

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Camino Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 13922 Cerise Avenue Hawthorne, CA 90250	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48778</p> <p>Based on observation, interview and record review, the facility failed to ensure one of 3 residents' (Resident 2) low air loss mattress (LAL, a medical mattress that uses air to prevent and treat pressure wounds, also known as bed sores) was set in the appropriate mattress setting.</p> <p>This deficient practice had the potential to delay wound healing process and risk for further skin breakdown.</p> <p>Findings:</p> <p>During a review of Resident 2s Admission Record, the Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought).</p> <p>During a review of Resident 2 ' s Minimum Data Set ([MDS] a resident assessment tool), dated 10/27/2024, the MDS indicated Resident 2 had no cognitive (the ability to think and reason) impairment. The MDS indicated Resident 2 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for Activities of Daily Living (ADLs) such as rolling left to right and requires partial/moderate assistance (helper does less than half of the effort. Helper lifts or holds trunk or limbs and provides less than half the effort) with toileting hygiene.</p> <p>During an review of Resident 2 ' s Order Summary Report dated 12/6/2024, the order indicated Low Air Loss (LAL) for management of Stage 4 sacral (tailbone) ulcer (full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle, bones).</p> <p>During a review of Resident 2 ' s care plan dated 1/20/2023, the intervention indicated low air loss mattress for skin management.</p> <p>During a review of Resident 2 ' s Treatment Administration Record (TAR) dated 1/23/2023, the TAR indicated to monitor LAL for proper function and setting (not specified) every shift.</p> <p>During a review of Resident 2 ' s weight dated 11/7/2024, Resident 2 had a weight of 141 pounds (lbs).</p> <p>During an observation on 12/5/2024 at 10:10 a.m. in Resident 2 ' s room, Resident 2 ' s LAL mattress was observed with the setting set to firm with the dial pointed to 350.</p> <p>(continued on next page)</p>

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
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/5/2024 at 1:41 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated that the pressure to be set on a LAL mattress should be set the same as the resident ' s weight.</p> <p>During a concurrent observation and interview on 12/5/2024 at 2:10 p.m. with LVN 2 at Resident 2 ' s bedside, LVN 2 observed the setting for Resident 2 ' s bed to be set at 350. LVN 2 stated that Resident 2's weight was 141 lbs, so the pressure should have been set at 141.</p> <p>During an interview on 12/6/2024 at 12:47 p.m. with LVN 3, LVN 3 stated Resident 2 ' s LAL mattress setting should be checked to ensure it is on the correct setting. LVN 3 stated, 350 is not the right setting and it should match Resident 2 ' s weight that was 141 lbs. LVN 3 stated, If the LAL mattress is not at the right setting, it could mess up the wound and could also create a new wound.</p> <p>During an interview on 12/6/2024 at 3:28 p.m. with Director of Nursing (DON), DON stated that it is important for the setting to be appropriate for the resident because it would help prevent breakdown of a sore and that staff are to check and ensure that it is in the right setting.</p> <p>During a record review of facility ' s manual for facility ' s current air loss mattresses titled, Med-Aire 8 Alternating Pressure Mattress Replacement System with Low Air Loss, undated, the manual indicated when setting up the mattress, adjust the dial to correspond the patient ' s appropriate weight setting or comfort level.</p> <p>During a record review of facility ' s P&P titled, Skin and Wound Monitoring and Management, dated 12/2023, the P&P indicated, a resident who have a pressure injury(s) should receive the necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing. The P&P indicated in order to prevent development of skin breakdown or prevent existing pressure injuries from worsening, nursing staff should implement approaches consistent with the resident ' s care plan such as, use pressure relieving/reducing and redistributing devices (including but not limited to low air loss mattresses, wedges, pillows, etc.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48778</p> <p>Based on observation, interview and record review, the facility failed to ensure one of 3 residents' (Resident 2) urinal containing urine was not placed on the bedside table when meal tray was served.</p> <p>This deficient practice had the potential for food cross contamination.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought).</p> <p>During a review of Resident 2 ' s Minimum Data Set ([MDS] a resident assessment tool), dated 10/27/2024, the MDS indicated Resident 2 had no cognitive (the ability to think and reason) impairment. The MDS indicated Resident 2 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for Activities of Daily Living (ADLs) such as rolling left to right and requires partial/moderate assistance (helper does less than half of the effort. Helper lifts or holds trunk or limbs and provides less than half the effort) for toileting hygiene.</p> <p>During a review of Resident 2 ' s care plan dated 5/26/2021, the care plan indicated Resident 2 preferred to place urinal on the bedside table. The intervention (action to address or solve) indicated to observe and monitor resident every shift for appropriate placement of urinal.</p> <p>During an observation on 12/5/2024 at 12:59 p.m. in Resident 2 ' s room, Certified Nursing Assistant (CNA) 2 was observed passed meal tray in Resident 2 ' s room. CNA 2 placed Resident 2 ' s meal tray on Residen 2t ' s bedside table next to the urinal with urine.</p> <p>During an interview on 12/5/2024 at 1:05 p.m., CNA 2 stated the urinal should have been emptied and removed on the bedside table prior to putting REsident 2's food on the bedside table. CNA 2 stated meal tray should never be placed next to a food tray due to potential contamination.</p> <p>During an interview on 12/6/2024 at 11:43 a.m., Licensed Vocational Nurse (LVN) 1 stated , if staff observed a urinal on a resident's bedside table when passing meal trays, staff should explain to residents who had preference in keeping a urinal on the bedside table for it to be moved during meal times. LVN 1 stated the staff should remove the urinal, clean the table, then put the meal tray to avoid cross contamination.</p> <p>During an interview on 12/6/2024 at 3:28 p.m., the Director of Nursing (DON) stated that nurses should throw out any urine from the urinal before setting a meal tray on the bedside table for infection control.</p> <p>During a record review of facility ' s policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 06/2021, the P&P indicated the facility personnel should conduct themselves and provide care in a way that minimizes the spread of infection.</p>		