

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555677	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/04/2025
NAME OF PROVIDER OR SUPPLIER  Hawthorne Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE  11630 South Grevillea Ave. 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview and record review, the facility failed to implement its policy and procedure (P&amp;P) titled, Dietary Department-Infection Control. Dietary Aide 1 did not wear a hairnet while working in the kitchen. This failure had the potential for cross contamination and increase the risk of infections among residents.</p> <p>Findings:</p> <p>During an observation on 6/4/2025 at 1:50 p.m., with the Dietary Manager, Dietary Aide 1 was observed working in the kitchen without a hairnet. During a concurrent interview, Dietary Aide 1 stated she removed her hairnet as she was coming to the kitchen door. There was no hairnet was observed in Dietary Aide 1's hand. Dietary Aide 1 did not state how the lack of a hairnet may affect residents. The Dietary manager stated that not wearing a hairnet in the kitchen increased the risk of hair falling and cross contamination to foods and utensils.</p> <p>During a review of the facility policy and procedure titled, Dietary Department-Infection Control, dated 2/29/2024, indicated personal cleanliness was required in sanitary food preparation, clean working attire would be worn, cover head, beard, and mustache with an effective hair restraint, such as hats, hair coverings or nets while in any kitchen and food storage areas.</p>

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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