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	08/22/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2025

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to implement their abuse policy and procedures for one of three sampled residents (Resident 1) when the facility did not report Resident 1's allegation of abuse. This failure resulted in Resident 1's allegation of abuse not reported to required agencies California Department of Public Health [CDPH], law enforcement agency, and Long-Term Care Ombudsman). This failure had the potential to compromise the safety of the residents in the facility.During an interview on 5/15/25 at 1:11 p.m., with Resident 1. Resident 1 stated she has a concern about a gentleman that comes in her door, she stated she is afraid for other residents what the gentleman can do to them. Resident 1 stated the gentleman's room was two doors next to hers. Resident 1 stated she filed a grievance for that, and social services knows. During a review on 5/15/2025 of Resident 1's Face sheet (FS, document that summarizes a person's information such as medical history), the FS indicated Resident 1 was initially admitted on [DATE] to the facility with diagnoses including urinary tract infection, anxiety disorder unspecified (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life), and major depressive disorder (a serious mood disorder characterized by persistent feelings of sadness, loss of interest or pleasure, and other symptoms that impair daily functioning).Review of Resident 1's admission minimum data set (MDS, a resident assessment tool) dated 4/8/2025, indicated Resident 1's brief interview for mental status (BIMS, a tool used to assess cognition level) score was 15 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). During an interview on 5/15/25 at 3:31 p.m., with the Social Service Director (SSD), the SSD stated she met with Resident 1. The SSD stated Resident one invited Resident 2 to her room, and they talked about spouses then Resident 1 asked Resident 2 to leave the room because it made her uncomfortable.During a review of Facility's Grievance (a standardized document that an individual, typically an employee, uses to formally report a complaint or concern about unfair treatment, a policy violation, or a breach of their employment contract or collective bargaining agreement) Form dated 4/28/25, it indicated, Resident states she invited resident [room AA] into her room-Started talking about his wife and children. He came towards me and feeling my leg. At- Which point I quickly escorted him out of the Room.During a concurrent interview and record review on 5/16/25 at 3:22 p.m. of Resident 1's grievance form dated 4/28/25., with the SSD, the SSD stated Resident 1 came to her office and she helped Resident 1 fill up the grievance form. The SSD further stated those are Resident 1 words she just helped her write it. During the follow-up interview on 5/16/25 at 2:43 p.m., with Resident 1, she stated she was sitting in her bed, then Resident 2 came forward to her, and started talking about his family. He [Resident 2] started stroking her right leg, she pushed him away and yelled at him, he back away and started making mouth gestures. Resident 1 stated she reported it to the night nurse and the night social worker on Friday. Resident 1 stated she was told this gentleman will leave on Tuesday. Resident 1 stated she felt like she was violated, and she didn't give him consent to touch her. During an interview on 5/16/25 at 3:44 p.m., with the Director of Nursing (DON), the DON stated it's not reported, from her understanding she [Resident 1] invited him [Resident 2] to her room so it's consensual, the DON further stated she only talked to Resident 2, and he denied it on 5/1/25.During an interview on 5/16/25 at 3:55 p.m., with the Administrator (ADM), The ADM stated there was no further concern from Resident 1. ADM stated Resident 1 was okay that Resident 2 will be discharged the following day. The ADM stated they thought it was not abuse, and she (Resident 1) just wanted to let them know.During an observation on 5/15/2025 at 12:50 p.m., noted Resident 2 was still in the facility. During another observation on 8/22/2025 at 11:25 a.m., Resident 2 was observed still in the facility but has been moved to another room further away from Resident 1. During a review of Resident 2's clinical records on 8/22/2025, Resident 2's clinical records indicated he was admitted on [DATE] with diagnoses including cerebral infarction unspecified (a medical term that refers to a stroke where the specific cause of the blockage in a brain artery is unknown) and type 2 diabetes mellitus (a condition which affects the way the body processes blood sugar) without complications and he was never discharged from the facility as of 8/22/2025. A Review of Facility's Five Day summary dated 5/20/2025 indicated Based on initial and further investigation beginning on 4/28/25 that included interviews with staff and residents, the facility was unable to substantiate the allegation of abuse. During a concurrent interview and record review on 8/22/25 at 12:18 p.m., with the Nurse Supervisor (NS), the NS reviewed Resident 1's progress notes from 4/21/25 to 4/30/25, she confirmed that there was no