

|   |  |   |  |
|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>056267 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>02/17/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Camino Healthcare |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>13922 Cerise Avenue<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Perform hand hygiene before touching the forehead of Resident 1. This failure had the potential to result in exposing Resident 1 to harmful organisms on the hand of CNA1. During a review of Resident 1's Face Sheet, with an admission date of 4/9/2022, the Face Sheet indicated Resident 1 is diagnosed with Dementia, Alzheimer's Disease, and Dysphagia following nontraumatic intracerebral hemorrhage. During a review of Resident 1's History and Physical, dated 1/2/2025, the History and Physical indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1's Order Summary Report, dated 4/9/2022, the Order Summary Report indicated Resident 1 is ordered to have a fortified puree diet, pain assessments with pain management, and staff are to monitor right and left lower extremities for redness, discoloration, swelling, and pain, every shift for immobilizer use. During a concurrent observation and interview on 2/17/2026, at 11:19 a.m., CNA1 entered room [ROOM NUMBER] and touched the forehead of Resident 1 without performing hand hygiene. CNA 1 stated they are supposed to perform hand hygiene before touching the residents because not performing hand hygiene could cause an infection. During a review of the facility's policy and procedure titled, Hand Hygiene, dated, 12/2023, the Hand Hygiene policy indicated to use an alcohol-based hand rub containing at least 62% alcohol; or alternatively soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents. |

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                            |
| FORM CMS-2567 (02/99)<br>Previous Versions Obsolete                   | Event ID: | Facility ID:<br>056267               |
|   |           | If continuation sheet<br>Page 1 of 1 |