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	05/05/2026

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 observation, interview, and record review, the facility failed to clarify physician's order on how to inspect the skin on one of four sampled residents (Resident 1), who has a knee immobilizer (a medical device designed to keep the knee joint in a fixed, straight position to promote healing and prevent further injury) for the management of right tibia and fibula (long bone in the lower leg) fracture (broken bone).This deficient practice resulted in Resident 1 to develop a pressure ulcer on her right leg.Findings: During an observation on 5/5/2026 at 8:35 a.m., Resident 1's skin was inspected and had a Stage 3 (deep and painful wounds in the skin) pressure ulcer noted on the calf of the right leg (back portion of the lower leg). During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included encephalopathy (any disease damage or malfunction that affects the brain's structure or function resulting in an altered mental status), urinary tract infection (UTI), fracture of the right tibia and fibula. During a review of Resident1's Minimum Data Set ([MDS] a resident assessment tool) dated 4/29/2026, the MDS indicated Resident 1 had the ability to make her needs known. Resident 1 was dependent on staff on the ability to roll from lying on back to left and right side, and return to lying on back on the bed. During a review of Resident 1's medical records from General Acute Hospital (GACH) dated 3/22/2026, it indicated that Resident 1 was treated for right leg fracture and Knee immobilizer was applied on the right knee. During a review of Resident 1's GACH Discharge Summary instructions/ documentation, dated 3/22/2026, the documentation indicated a plan for Resident 1 to wear the knee immobilizer (a medical device designed to keep the knee joint in a fixed, straight position to promote healing and prevent further injury) due to the right medial tibial fracture and non-weight bearing (cannot bear weight on the affected side) for 6 weeks. During a review of Resident 1's Order Summary Report dated 3/24/26, the order indicated right knee immobilized: monitor for any discoloration, new edema, odor that may indicate infection or skin breakdown and notify MD (physician). During a review of Resident 1's Situation, Background, Assessment, and Recommendation ([SBAR] a structured way to communicate to the care team about a resident's change in condition), dated 4/22/2026, the SBAR indicated, Resident 1 was transferred to GACH for evaluation due to altered mental status. During a review of Resident 1's Discharge Summary from GACH, dated 4/26/2026, the notes indicated Resident 1 had a Stage 3 pressure ulcer at the edge of the right lower extremity splint. During a review of Resident 1's Skin Check document dated 4/27/2026, the skin check indicated Resident 1 had an unstageable pressure ulcer on the right lateral calf measuring 6 centimeters (cm- a unit of measurement) in length, 4 cm in depth with 90% eschar (dead, necrotic tissues, usually dry/ black firmly attached to the wound bed) and 10% slough (nonviable tissue in a wound, typically yellow or white). During a review of Resident 1's Surgical Consult notes dated 5/4/2026, the notes indicated Resident 1 had a wound located at the right lower calf that was revealed after the removal of orthopedic knee brace (knee immobilizer). During an interview on 5/5/2026 at 9:30 am with the License Vocational Nurse (LVN 1), LVN 1 stated after Resident 1 fell and sustained right leg fracture, Resident 1 had the knee immobilizer on. LVN 1 stated Resident 1's skin was monitored around the knee immobilizer for any signs of infection or skin (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breakdown. LVN 1 stated that he did not inspect the skin inside the knee immobilizer because there was no physician order to do so. On 4/22/2026, Resident 1 was transferred to GACH and returned on 4/26/2026. The knee immobilizer was removed and revealed a Stage 3 pressure ulcer on Resident 1's right leg. During a telephone interview on 5/5/2026 at 12:25 pm with Resident 1's primary physician (PCP), the PCP stated Resident 1 did not allow him to examine her leg during his visits. The PCP stated Resident 1's right leg pressure ulcer was caused by the knee immobilizer and could have been prevented, if the resident allowed him to examine her leg during his visits. During a concurrent interview and record review on 5/5/26 at 1:40 pm with the Director of Nursing (DON), Resident 1's physician order summary report dated 3/24/2026, was reviewed. The DON stated there was no physician's order to always wear the knee immobilizer for 6 weeks, nor an order to remove the knee immobilizer during skin inspection. The nursing staff monitored Resident 1's skin around the knee immobilizer. The DON stated nursing staff should have called Resident 1's PCP to clarify the order if the knee immobilizer can be removed for skin inspection. During a review of the facility's policy and procedures (P&P) titled, Skin and Wound Monitoring and Management, dated 1/2024, the P&P indicated the facility should identify risk factors which relate to the possibility of the development of pressure injury which include impaired/ decreased mobility, impaired diffuse or localized blood flow, resident refusal of some aspects of care and treatment. All risk factors identified should be documented in the resident's clinical record and when appropriate be addressed through a care plan. The P&P indicated a licensed nurse will assess/evaluate the resident's skin at least weekly. The P&P indicated for those residents admitted with a cast/ splint to an extremity that is being managed outside the facility, nursing staff should assess and evaluate the casted/ splinted area at least weekly to check the status of the skin. Any changes in the resident's skin as identified daily, weekly must be communicated to the resident's physician.