CENTERS FOR MEDICARE & MEDICAID SERVI STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION N		IER/CLIA	(X2) MULTIPLE	CONSTRUCTION 1 3 13 13 13 13 13 13 13 13 13 13 13 13	1	
AND PLAN O	- CORRECTION	IDENTIFICATION N	UMBER:	A. BUILDING _	77	(X3) DATE SURVEY COMPLETED
		0560	3	B. WING	<u>*************************************</u>	C 06/03/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 UditulE0E0
INFINITY	Care of East Los an	GELES	•		01 S FICKETT STREET OS ANGELES, CA 90033	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENC Y MUST BE PRECEDED	IES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
TAG	REGULATORY OR	LSC IDENTIFYING INFOR	MATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ON (XS) D BE COMPLETION PRIATE DATE
F 000	INITIAL COMMENTS	;		F 00 0	Plan of Correction	:
	The following reflect	s the findings of the		: !	Infinity Care of East Los	•
•	California Departmen	it of Public Health d	uring a	į	Angeles makes every effort t	
	complaint visit.		į	comply with State and Feder		
	Complaint number of	400004444			regulations. Nothing in this p	olan
	Complaint number: C	antiated.	i	of correction is an admission		
	· Representing the Department of Public I		lealth:		otherwise. Infinity Care of E	ast
					Los Angeles has submitted the	
	HFEN 31331				plan of correction to comply	
	HFEN 39230			•	with the regulatory obligation	:
	Resident Sample: 3				and does not waive any	• •
			,		objections obtained therein.	:
	S/S: D				This Plan of Correction is	i
	The inspection was li			1	Infinity Care of East Los	
	complaint(s) investiga	miled to the specific	Nrocont .		Angeles' credible allegation	·•
	the findings of a full in	spection of the faci	ity.		compliance.	JI ;
F 710	Resident's Care Supe	ervised by a Physici		F 710	omphaloe.	:
SS=D	CFR(s): 483.30(a)(1)	(2)			F710 Resident's care	:
	§483.30 Physician Se				Supervised by a Physician	
	A physician must per		ritina a			<u>:</u> :
	recommendation that	an individual be ad	nitted to		It is the policy of the facility t	·n :
	a facility. Each reside	ent must remain und	er the	i i	follow the Physician's order t	
	care of a physician.				check the blood sugar levels a	
	assistant, nurse pract specialist must provid			•	administer insulin as ordered	
	immediate care and r		ueill 5	•	the Physician and to follow th	
				:		
	§483.30(a) Physician	Supervision.		:	policy to document blood sug level and medication	ar
	The facility must ensu	ire that-		:	administration.	
	§483.30(a)(1) The me is supervised by a ph	edical care of each (ysician;	esident		administration.	
	§483.30(a)(2) Anothe	r physician supervis	es the	•		
BORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTAT	WE'S SIGNATUR	E ,	TITLE	(X6) DATE
ENG	もんに ナノユ		7	Å	FUMINISTRATOIZ	6-10-20

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 actility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CM8-2567(02-99) Previous Versions Obsolete

Event ID: 9Y1G11

Facility ID: CA970000070

If continuation sheet Page 1 of 5

Jun. 10. 2020 1:32PM DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 1398 P. 3

P. 3 PRINTED: 06/03/2020 FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPP	ICDICI IA				OMB NO. 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION	LIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С
		0560	53	B. WING			06/03/2020
NAME OF PROVIDER OR SUPPLIER					STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/03/2020
INFINITY	CARE OF EAST LOS AN	GELFS			101	S FICKETT STREET	
THE OF EAST EGG ANGELES					LO	S ANGELES, CA 90033	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIEN	HES	ID	_	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	(EACH DEPICIENC REGULATORY OR I	Y MUST BE PRECEDED LSC (DENTIFYING (NFOR	BY FULL MATION)	PREFI TAG	× 	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E : COMPLETION ATE DATE
F 710	Continued From page	e 1		F	710	Corrective action:	
	medical care of reside	nding			-		
	physician is unavailable.			•	;	After the deficient practice was	
	This REQUIREMENT	is not met as evid	enç s d	i	:		
	by:			i	:	identified, a 1:1 in-service	
	Based on interview a	ne facility		•	given by the Director of Nursing	g	
	failed to follow the phy blood sugar levels and	reck the	!	:	on 6/9/20 to Licensed Nurse		
	ordered by the physic	as liou ite			assigned to Resident 1 and 2 re:		
	policy to document blo	HOAN ITS	i : :	:	F710 - Resident's care	;	
	medication administra		:	į	Supervised by a Physician by		
	sampled residents (Residents 1 and 2).			: !	. ;	following the Physician's order	
						to check the blood sugar levels	
	The deficient practice	had the potential f	or the		:		
	residents medical nee	ds will not be met	hat could		:	and administer insulin as	
	lead to adverse (harm complications.	itul) consequences	and	· I		ordered by the Physician and to	
	Findings:		-			follow its policy to document	
			•			blood sugar level and	
						medication administration. A	
	a. A review of an Adm			•		counseling given to Licensed	•
	Resident 1 was original	facility			Nurse assigned to Residents 1		
	on 9/19/12 and readm	yith			and 2 for failure to check the	:	
	diagnoses that include	ed diabetes mellitu:	s (DM- a				
	disease in which the baugar in the blood).	el of			blood sugar levels and		
	augai iii tile blood).					administer insulin as ordered a	:
	A review of the Minimi	um Data Set (MDS	. a			failure to follow the policy to	į
	standardized resident	assessment and				document blood sugar level and	i
	care-screening tool), o	ated			medication administration.	•	
:	Resident 1's cognition	(a mental process	of .				
:		iring knowledge and understanding				Other residents potentially	
	intact. Resident 1 was			•	affected:		
	mobility, transfer, walking, dressing, eating use, personal hygiene, and bathing. Res received insulin injections.		g, toilet			anccieu:	
			uent 7		:		Ì
:	modeli injood	VI OI				All residents are affected by this	ĺ
•	During a review of Res	sident 1's physiciar	's (MD)		•	deficient practice. An in-service	ł
:	order, dated 6/12/19, i	ndicated to check	lood			given by the Director of Nursing	;
:	sugar level and cover	with Humalog (insi	iin- drug		i		

Jun. 10. 2020 1:38PM DEPAKIMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 1398 P. 4/10
PRINTEU: Ut/03/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SU IDENTIFICATION		(X1) PROVIDER/SUPP IDENTIFICATION (JER/CLIA IUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		<u> </u>	C			
		0560	3 3	B. WING		06/03/2020
NAME OF PROVIDER OR SUPPLIER INFINITY CARE OF EAST LOS ANGELES			_	101	REET ADDRESS, CITY, STATE, ZIP CODE S FICKETT STREET S ANGELES, CA 90033	1 00/04/2020
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIEN ENCY MUST BE PRECEDED OR LSC IDENTIFYING INFOR	RY EULI	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 710	subcutaneous (und times a day at 8 a.) During a concurrer on 4/9/20, at 10:25 (DON), stated Res Administration Red for blood sugar cheinsulin sliding scale indicated at 12 p.m was no licensed no documentation to documentation to do sugar level was ched dosage was given b. A review of an A Resident 2 was or on 5/8/17 and read diagnoses that includiabetic neuropath	ar level) sliding scale der the skin, into the fm., 12 p.m., and 5 p.m. tinterview and record a.m., with Director of a.m., with Director of dent 1's "Medication cord (MAR)," dated Meck to cover with Huma. The MAR on 3/29/2n., administration time urse (LN) initial and/ordemonstrate that the tecked and the Humal	n. I review Nursing Irch 2020 alog 0, there lood og insulin eated facility s with ss, and	F 710	on 6/9/20 and 6/10/20 to Licensed Staff re; F710 — Resident's Care Supervised by Physician. DON emphasized to the Licensed Nurses the importance of following the Physician's order to check the blood sugar levels and administer insulin as ordered by the Physician and to follow its policy to document blood sugar level and medication administration. Medical Record Director performed audit of the MAR and no other deficient practice were noted. Measures and systemic changes:	; ; ; y
	Resident 2's cognitotally dependent of physical assist for personal hygiene, a received insulin injulated to (supplement) 325 it times a day for and 500 mg by mouth to	nt 2's MD's order, dat give Ferrous Sulfate milligrams (mg) by mo emia, Vitamin C (supp wo times a day, and (mg by mouth two tin	ent 2 was T et use, 2 ed uth two ement) clace		Under the supervision of the Director of Nursing, Charge Nurse will make sure to follow the Physician's order in checking the blood sugar levels and administer insulin and to follow its policy to document sugar level and medication administration. Random check will be done by the DON and o RN Supervisor during the pass	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 1398 P. 5/10 PRINIEU: 40/03/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPI		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	0560	63	B. WING		c
NAME OF PROVIDER OR SUPPLIER] b. 111110		06/03/2020
INFINITY CARE OF EAST LOS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 S FICKETT STREET LOS ANGELES, CA 90033		
PREFIX (BACH DEFIC	Y STATEMENT OF DEFICIEN ENCY MUST BE PRECEDED OR LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACYION SHOULD CROSS-REPERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
indicated to check with Humulin R (in level) sliding scale day before meals A review of Resid indicated to give is subcutaneous threbefore meals for It During a concurre of Resident 2's M with DON, indicated administration threbefore documentation to sugar was checked given to Resident administration time documentation to Suffate, Vitamin Concurrence DON stated per from the decident administration to and given per MC condition. During a review of procedure (P&P) dated September glucose per physDocument incluresult, as ordered	ent 2's MD order, data to blood sugar level an sulin- drug to lower to subcutaneous three and at bedtime. ent 2's MD order, data dumulin R six units ee times a day 10 to	d cover lood sugar times a d 2/19/20, d review a.m., d and/or blood lin was 5 p.m., d ar level after as checked dent's d atration," heck blood brotocol bd glucose	F 71	medication of the Charge Nurs	
During a review o	of the facility's P&P tit	led,	<u>:</u> :	responding for anguing tin	

Jun. 10. 2020 1:39PM

No. 1398 P. 6/10 PRINTED: 08/03/2020

	S FOR MEDICARE &						FORM APPROVED
	F DEFICIENCIES	(X1) PROVIDER/SUP		(X2) M(8)	TIDI E A	CONSTRUCTION	OMB NO. 0938-0391 (X3) Date Survey
	CORRECTION	IDENTIFICATION		A. BUILOI			COMPLETED
		056	63	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER				ŜT	REET ADDRESS, CITY, STATE, ZIP CODE	06/03/2020
	NADE OF EACT 66 AM	251.50				1 S FICKETT STREET	
MEMILIA (CARE OF EAST LOS AND	geles	LOS ANGELES, CA 90033			DS ANGELES, CA 90033	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIE! Y MUST BE PRECEDER SC IDENTIFYING INFO	BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
5				İ		Licensed Nurses are following	
F 710	Continued From page			F	710	the Physician's order to check	
	"Administering Medic indicated, medication					the blood sugar levels and	
	and timely menner, a					administer insulin as ordered by	,
,	individual administeri			:	:	the Physician and to follow its	
	resident's MAR on the	e appropriate line	after	•		policy to document blood sugar	
	giving each medication the next ones. As req					level and medication	•
	medication, the indivi			:		administration. Medical Record	<u>:</u>
	medication records in					Director will be responsible to	•
	record included the d	osage and injection	n site.			check on a daily basis 5x/week	:
			ł	:	• :	to make sure the blood sugar	: ,
			Í		į	level and medication	
			l		i	administration are being	
				!		documented by the Licensed	•
	••			• •	ļ	Nurse in the MAR. The Directo	ı r
					İ	of Nursing and Medical Record	
					į	Director will report the findings	
			:			of the PIP with the Quality	,
	:			:	•	Assurance and Performance	
]	•	:	Improvement (QAPI)	i
						committee to ascertain the	
						effectiveness of the corrective	į
						action at least every month in	
						the next three (3) months or	<u>!</u>
			1	:	:	until 100% compliance	
				!		threshold is achieved and	
						sustained.	
						Completion Date: 6/12/2020	<u> </u>
	•					:	