191 S FICKETT STREET LOS ANGELES, CA 90033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure personal privacy and confidentiality of the clinical record for one of 19 sample residents (5). Licensed Nurse 1 left Resident 5's clinical record on the roommate's over bed table. This deficient practice had the potential to result in unauthorized disclosure of medical information. Findings: On 2/10/12, at 9:25 a.m., Resident 5 was observed sitting in his room not wearing an identification band/bracelet. Licensed Nurse 1 brought the resident's clinical record into the resident's room in order to identify the resident with his photo. Licensed Nurse 1 then placed the clinical record on the roommate's over bed table and left the room. At 9:55 a.m., Certified Nursing Assistant 1 (CNA 1), who was assigned to the resident, observed the clinical record left unattended on the over bed table, took it and gave it to the medication nurse. At 10 a.m., during an interview, Licensed Nurse 1 acknowledged he should not have left the clinical record unattended in the resident's room because it was a violation of the resident's confidentiality rights.	F 164	• ID band was placed to resident's wrist for proper identification. All staff includes in the daily rounds checking of ID bands to ensure each resident admitted in the facility have proper means of identification. Photograph are also placed in the chart and in the MAR	2/10/12
F 248	483.15(e)(1) REASONABLE ACCOMMODATION	F 248		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050063	A. BUILDING _____ B. WING _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINITY CARE OF EAST LOS ANGELES	101 S PICKETT STREET LOS ANGELES, CA 90033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246 SS=D	Continued From page 2 OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident received services with reasonable accommodations of individual needs for one randomly selected resident (20). Resident 20's call light was placed out of the resident's reach. This deficient practice limited the resident's ability to call staff for assistance. Findings: On 2/9/12, at 2:30 p.m. during the initial tour, and on 2/13/12, at 9 a.m., Resident 20 was observed sitting in a geri-chair (reclining chair that prevents rising and self-propelling) at the bedside and was noted to have her arms and legs with contractures. During both observation, the resident's call pad was secured to the resident's upper right shoulder and the resident could not reach it to activate the call light. The resident refused to participate in an interview. A review of the clinical record revealed the	F246	• Resident's call light was checked for proper placement and positioning • All staff inservice was conducted regarding placement and positioning of resident's call light to be within easy reach • IDTs to continue with QA rounds in checking to ensure that all resident call lights are within easy reach and clipping mechanism is in place.	3/2/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 3 resident was admitted to the facility on 8/4/07, with diagnoses that included Alzheimer's disease and schizoeffective disorder (condition in which a person experiences a combination of schizophrenia symptoms - such as hallucinations or delusions - and of mood disorder symptoms, such as mania or depression). The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 12/9/11, indicated the resident was alert and able to make her needs known, was incontinent of both bowel and bladder, and required extensive to total assistance with daily living activities such as bed mobility, transferring, eating, toileting, and bathing. A care plan developed for the resident's potential for self-care deficit dated 6/11/11, indicated as one of the approach plans, to maintain the call light within easy reach and answer promptly. On 2/13/12, at 9: 10 a.m., during an interview, Licensed Vocational Nurse 3 (LVN 3) indicated the call pad should be placed within the resident's reach.	F 246		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F309	• LVN clarified with the attending physician the order of Docusate Sodium 100 mg twice daily to include holding the medication if resident has diarrhea or loose stools • Licensed Nurses inservice was conducted by DNS to discuss to ensure when receiving order for medication for bowel management to include holding the medication if resident has loose stools or diarrhea	2/14/2012 3/10/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINITY CARE OF EAST LOS ANGELES	101 S PICKETT STREET LOS ANGELES, CA 90033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 4 review, the facility failed to provide care and services in accordance with the plan of care, physician's orders and policies and procedures for three of 19 sample residents (2, 5, 13). Resident 2, who was receiving a stool softener twice daily and was experiencing episodes of diarrhea, was not monitored for presence of diarrhea and an order to hold the stool softener, when there was diarrhea, was not obtained. Resident 5 did not receive his daily dose of anti-seizure medications Phenytoin and Neurontin, the anti-depressant Effexor, and insulin (for high blood sugar), after returning to the facility from an appointment on 2/13/12. Resident 13 was not provided with effective pain management. This deficient practice had the potential to result in complications, discomfort and inadequate pain relief. Findings: 1. On 2/14/12, at 11:55 a.m., during an interview, Certified Nursing Assistant 2 (CNA 2) stated Resident 2 had occasional episodes of diarrhea for the past month, and had four episodes of diarrhea each day on 2/11/12 and 2/12/12, during CNA 2's shift (7 a.m. to 3 p.m.). A review of the clinical record revealed the resident was re-admitted to the facility on 1/16/12, with diagnoses which included history of stroke and encephalopathy (brain damage caused by lack of oxygen to the brain). The Minimum Data Set (MDS- standardized assessment and care planning tool) dated 1/26/12, indicated the resident was severely cognitively impaired, was incontinent of bowel, had an indwelling urinary catheter, and was being	F 309	• DNS to monitor during daily chart review to ensure orders for medications for bowel management to include holding of medication if resident has loose stools or diarrhea • DNS will report to QA &A during it's monthly meeting • MRD to include in the audits to check for holding of medications for bowel management when resident has loose stools or diarrhea • LN were inserviced by DNS to ensure that when residents are sent out for appointments that medications are clarified with the attending physician whether they should be resumed or given upon return to the facility and documented. Resident was observed and monitored for any change in condition and no adverse outcome was noted • DNS to monitor to ensure that licensed nurses notify the the attending physician to clarify all medications held and missed prior to appointment if to be resumed upon return to the facility • Resident #13 was re-assessed for need of pain medication and medicated as per MD order. Attending physician was notified to inform of resident need to be medicated on a routine basis.	3/10/2012 2/16/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056083	A. BUILDING _____ B. WING _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 5 fed through a gastrostomy tube (GT - tube which is surgically inserted through the abdominal wall into the stomach for purposes of providing nutrition and medication administration). The resident was unable to walk, and was totally dependent on staff for bed mobility, turning, toileting, and bathing. A physician's order dated 1/16/12, indicated to administer Docusate Sodium (stool softener) 100 milligrams (mg) twice daily through the GT for bowel management. The order did not include to hold the medication if diarrhea. Further review of the licensed nursing notes revealed no documentation the resident had diarrhea episodes during the month of 2/2012. On 2/14/12, at 1 p.m. during an interview, the 7 a.m. to 3 p.m. charge nurse stated she was unaware the resident had any recent episodes of diarrhea. She further stated she would clarify the order with the resident's physician regarding withholding the stool softener for episodes of diarrhea. 2. On 2/13/12, at 8:30 a.m., during an interview, a licensed nurse stated Resident 5 left that morning for a GT replacement at an acute care hospital and was expected to return that afternoon. A review of the clinical record revealed the resident was re-admitted to the facility on 8/16/11, with diagnoses that included history of stroke with hemiparesis (weakness/paralysis of one side of the body), diabetes mellitus, history of seizure disorder, history of right below the knee amputation and GT feeding. The MDS assessment dated 12/24/11, indicated the resident was alert and oriented to his	F 309	Order was received to administer Tylenol 325 mg 2 tabs orally x 30 days then re-evaluate • All residents are screened for pain on admission, readmission, quarterly and condition change. A care plan is formulated for all residents identified with pain. Use of non-drug intervention is included as part of the plan of care for pain • DNS to follow-up and monitor on an ongoing basis during IDT Pain Mgt Committee.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6 surroundings, used a wheelchair for locomotion, and required extensive staff assistance with his daily living activities. The physician's orders dated 12/13/11, included Phenytoin 200 mg via GT at 9 a.m. and at 1 p.m. daily for seizure; Neurontin 100 mg via GT three times daily for seizure; Effexor (anti-depressant) 37.5 mg GT daily; and Levimir Insulin 36 units subcutaneously (SQ) daily for diabetes. On 2/13/12, at 3:55 p.m., upon arrival to the facility after the GT replacement, the physician ordered the GT could be used and to resume previous orders. On 2/14/12, at 7:10 a.m. during a review of the medication administration record (MAR), it was revealed that on 2/13/12, two doses of Phenytoin (timed at 9 a.m. and 1 p.m.), two doses of Neurontin (timed at 9 a.m. and 1 p.m.), one dose of Effexor (timed at 9 a.m.), and one dose of Levimir Insulin (timed at 9 a.m.), were not given. On 2/14/1, at 7:20 a.m., during interview, Licensed Vocational Nurse 2 stated he should have contacted the physician for instructions regarding administration of medication that had been missed when the resident was out of the facility. 3. On 2/10/12, at 12:25 p.m., and on 2/14/12, at 7:15 a.m., Resident 13 was observed reclining in a geri-chair (reclining chair that prevents rising and self-propelling) wearing splints two both legs and complaining that his right leg was hurting. A review of the clinical record revealed the resident was readmitted to the facility on 8/24/11, with diagnoses which included history of stroke with left hemiplegia (paralysis on one side of the	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7 body), neuropathy (nerve damage which causes pain and numbness in the extremities) and degenerative joint disease. The MDS dated 12/03/11, indicated the resident was alert and able to make his needs known, was incontinent of bowel and bladder, and required total assistance with feeding, transferring, toileting and bathing. A plan of care dated 8/2011, developed for the resident's potential for pain due to arthritis and somatic pain, included in the approaches to assess pain symptoms, administer medications as ordered, monitor effectiveness of pain medications and notify the physician of increased pain. The physician's orders included two routine oral medication for pain, Neurontin 300 mg three times a day (dated 9/16/11) and Cymbalta 60 mg orally daily for somatic complaints of persistent pain (pain related to the body as opposed to the mind - dated 12/12/11). There were two pain medications ordered to be given as needed (PRN), Tylenol 650 mg every four hours PRN mild pain (dated 8/24/11) and Vicodin 5/500 mg every six hours PRN moderate to severe pain (1/25/12). The Pain Management Flow Sheet revealed a pain scale from zero to 10, zero indicated no pain; pain rated 1 to 3 indicated mild pain; 4 to 6 indicated moderate pain; 7 to 8 indicated severe pain; and 9 to 10 indicated worst possible pain. A review of the 2/2012, MAR and the Pain Management Flow Sheet indicated the resident's pain level was 8/10 once a day from 2/1/12 to 2/4/12, from 2/6/12 to 2/9/12, and on 2/11/12. Both the MAR and the Pain Flow Sheet indicated that on 2/10/12 (when the first observation was	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINITY CARE OF EAST LOS ANGELES	101 S PICKETT STREET LOS ANGELES, CA 90033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 conducted), the resident did not receive Vicodin or Tylenol and there was no documentation the resident was complaining of pain. An interdisciplinary team Pain Management Review Committee dated 1/3/12, indicated to conduct a re-assessment to determine effectiveness of pain medication ordered through pain rating scale using the numbered scale, face scale, word descriptive scale, and non-verbal scale. According to the policy, "Pain Management" dated 8/4/07, it was the policy of the facility to assess for pain, and provide patient care services for the management of pain. The policy included to develop a comprehensive long-term plan of care to address identified problems and ensure resident is provided with care and services necessary for resident to be free of pain and/or discomfort within the limits of resident's medical condition or achieve acceptable level of pain. On 2/16/12, at 7:15 a.m. the resident was sitting in the geri-chair, wearing both leg splints and was complaining of pain in his legs. On 2/16/12, at 8:35 a.m. during an interview, Licensed Vocational Nurse 2 indicated the resident would benefit from a scheduled pain medication regime for more consistent pain management, and would speak with the resident's physician.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314	• Resident # 8 was assessed for any signs and symptoms of infection on the sacrococcyx area and none was noted.	2/14/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 9 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident with pressure sore received appropriate treatment to promote healing and prevent infection for one of 19 sample residents (8). Resident 8 had a pressure ulcer on the sacrococcyx (tailbone area). The treatment nurse cleaned the pressure sore starting from a soiled area, the perianal area. This deficient practice had the potential to contaminate the pressure sore with fecal matter and prevent the sore from healing. Findings: During a treatment observation on 2/14/12, at 10:26 a.m., the treatment nurse, cleansed Resident 8's Stage III pressure ulcer on the sacrococcyx area. The treatment nurse cleansed the open sore with a gauze wet with normal saline by wiping from the bottom area of the sore, the perianal area (soiled area), to the top of the sore. After cleansing the wound, the treatment nurse used a dry gauze to pat the sore starting from the perianal area to the top of the sore. The treatment nurse then applied Hydrogel (wound gel) from the perianal area to the top and then back to the perianal area.	F 314	• Wound nurse monitors during treatment on a daily basis for any signs and symptoms of infection and presents and discusses during weekly wound meeting any concerns • Inservice was provided to all licensed staff the proper way of cleansing and treating wounds aseptically- from clean to dirty • DNS conducted treatment observation to wound nurse to ensure correct procedure is being done	2/22/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINITY CARE OF EAST LOS ANGELES	151 S PICKETT STREET LOS ANGELES, CA 90033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 10 At 11:05 a.m., during an interview, the treatment nurse stated she should have cleaned the pressure sore starting from the top of the sore to the bottom to prevent contamination. At 11:40 a.m., during an interview, the director of nursing (DON) stated the motion when wiping or cleaning the pressure sore should be from a clean area to an area considered dirty. A review of the clinical record revealed the resident was admitted to the facility on 2/3/12, with diagnoses that included diabetes mellitus, pressure sore and hypertension. According to the Nursing Admission Data Collection Assessment dated 2/3/12, the resident was severely impaired in decision-making and was totally dependent on staff for activities of daily living (ADLs). A physician's treatment order dated 2/3/12, indicated to cleanse the Stage III pressure ulcer on the sacrococcyx with normal saline, apply hydrogel, and cover with dry dressing every day for 30 days. According to the plan of care initiated on 2/3/12, for the management of Stage III pressure sore in the sacrococcyx area, one of the approach plan was for nursing services to practice good infection control when dealing with pressure sore.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F315	• Resident's foley catheter was secured immediately and positioned correctly to facilitate proper flow of urine to the drainage bag and to avoid urinary retention and occurrence of UTI	2/14/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056053	A. BUILDING _____ B. WING _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINITY CARE OF EAST LOS ANGELES	191 S FICKETT STREET LOS ANGELES, CA 90033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 11 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide appropriate care and services to keep an indwelling catheter anchored or secured to prevent dislodgement, and failed to develop a care plan to monitor complications resulting from the use of the indwelling catheter as stated in the facility's policy and procedure for one of 19 sample residents (8). Resident 8 had an indwelling catheter that was not secured and the clinical record lacked a care plan to monitor complications resulting from the use of the catheter. This deficient practice had the potential to result in injury of the urethra (the canal through which the urine is discharged from the bladder). Findings: During a treatment observation on 2/14/12, at 10:26 a.m., the treatment nurse cleansed Resident 8's Stage III pressure ulcer on the sacrococcyx (tailbone) area while the resident was lying on her left side. The resident had an indwelling catheter for urine drainage that was connected to a drainage bag. The catheter tubing was noted hanging under the right side of the bed. The indwelling catheter was not secured to the resident's thigh. At 11:05 a.m., during an interview, the treatment	F 315	• Licensed nurses and CNA inservice was conducted and discussed securing of foley catheter tubing to resident's thigh to avoid urinary retention and occurrence of UTI • Licensed nurses and CNAs were also in-serviced to secure foley catheter when disconnected or displaced.	3/10/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 12 nurse confirmed the indwelling catheter was not secured on the resident's thigh. At 2:30 p.m., during an interview, the Director of Staff Development (DSD) stated staff members normally do not secure the indwelling catheter on the resident's thigh. A review of Resident 8's clinical record indicated the resident was admitted to the facility on 2/3/12, with diagnoses that included diabetes mellitus, pressure sore and hypertension. According to the Nursing Admission Data Collection Assessment dated 2/3/12, the resident was severely impaired in decision-making and was totally dependent on staff for activities of daily living (ADLs). A physician's order dated 2/3/12, indicated the use on an indwelling catheter for pressure sore management. There was no plan of care developed for the resident's use of an indwelling catheter and the interventions nursing staff should implement to prevent complications. According to the facility's policy and procedure titled "Foley/Indwelling Catheter," dated 8/4/07, care approaches shall reflect steps to secure or anchor catheter to facilitate flow of urine and prevent excessive tension on the catheter. The policy also indicated a plan of care shall include monitoring of complications resulting from use of an indwelling catheter (e.g., symptoms of blockage of catheter with associated bypassing of urine, expulsion of the catheter, urethral explosion, bladder spasms, pain, discomfort, bleeding/hematuria, leakage around the catheter, urinary tract infection, and urosepsis).	F 315		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 13 According to the AJN (American Journal of Nursing), December 2008, Vol. 108, No. 12, pages 44- 45 titled "Securing the Indwelling Catheter", indicated although a physician or NP (nurse practitioner) usually makes the decision to place an indwelling catheter, nurses are responsible for its ongoing management. Optimal management of an indwelling catheter includes securing the catheter to the thigh or abdomen in a way that prevents the catheter or its retention balloon from exerting excessive force on the bladder neck or urethra.	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident with a gastrostomy tube (GT) received water before and after medication administration as ordered by the physician for one of 19 sample residents (5). Medication Nurse 1 failed to flush Resident 5's GT prior to medication administration, and flushed the tube with five milliliters (ml) of water following medication administration and not with 50 ml of water prior to, and after, medication	F 322	• Resident was assessed and monitored and noted no signs of dehydration • All Licensed Nurses were inserviced on proper medication administration that included correct amount of GT flushing as ordered by the physician • Licensed Nurses Competency skills check was done • One-on-one inservice was provided to the concerned Licensed staff on 6 rights of medication administration. Inservice training was provided by the DNS on policy and probedures on medication administration and clinical competency skills check conducted	3/10/12 3/2/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 14 administration as per physician's order. The medication nurse also failed to flush the GT with 20 ml of water before and after Phenytoin (Dilantin) administration as ordered. Findings: A review of the clinical record revealed Resident 5 was re-admitted to the facility on 8/16/11, with diagnoses that included history of stroke, diabetes mellitus and history of seizure disorder. The resident had a GT (tube surgically inserted through the abdominal wall into the stomach for purposes of providing nutrition and medication administration). The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 12/24/11, indicated the resident was alert and oriented to his surroundings and required extensive staff assistance with his daily living activities. A physician's order dated 12/13/11, indicated to flush the GT with 50 ml of water pre and post medication administration. The physician also ordered to flush the GT with an additional 20 ml before and after administration of Dilantin (anti-seizure medication). On 2/10/12, at 9:10 a.m. during the medication pass observation, Medication Nurse 1 administered a total of nine medications including Dilantin 200 milligrams. Medication Nurse 1 also administered two scoops of the protein supplement Pro Source diluted in four ounces of water. Medication Nurse 1 did not flush the GT with 50 ml prior to, or following medication administration, and did not flush with an additional 20 ml before and after administration of Phenytoin.	F 322		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/29/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 15 On 2/10/12, at 1:50 p.m., during an interview, Medication Nurse 1 stated she should have followed the physician's orders for flushing the GT during medication administration. The facility's policy and procedure on Medication and Treatment Administration dated 8/4/07, indicated medications and treatments shall be administered as prescribed.	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a personal alarm was applied to the resident when in bed to prevent fall and injury as ordered by the physician and as stated in the plan of care for one of 19 sample residents (7) and failed to maintain an environment free from accident hazards by not securing two portable refrigerators placed on top of the residents' bedside tables and by not securing oxygen cylinders to the wall. Resident 7 was lying in bed without the personal alarm attached to his clothing. This deficient practice has the potential for falls and injuries.	F323	• Licensed nurses were inserviced to ensure to include during change of shift rounds that personal safety device (alarm) are secured and in place. Reports are given to all CNAs to monitor and place alarms when observed not attached to the resident to avoid and prevent falls • DNS will present to QA & A committee status of compliance and any continuing issues or concerns will be reported to the administrator for further corrective measures.	3/10/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16 Findings: 1. On 2/9/12, at 3:10 p.m., during the initial tour with Registered Nurse 4 (RN 4), Resident 7 was observed lying in bed. A personal alarm was placed beside his left shoulder, but it was not attached to his clothing. At the time of the observation, RN 4 explained the personal alarm should be attached to the resident in order to be activated if the resident attempted to get up or get out of bed unassisted: RN 4 proceeded to attach the personal alarm on the left sleeve of the resident's shirt. A review of the clinical record revealed the resident was admitted to the facility on 4/26/10, and re-admitted on 5/14/10, with diagnoses that included diabetes mellitus, cellulitis of the foot, general muscle weakness, and hypertension. The quarterly Minimum Data Set (MDS - standardized assessment and care planning tool) dated 1/28/12, indicated the resident was able to make his needs known, was able to understand others, did not walk and required limited to extensive assistance with activities of daily living (ADLs). The physician ordered on 9/14/10, to apply a bed and wheelchair alarm at all times to alert staff when resident is getting up. A care plan initiated on 7/28/11, developed for resident's need to have a personal alarm when in bed and wheelchair due to getting up without calling for assistance, had a goal to minimize the risk for fall. The interventions included applying the personal alarm as ordered. 2. On 2/9/12, at 3:30 p.m., during the environmental tour of the facility, in the presence of the maintenance supervisor, the following was	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056083	A. BUILDING _____ B. WING _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 17 observed: a. Rooms 101C and 118C had each a small refrigerator placed on top of a small wooden bedside table. The refrigerators were not secured to the tables and could easily fall posing a hazard risks for anybody in the vicinity. b. An oxygen cylinder in Room 117A and another in the (third floor)activity room were not secured to a wall or to a cart. c. There was an exposed electrical wire from an electrical outlet in Room 116 above bed B. In an interview, on 2/9/12, at 3:40 p.m., the maintenance supervisor stated the above appliances and the oxygen cylinders will be secured for safety of the residents.	F 323	• All table top appliances that may present a falling hazard (TV's, Personal refrigerators, other) have been secured to the table top surface • All oxygen cylinders that present a falling hazard when unattended, have been secured. Daily monitoring by CNA's will be conducted to ensure secure attachments to prevent unanticipated tipping or falling. • Exposed electrical wiring found in Room 116 was covered immediately with matching trim/conduit. Room audits will be conducted weekly for needed repairs and reported in "Stand Up" to the Executive Director.	2/10/12 2/10/12 2/9/12
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication error for one of 19 sample residents (7). Resident 7 did not receive, on two occasions, the correct dose of insulin coverage as ordered by the physician. This deficient practice has the potential for complications from inadequate treatment of a disease. Findings:	F333	• All residents on sliding scale for blood sugar monitoring reviewed and MRD to ensure audits are performed on a weekly basis • One-on-one inservice was provided to the concerned Licensed staff on 6 rights of medication administration. Inservice training was provided by the DNS on policy and procedures on medication adminstration and clinical competency skills check conducted	2/13/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINITY CARE OF EAST LOS ANGELES	101 S PICKETT STREET LOS ANGELES, CA 90033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 18 A review of the clinical record revealed Resident 7 was admitted to the facility on 4/26/10, and re-admitted on 5/14/10 with diagnoses that included diabetes mellitus and hypertension. According to the quarterly Minimum Data Set (MDS - standardized assessment tool) dated 1/28/12, the resident was able to make his needs known, was able to understand others, did not walk and required limited to extensive assistance with activities of daily living (ADLs). A physician's order dated 5/29/10, indicate to check the resident's blood sugar before meals and administer subcutaneous (SQ) Novolog insulin as per sliding scale as follows: 120-150 milligrams per deciliters (mg/dL) = 2 units 151-200 mg/dL = 4 units 201-250 mg/dL = 6 units 251-300 mg/dL = 8 units 301-350 mg/dL = 10 units 351-400 mg/dL = 12 units; and Call MD if the blood sugar is below 60 mg/dL or above 400 mg/dL. According to the Medication Administration Record (MAR), the resident's blood sugar on 2/1/12, at 11:30 a.m. was 139 mg/dL and one unit of insulin was administered. On 2/2/12, at 11:30 a.m., the resident's blood sugar was 178 mg/dL and three units of insulin were administered. On 2/13/12, at 11:20 a.m., after reviewing the clinical record, Registered Nurse 3 (RN 3) stated the resident should have been given two units of insulin for the blood sugar of 139 mg/dL and four units of insulin for the blood sugar of 178 mg/dL. A review of the facility's policy and procedure titled "Insulin Injection Administration," dated 1/09, indicated it is the facility's policy to aid oxidation and utilization of the blood glucose by	F 333		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 19 the tissues and to control the blood glucose levels in patients with diabetes mellitus through the correct administration of insulin. One of the procedures was to check the prescriber's order.	F 333		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident received a therapeutic diet as prescribed by the physician for one of 18 sample residents (12). Resident 12, who had an order for mechanical soft diet, was served food which was not pre-cut. This deficient practice had the potential to cause choking. Findings: On 2/10/12, at 12:15 p.m. during a meal observation, Resident 12 was attempting to eat an enchilada (usually corn tortilla rolled around a savory mixture, covered with chili sauce, and usually baked) which had been served uncut. The resident picked up the enchilada with her fork, and started to chew on the end of it. After several minutes, Licensed Nurse 2 approached the resident and proceeded to cut the enchilada into several sections. A review of the clinical record revealed the resident was re-admitted to the facility on 1/28/12, with diagnoses that included end stage renal	F367	Dietary personnel will ensure contents of meal trays reflects what is indicated on the tray card Licensed Nurses to monitor and ensure that meal trays are checked in accordance with physician's orders before meal trays are served Dietary Supervisor and DNS to present to QA & A committee during the monthly meeting the compliance with plan of correction	3/10/12 3/10/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 367	Continued From page 20 disease, history of esophagitis (inflammation of the esophagus), and diabetes. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 12/27/11, indicated the resident was alert and oriented and required extensive assistance with most of her daily living activities. A physician's ordered on 1/28/12, a mechanical soft, renal diet, with no added salt, and no concentrated sweets. On 2/13/12, at 12:35 p.m. during an interview, the dietary service supervisor (DSS) explained a mechanical soft diet means that the food is served already cut in order to facilitate easier swallowing. On the same day, at 1:10 p.m., Licensed Nurse 2 stated the resident's tray should have been checked to ensure the food was cut or chopped prior to being served. A review of the facility policy titled "Diet Orders" and dated 8/04/07, stipulated that nursing services shall adhere with resident diet orders, monitoring meal trays every meal to ensure resident receives diet as prescribed by physician.	F 367		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	* Dietary Supervisor provided in-services to all dietary and activity staff to ensure that hairnets are worn during food preparation * Random check of dietary and activity staff conducted by dietary supervisor during food preparation and during tray line.	3/10/2012

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050063	A. BUILDING _____ B. WING _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINITY CARE OF EAST LOS ANGELES	101 S PICKETT STREET LOS ANGELES, CA 90033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 21	F 371		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure food was prepared, stored and served under sanitary conditions. Activity staff members did not wear hairnets during food preparation and service at the satellite kitchen as stated in the facility's policy and procedure. The temperature of food stored in the freezer was at 12 degrees Fahrenheit (F). The can opener blade was soiled. There was one dented food can stored with non-dented cans. This deficient practice has the potential for food contamination and foodborne illness.

Findings:

1. On 2/10 12, at 11:55 a.m., during a meal observation in the third floor dining/activity room, a satellite kitchen was set up in the activity office which was adjacent to the dining/activity room. The activity director and three activity assistants, who were wearing white chef shirts, were observed obtaining plates of food from the satellite kitchen and serving them to the residents without a cover. Two activity assistants alternately scoop food from portable steam trays, a crock pot, and a jar of soup. The activity director and the three activity assistants were not wearing hairnets during food serving.

On 2/14/12 at 11:50 a.m., during a second meal observation in the third floor dining/activity room, the activity director and the three activity

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055063	A. BUILDING _____ B. WING _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 22 assistants were not wearing hairnets during food preparation and distribution. On 2/14/12, at 12:20 p.m., during an observation, Activity Assistant 1 was scooping food from the portable steam trays without wearing a hairnet. When asked if he was supposed to wear a hairnet, he stated, "Yes, but I forgot," and pointed to a box of hairnets in a nearby shelf. At 12:25 p.m. during an interview, the activity director stated the person assigned to scoop the food from the steam trays had to wear a hairnet. At 2:15 p.m., during an interview, the Dietary Service Supervisor stated the activity director and the activity assistants were provided in-services regarding wearing a hairnet during trayline. According to the facility' s policy and procedure titled "Sanitation and Infection Control," dated 2011, a hairnet and/or head covering which completely covers all hair should be worn during meal preparation and service. 2. On 2/9/12, at 2:15 p.m., during the initial tour of the facility's kitchen in the presence of the dietary service supervisor (DSS), the following was observed: a. The temperature of a four-ounce ice cream container in the reach-in freezer was measured at 12 degrees F. One calibrated facility's probe thermometer was left in the ice cream for 30 minutes to confirm the temperature test and the same reading was obtained.	F 371	• The temperature of the reach-in freezer will be monitored daily for two weeks with temperatures measured both from the internal/external gauges as well as measured food temperatures (which should be frozen solid). Results will be reported daily to the Dietary Supervisor and at "Stand Up" the following day to the Executive Director. Thereafter, the same temperature information will be checked and reported bi-monthly on the 1st and 15th of each month. Reports will be presented to the monthly QA/UR committee for review and compliance. • All dietary equipment used in the preparation of any food product will be cleaned thoroughly each day. The Dietary Supervisor will perform "Quick Rounds" daily for two weeks, then weekly to ensure cleaning practices. Reports/findings will be given to the Executive Director and forwarded to the QA/UR committee monthly for review and compliance.	3/10/12 3/10/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 23 b. The can opener blade was soiled with what appeared dried food particles. c. One dented food can was stored with non-dented cans in the dry food storage room. The facility's policy and procedures on dietary service indicated frozen foods must be stored at a temperature of 0 degrees F or below.	F 371	• The slightly dented rim of one can which appeared to be transportation related, was permanently removed from storage. The facility will not accept or store any cans with any apparent damage. This will be monitored as above, in the "Quick Rounds" by the Dietary Supervisor".	3/10/12
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure intravenous	F 425		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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 _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINITY CARE OF EAST LOS ANGELES	101 S PICKETT STREET LOS ANGELES, CA 90033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 24 (IV) medication emergency kit (e-kit) was replaced within 72 hours after the kit was opened and a medication was removed from the kit, as stated in the facility's policy and procedure. This deficient practice has the potential to result in delayed treatment in an event of an emergency. Findings: On 2/10/12 at 10 a.m., during the medication room inspection with Registered Nurse 6 (RN 6), the IV medication e-kit was observed to be sealed by one red tag. At the time of the observation, RN 6 explained one red seal indicated the IV e-kit was opened and a medication was taken out. RN 6 continued to explain that when the pharmacy replaces the kit or the medication, they seal the kit with two tags, one in each side of the kit. At 10:15 a.m., after reviewing the Emergency Log Sheet, RN 6 stated a Dextrose 50% (a medication used in emergency care to treat hypoglycemia and in the management of coma of unknown origin) was taken from the IV e-kit on 1/15/12, at 7:55 a.m. and the pharmacy should have replaced the used medication within two to three days from 1/15/12 RN 6 stated the RN supervisor was supposed to follow up with pharmacy. According to the facility's policy and procedure titled "Emergency Pharmacy Service and Emergency Kits," dated 4/1/08, if exchanging kits, opened kits are replaced with sealed kits within 72 hours of opening. If replacing used medications, the replacement doses are added to the kit within 72 hours of the opening.	F425	• Pharmacy was notified and IV Ekit was immediately replaced • RN Supervisors to monitor that all Ekits are sealed and to make sure replacements are ordered once opened. RN Supervisors monitor and records that Ekits are sealed at start of shift	2/10/2012
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	F 456		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056083	A. BUILDING _____ B. WING _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 25 The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain essential mechanical laundry equipment in a safe operating condition. There was a defective electrical switch on one of the dryers. (Dryer #2). Findings: On 2/14/12, at 8:50 a.m., during the general observation of the laundry room, in the presence of the maintenance supervisor, the laundry staff was observed using a piece of cardboard to hold the switch behind Dryer #2 door. The switch was observed broken and loose. At the time of the observation, the maintenance supervisor stated the laundry dryer would be repaired.	F 456	Plan of Correction Infinity Care of East Los Angeles makes every effort to comply with State and Federal regulations. Nothing in this plan of correction is an admission otherwise. Infinity Care of East Los Angeles has submitted this plan of correction to comply with the regulatory obligation and does not waive any objections contained therein. This Plan of Correction constitute Infinity Care of East LA's written credible allegation of compliance for the deficiencies noted. • All residents had the potential to be affected by the deficient practice to maintain mechanical laundry equipment in a safe operating condition. The defective electrical switch on the dryer was replaced/repaired. • A defective electrical switch on any laundry equipment has the potential to affect all residents in the facility. Notification of any further laundry mechanical or electrical problems will be reported to the Executive Director each morning at "Stand Up" until resolved, repaired, or replaced.	3/10/2012 3/10/12

California Department of Public Health

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 _____	0216/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F456 (cont)		F456 (cont)	• The Administrator will formally track, in written chart format, all mechanical or electrical breakdowns or needed repairs each morning at "Stand Up" via a "Daily Quality Improvement / Quality of Care" tracking form. It will be reviewed each morning/daily at "Stand Up". The laundry/housekeeping supervisor will report each morning on the operational status or issues needing repair in the laundry department.	3/10/12
			• The "Daily Quality Improvement / Quality of Care" tracking form shall be reviewed by the Administrator, Director of Nursing and other facility Department Heads each morning in "Stand Up". The tracking form will be reviewed and continuing problems addressed at the monthly QA/UR meeting for changes or improvements and evaluation of continued effectiveness.	3/10/12