STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055109	A. Building B. Wing	10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Driftwood Healthcare Center - Santa Cruz	675 24th Avenue Santa Cruz, CA 95062

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44733 Based on observation, interview, and record review, the facility failed to prevent accidents for one of two sampled residents (Resident 1) when: 1. Staff did not provide supervision or the required assistance, 2. Staff did not develop a care plan for Activities of Daily Living (ADL), and 3. Staff did not implement resident-centered interventions for falls. These failures resulted in Resident 1's fall in the facility with a fracture (broken) of the second cervical vertebra (vertebra of the neck). Findings: 1. Review of Resident 1's clinical record indicated she was admitted on [DATE] and had the diagnoses of Leigh's disease (a neurometabolic disorder that affects the central nervous system), restlessness and agitation, dementia (a disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), major depressive disorder (a mood disorder that causes persistent feelings of sadness and loss of interest), hypertension (high blood pressure), diabetes mellitus (high blood sugar), osteoporosis (weak bone), and displace fracture of the second cervical vertebra. During a review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 7/08/23, the MDS indicated she had a brief interview for mental status (BIMS) score of 6 (a severe cognitive impairment) and required limited assistance (staff provide guided maneuvering of limbs or non-weight-bearing assistance) with one-person physical assist for transfers and walking. The MDS also indicated Resident 1 was not steady and was only able to stabilize with staff assistance for walking and turning around. The MDS further indicated that ADL functional/rehabilitation potential was triggered as a care area (for each triggered care area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem identified in the assessment of the care area). During a review of Resident 1's Fall Risk Data Collection (FRDC) dated 7/04/23, the FRDC indicated a fall risk score of 18 (a score of 14 or higher represents high risk). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's fall risk care plan, dated 7/07/23, the fall care plan indicated she was at high risk for falls due to balance problems, muscle weakness, wandering, use of psychotropic medication (medications capable of affecting the mind, emotions, and behavior), and cognitive deficits. The interventions in the care plan included establish resident ' s physical function and capabilities and provide measures/approaches to assist resident. During a review of Resident 1's care plans, the care plans indicated there was no care plan for ADL functional/rehabilitation potential. During a review of Resident 1's situation, background, assessment, recommendation (SBAR) Fall, dated 7/27/23, the SBAR indicated she was found in another resident ' s room on the ground at 1:10 a.m. and was noted with a laceration on the left side of her eyebrow. During a review of Resident 1's Risk Meeting Notes Initial Week One, dated 7/27/23, the risk meeting notes indicated Resident 1 had an unwitnessed fall and fracture. The risk meeting notes indicated Resident 1 was disoriented/confused, independent with walking, walked into another resident ' s room, and staff found her sitting on the floor. The risk meeting notes further indicated that she was sent to the acute hospital for further evaluation and treatment. During a review of a Transfer Record from the acute hospital, dated 7/27/23, the record indicated Resident 1 had a cervical fracture, facial laceration, and urinary tract infection. The record further indicated that Ambulation okay with cervical collar on. During an observation on 7/27/23, Resident 1 was lying in her bed and wearing a cervical collar. During an interview and record review with Registered Nurse A (RN A) on 8/11/23 at 1:10 p.m., RN A confirmed that Resident 1 required limited assistance with one-person physical assist for transfers and walking. RN A explained that one-person physical assistance meant staff should be with the resident and provide supervision/assistance. RN A stated Resident 1 should have received limited assist with transfer and walking, even during the night. RN A added that all residents should be checked frequently for their needs. During a follow-up interview with Registered Nurse A (RN A) on 8/11/23 at 1:40 p.m., RN A confirmed that there was no care plan for ADL care and acknowledged that an ADL care plan should have been developed. RN A also acknowledged that Resident 1's fall care plan interventions were not resident-centered and were not tailored to Resident 1's needs. During an interview with Licensed Vocational Nurse A (LVN B) on 9/07/23 at 10:56 a.m., LVN B stated the last time she saw Resident 1 prior to the fall was at her first round after shift report, and a Certified Nurse Assistant (CNA) reported the resident's fall in another resident's room around 1 a.m. LVN B further stated that staff should have checked on the resident frequently and provided the required assistance. During an interview with CNA C on 9/07/23 at 11:18 a.m., he stated the last time he saw Resident 1 prior to the fall was at his first round, when she was on her bed. The next round, she was not on her bed, and his co-CNA found her in another resident ' s room on the floor. CNA C further stated that Resident 1 needed assistance with walking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Occupational Therapy recertification and updated plan of treatment, started on 7/11/23, the document indicated, Resident will perform functional mobility during ADLs with Front Wheel [NAME] (FWW) .7/11/23: Minimum Assistant. The report included verbal cues for safety awareness. During an interview and record review with the Director of Rehabilitation (DOR) on 9/07/23 at 10:40 a.m., the DOR confirmed that Resident 1 required FWW gait with minimum assistance (resident did 75 percent of activity and staff provided 25 percent assistance) and verbal cues for safety. The DOR stated that Resident 1 was forgetful and impulsive. The DOR further stated that when staff reminded Resident 1 to use FWW, she would follow the direction but not remember to do so. During an interview with LVN D on 9/07/23 at 1 p.m., she stated Resident 1 was in room [ROOM NUMBER] and found in room [ROOM NUMBER]. LVN D stated staff didn't know Resident 1 got up and walked to another resident ' s room on her own until they found her in room [ROOM NUMBER] on the floor. LVN D stated that all residents should be checked frequently for their needs. During a review of the facility's policy and procedure (P&P) titled Quality of Care, revised 11/2018, the P&P indicated the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan. The facility identifies and provides needed care and services that are resident centered, in accordance with the resident's physical, mental, and psychosocial needs. During a review of the facility's undated P&P titled Fall Management, the P&P indicated Resident-Centered Approaches to Managing Falls and Fall Risk: The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.