STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056267	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camino Healthcare	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36331 Based on interview and record review, the facility failed ensure the Post Discharge Plan of Care was completed and contained the amount and lists of post discharge medications, for 1 of 4 sampled residents (Resident 1) who was discharged to a Board and Care facility ([B&C] a small residential facility, often referred to as a residential care facility for the elderly (RCFE) or assisted living facility, that provides room, board, and personal care services for a small group of individuals, typically 6 to 10 residents), as indicated in the facility ' s policy and procedure (P&P) titled Discharge Summary. This failure resulted in Resident 1 being discharged with 78 controlled medications (drug prescription specifically regulated by the government due to potential for abuse or harm) and placed the resident at risk for drug overdose, hospitalization and death. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of Alzheimer ' s disease (progressive mental deterioration that can occur in middle or old age, due to generalized degeneration of the brain), cardiomegaly (occurs when the heart is abnormally thick or overly stretched), difficulty walking and a history of falling. During a review of Resident 1 ' s Minimum Data Set (MDS -a resident assessment tool) dated 2/9/2025, the MDS indicated Resident 1 had clear speech, had difficulty communicating some words or finishing thoughts but was able, if prompted or given time, and usually understands. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching assistance as resident completes the activity) with eating, oral hygiene, and personal hygiene. During a review of Resident 1 ' s Order Summary Report, dated 3/1/2025, the order summary report indicated a physician order of Norco (strong pain medicine) oral tablet 5-325 milligrams ([mg] a unit of measurement), give 1 tablet by mouth every 4 hours as needed for moderate pain (4-6) (a numerical pain scale used in a facility with 0 no pain, 1-3 mild pain, 4-6 moderate pain, 7-8 severe pain, 9-10 worst pain possible), and give 2 tablets by mouth every 4 hours as needed for severe pain (7-10). (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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Controlled Medication Count Sheet, the count sheet indicated the facility received 81 tablets of Norco 5-325 mg on 3/30/2025 and dispensed 2 tablets of Norco 5-325 mg on 3/30/2025 for severe pain. The count sheet indicated Norco 5-325 mg 1 tablet was dispensed on 3/31/2025 for moderate pain. The bubble pack (a pack containing medications) had a total of 78 Norco 5-325 mg tablets left. During a review of Resident 1 ' s physician order dated 4/2/2025, at 9:25 a.m., the physician order indicated may discharge Resident 1 home per family request on 4/2/2025. The physician order did not indicate the name of medication or amount of medication to provide upon discharge. The physician order had a printed date of 2/14/2025, at 10:15 a.m. During a review of Resident 1 ' s Post Discharge Plan Of Care (DC plan document), dated 4/2/2025, the DC plan document indicated the discharge planning was developed with the responsible party and Resident 1 was being transferred to a B&C facility. The medication section of the DC plan document was left blank indicating See med charts. The DC plan document did not indicate the name of medications, frequency, special instructions or the amount of medications released. The DC plan document had no name of the Interdisciplinary Team (IDT) representative who completed the Post Discharge Plan of Care document, was undated and did not indicate signature who accepted the Post Discharge Plan of Care. During a review of Resident 1 ' s Transfer/Discharge Report, dated 5/14/2025, the report indicated a list of Resident 1 ' s current medications and the date and time last of administration. The Transfer/Discharge Report did not indicate the name and amount of each medication provided to resident/resident family. During a telephone interview on 5/20/2025 at 1:15 p.m., with Resident 1 ' s family member (FM 1), FM1 stated the B&C facility received 81 tables of Norco several days before Resident 1 was discharged (date unspecified). FM 1 stated the facility provided 75 tablets of Norco on the day of discharge. FM 1 stated she felt the facility had committed fraud and was stealing resident ' s narcotics. During a concurrent interview and record review on 5/22/2025 at 10:55 a.m. with Licensed Vocational Nurse (LVN 2), Resident 1 ' s physician order dated 4/2/2025, at 9:25 a.m., indicating may discharge Resident 1 home per family request on 4/2/2025 was reviewed. LVN 2 stated there was a new discharge order (date not known) found that indicated to discharge home with all medications. The newly found discharge order with all medications did not specify any medications. During a telephone interview on 5/22/2025 at 3:40 p.m. with Resident 1 ' s attending physician, the Attending Physician stated he and his Nurse Practitioner were not informed of the medications Resident 1 was discharging home with. The Attending Physician stated he would not discharge Resident 1 home with Norco because it ' s a narcotic and too harmful. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/23/2025 at 2 p.m. with the discharging Registered Nurse (RN 1), RN 1 recalled Resident 1 had a physician order to discharge home with all medications. RN 1 was unable to recall the specific medications and amount of medications Resident 1 was discharged with. RN 1 stated the normal process of discharging a resident with a narcotic was to indicate amount of narcotic on Transfer/Discharge Report and Discharge Summary and have the resident sign and date when received. RN 1 stated the Transfer/Discharge Report and Discharge Summary had inaccurate documentation because she was in a hurry and did not want Resident 1 and FM waiting. RN 1 stated not indicating the amount of Norco dispensed during Resident 1 ' s discharge had the potential to cause drug overdose and respiratory depression which could lead to death. During a review of the facility ' s P&P titled Discharge Summary, dated 12/2023, the P&P indicated it is the policy of this facility that a discharge summary be prepared when a resident is expected to be discharged . The P&P indicated when the facility anticipated a resident ' s discharge, the discharge summary should include a reconciliation of all pre-discharge medications with the resident ' s post discharge medications (both prescribed and over the counter).

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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** 36331 Based on interview and record review, the facility failed to ensure the Norco (strong pain medicine) medication removed on 3/1 at 5 p.m., 3/13 at 4 p.m., 3/14 at 9 p.m., and the 2 tablets on 3/18 (no years indicated), as indicated in the Controlled Medication (drug prescription specifically regulated by the government due to potential for abuse or harm) Count Sheet dated 8/5/2024, for 1 of 4 sampled residents (Resident 1), were documented in the resident ' s e-MAR (Electronic Medication Administration Record) . This failure had the potential to cause drug diversion (unlawful use of drugs), healthcare personnel miscommunication and cause the resident, drug overdose. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of Alzheimer ' s disease (progressive mental deterioration that can occur in middle or old age, due to generalized degeneration of the brain), cardiomegaly (occurs when the heart is abnormally thick or overly stretched), difficulty walking and a history of falling. During a review of Resident 1 ' s Minimum Data Set (MDS -a resident assessment tool) dated 2/9/2025, the MDS indicated Resident 1 had clear speech, difficulty communicating some words or finishing thoughts but was able, if prompted or given time, and usually understands. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching assistance as resident completes the activity) with eating, oral hygiene, and personal hygiene. During a review of Resident 1 ' s Order Summary Report, dated 3/1/2025, the order summary report indicated a physician order of Norco oral tablet 5-325 milligram (mg- a unit of measurement), give 1 tablet by mouth every 4 hours as needed for moderate pain (4-6) (a numerical pain scale used in a facility with 0 no pain, 1-3 mild pain, 4-6 moderate pain, 7-8 severe pain, 9-10 worst pain possible), and give 2 tablets by mouth every 4 hours as needed for severe pain (7-10). During a review of Resident 1 ' s Controlled Medication Count Sheet, dated 8/5/2024, the count sheet indicated a licensed staff removed one tablet of Norco 5/325 mg on 3/1 at 5 p.m. (no year indicated), 3/13 at 4 p.m. (no year indicated), 3/14 at 9 p.m. (no year indicated), and two (2) tablets on 3/18 at 10 p.m. (no year indicated). During a review of Resident 1 ' s March 2025 e-MAR, the e-MAR did not indicate Resident 1 received Norco 5/325 mg, one tablet on 3/1 at 5 p.m., 3/13 at 4 p.m., 3/14 at 9 p.m., and the 2 tablets on 3/18 at 10 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/22/2025 at 10:55 a.m., with the Licensed Vocational Nurse (LVN 2), Resident 1 ' s Controlled Medication Count Sheet, dated 8/5/2024, for the medication Norco 5/325 mg, and the MAR for March 2025 were reviewed. LVN 2 stated nurses did not sign the e-MAR to reflect what was removed from the narcotic count sheet. LVN 2 stated not signing the e-MAR may result to drug overdose, altered level of consciousness and harm the resident. During a review of the facility ' s policy and procedure (P&P) titled Medication Administration Controlled Medications, dated 5/2020, the P&P indicated when a controlled medication is administered, the licensed nurse administering the medication should immediately enter all the following information on the accountability record after the medication is actually administered. Date and time of administration. Amount administered. Signature of the nurse administering the dose.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36331 Based on observation, interview and record review, the facility failed to implement its policy and procedure (P&P) titled Infection Control Policy/Procedure, by failing to disinfect the wrist blood pressure monitor before and after use, by 1 of 4 sampled residents (Resident 2). This failure had the potential to spread germs and increase the risk of infections among residents and staff. Findings: During a concurrent observation and interview on 5/14/2025 at 10:05 a.m. with the Licensed Vocational Nurse (LVN 1) at Resident 2 ' s bedside, LVN 1 was observed putting the wrist blood pressure monitor on Resident 2 ' s wrist, had several attempts to check and was unsuccessful in obtaining the blood pressure readings. LVN 1 removed the monitor from the resident ' s wrist, put the blood pressure monitor inside the drawer of the Medication cart 1 without disinfecting. LVN 1 stated she failed to disinfect the wrist blood pressure monitor before and after using on the resident. LVN 2 stated failing to disinfect the wrist blood pressure monitor may spread germs and increase the risk of infection. During an interview on 5/14/2025 at 1:10 p.m. with the Infection Preventionist Nurse (IPN), the IPN stated failure to clean the wrist blood pressure monitor before and after use will increase the risk of spreading a communicable disease to the residents. During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 2 ' s diagnoses included dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change), chronic obstructive pulmonary disease (COPD- is a lung disease that makes it difficult to breathe), and muscle weakness. During a review of Resident 2 ' s Minimum Data Set (MDS - resident assessment tool), dated 3/12/2025, the MDS indicated Resident 2 had clear speech, difficulty communicating some words or finishing thoughts but is able if prompted or given time, and usually understood. The MDS indicated Resident 2 was dependent on staff for assistance with eating, toileting hygiene and personal hygiene. During a review of Resident 2 ' s care plan, no title, date initiated 3/28/2024, the care plan indicated Resident 2 had actual impairment to skin integrity related to left hip wound infection. The care plan goals indicated Resident 2 will have no complications related to skin injury/infection. One of the interventions indicated to avoid scratching and keeping hands and body parts from excessive moisture, keeping fingernails short, and educate resident/family/caregivers of causative (effective or operating as a cause or agent) factors and measures to prevent skin injury. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s undated P&P titled, Infection Control Policy/Procedure, the P&P indicated it is the policy of this facility to provide supplies and equipment that are adequately cleaned, disinfected or sterilized. The P&P indicated supplies, and equipment should be cleaned immediately after use.