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 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camino Healthcare	13922 Cerise Avenue Hawthorne, CA 90250

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49906 Based on observation and interview, the facility failed to maintain a clean air vent above Resident 15's bed and to ensure the room temperature was between 71- and 81-degrees Fahrenheit for Residents' 5, 38, and 301's rooms. These deficient practices had the potential for the resident to be exposed to dust and allergens affecting her respiratory health and the increased level of discomfort and to negatively impact the residents' quality of life. Findings: a). During an initial tour on 12/17/2024 at 11:31 a.m., the air vent above the head of Resident 15's bed was covered with dust. During a review of the Admission Record, the admission record indicated Resident 15 was admitted to the facility on [DATE] with diagnoses that included breast cancer, muscle weakness, and difficulty walking. During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 11/19/2024, the MDS indicated that Resident 15 usually made herself understood and was usually able to understand others. During a review of the document titled HVAC Maintenance Log dated 11/25/2024, the log indicated a written comment from the MS All, vents clean. During an interview on 12/17/2024 at 1:44 p.m. with Resident 15, Resident 15 stated when she looked up at the vent and the dust is moving, it looked like there were bugs there. During an interview on 12/19/2024 at 11:15 a.m. with the Maintenance Supervisor (MS), the MS stated the vents in the resident rooms are cleaned monthly. The MS agreed the vent above Resident 15's bed was dirty, but that the vent is a return vent to recycle air. The MS stated the vent sucks air in and should not affect the resident. (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b). During an interview on 12/18/2024 at 8:45 a.m. with Resident 5, Resident 5 was observed in bed under two blankets up to her neck and a blanket covering her face. Resident 5 stated she was cold and would leave her bed when it was time for physical therapy. Resident 5 stated she was given an extra blanket and she used it to cover her head due to the cold room. A review of the Admission Record indicated Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included legal blindness and muscle weakness. During a review of the MDS dated [DATE], the MDS indicated Resident 5 had the ability to understand others and to be understood. c). During an interview on 12/18/2024 at 11:53 a.m. with Resident 38, Resident 38 stated he is freezing at night in bed even with the extra blanket he asked for. During a review of the Admission Record, the admission record indicated Resident 38 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included heart failure and chronic cough. During a review of the MDS dated [DATE], the MDS indicated Resident 38 had the ability to understand others and to be understood. d). During an interview on 12/19/2024 at 1:13 p.m. with Resident 301, Resident 301 was sitting in a wheelchair next to her bed and stated the temperature in her room was good. Her bed was by the window and the window was open. Resident 301 stated she liked to keep her window open for fresh air. The thermostat on the wall indicated a temperature of 69 degrees Fahrenheit. During a review of the Admission Record, the admission record indicated Resident 301 was admitted to the facility on [DATE] with diagnoses that included spinal stenosis (a narrowing of the spine [backbone]) and major depression. During a review of the MDS dated [DATE], the MDS indicated Resident 301 had the ability to understand others and to be understood. During a concurrent observation and interview on 12/20/2024 at 11:15 a.m. with the MS, the MS observed and confirmed the wall thermostat in Resident 301's room indicated a temperature of 69 degrees Fahrenheit. The MS stated that the thermostat controlled the temperature in rooms 1, 2, 3, 5, 7, and 9. The MS stated he tried to maintain a temperature of 76 degrees Fahrenheit in the rooms, but anyone can change the temperature on the thermostat, and it would affect all the above-mentioned rooms. During a review of the facility's revised policy and procedure (P&P) dated 11/2019, titled Physical Environment, the P&P indicated the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public through monthly environmental rounds.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure the Minimum Data Set ([MDS] a resident assessment tool) was completed accurately for one of 21 sampled residents (Resident 20). This deficient practice had the potential to negatively affect the plan of care and delivery of care and services for Resident 20. Findings: During a review of Resident 20's Admission Record, the Admission Record indicated, Resident 20 was admitted to the facility on [DATE] with diagnoses including End Stage Renal Disease ([ESRD] irreversible kidney failure), heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and cirrhosis of liver (a condition in which the liver is scarred and permanently damaged). During a review of Resident 20's History and Physical (H&P) dated 7/23/2023, the H&P indicated, Resident 20 had the capacity to understand and make decisions. During a review of Resident 20's MDS assessment dated [DATE], the MDS indicated, Resident 20's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 20 required set up assistance (staff sets up, resident completes activity) for Activities of Daily Living (ADLs) such as oral hygiene and personal hygiene. During a concurrent interview and record review on 12/18/2024 at 4:30 p.m., with the MDS Nurse (MDSN), Resident 20's MDS assessment, dated 11/10/2024 was reviewed. The MDSN stated, the previous MDS Nurse completed Resident 20's MDS, section O0250 (Influenza Vaccine) inaccurately. The MDSN stated Resident 20 MDS, section O0250 was coded 1 (yes), however should have been coded as 0 (No) because the resident last received Influenza Vaccine on 9/25/2023 and there was no documentation to indicate Resident 20 received, was offered, or declined the Influenza vaccine this year. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment and Associated Processes, dated 12/2023, the P&P indicated, Each individual who completes a portion of the assessment will electronically sign and certify the accuracy of that portion of the assessment. The P&P indicated the facility will electronically transmit encoded, accurate, and complete MDS data to the CMS system.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712 Based on interview and record review, the facility failed to ensure one of five residents (Resident 21) received a Pre-Admission Screening and Resident Review ([PASRR] a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) level II assessment. This deficient practice had the potential to result in Resident 21 not receiving the required services for her mental health condition. Findings: During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was admitted to the facility on [DATE] with diagnoses including depression (mood disorder that causes a persistent feeling of sadness and loss of interest that could interfere with daily living), Schizophrenia (a mental illness that is characterized by disturbances in thought), and anxiety (a feeling of fear, dread, and uneasiness). During a review of Resident 21's Care Plan, dated 7/31/2023, the Care Plan indicated staff will follow PASRR level II recommendations. During a review of Resident 21's History and Physical (H&P), dated 5/6/2024, the H&P indicated Resident 21 had fluctuating capacity to understand and make decisions. During a review of Resident 21's Minimum Data Set ([MDS] a resident assessment tool), dated 10/30/2024, the MDS indicated Resident 21's cognition (the ability to think and reason) was intact. The MDS indicated Resident 21 was dependent on staff for Activities of Daily Living (ADLs) such as toileting, showering, and lower body dressing. During a concurrent interview and record review on 12/18/2024 at 12:18 p.m. with the MDS nurse (MDSN), Resident 21's PASRR level I was reviewed. The MDSN stated, Resident 21's PASRR level I, dated 7/30/2023, was positive and a PASRR level II assessment needed to be completed however, was not done for the resident. The MDSN stated, a PASRR II was needed to determine if a resident needed mental health services and to determine the appropriate care/services for the resident. The MDSN also stated, due to the PASRR level II not being completed, Resident 21 could potentially not receive the required services for the resident's mental health condition. During a review of the facility's policy and procedure (P&P) titled, PASSR, dated 12/2021, the P&P indicated the facility would review the need for PASRR level II referral.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview and record review, the facility failed to initiate a comprehensive care plan for one out of two sampled residents (Resident 20) who was non-compliant with fluid restriction (medical treatment that limits the amount of fluid a person can consume each day) as ordered by the physician. This deficient practice had the potential to place Resident 20 at risk for not receiving the appropriate interventions to prevent fluid overload (a condition where the body has too much water). Findings: During a review of Resident 20's Admission Record, the Admission Record indicated, Resident 20 was admitted to the facility on [DATE] with diagnoses including End Stage Renal Disease ([ESRD] irreversible kidney failure), heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney (s) have failed). During a review of Resident 20's History and Physical (H&P), dated 7/23/2023, the H&P indicated, Resident 20 had the capacity to understand and make decisions. During a review of Resident 20's MDS assessment dated [DATE], the MDS indicated, Resident 20's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 20 required set up assistance (staff sets up, resident completes activity) for Activities of Daily Living (ADLs) such as oral hygiene and personal hygiene. The MDS also indicated, Resident 20 required dialysis treatment. During a review of Resident 20's Order Summary Report (a document containing active orders), the Order Summary Report indicated, Resident 20 had a physician's order for fluid restriction of 1200 cubic centimeter ([cc] unit of measurement in volume; equivalent to milliliter [ml]) per 24 hours. The physician's order for fluid restriction included: Dietary 720 cc (breakfast 240 cc lunch 240 cc and for dinner 240 cc) and Nursing 480 cc, day shift (7 a.m. to 3 p.m.) 200 cc, evening shift (3 p.m. to 11 p.m.) 200 cc, night shift (11 p.m. to 7 a.m.) 80 cc. During an observation on 12/17/2024 at 9:50 a.m., in Resident 20's room, Resident 20 had 12 cans of lime soda (355 ml per can), 1 case of 24 water bottle (500 ml each bottle), and 1 case of 18 orange juice (200 ml each bottle) on top of the resident's rollator walker with seat (a mobility aid that helps people walk with more stability and independence). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/18/2024 at 7:50 a.m., with Resident 20 in his room, Resident 20 was observed with 21 water bottles (500 ml each bottle) and 16 bottles of orange juice (200 ml each bottle) on top of the resident's rollator walker with seat. Resident 20 stated he did not remember the staff telling him or reminding him not to drink a lot of fluid daily. Resident 20 stated the nurses have not explained to him about the problems associated with drinking excess fluids. During an interview on 12/18/2024 at 8:15 a.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 20 was on fluid restriction, but was not sure of the total amount of FR per day and how many fluids he can drink in day shift. LVN 4 stated Resident 20 was non-compliant with the fluid restriction. During a review of Resident 20's electronic clinical records, the records did not indicate there was a care plan addressing Resident 20's non-compliance with the fluid restriction. During an interview on 12/18/2024 at 11:46 a.m., with the Director of Nursing (DON), the DON stated Resident 20 had been non-compliant with the fluid restriction since he was admitted to the facility. The DON stated Resident 20's family member (unnamed) was bringing water, soda, and orange juice for the resident. The DON stated, there was no care plan to address Resident 20's noncompliance with the fluid restriction. The DON stated Resident 20 was at risk for fluid overload since he was non-compliant with the fluid restriction. The DON also stated it was important to develop a comprehensive care plan for continuity of care for the resident. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 12/2023, the P&P indicated It was the policy of the facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. The P&P also indicated, in the event that a resident refused certain services posing a risk to resident's health and safety, the comprehensive care plan would identify care, or services declined, the associated risks, IDT's effort to educate the resident and resident representative and any alternate means to address risk.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712 Based on observation, interview, and record review, the facility failed to ensure one of one resident, Resident 16, received grooming of his long fingernails. This deficient practice had the potential to cause the resident to scratch and cause skin break down, potentially causing skin infection. Findings: During a review of Resident 16's Admission Record, the Admission Record indicated Resident 16 was admitted to the facility on [DATE] with diagnoses including diabetes (a disorder characterized by difficulty in blood sugar control), hypertension ([HTN]-high blood pressure), and dementia (a progressive state of decline in mental abilities). During a review of Resident 16's History and Physical (H&P), dated 11/1/2024, the H&P indicated Resident 16 did not have the capacity for medical decision making. During a review of Resident 16's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 11/8/2024, the MDS indicated Resident 16 had severe cognitive impairment. Resident 16 was dependent on staff for all activities of daily living ([ADLs]- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 16's care plan, dated 6/16/2023, the care plan indicated if resident has thick nails, staff will refer to podiatry (area of medicine that treats conditions of the foot and nail disorders). During an observation on 12/17/24 at 4:20 p.m., Resident 16 was noted to have long thick nails on both thumbs. The thumb nails had debris (junk matter) underneath. During a concurrent observation and interview on 12/18/24 at 12:28 p.m. with Licensed Vocational Nurse (LVN) 1, LVN1 stated Resident 16's nails need to be cut for infection control. LVN1 stated the Social Services Director (SSD) will arrange the podiatry appointment and the podiatrist will cut the thumb nails due to the resident having diabetes. LVN1 stated he did not notify the SSD about Resident 16's long nails on both thumbs. During an interview on 12/18/24 at 12:34 p.m., the SSD stated the nurse notifies her when a resident needs podiatry services for nail grooming. The SSD stated no one has notified her of Resident 16's need for podiatry services for his nails. During a review of the facility's policy and procedure (P&P) titled, Dignity and Respect, dated 10/2015, the P&P indicated residents will be well groomed. During a review of the facility's P&P titled, ADL Care, dated 11/2021, the P&P indicated the podiatrist will provide nail care to all residents with diabetes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49131 Based on observation, and interview, the facility failed to ensure two sharps container (a puncture-proof container used to contain used and discarded needles and other sharp tools for patient care) on Medication Cart #2 and Medication Cart #4 were replaced with a new one when it reached the Full line. This deficient practice had the potential to result in staff or residents to sustain an injury. Findings: During an observation on 12/19/2024 at 9:26 a.m., the sharps container on Medication Cart #4 was full and had objects protruding out from the sharp's container lid. During an observation on 12/19/2024 at 9:33 a.m., the sharps container on Medication Cart #2 had objects in it that was past the Full line. During a concurrent observation and interview on 12/19/2024 at 2 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Medication Cart #2 and Medication Cart #4 was past the full line and Medication Cart #4 had items that were protruding out of the container lid. LVN 1 stated the sharps container had to be switched to a new one once items in the container have reached the Full line on the container. LVN 1 stated a staff or resident may be injured due to a full sharp's container.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712 Based on observation, interview, and record review, the facility failed to ensure one of 1 sampled resident, Resident 16, who had a 10 pounds weight loss within 30 days, was reported to the physician. This deficient practice had the potential to result in a delay in care for Resident 16. Findings: During a review of Resident 16's Admission Record, the Admission Record indicated Resident 16 was admitted to the facility on [DATE] with diagnoses including diabetes (a disorder characterized by difficulty in blood sugar control), hypertension ([HTN]-high blood pressure), and dementia (a progressive state of decline in mental abilities). During a review of Resident 16's History and Physical (H&P), dated 11/1/2024, the H&P indicated Resident 16 did not have the capacity for medical decision making. During a review of Resident 16's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 11/8/2024, the MDS indicated Resident 16 had severe cognitive impairment. Resident 16 was dependent on staff for all activities of daily living ([ADLs]- activities such as bathing, dressing and toileting a person performs daily). During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 1 on 12/19/2024 at 2:39 p.m., Resident 16's weights were reviewed. LVN1 stated the facility should provide interventions for weight loss greater than three pounds. LVN1 stated the nurse should call the doctor and complete a change condition ([COC]- a communication tool used by healthcare workers when there is a change of condition among the residents) form. LVN1 stated weight loss is critical. LVN1 stated Resident 16's clinical records indicated on 11/7/2024, Resident 16's weight was 147 pounds and on 12/7/2024 the weight was 137 pounds (10 pound/6.8% loss). The clinical record indicated a COC was completed on 12/18/2024 indicating a 19-pound weight loss in three months. LVN1 stated the COC should have been completed on 12/7/2024. The doctor should have been notified to obtain new orders to care for Resident 16. During a concurrent interview and record review on 12/20/2024 at 12:15 p.m. with the Director of Staff Development (DSD), Resident 16's clinical record was reviewed. The DSD stated on 12/7/2024 a COC should have been completed and the doctor notified of the 10-pound weight loss over 30 days. The DSD stated an Interdisciplinary Team ([IDT] group of healthcare professionals, including resident/ resident representative, working together to provide residents with needed care) meeting was not been completed. An IDT is important to plan care for the resident. During a review of the facility's policy and procedure (P&P) titled, Nutrition Status Management, dated December 2023, the P&P indicated any resident weight that varies from the previous reporting period by 5% or 5 pounds in 30 days will be evaluated by the interdisciplinary team ([IDT]-a group of various health professionals that plan and coordinate care). The P&P indicated the nurse will notify the physician.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to ensure a peripheral intravenous line ([IV] - a thin tube inserted into a vein for administration of medications, fluids and/or blood products) was removed after IV antibiotic (a drug used to treat infections caused by bacteria) was completed for one of two sampled residents (Resident 75). This deficient practice had the potential for the IV insertion site to develop infection and/or hospitalization for Resident 75. Findings: During a review of Resident 75's Admission Record, the Admission Record indicated, Resident 75 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated, Resident 75's diagnoses included End Stage Renal Disease ([ESRD] - irreversible kidney failure), sepsis (a life-threatening blood infection), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 75's History and Physical (H&P), dated 9/27/2024, the H&P indicated, Resident 75 could make needs known but could not make medical decisions. During a review of Resident 75's Minimum Data Set ([MDS] - a resident assessment tool), dated 11/2/2024, the MDS indicated, Resident 75's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS indicated, Resident 75 was totally dependent (helper does all of the effort) from staff with toileting hygiene and lower body dressing. The MDS indicated, Resident 75 required dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney (s) have failed) treatment. During a review of Resident 75's Order Summary Report (a document containing active orders), dated 12/18/2024, the Order Summary Report indicated, Resident 75 had a physician's order of Meropenem (medication to treat infection) 500 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) IV once day for bacteria (microscopic living organisms that have only one cell) in the blood until 12/14/2024. During a concurrent observation and interview on 12/17/2024 at 2:20 p.m., with Registered Nurse 2 (RN 2), in Resident 75's room, Resident 75 had an IV line on the left forearm with dressing dated 11/26/2024. RN 2 stated Resident 75's IV antibiotic was completed last week. RN 2 stated the licensed nursing staff who administered the last dose of IV antibiotic of Resident 75 should have removed the IV peripheral line immediately to prevent infection on the IV site. During a review of the facility's policy and procedure (P&P) titled, Insertion of Peripheral IV Catheter, dated 5/2022, the P&P indicated to remove the IV line whenthe therapy is discontinued.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 39) had her oxygen saturation ([O2 sat]- a measurement of how much oxygen the blood is carrying as a percentage) levels checked to keep the oxygen (O2) saturation above 90% as indicated in the physician's orders and care plan. This deficient practice had the potential to result in Resident 39 experiencing respiratory distress. Findings: During an observation on 12/18/2024 at 12:41 p.m., Resident 39 had an oxygen concentrator machine (a machine used to deliver oxygen to an individual) and a nasal cannula ([NC]- a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) by her bedside, but the equipment was not in use. During a review of Resident 39's Admission Record (Face Sheet), the Admission Record indicated Resident 39 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain), and heart failure (a condition where the heart can't pump enough blood and oxygen to the body's organ). During a review of Resident 39's Order Summary Report, the order summary report indicated an order was placed on 10/18/2024 to apply oxygen via NC at 2 liters per minute ([LPM]- amount of oxygen delivered per minute) continuously to keep O2 sat at or above 90% as needed for shortness of breath (SOB). During a review of Resident 39's Minimum Data Set ([MDS]- a federally mandated assessment tool), dated 10/23/2024, the MDS indicated Resident 39 was not cognitively intact (able to reason, understand, remember, judge, and learn). During a review of Resident 39's Care Plan, dated 11/4/2024, it indicated to apply oxygen via NC at 2 LPM continuous to keep saturation at or above 90% as needed for SOB. Another order was placed on 11/12/2024 to apply oxygen via NC up to 2 LPM to keep O2 sat at or above 90% and titrate (continuously measure and adjust as needed) as needed for SOB/wheezing. During a review of Resident 39's Weights and Vitals Summary, it indicated Resident 39 had her O2 sat checked on the following dates: 10/19/2024 at 1:15 p.m. 11/5/2024 at 5:35 p.m. 12/5/2024 at 2:46 p.m. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Camino Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 13922 Cerise Avenue Hawthorne, CA 90250	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/14/2024 at 8:59 a.m. During a concurrent interview and record review on 12/19/2024 at 12:05 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 39's care plan, order summary report, and vital signs were reviewed. LVN 1 stated vital signs are generally taken at least once a day or as ordered and should include heart rate, temperature, blood pressure, respiratory rate, and O2 sat. LVN 1 reviewed Resident 39's care plan, order summary report, and vital signs and stated there was an order on 10/18/2024 and 11/12/2024 to keep Resident 39's O2 sat above 90% and stated O2 sat was only checked once each month in October and November and twice in December. LVN 1 stated for staff to determine if O2 sat was above 90% it would have to be checked more often than once a month, and the staff could have clarified with the doctor how frequent the O2 sat should have been checked. LVN 1 stated if O2 sat was not above 90%, the staff would not know when to give the resident oxygen. During a review of the facility's policy and procedure (P&P), titled Monitoring Weights and Vital Signs, dated 7/2018, the P&P indicated monitor the weights and vital signs of residents as ordered by the physician and monthly per facility protocol.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to ensure, two of three sampled residents (Resident 20 and 75), who received hemodialysis ([HD] - a treatment to cleanse the blood of wastes and extra fluids artificially through a machine) treatment, received care in accordance with professional standards of practice by failing to: 1. Implement Resident 20's fluid restriction (medical treatment that limits the amount of fluids a person can consume each day) order accurately. This deficient practice placed Resident 20 at risk for swelling, discomfort, and shortness of breath. 2. Collaborate and communicate with the dialysis center, which hypertensive medications (drugs that can lower blood pressure) were to be held for Resident 20 before dialysis treatment. This deficient practice had the potential to result in adverse condition for Resident 20 during dialysis treatment. 3. Ensure Resident 75's dialysis emergency kit (E-KIT - supplies to help meet the needs of a dialysis resident in the event of an emergency) was readily available at the bedside, in case of excessive bleeding from the dialysis site. This deficient practice had the potential to result in staff inability to manage and control the bleeding from Resident 75's dialysis site, resulting in complications, hospitalization and death. Findings: 1. During a review of Resident 20's Admission Record, the Admission Record indicated, Resident 20 was admitted to the facility on [DATE]. The Admission Record indicated, Resident 20's diagnoses included End Stage Renal Disease ([ESRD] - irreversible kidney failure), heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney (s) have failed). During a review of Resident 20's History and Physical (H&P), dated 7/23/2023, the H&P indicated, Resident 20 had the capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/10/2024, the MDS indicated, Resident 20's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 20 required set up assistance (helper sets up, resident completes activity) from staff with oral hygiene and personal hygiene. The MDS indicated, Resident 20 required dialysis treatment. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 20's Order Summary Report (a document containing active orders), the Order Summary Report indicated, Resident 20 had a fluid restriction order of 1200 cubic centimeter ([cc] - unit of measurement in volume) per 24 hours. The fluid restriction breakdown were as follows: Dietary 720 cc's for breakfast 240 cc's, lunch 240 cc's and for dinner 240 cc's. Nursing was to give 480 cc's, day shift (7 a.m. to 3 p.m.) 200 cc's, evening shift (3 p.m. to 11 p.m.) 200 cc's, night shift (11 p.m. to 7 a.m.) 80 cc's. The Order Summary Report indicated, Resident 20 was to receive HD treatment every Tuesday, Thursday, and Saturday from 8:30 a.m. to 12:30 p.m. During a review of Resident 20's Meal Ticket, the Meal Ticket did not indicate Resident 20 was on fluid restriction and its breakdown. During a review of Resident 20's care plan titled Dependence on Renal Dialysis, revised and initiated on 2/16/2023, the care plan goal indicated Resident 20 will have no signs and symptoms of complications from dialysis through the review date on 2/13/2025. The care plan intervention was to monitor intake and output. The care plan did not indicate the total amount of fluid restriction and how to manage and monitor resident's fluid intake accurately. During a review of Resident 20's Nutrition Interdisciplinary Team Update, dated 12/8/2024, the Nutrition Interdisciplinary Team Update indicated, Resident 20 had no fluid restriction order. During an observation on 12/17/2024 at 9:50 a.m., in Resident 20's room, observed 12 cans of lime soda (355 milliliter ([ml] - unit of measurement in volume) per can), 1 case of 24 water bottle (500 ml each bottle), and 1 case of 18 orange juice (200 ml each bottle) sitting in rollator walker with seat (a mobility aid that helps people walk with more stability and independence). During a concurrent observation and interview on 12/18/2024 at 7:50 a.m., with Resident 20 in his room, observed 21 water bottle (500 ml each bottle) and 16 orange juice (200 ml each bottle) sitting in rollator walker with seat. Resident 20 stated he did not remember the staff telling him or reminding him not to drink a lot of fluid on a daily basis. Resident 20 stated the nurses have not explained to him about the problems associated with drinking excess fluids. During an observation on 12/18/2024 at 7:57 a.m., in Resident 20's room, observed Resident 20 drinking 200 ml of sunny delight orange juice. Resident 20 consumed 200 ml of orange juice. During an interview on 12/18/2024 at 7:59 a.m., with Certified Nurse Assistant 2 (CNA 2), CNA 2 stated she was not aware Resident 20 was on fluid restriction. CNA 2 stated Resident 20's family member had been bringing bottled water and orange juice. CNA 2 stated she could not track and monitor Resident 20's fluid intake in day shift accurately. During a concurrent observation and interview on 12/18/2024 at 8:15 a.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 20 had 15 orange juices (200 ml each bottle) and 20 water bottles sitting on his rollator walker. LVN 4 stated Resident 20 was on fluid restriction but was not sure the total amount of fluid restriction per day and how many fluids he can drink in day shift. LVN 4 stated Resident 20's fluid restriction was not being enforced as per physician's order and fluid intake was not being monitored accurately. LVN 4 stated it was very important to follow and monitor Resident 20's fluid restriction order accurately since the resident was receiving HD treatment and too much fluid would cause swelling and chest pain that would likely require hospitalization . (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/2024 at 11:46 a.m., the Director of Nursing (DON) stated she was aware Resident 20's family member was bringing water, soda, and orange juice. The DON stated the facility did not monitor Resident 20's fluid intake consistently and implement 1200 cc fluid restriction as ordered by the physician because resident had stock of water and orange juice kept at his bedside. During a review of the facility's policy and procedure (P&P) titled, Significant Change of Condition, Response, under Quality of Care, dated 12/2023, the P&P indicated, It is the policy of the facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care. 2. During a review of Resident 20's Order Summary Report, dated 12/18/2024, the Order Summary Report indicated, Resident 20 was to receive the following medications: A. Amlodipine 10 mg (mg- unit of measurement, used for medication dosage and/or amount) to give 1 tablet once a day (9 a.m.) for hypertension ([HTN] high blood pressure), to hold for systolic blood pressure ([SBP] - force caused by contraction of left ventricle) less than 110, pulse rate ([PR] - the number of times the heat beats per minute) less than 60. B. Hydralazine 50 mg to give 1 tablet every 8 hours (6 a.m., 2 p.m., and 10 p.m.) for HTN, to hold for SBP less than 110, PR less than 60. C. Losartan 50 mg to give once a day (9 a.m.) for HTN. D. Carvedilol 3.125 mg to give 1 tablet every 12 hours (9 a.m., and 9 p.m.) for HTN, to hold for SBP less than 110. During a concurrent interview and record review on 12/18/2024 at 12:29 p.m., with the Minimum Data Set Nurse (MDSN), Resident 20's Electronic Medication Administration ([EMAR] - daily documentation record used by a licensed nurse to document medications and treatment given to a resident) from 12/1/2024 to 12/18/2024, was reviewed. The MDSN stated Resident 20 was scheduled to HD treatment 3x/week every Tuesday, Thursday, and Saturday at 8:30 a.m. The MDSN stated, Resident 20's medications of amlodipine10 mg 9 a.m. dose, losartan 50 mg 9 a.m. dose, and carvedilol 3.125 mg 9 a.m. doses were not given and coded as 2 (hold/see nurses notes) on dialysis days (Tuesday, Thursday and Saturday). The MDSN stated Resident 20's Hydralazine 50 mg 6 a.m. dose was given on dialysis days. The MDSN the physician would indicate if to hold or give the hypertensive medications of Resident 20 during hemodialysis days. The MDSN stated the facility had no documentation indicating facility staff coordinated with the dialysis center staff if Resident 20's hypertensive medications should be administered, adjusted, or withheld prior to dialysis. During a review of facility's P&P, titled Pre- and Post-Care Dialysis, dated 1/2022, the P&P indicated, It is the policy of the facility to participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The P&P also indicated medications scheduled for administration while at dialysis during dialysis days may be held unless otherwise specified by the provider. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During a review of Resident 75's Admission Record, the Admission Record indicated, Resident 75 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated, Resident 75's diagnoses included ESRD, and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 75's H&P, dated 9/27/2024, the H&P indicated, Resident 75 could make needs known but could not make medical decisions. During a review of Resident 75's MDS, dated [DATE], the MDS indicated, Resident 75's cognitive skills for daily decision making was severely impaired. The MDS indicated, Resident 75 was totally dependent (helper does all of the effort) from staff with toileting hygiene and lower body dressing. The MDS indicated, Resident 75 required dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney (s) have failed) treatment. During a review of Resident 75's Order Summary Report, dated 12/18/2024, the Order Summary Report indicated, Resident 75 was to receive HD treatment every Tuesday, Thursday, and Saturday from 6:30 a.m. to 10:00 a.m. During an interview on 12/17/2024 at 10:22 a.m., LVN 3 stated Resident 75 had an arteriovenous shunt ([AV] - a connection between an artery and a vein that allows for hemodialysis access) on right upper arm. LVN 3 stated she had not seen and was not sure what the purpose of an HD e-kit for a dialysis resident. During a concurrent observation and interview on 12/17/2024 at 10:31 a.m., with Registered Nurse 2 (RN 2), in Resident 75's room. RN 2 acknowledged and verified there was no dialysis e-kit available at bedside. RN 2 stated dialysis e-kit consisted of dressing, gauze, alcohol swab and torniquet (a device that checks bleeding or blood flow by compressing blood vessels). RN 2 stated dialysis e-kit should be accessible and available at resident bedside at all times in case of emergency bleeding. RN 2 stated too much bleeding would cause hemorrhagic shock (a life-threatening condition that occurs when the body loses a significant amount of blood in a short period of time) that would likely require hospitalization . During a concurrent observation and interview on 12/17/2024 at 10:43 a.m., with the Director of Nursing (DON), the DON confirmed there was no dialysis e-kit available at the bedside of Resident 75. The DON stated dialysis e-kit should be easily accessible to prevent further bleeding complication. During a review of facility's P&P, titled Pre- and Post-Care Dialysis, dated 1/2022, the P&P indicated, Any problems with a resident's access should be addressed immediately. Excessive bleeding from graft site, redness, swelling, pain, or non-functioning graft requires medical attention.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Ensure one of one sampled resident (Resident 60) was provided necessary behavioral health care services for treatment of the residents mental condition by ensuring a psychiatrist (a physician who specializes in psychiatry - the branch of medicine devoted to the diagnosis, prevention, study, and treatment of mental disorders) was notified when Resident 60 had episodes of refusal of care. This deficient practice had the potential to result in lack of interventions to Resident 60's refusal of care and worsening of his mental health condition. Findings: During a review of Resident 60's Admission Record, the Admission Record indicated, Resident 60 was admitted to the facility on [DATE]. Resident 60's diagnoses included multiple myeloma (a cancer that begins in plasma cells), anemia (a condition where the body does not have enough healthy red blood cells), and hypertension ([HTN] - high blood pressure). During a review of Resident 60's History and Physical (H&P), dated 12/2/2023, the H&P indicated, Resident 60 had the capacity to understand and make decisions. During a review of Resident 60's Minimum Data Set ([MDS] - a resident assessment tool), dated 9/28/2024, the MDS indicated, Resident 60's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 60 required set up assistance (helper sets up and resident completes activity) from staff with oral hygiene and personal hygiene. During a review of Resident 60's Order Summary Report (a document containing active orders), dated 12/19/2024, the Order Summary Report indicated, Resident 60 had a physician order, dated 11/11/2024, for psychiatric evaluation. During a review of Resident 6's Situation, Background, Assessment and Recommendation ([SBAR] - a communication tool used by healthcare workers when there is a change of condition among the residents), dated 11/11/2024, the SBAR, indicated Resident 60 had episode of refusal of care such as showering, bathing, and changing clothes. The SBAR indicated, Resident 60's physician recommended psychiatric evaluation. During an interview on 12/19/2024 at 11:30 a.m., with the Social Service Director (SSD), the SSD stated she was responsible in referring residents to psychiatrist. The SSD acknowledged Resident 60 exhibited behavior of refusal of care and assistance from staff multiple times. The SSD stated the licensed nursing staff did not communicate to her about the physician order for Resident 60's psychiatric referral. The SSD stated the risk of Resident 60's not being evaluated by psychiatrist would continue his same behavior of refusing care that would jeopardize his health condition and affect his quality of life. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/2024 at 11:48 a.m., with the Director of Nursing (DON), the DON stated Resident 60 was noncompliant with care. The DON verified the psychiatric referral was not followed through by facility staff. The DON stated the psychiatrist would be able to help and manage Resident 60's behavior, develop treatment plan and provide accurate diagnosis. During a review of the facility's policy and procedure (P&P) titled, Behavioral Health Services, dated 12/2023, the P&P indicated, the facility will provide residents with necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The P&P indicated the physician in collaboration with the IDT team, will determine the appropriate psychiatric or psychological services needed and treatment will be provided as ordered by the physician.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to: 1. Ensure a follow-up appointment for urology (a medical and surgical specialty that deals with diseases of the urinary tract and male reproductive system in both men and women) evaluation/referral was completed for one of one sampled resident (Resident 80). This deficient practice had the potential to result in the delay of necessary care and services for Resident 80. Findings: During a review of Resident 80's Admission Record, the Admission Record indicated, Resident 80 was admitted to the facility on [DATE]. The Admission Record indicated, Resident 80's diagnoses included urinary retention (a condition that makes it difficult to empty the bladder), obstructive uropathy (a condition in which the flow of urine is blocked), and acute cystitis (infection of the bladder). During a review of Resident 80's History and Physical (H&P), dated 724/2024, the H&P indicated, Resident 80 had the capacity to understand and make decisions. During a review of Resident 80's Minimum Data Set ([MDS - a resident assessment tool), dated 10/27/2024, the MDS indicated, Resident 80's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 80 had indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine). During a review of Resident 80's Order Summary Report (a document containing active orders), dated 12/18/2024, the Order Summary Report indicated, Resident 80 had a physician order, dated 10/10/2024, for urology consult due to obstructive uropathy. During an observation and interview on 12/17/2024 at 12:25 p.m., with Resident 80 in his room, Resident 80 was observed in bed with indwelling urinary catheter. Resident 80 stated he wanted to see a medical doctor so he could remove his catheter. Resident 80 stated he had been getting urine infection. During a concurrent interview and record review on 12/18/2024 at 1:07 p.m., with the Director of Nursing (DON), Resident 80's electronic clinical records were reviewed. The DON stated Social Services was responsible for setting up transportation and medical appointments for residents. The DON stated there was no documentation indicating the facility staff scheduled Resident 80's appointment for urology consult. The DON stated it was important for Resident 80 to be seen by a urologist (a medical doctor who specializes in diagnosing and treating diseases of the urinary system and reproductive organs) to evaluate the reason why Resident 80 had a blockage on his bladder (a hollow, muscular organ that stores urine and is part of the urinary system) and having urinary retention. The DON stated the risk of not following up with a urology referral could result in bladder infection since Resident 80 had an indwelling urinary catheter. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/19/2024 at 11:15 a.m., with the Social Service Director (SSD), Resident 80's Social Services Progress Notes, dated 10/24/2024, was reviewed. The SSD stated Resident 80 needed a urology referral directly from his primary physician. The SSD stated she did not follow-up with Resident 80's primary physician for urology referral. The SSD stated she did not schedule Resident 80's medical appointment for urology consult. The SSD stated it was important for Resident 80 to be referred to a urologist in a timely manner to prevent delay of care and treatment. During a review of the facility's policy and procedure (P&P) titled, Provision of Medically Related Social Services, dated 12/2023, the P&P indicated, it is the policy of the facility to provide medically related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident. The P&P indicated the Social Services is responsible for providing for the medically related social services needs of each resident that includes scheduling of appointments.

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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 48712

Based on observation, interview, and record review, the facility failed to provide appropriate pharmaceutical services to meet the needs of two of 7 sampled residents (Residents 3 and 55), by failing to ensure:

a. Resident 3's jardiance (medication used to control high blood sugar), apixiban (medication given to thin the blood to prevent blood clots), breo ellipta (medication used to improve air flow in lung disease), metoprolol tartrate (medication used to lower the blood pressure), and sitagliplin (medication used to control high blood sugar) were ordered timely from the pharmacy to prevent outage. This deficient practice put Resident 3's health at risk due to missed doses of the medications.

b. Licensed Vocational Nurse (LVN) 1 documented the administration of carvedilol (medication used to treat high blood pressure) in a timely manner. This deficient practice had the potential to result in Resident 55 receiving a duplicate dose of Carvedilol.

Findings:

a). During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including diabetes (a disorder characterized by difficulty in blood sugar control), hypertension ([HTN]-high blood pressure), and dementia (a progressive state of decline in mental abilities).

During a review of Resident 3's History and Physical (H&P), dated 11/1/2024, the H&P indicated Resident 3 can make needs known but cannot make medical decisions.

During a review of Resident 3's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 9/2/2024, the MDS indicated Resident 3 had severe cognitive impairment. Resident 3 was dependent on staff for all activities of daily living ([ADLs]- activities such as bathing, dressing and toileting a person performs daily).

During a concurrent observation and interview on 12/19/24 at 9:18 a.m. with Licensed Vocational Nurse (LVN) 1 during medication administration, LVN1 stated Resident 3's Jardiance is not available to be given today. LVN1 stated Resident 3 did not receive the medication yesterday because it is out of stock. LVN1 stated missing a dose of this medication can potentially result in Resident 3's high blood sugar levels. LVN1 stated medications should be ordered when there are three remaining to prevent you from running out.

(continued on next page)

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 12/20/2024
NAME OF PROVIDER OR SUPPLIER Camino Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 13922 Cerise Avenue Hawthorne, CA 90250	

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Director of Staff Development (DSD), Resident 3's medication administration record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) was reviewed. The MAR indicated on 12/14/2024, sitagliptin, metoprolol, breo ellipta, jardiance, and apixiban were not available to be administered. The MAR indicated on 12/5/2024, Apixiban and Breo Ellipta we not available to be given. The MAR indicated on 11/24/2024, Jardiance was not available to be given. The DSD stated medications should be reordered when it gets down to three pills to ensure there is time for delivery to prevent missed doses. The DSD stated missed doses can affect the resident's health. During a review of the facility's policy and procedure (P&P) titled, Administration of Medications and Fluids, Intravenous, dated December 2019, the P&P indicated medications will be administered within the prescribed time frames. During a review of the facility's P&P titled, Medication Errors and Adverse Reactions, dated December 2023, the P&P indicated a medication error includes doses that are ordered but not administered. During a review of the facility's job description, titled Licensed Vocational Nurse, dated December 2021, the job description indicated the LVN will ensure adequate stock levels of medications are maintained. b). During a review of Resident 55's Admission Record, the Admission Record indicated Resident 55 was admitted to the facility on [DATE] with diagnoses including HTN, heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and muscle weakness. During a review of Resident 55's H&P, dated 6/15/2024, the H&P indicated Resident 55 had the capacity to understand and make decisions. During a review of Resident 55's MDS dated [DATE], the MDS indicated Resident 55's cognition was intact. The MDS indicated Resident 55 needed moderate assistance with ADLs such as toileting, showering, and lower body dressing. During a concurrent interview and record review on 12/19/24 at 9:23 a.m. LVN 1, Resident 55's MAR was reviewed. LVN 1 stated he administered carvedilol to Resident 55 at 8:40 a.m. and had not documented it. LVN 1 stated he should have documented administration right away after administering the medication to Resident 55. During an interview on 12/19/24 at 9:48 a.m. with the Assistant Director of Nursing (ADON), the ADON stated medications should be documented as soon as they are given to prevent confusion. The ADON stated, a resident could possibly receive a double dose of the medication due to a lack of documentation. During a review of the facility's P&P titled, Administration of Medications and Fluids, Intravenous, dated 12/2019, the P&P indicated to ensure safety and accuracy of administration, staff would document administration after administration. (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 review of the facility's job description, titled Licensed Vocational Nurse, dated 12/2021, the job description indicated the LVN would chart in a professional and appropriate manner that timely and accurately reflects the care provided.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712 Based on observation, interview, and record review, the facility failed to: 1. Ensure Resident 3 received her Jardiance (medication used to control high blood sugar) dose as ordered by the physician. This deficient practice put Resident 3's health at risk due to a missed dose of medication. Findings: During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including diabetes (a disorder characterized by difficulty in blood sugar control), hypertension ([HTN]-high blood pressure), and dementia (a progressive state of decline in mental abilities). During a review of Resident 3's History and Physical (H&P), dated 11/1/2024, the H&P indicated Resident 3 can make needs known but cannot make medical decisions. During a review of Resident 3's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 9/2/2024, the MDS indicated Resident 3 had severe cognitive impairment. Resident 3 was dependent on staff for all activities of daily living ([ADLs]- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 3's care plan, dated 3/31/2023, the care plan indicated staff will give diabetes medication as ordered by the doctor. During a concurrent observation and interview on 12/19/24 at 9:18 a.m. with Licensed Vocational Nurse (LVN)1 during medication administration, LVN1 stated Resident 3's Jardiance is not available to be given. LVN1 stated Resident 3 did not receive Jardiance yesterday. LVN1 stated Resident 3 missing a dose of this medication can potentially result in high blood sugar levels. During a review of the facility's policy and procedure (P&P) titled, Administration of Medications and Fluids, Intravenous, dated December 2019, the P&P indicated medications will be administered within the prescribed time frames. During a review of the facility's policy and procedure (P&P) titled, Medication Errors and Adverse Reactions, dated December 2023, the P&P indicated a medication error includes doses that are ordered but not administered. During a review of the facility's job description, titled Licensed Vocational Nurse, dated December 2021, the job description indicated the LVN will administer medications as ordered by the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48712 Based on observation, interview, and record review, the facility failed to: 1. Ensure the medication refrigerator did not contain an emergency kit (a box that contains a small supply of medications) and three bags of ertapenem (medication given to treat infection) that were past the discard date. This deficient practice had the potential to result in harm to a resident if administered. Findings: During a concurrent observation and interview with the Assistant Director of Nursing (ADON) in the medication storage room, the medication refrigerator was observed with an emergency kit labeled to be discarded after September 2024. and three bags of ertapenem that were past the discard date. The ertapenem bags indicated they should be discarded on 12/13/2024, 12/14/2024, and 12/16/2024. The ADON stated the emergency kit and ertapenem should not be there. The ADON stated, if the medications were used, a resident could have harmful effects. During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, dated May 2022, the P&P indicated outdated medications are immediately removed from inventory.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48712 Based on observation, interview, and record review, the facility failed to: 1. Ensure Resident 16 had a Complete Blood Count ([CBC] a blood test that measures the number and type of cells in your blood), Comprehensive Metabolic Panel ([CMP] a blood test that measures 14 substances in your blood to provide an overall picture of your body's chemical balance), Hemoglobin A1C ([HgA1c] a blood test that measures the average blood sugar level over the past two to three months), Thyroid Synthesizing Hormone ([TSH] a blood test used to determine the level of hormones being produced by the thyroid), and Lipid panel (a blood test that determines the level of fat in the blood) completed on 11/4/2024 per physician's order. This deficient practice had the potential to result in a lack of required monitoring of Resident 16's health conditions. Findings: During a review of Resident 16's Admission Record, the Admission Record indicated Resident 16 was admitted to the facility on [DATE] with diagnoses including diabetes (a disorder characterized by difficulty in blood sugar control), hypertension ([HTN]-high blood pressure), and dementia (a progressive state of decline in mental abilities). During a review of Resident 16's History and Physical (H&P), dated 11/1/2024, the H&P indicated Resident 16 did not have the capacity for medical decision making. During a review of Resident 16's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 11/8/2024, the MDS indicated Resident 16 had severe cognitive impairment. Resident 16 was dependent on staff for all activities of daily living ([ADLs]- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 16's care plan, dated 6/16/2023, the care plan indicated staff will obtain and monitor lab work as ordered. Staff will report results to the physician and follow up as indicated. During a review of Resident 16's Order Summary Report, the report indicated Resident 16 had a physician's order to complete a CBC, CMP, HgA1C, TSH, and Lipid Panel on 11/4/2024. During a concurrent interview and record review on 12/16/2024 at 2:39 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 16's laboratory results were reviewed. LVN 1 stated Resident 16 did not have lab tests completed on 11/4/2024 as ordered. LVN1 stated staff cannot monitor Resident 16's health status if lab tests were not completed per physician's order. LVN1 cannot state why the tests were not completed. During a review of the facility's policy and procedure (P&P) titled, Diagnostic Test Results Notification, dated December 2023, the P&P indicated the facility will obtain laboratory services when ordered by a physician and promptly notify the provider of test results.

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	056267	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camino Healthcare	13922 Cerise Avenue Hawthorne, CA 90250

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure that the hospice (compassionate care for people who are near end of life) services meet professional standards for one of one sampled resident (Resident 71) by failing to: 1. Ensure hospice representative participates with facility interdisciplinary team ([IDT] - team members from different disciplines who come together to discuss resident care) care conference meeting. Findings: During a review of Resident 71's Admission Record, the Admission Record indicated, Resident 71 was admitted to the facility on [DATE]. The Admission Record indicated, Resident 71's diagnoses included protein calorie malnutrition ([PCM] - a nutritional condition that occurs when a person doesn't consume enough protein and calories to meet their nutritional needs), chronic obstructive pulmonary disease ([CPOD] - a chronic lung disease causing difficulty in breathing), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 71's Minimum Data Set ([MDS] - a resident assessment tool), dated 10/23/2024, the MDS indicated, Resident 71's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS indicated, Resident 71 was on hospice care. During a concurrent interview and record review on 12/18/2024 at 1:43 p.m., with the Social Service Director (SSD), Resident 71's IDT Care Plan Review, dated 7/25/2024, was reviewed. The SSD stated the IDT Care Plan Review record did not indicate a hospice representative was among the members attended the meeting. The SSD stated if it was not written then it did not happen. The SSD stated she was responsible in coordinating with hospice representative for the IDT care plan meeting. The SSD stated there was no IDT care plan meeting held with hospice representative in October 2024. The SSD stated IDT care plan meeting should be conducted every 3 months per state and federal requirement. The SSD stated the hospice staff should be actively involved in the care for Resident 71 by participating in the IDT care plan meeting. The SSD stated it was mandatory for the hospice representative to attend scheduled IDT care plan meeting with the facility staff so there would be continuity in the care provideed to Resident 71. The SSD stated the purpose of the IDT care plan meeting was to coordinate and collaborate the plan of care of resident. During a review of the facility's policy and procedure (P&P) titled, End of Life, Hospice and/or Palliative Care, dated 12/2023, the P&P indicated, Hospice services will be integrated into the overall individualized, interdisciplinary care plan. The P&P indicated collaboration with hospice will include processes for orienting staff to facilities polices and procedures.