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	04/03/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive assessment (a nurse assesses a patient) was completed for one of three sampled residents (Resident 2) before Resident 2 left the facility out on pass ([OOP]- an approved temporary absence of an patient from a facility for a few hours) and after Resident 2 returned to the facility.This deficient practice had the potential to place Resident 2 at risk for the facility not being aware of any changes following her time outside of the facility.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included muscle weakness (a reduction in the strength of voluntary muscles), bone density disorder (the deterioration of bone tissue, and decreased bone strength), and lack of coordination (inability to produce smooth, accurate, and purposeful muscle movements).During a review of Patient 2's History and Physical (H&P), dated 9/19/2025, the H&P indicated Resident 2's capacity (ability) for medical decision making waxed and waned (increased and decreased) due to mental incapacitation (the inability through mental illness to carry on the everyday affairs of life).During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 2/5/2026, the MDS indicated Resident 2's cognition (process of thinking) was severely impaired. The MDS indicated Resident 2 was dependent (helper does all the effort and resident does none of the effort to complete the activity) on staff for toileting hygiene, showering, and dressing.During a review of Resident 2's progress notes, dated 3/1/2026 through 3/30/2026, the progress notes indicated there was no nursing documentation on 3/18/2026 regarding Resident 2 leaving out on pass and coming back from out on pass. The progress notes indicated on 3/19/2026 at 10:17 p.m., Resident 2 was noted with swelling on her left lower extremity with skin discoloration and Resident 2's daughter stated when she took Resident 2 out of the facility the day prior, Resident 2 hit her left leg while in the vehicle.During a review of Resident 2's Situation, Background, Assessment, Recommendation ([SBAR]- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 3/19/2026, the SBAR indicated Resident 2 had swelling on the left lower extremity with skin discoloration. The SBAR indicated interventions included X-ray (imaging that can detect broken bones) the left lower extremity.During a review of Resident 2's Pacific Mobile diagnostics, dated 3/20/2026, the X-ray indicated Resident 2 had a nondisplaced fracture (a broken bone where the pieces remain in their proper anatomical alignment) to the left ankle and foot.During a review of Resident 2's Release of Responsibility for Leave of Absence (OOP), dated 3/18/2026, the OOP indicated Resident 2 had left the faciity on 3/18/2026 at 9:20 a.m. and had returned to the facility on 3/18/2026 at 2pm.During a concurrent interview and record review on 4/3/2026 at 3 p.m., with Licensed Vocational Nurse (LVN) 2, Resident 2's Weights and Vitals Summary, was reviewed. The Weights and Vitals Summary indicate vitals were not taken before Resident 2 had gone OOP and when she had returned to the facility. LVN 2 stated vital signs and assessments needed to be completed before Resident 2 leaves and when Resident 2 returns to the facility. LVN 2 stated he did not recall the vitals being taken when Resident 2 left and returned to the facility on 3/18/2026. LVN 2 stated it was important to do vitals for Resident 2 and assess her to make sure there was no (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	significant change in condition.During a concurrent interview and record review on 4/3/2026 at 3:42 p.m., with Director of Nursing (DON), Resident 2's progress notes were reviewed. The progress notes indicated there was no assessment or documentation when Resident 2 went OOP and when she returned to the facility on 3/18/2026. The DON stated when Resident 2 left for OOP and returned to the facility, there was no assessment. The DON stated it was important to assess the resident to identify any possible medical changes in her condition.During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 5/2021, the P&P indicated resident's clinical record was a concise account of treatment, care, response to care, signs, symptoms and progress of the resident's condition. The P&P indicated notes were to be written on all long-term residents by day, evening, and night shifts. The P&P indicated continuous nurse's notes were required on all residents.During a review of the facility's P&P titled, Resident Out on Pass, dated 11/2021, the P&P indicated nursing would document when the resident returned, and any pertinent information regarding his/her or events which took place while out on pass.