

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  08/07/2025
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)		
F 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.  (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to report an unusual occurrence to the state agency. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with a readmission on [DATE]. Resident 1's diagnoses included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN- high blood pressure), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 1's History and Physical (H&amp;P), dated 2/6/2025, the H&amp;P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/22/2025, the MDS indicated Resident 1 was not able to stand, or walk 10 feet. Resident 1 was dependent (helper does all the effort) on staff to transfer from chair to bed. During a review of Resident 1's care plan, dated 2/1/2025, the care plan indicated Resident 1 had impaired mobility. The care plan interventions indicated the facility would use the appropriate assistive device. The facility would provide the level of assistance that meets the residents' needs. The Charge Nurse will be notified if the resident complained of pain when performing or receiving assistance. During a review of Resident 1's Physical Therapy Progress Report for certification period 5/26/2025-6/22/2025, the report indicated Resident 1 was mostly bedbound and occasionally up in her wheelchair via hooyer lift. The report further indicated Resident 1 needed maximum assist with bed mobility and was non-ambulatory for a long time. Resident 1's baseline was total dependence with bed mobility. During a review of Resident 1's Occupational Therapy Progress Report for certification period 5/26/2025-6/22/2025, the report indicated Resident 1 used a hooyer lift for transfers. During a review of Resident 1's Radiology Results Report, dated 7/31/2025, the report indicated Resident 1 had a mildly displaced fracture of the right medial malleolus (bone on the inner side of the ankle) and a nondisplaced fracture of the lateral malleolus (bone on the outer side of the ankle). During a review of Resident 1's General Acute Care Hospital (GACH) records, dated 8/2/2025-8/4/2025, the records indicated Resident 1 was admitted to the hospital on [DATE] and underwent an open reduction and internal fixation (ORIF- a surgical procedure used to treat a bone fracture) of the right ankle on 8/3/2025. During an interview on 8/5/2025 at 11:53 a.m. with the Family Member (FM), the FM stated Resident 1 went out to a doctor's appointment on 7/16/2025 and when she returned staff transferred Resident 1 back to bed. The FM stated Resident 1 is bedbound (being confined to a bed due to illness or physical limitations) and is supposed to be transferred with a hooyer lift (a mechanical device used to safely transfer patients who have mobility limitations). Staff requested another Certified Nursing Assistant (CNA) to come assist with the transfer. The FM stepped out into the hallway and the door was closed. The FM heard Resident 1 scream You broke my foot. The FM entered the room and found Resident 1 in bed crying and asking for pain medication. The FM asked the CNA what happened, and the CNA did not respond, just shrugged his shoulders and left the room. On 7/31/2025 the FM noticed Resident 1's legs were swollen and reported it to the nurse. The FM requested an X-ray be done. The FM was notified the next day the Xray was completed and showed the right ankle was fractured. During an interview on 8/6/2025 at 10:50 a.m. with the CNA, the CNA stated on 7/16/2025 he assisted transferring Resident 1 to the bed using a 2-person assist. The CNA stated he and the assigned nurse placed an arm under Resident 1's armpit and held her waistline, then transferred her to bed. Resident 1 did not have complaints after being placed in bed. The CNA stated he received training on how to transfer residents during his CNA course. If you don't use the right technique to transfer a resident they can be injured. The CNA received training on use of the hooyer lift at the facility. During an interview on 8/6/2025 at 1:43 p.m. with the Registered Nurse (RN), the RN stated on 8/1/2025 X-ray results were received and indicated Resident 1 had a right ankle fracture. Resident 1 was assessed and there was no swelling, redness, or bruising noted on the ankle. Resident 1 complained of soreness when the right ankle was touched. The RN notified the FM Resident 1 had an ankle fracture and we don't know how it happened. The RN stated, This was a new injury and how it happened was unknown. The RN had not previously heard anything about the Resident having a fracture. The FM then told the RN staff were placing Resident 1 back to bed on 7/16/2025 and the FM heard Resident 1 scream. Resident 1 stated my leg is hurting. The RN stated this is a red flag because Resident 1 was complaining of pain and no one knew what happened. The RN stated the FM informed her Resident 1 has complained of pain since that day. The RN stated the signs of</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (continued on next page)

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide a safe and accident-free environment for one of three sampled residents (Resident 1), who had impaired functional mobility (a reduction in a person's ability to move independently and perform daily activities) by failing to: -Ensure Certified Nursing Assistants (CNAs) 1 and 2 transferred Resident 1 from the wheelchair to Resident 1's bed by using appropriate assistive device (any item, piece of equipment that are designed to help individuals with disabilities increase, maintain, or improve their functional capabilities) such as the Hoyer lift (a mechanical device used to safely transfer patients who have limited mobility from one surface to another, such as from a bed to a chair or wheelchair) as indicated in Resident 1's untitled care plan dated 2/1/2025. This deficient practice resulted in Resident 1 screaming out in pain on 7/16/2025, when CNAs 1 and 2 transferred Resident 1 from the wheelchair to Resident 1's bed. Resident 1 also experiencing right foot pain and swelling to the right lower extremity, and was transferred to the General Acute Care Hospital (GACH) on 8/2/2025 where Resident 1 was diagnosed with a right trimalleolar fracture (a break in all three bony prominences of the ankle [medial {inner ankle}, lateral {outer ankle} and posterior {back part of shin}], a serious type of ankle fracture requiring surgical intervention). At the GACH Resident 1 received general anesthesia (a drug-induced state of unconsciousness, typically used for major surgical procedures) and had an open reduction and internal fixation (ORIF- a type of surgery used to stabilize and repair broken bones; some form of hardware is used to hold the bone together so it can heal) surgery of the right ankle. 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 including hemiplegia (total paralysis to one side of body) and hemiparesis (slight muscle weakness or partial paralysis) affecting both right and left (dominant) side, muscle wasting and atrophy (gradual decline in effectiveness and causing a person or a part of the body to become progressively weaker). During a review of Resident 1's untitled care plan, dated 2/1/2025, the care plan indicated Resident 1 had Impaired Functional Mobility with Activities of Daily Living (ADL) self-care deficit. The care plan goal indicated to reduce the risk of complications related to impaired mobility. The care plan interventions indicated the facility would use the appropriate assistive device (non-specified) and provide a level of assistance that meets the residents' needs. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/21/2025, the MDS indicated Resident 1 was usually able to express ideas and usually able to understand others. The MDS indicated required substantial / maximal assist (helper did more than half the effort) from sitting to lying, was not able to stand or walk 10 feet, and was dependent (helper does all the effort) on staff to transfer from chair to bed. During a review of Resident 1's Occupational Therapy (OT, a branch of health care that helps people of all ages who have physical, sensory, or cognitive problems) Progress Report for certification period 5/26/2025 - 6/22/2025, the report indicated Resident 1 used a Hoyer lift for transfers. During a review of Resident 1's Physical Therapy (PT, a healthcare profession focused on improving movement and function through various techniques like exercise, manual therapy, and education) Progress Report for certification period 5/26/2025 - 6/22/2025, the report indicated Resident 1's baseline was total dependence with bed mobility. The report indicated Resident 2 was mostly bedbound and occasionally up in her wheelchair via Hoyer lift. The report indicated Resident 1 needed maximum assistance with bed mobility and was non-ambulatory for a long time. During a review of Resident 1's Transfer Level Notes, undated, the notes indicated Resident 1 required a Hoyer lift for transfer. During a review of Resident 1's July 2025 Medication Administration Record (MAR), the MAR indicated from 7/1 - 7/15/2025 Resident 1 received Tramadol (medication used to treat moderate pain in adults) 50 milligrams (mg, unit of measurement) four times out of fifteen days. The MAR indicated on 7/10/2025 Resident 1's highest pain rating score during this time was a 6 out of 10, using the zero to ten pain scale (zero indicating no pain and 10 indicating most severe pain, 6 indicated moderate pain) and there was no location of the pain documented. During a review of Resident 1's MAR dated 7/16/2025 at 2:43 p.m. (date of transfer incident), the note indicated Resident 1 was given Tramadol 50 mg for complaint of body pain rated at seven out of 10 (seven indicated strong / severe pain). During a review of Resident 1's MAR dated from 7/16 - 7/31/2025, Resident 1 received Tramadol 50 mg fourteen times out of sixteen days (almost every day). The MAR indicated Resident 1's highest pain rating score of seven on 7/16 for body pain, 7/23 for knee pain with no score, and 7/28/2025 for feet pain with no score documented. During a review of Resident 1's Nursing Note</p>		