

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 06/24/2024
NAME OF PROVIDER OR SUPPLIER Driftwood Healthcare Center - Santa Cruz		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409</p> <p>Based on interview and record review, the facility failed to ensure three of four residents (39, 48, and 64) had informed consents (written permission before implementing a healthcare intervention) prior to initiating psychotropic medication (medication capable of affecting the mind, emotions, and behavior). These failures resulted in the residents receiving psychotropic medications without being informed about their risks and side effects.</p> <p>Findings:</p> <p>Review of Resident 39's Admission Record indicated he was admitted to the facility on [DATE] with diagnoses including psychosis (a mental disorder characterized by a disconnection from reality) and depression (a persistent feeling of sadness and loss of interest).</p> <p>Review of Resident 39's physician orders indicated he had orders, started on 3/18/24, for olanzapine (used to treat several mental health conditions) 2.5 milligrams (mg, a metric unit of mass) every day and 5 mg at bedtime for psychotic disorder and trazodone (used to treat depression) 50 mg at bedtime for depression. However, there were no informed consents for these medications found in Resident 39's clinical record.</p> <p>Review of Resident 48's Admission Record indicated he was admitted to the facility on [DATE] with diagnoses including psychosis and mood disorder (a mental health condition that causes intense shifts in mood, energy levels, thinking patterns and behavior).</p> <p>Review of Resident 48's physician orders indicated he had orders, started on 3/8/24, for Depakote (used to treat certain psychiatric conditions) 500 mg twice a day for mood disorder and olanzapine 5 mg three time a day for psychosis. However, there were no informed consents for these medications found in Resident 48's clinical record.</p> <p>Review of Resident 64's Admission Record indicated he was admitted to the facility on [DATE] with psychotic disorder.</p> <p>Review of Resident 64's physician order indicated he had an order, started on 6/1/24, for valproic acid (used to treat certain psychiatric conditions) 250 mg three time a day for schizophrenia (a mental illness that affects how a person thinks, feels, and behaves). However, there was no informed consent for this medication found in Resident 64's clinical record.</p> <p>(continued on next page)</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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the director of nursing (DON) on 6/24/24, at 1:35 p.m., she reviewed Resident 39's, Resident 48's, and Resident 64's clinical records and was unable to locate the informed consents for Resident 39's olanzapine and trazodone, Resident 48's olanzapine and Depakote, and Resident 64's valproic acid. The DON stated that she would check with medical records.</p> <p>During an interview with the DON on 6/24/24, at 4 p.m., the DON was unable to provide the informed consents for Resident 39's olanzapine and trazodone, Resident 48's olanzapine and Depakote, and Resident 64's valproic acid.</p> <p>Review of the facility's policy, Health Information/Record Manual, dated 9/2021, indicated The Licensed Nurse carrying out the Physician's order for use of a psychotropic will verify with the Physician to make certain that an informed consent has been obtained by the Physician with the resident or resident representative. The Licensed Nurse will document such information and in the Informed Consent form.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583</p> <p>Based on interviews, record review, and policy review, the facility failed to ensure two of eight residents (Residents 6 and 284) had been informed about having an advance directive (AD, legal form directing their wishes about their healthcare, whether from them or a named individual on their behalf), when no documentation was found about AD and the Physician Orders for Life -Sustaining Treatment (POLST, a legal document stating the kinds of medical treatment patients want toward the end of their lives) was not completed and readily available in the event of a medical emergency.</p> <p>This failure had the potential to result in inability to make medical decisions and could lead to the delivery of unnecessary or inappropriate medical services.</p> <p>Findings:</p> <p>1. Review of Resident 6's face sheet (summary page of a patient's important information) indicated, Resident 6 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (also known as stroke), unspecified lack of expected normal physiological development in childhood-developmental delay, unspecified dementia (a group of symptoms affecting thinking and social abilities interfering with daily functioning), unspecified severity, with other behavioral disturbance and parkinsonism (a disease that include symptoms of slowness of movements, muscle rigidity, involuntary tremors/shaking and impaired balance and posture).</p> <p>During a concurrent interview with director of nursing (DON) and record review on 6/20/2024 at 10:50 a.m., DON reviewed Resident 6's chart and confirmed the POLST was incomplete. DON stated the sections B (about Medical Interventions: If patient is found with a pulse, and /or breathing: Full treatment, selective treatment, and comfort-focused treatment), C (about Artificially Administered Nutrition: Offer food by mouth if feasible and desired. Can have long term artificial nutrition, including feeding tubes, trial period of artificial nutrition, including feeding tubes, no artificial means of nutrition, including feeding tubes), and D (Information and signatures: with Advance Directive, Advance Directive not available and no Advance Directive) were not marked completely. DON further stated nurses should have followed up and social services should have followed up during care conference.</p> <p>During a concurrent interview with social service director (SSD) and record review on 6/21/2024 at 10:07 a.m. , SSD reviewed Resident 6's POLST. SSD confirmed Resident 6 POLST was not completed. SSD stated she should have reviewed Resident 6's POLST during their initial care conference with Resident 6's responsible party (RP, a person empowered to make decisions for the resident/ person legally responsible and liable for a decision or an action).</p> <p>During a follow up interview with SSD on 6/21/2024 at 10:36 a.m., SSD confirmed Resident 6 did not have an advance directive.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident 284's face sheet indicated, Resident 284 was admitted to the facility on [DATE] with diagnoses including sepsis (blood poisoning due to an infection, causing the organs to work poorly), open wound to right and left lower legs, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and type 2 diabetes mellitus with other circulatory complications (occurs when the body is unable to regulate glucose [sugar] in the blood, with damage to the blood vessels).</p> <p>During a concurrent interview with DON and record review on 6/20/2024 at 10:50 a.m., DON reviewed Resident 284's chart. DON confirmed Resident 284's POLST was not in the chart. DON also reviewed Resident 284's electronic health record (EHR). DON confirmed Resident 284 did not have a POLST.</p> <p>During an interview with SSD on 6/21/2024 at 10:13 a.m., SSD confirmed Resident 284 did not have a POLST and did not have an advance directive. SSD stated POLST should have been completed in a timely manner.</p> <p>During a review of the facility's undated job description titled, SOCIAL SERVICES - SALARIED, indicated, ESSENTIAL DUTIES AND RESPONSIBILITIES include the following. Other duties may be assigned . Facilitates advanced directive decision-making process.</p> <p>During a review of the facility's undated policy and procedure titled, Advance Directive, indicated, The Resident has a right to accept or refuse medical or surgical treatment and to formulate an Advance Directive in accordance with state and federal law . Prior to or upon admission of a resident, the Admissions Coordinator or designee inquires of the Resident, his/her family members and/or his or her legal representative, about the existence of any written Advance Directive .If the Resident Does not have an Advance Directive .c. The Social Worker will follow up with the Resident or representative upon admission about the availability of the Advance Directive. If there is no Advance Directive, will offer assistance by providing information on how to initiate an Advance directive and will document in the Social Services notes if Resident or representative accept or decline assistance .If the Resident Has an Advance Directive .The assigned Licensed Nurse is requires to inform emergency medical personnel of a Resident's Advance Directive regarding treatment options and provide such personnel with a copy of the Advance Directive and/or POLST when transfer from the facility via ambulance or other means is made.</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583</p> <p>Based on observation, interview, and policy review, the facility failed to protect a resident's rights to confidentiality of protected health information (PHI, any information in the medical record that can be used to identify an individual and that was created, used, or disclosed in the course of providing a health care service such as diagnosis or treatment) when the licensed nurse left the computer screen open and unattended on top of the treatment cart for two of eight residents (Residents 31 and 64).</p> <p>This deficient practice had the potential to compromise the resident's privacy and confidentiality.</p> <p>Findings:</p> <p>1. During an observation on 6/24/2024 at 9:28 a.m., registered nurse K (RN K) left the computer screen open on Resident 31's physician's treatment orders at the hallway facing Resident 31's bedroom door. The physician's orders indicated Resident 31's wound treatments. The computer screen was left on while RN K was with Resident 31 providing incontinent care and wound treatment.</p> <p>During an interview with RN K on 6/24/2024 at 10:06 a.m., RN K confirmed she left the computer screen on when she entered Resident 31's room.</p> <p>During an interview with director of nursing (DON) on 6/24/2024 at 12:02 p.m., DON stated nurses should sign out from the computer prior to entering the resident's room, even though the computer was facing the room. DON further stated the hallway was busy with passersby like housekeepers, visitors, and other staff.</p> <p>During a review of the undated policy and procedure titled, Confidentiality, indicated, All resident, personnel, and financial information are considered confidential. To protect the privacy rights of residents. Special care must be given to retrieving records where the computer screen can be observed by unauthorized persons. When a computer is left unattended, the last person accessing information should exit the application.</p> <p>37409</p> <p>2. Review of Resident 64's Admission Record indicated he was admitted to the facility on [DATE].</p> <p>Review of Resident 64's 6/2024 Treatment Administration Record (TAR) indicated he had wounds on his left and right gluteal folds (the horizontal skin crease that forms below the buttocks, separating the upper thigh from the buttocks).</p> <p>During an observation on the treatment for Resident 64's wounds with registered nurse K (RN K) on 6/20/24, at 11:12 a.m., RN K turned on the computer on her treatment cart to review Resident 64's wound treatment orders. RN K prepared the supplies for the treatment, then provided the treatment for Resident 64's wounds in his room and left her computer with Resident 64's wound treatment information opened on the treatment cart and in the hallway.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's undated policy, Confidentiality, indicated Our residents have a right to privacy of their protected health information . Employees must keep residents' medical, financial, and social information confidential .</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>48935</p> <p>Based on interview and record review, the facility failed to develop and implement a comprehensive care plan for one out of 18 residents (Resident 59) when they did not include a care plan to include goals, approaches, interventions, and the monitoring for the signs of symptoms of bleeding related to an anti-coagulant medication:</p> <p>Findings:</p> <p>Review of Resident 59's medical record indicated he was admitted to the facility with diagnoses including unspecified mood disorder and history of a traumatic brain injury.</p> <p>Review of Resident 59's physician order, dated 4/4/24, indicated Eliquis [an anticoagulant to prevent blood clots] 5 mg 1 tablet twice a day at 9:00 AM and 5:00 PM for DVT [deep vein thrombosis, a blood clot in a deep vein, usually in the legs] Prevention.</p> <p>A review of Resident 59's medical record indicated there was no comprehensive care plan developed for the use of Eliquis.</p> <p>During an interview and concurrent record review with the director of nursing (DON) on 6/20/24 at 1:02 PM, the DON stated There should be a care plan for Eliquis.</p> <p>Review of facility's policy and procedure, unknown date, titled Comprehensive Plan of Care indicated, a Comprehensive Care Plan is completed within 7 days after completion of the comprehensive assessment, and The comprehensive plan of care must: Include interventions to prevent avoidable decline in function or functional level; Include interventions to attempt to manage risk factors.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583</p> <p>Based on interview and record review, the facility failed to ensure care plans related to alleged abuse were reviewed and updated by the interdisciplinary team (IDT, a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the resident) for three of six residents (Residents 61, 63, and 75).</p> <p>This deficient practice had the potential to place the residents at risk of psychosocial and emotional distress.</p> <p>Findings:</p> <p>1. Review of Resident 61's face sheet (summary page of a patient's important information) indicated, Resident 61 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (COPD, a disease that affects airflow in the lungs and makes it difficult to breathe), unspecified asthma (inflammatory disease of the airway that often causes wheezing, coughing, and shortness of breath), and pain in right shoulder.</p> <p>Review of Resident 61's admission minimum data set (MDS, an assessment tool) dated 4/21/2024, indicated Resident 61's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 12 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</p> <p>Review of Resident 61's SBAR-GENERAL [Situation, Background, Assessment, and Recommendation - an assessment tool used to facilitate prompt and appropriate communication of a problem] dated 6/10/2024, indicated Resident 61 was angry and stated someone stole his money from his wallet.</p> <p>Review of the IDT note for Resident 61's missing money, dated 6/11/2024, indicated, the IDT discussed Resident 61's missing money. Further review indicated, IDT will continue to monitor and follow up with plan of care as needed.</p> <p>Review of Resident 61's care plan titled, Missing Money, dated 6/11/2024, the goal indicated, Resident will have minimal complications related to missing money. Further review of the care plan's approach indicated, Md (physician), SOC 341 [a form uses to report a suspected elder abuse] complete, SBAR, COC [change of condition], Ombudsman notified, sheriff and CDPH (California Department of Public Health) notified. No other approach added to address how to meet their goal.</p> <p>During an interview with Resident 61 on 6/17/2024 at 3:50 p.m., Resident 61 reported someone stole his money worth \$260. Resident 61 stated, I don't want to know who took it.</p> <p>During a concurrent interview with director of nursing (DON) and record review on 6/19/2024 at 11:19 a.m., DON reviewed Resident 61's care plan related to missing money. DON confirmed the care plan should have been updated based on their IDT meeting to reflect interventions to prevent any complications related to missing money.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review of Resident 63's face sheet indicated, Resident 63 was admitted to the facility with diagnoses including sepsis (blood poisoning due to an infection, causing the organs to work poorly), candidiasis (an infection caused by an overgrowth of yeast [Candida]), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and multiple sclerosis (a disabling disease of the brain and spinal cord).</p> <p>Review of Resident 63's admission MDS dated [DATE], indicated Resident 63's BIMS score was 15 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</p> <p>Review of Resident 63's SBAR-GENERAL dated 6/19/2024, indicated, Resident alleged roommate verbally abused her.</p> <p>Review of the IDT note for Resident 63's allegation of abuse by roommate dated 6/19/2024, indicated, IDT recommends and SOC 41 filed, notification to sheriff, ombudsman and CDPH, SBAR, COC, alert charting for emotional distress x (for) 72 hours, SSD (social services director) to follow up with residents, psych [psychological or psychiatric] eval [evaluation], and on monitoring for emotional distress, resident was offered a room change but declined.</p> <p>Review of Resident 63's care plan titled, Alleged Verbal Abuse by roommate, dated 6/19/2024, indicated, Goal: Resident will have minimal emotional distress related to alleged related to alleged verbal abuse by roommate. Further review of the care plan reflected, Approach: MD aware, SBAR, COC, ALERT CHARTING, CDPH, OMBUDSMAN AND SHERIFF AWARE, REFUSED ROOM CHANGE. No other approach added to address how to meet their goal.</p> <p>During an interview with nursing supervisor (NS) on 6/21/2024 at 11:46 a.m., NS confirmed Resident 63's care plan related to an alleged abuse by her roommate should have been updated after their IDT meeting to reflect the plan of care.</p> <p>3a. Review of Resident 75's face sheet indicated, Resident 75 was admitted to the facility with diagnoses including fracture (broken bone) of left femur (thighbone), complete traumatic amputation (the loss of a body part, usually a finger, toe, arm, or leg, that occurs as a result of an accident or injury) of two or more left lesser toes, person injured in unspecified motor-vehicle accident, traffic, nontraumatic subarachnoid hemorrhage (bleeding in the space that surrounds the brain) and nontraumatic subdural hemorrhage (a type of bleeding in which a collection of blood gathers between the inner layer of the meninges [the three thin layers that cover and protect the brain and spinal cord] surrounding the brain).</p> <p>Review of Resident 75's admission MDS dated [DATE], indicated Resident 75's BIMS score was 13 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</p> <p>Review of Resident 75's SBAR-GENERAL dated 6/13/2024, indicated, Allegation of Physical Abuse. Further review of the SBAR indicated, Resident 75 reported to staff a certified nursing assistant (CNA), threw her in the wheelchair and that he verbally abused her telling her she is loud and an old lady that talks to much. The SBAR indicated, the incident happened on 6/5/2024.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the IDT notes related to alleged physical and verbal abuse, dated 6/13/2024, indicated some recommendations, will continue and intervene accordingly .Updated plan of care and reviewed with direct care staff.</p> <p>Review of Resident 75's care plan titled, Allegation of physical and verbal abuse, dated 6/13/2024, did not indicate interventions on how to minimize signs and symptoms of emotional distress.</p> <p>3b. Review of Resident 75's SBAR-GENERAL dated 6/14/2024, indicated, Alleged financial abuse. Per resident she had \$1000 in her purse in a wallet and last seen it at 1100 am, she went to take money out of her wallet at 1700 and money was missing .</p> <p>Review of Resident 75's care plan titled, Alleged financial abuse, dated 6/14/2024, did not reflect interventions to minimize signs and symptoms of emotional distress.</p> <p>3c. Review of Resident 75's SBAR-GENERAL dated 6/19/2024, indicated, Resident 75 was accused of being verbally abusive and went through her roommate's belongings.</p> <p>Review of the IDT notes related to Resident 75's being accused of verbally abusive to roommate, dated 6/19/2024, indicated, SSD to follow up with residents, psych eval.</p> <p>Review of Resident 75's care plan titled, Resident was accused of being verbally abusive to roommate. The care plan's approach only had one intervention and did not reflect the planned recommendation by the IDT. It indicated, MD aware, SBAR, COC, ALERT CHARTING, CDPH, OMBUDSMAN AND SHERIFF AWARE.</p> <p>During a concurrent interview with NS and record review on 6/21/2024 at 12:04 p.m., NS reviewed Resident 75's three care plans related to the incidents mentioned above. NS confirmed all three care plans were not updated to reflect the plan of care as indicated in the IDT notes.</p> <p>During a review of the facility's undated policy and procedure titled, Comprehensive Plan of Care, indicated, Re-evaluate and modify care plans: as necessary to reflect changes in care, service and treatment.</p> <p>During a review of the facility's undated policy and procedure titled, Care Plan Essential (CPE), indicated, During the morning meeting and any types of care conferences with the company's Interdisciplinary Team (IDT), the resident's CPE will be reviewed and updated accordingly.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409</p> <p>Based on observation, interview, and record review, the facility failed to ensure the residents received the necessary care and services for two of 18 residents (10 and 184) when:</p> <ol style="list-style-type: none"> 1. Resident 10 had five open skin areas on her face, but there was no treatment order for them; and 2. Resident 184 did not have floor mat at his bed side as ordered by the physician, recommended by the interdisciplinary team (IDT, a team comprises professionals from various disciplines who work in collaboration to address residents' needs), and indicated as one of the interventions in Resident 184's fall care plan. <p>These failures had the potential to affect the residents' care and could jeopardize their health and well-being.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Resident 10's Admission Record indicated she was admitted to the facility on [DATE]. <p>During an observation on 6/17/24, at 11:51 a.m., Resident 10 had five open skin areas on her face, but there was no treatment order for them.</p> <p>During the observations on 6/18/24, at 1:09 p.m., and on 6/20/24, at 10:30 a.m., Resident 10 still had five open skin areas on her face, and she still had no treatment order for them.</p> <p>During an observation and interview with licensed vocational nurse C (LVN C) on 6/20/24, at 10:35 a.m., she confirmed Resident 10 had five open skin areas on her face, but there was no treatment order for them. LVN C stated she would initiate a change of condition and obtain a treatment order for Resident 10's open skin areas.</p> <p>Review of the facility's undated policy, Pressure Ulcer and Skin Care Management, indicated Licensed nurse checks the resident's body for the presence of pressure ulcers, wounds, and other skin conditions.</p> <ol style="list-style-type: none"> 2. Review of Resident 184's Admission Record indicated he was admitted to the facility on [DATE] with dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) diagnosis. <p>Review of Resident 184's Fall Risk Assessments on 2/12/24, 2/26/24, and 6/13/24, indicated he was at high risk for fall.</p> <p>Review of Resident 184's Unwitnessed Fall Report, dated 2/25/24, indicated Resident 184 was found on the floor in his room.</p> <p>Review of Resident 184's Risk Meeting Notes, dated 2/26/24, indicated the IDT recommended floor mat at bed side for Resident 184.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 184's physician order, dated 2/26/24, indicated he had an order for floor mat at bedside, and the placement of the floor mat should be monitored every shift.</p> <p>Review of Resident 184's fall care plan indicated floor mat at bed side was one of the interventions for Resident 184's fall, started on 2/26/24.</p> <p>During the observations on 6/17/24, at 10:22 a.m., and on 6/20/24 at 10:28 a.m., Resident 184 was in bed, and there was no floor mat at his bed side.</p> <p>During an observation and interview with licensed vocational nurse C (LVN C) on 6/24/24, at 10:05 a.m., Resident 184 was in bed, and there was no floor mat at his bed side. LVN C reviewed Resident 184's physician order and fall care plan and confirmed that Resident 184 should have a floor mat at his bed side, and she would provide a floor mat to Resident 184's bed side.</p> <p>Review of the facility's undated policy, Fall Management, indicated . staff will identify and implement relevant interventions to try to minimize serious consequences of falling.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>44583</p> <p>Based on observation, interview, and record review, the facility failed to provide appropriate care and services for indwelling catheter for one of three residents (Resident 31) when Resident 31's indwelling catheter (a catheter which is inserted into the bladder [a sac-shaped muscular organ that stores the urine secreted by the kidneys], via the urethra [the tube through which urine leaves the body] and remains in place to drain urine) was not properly secured and the urinary tube connected to a urine drainage bag was filled with thick yellow sediments (caused by the precipitation of calcium, phosphorus, and magnesium minerals in the urine).</p> <p>This failure had the potential for the resident to develop urinary tract infection (UTI, an infection cause by a bacteria (germs) that get into the bladder or kidneys (a pair of organs that are on either side of the spine, just below the rib cage of a person's back).</p> <p>Findings:</p> <p>Review of Resident 31's Physician Order Report dated 5/21/2024-6/21/2024, indicated an order of indwelling foley catheter for diagnosis of obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional).</p> <p>Review of Resident 31's clinical records did not reveal a documentation of when Resident 31's indwelling catheter, urine bag and the catheter stabilization device (an adhesive catheter foam anchor pad) were changed.</p> <p>During a wound treatment observation on 6/24/2024 at 9:44 a.m., inside Resident 31's room, Resident 31 was lying in bed with indwelling catheter connected to a urine bag. Registered Nurse K (RN K) removed Resident 31's cover and revealed the following: Resident 31's catheter stabilization device placed in the left thigh had some surgical tape to keep it in placed, a small amount of dried blood was observed on Resident 31's left thigh and the urinary tube connected to the urine drainage bag was filled with thick yellow sediments.</p> <p>During an interview with RN K on 6/24/2024 at 10:06 a.m., RN K confirmed above observations. RN K stated, the urine bag should have been changed at least monthly or as needed. RN K further stated, the catheter stabilization device should have been changed weekly to prevent skin irritation.</p> <p>During an interview with director of nursing (DON) on 6/24/2024 at 12:02 p.m., DON stated the urinary bag should be changed weekly and as needed, for blockage, leakage or if with noticeable sediment build up. DON further stated, the catheter stabilization device should be changed at the same time with the urine bag, weekly and as needed.</p> <p>During a review of the facility's undated policy and procedure titled, Indwelling Catheter Care, indicated, Routine catheter care helps prevent infections and other complications, and is usually performed daily. Inspect catheter for any problems. Check urine drainage characteristics. Provide enough slack before securing catheter to prevent tension on tubing.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's undated policy and procedure titled, Urinary Catheter, indicated, Change them only when they leak, malfunction, or are becoming obstructed. When the system needs to be cleaned: change the entire system at once - catheter and drainage bag .Indwelling catheters should be properly secured to prevent movement and urethral traction.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>44583</p> <p>Based on observation, interview, and record review, the facility failed to ensure the proper use of side or bed rails (adjustable rigid bars attached to the side of a bed) for five (Residents 81, 285, 22, 26, and 28) of 14 residents (residents who used bed or side rails) when:</p> <ol style="list-style-type: none"> Residents 81 and 285 had side or bed rails even when their siderail evaluation revealed both residents did not require the use of siderails; Residents 22 and 28 had side or bed rails even when their siderail evaluation revealed both residents did not require the use of siderails; and Residents 22 and 26 did not have a documented physician's order for the use of siderails. <p>These failures had the potential to place the residents at risk of entrapment and serious injury.</p> <p>Findings:</p> <p>1a. During an observation on 6/17/2024 at 10:18 a.m., inside Resident 81's room, Resident 81 was seated on a wheelchair and her bed was observed with right bed rail in upright position while the left bed rail was not raised up.</p> <p>During a concurrent observation and interview with director of nursing (DON) on 6/20/2024 at 10:05 a.m., inside Resident 81's room, Resident 81's right bed rail was in upright position while the left bed rail was not raised up. DON confirmed the observation.</p> <p>During a concurrent interview with DON and record review on 6/20/2024 at 10:13 a.m., DON reviewed Resident 81's siderail evaluation dated 5/28/2024. DON confirmed Resident 81's siderail evaluation revealed Resident 81 did not require the use of siderails. DON further confirmed there were no documentations indicated alternatives were offered, no physician order and consent were obtained and care plan for side rail used was not developed prior to Resident 81's used of side rail.</p> <p>1b. During an observation on 6/17/2024 at 10:29 a.m., inside Resident 285's room, Resident 285 was lying in bed and her bed had two upper bed rails in upright position.</p> <p>During a concurrent observation and interview with DON on 6/20/2024 at 10:11 a.m., Resident 285 was lying in bed and her bed had two upper bed rails in upright position. DON confirmed the observation.</p> <p>During a concurrent interview with DON and record review on 6/20/2024 at 10:23 a.m., DON reviewed Resident 285's siderail evaluation dated 6/14/2024. DON confirmed Resident 285's siderail evaluation revealed Resident 285 did not require the use of siderails. DON further confirmed there were no documentations indicated alternatives were offered, no physician order and consent were obtained and care plan for side rail used was not developed prior to Resident 285's used of side rail. DON stated there should be no bed rails installed upon residents' admission.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure titled, Side Rails, indicated, Requirements are the same as for other physical restraints, whether or not the side rails enable mobility: Nursing completes Side Rail Evaluation form, with input from IDT [interdisciplinary team, a group of health care professionals from diverse fields who work toward a common goal for residents] as indicated. Complete Informed Consent, reviewing risks and benefits with responsible party, including risk for entrapment (restraint or not a restraint). Obtain MD [medical doctor] order, including diagnosis/medical necessity for use of restraint .Care plan.</p> <p>37409</p> <p>2. During an observation on 6/18/24, at 9:08 a.m., Resident 22, Resident 26, and Resident 28 had bilateral bed side rails.</p> <p>Review of Resident 22's clinical record indicated she had no physician order for bed side rails, and her Siderail Evaluation, dated 4/9/24, indicated she did not require the use of side rails and the siderail evaluation did not proceed.</p> <p>Review of Resident 26's clinical record indicated he had no physician order for bed side rails.</p> <p>Review of Resident 28's Siderail Evaluation, dated 5/6/24, indicated she did not require the use of side rails and the siderail evaluation did not proceed.</p> <p>During an observation on Resident 22's, Resident 26's, and Resident 28's beds and interview with the director of nursing (DON) on 6/24/24, at 11:30 a.m., she confirmed that Resident 22, Resident 26, and Resident 28 had bilateral bed side rails. The DON reviewed Resident 22's, Resident 26's, and Resident 28's clinical records and confirmed that Resident 22 did not have physician order for bed side rails, and her 4/9/24 Siderail Evaluation indicated that she did not require the use of side rails and the siderail evaluation did not proceed; Resident 26 did not have physician order for bed side rails; and Resident 28's 5/6/24 Siderail Evaluation indicated that she did not require the use of side rails and the siderail evaluation did not proceed. The DON stated the resident should have physician order and Siderail Evaluation done for the use of bed side rails.</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583</p> <p>Based on observation, interview, and record review, the facility failed to monitor, evaluate and managed residents' behavior for one of two sampled residents (Resident 285) when Resident 285 had episodes of screaming which sounded like a baby crying. The failure had the potential for Resident 285, not attaining her highest practicable physical, mental, and psychosocial well-being and caused discomforts to other residents in the same hallway (Residents 19 and 61).</p> <p>Findings:</p> <p>During an observation on 6/17/2024 at 10:29 a.m., inside Resident 285's room, Resident 285 was lying in bed and her bed had two upper bed rails in upright position. Resident 285 was awake and quiet.</p> <p>During a concurrent observation and interview on 6/17/2024 at 12:44 p.m., inside Resident 19's room, Resident 19 was sitting at the edge of her bed. Resident 19 complained about the screamer, pointing towards Resident 285's room. Resident 19 stated, it was hard for her to sleep at night because of the screamer.</p> <p>During a concurrent observation and interview on 6/17/2024 at 3:50 p.m., inside Resident 61's room, Resident 61 was seated on his four wheeled walker and heard Resident 285 screamed. Resident 61 sounded irritated from the sound of Resident 285's scream, shook his head and stated, Can you please make that person stop?</p> <p>During an observation on 6/18/2024 at 9:40 a.m., in Station AA's hallway, Resident 285 could be heard screaming and sounded like a baby crying. Resident 285 was screaming continuously.</p> <p>None of the nurses or certified nursing assistant stopped to checked Resident 285.</p> <p>Review of Resident 285's face sheet ((summary page of a patient's important information), indicated, Resident 285 was admitted on [DATE] with diagnoses including sepsis (blood poisoning due to an infection), anemia (a condition in which the body does not have enough healthy red blood cells), type 2 diabetes mellitus with diabetic polyneuropathy (occurs when the body is unable to regulate glucose [sugar] in the blood, with nerve damage), unspecified dementia (a group of symptoms affecting thinking and social abilities interfering with daily functioning), dysphagia (difficulty swallowing), and gastrostomy status (G-tube or GT, a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach).</p> <p>Review of Resident 285's admission minimum data set (MDS, an assessment tool) dated 6/18/2024, indicated Resident 285 was usually understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time) and usually understands (misses some part/intent of message but comprehends most conversation). Further review of Resident 285's MDS indicated, Resident 285's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 6 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview with licensed vocational nurse D (LVN D) on 6/19/2024, in Station AA's hallway, Resident 285 could be heard screaming intermittently. LVN D confirmed Resident 285 had periods of screaming. LVN D stated, Resident D screamed mostly when she wanted to eat. LVN D confirmed Resident 285 had GT and her next feeding would be at 12:00 p.m.</p> <p>During a concurrent interview with director of nursing (DON) and record review on 6/20/2024 at 10:26 a.m., DON reviewed Resident 285's clinical records. DON confirmed the following: Resident 285 did not have an admission care conference, the behavior was not addressed, care plan regarding the behavior was not developed, and a risk meeting was done by the interdisciplinary team (IDT, a group of health care professionals from diverse fields who work toward a common goal for residents), but they did not address the behavior. DON stated Resident 285's behavior should have been monitored and managed with a plan of care.</p> <p>During an interview with the social services director (SSD) on 6/21/2024 at 10:50 a.m., SSD confirmed Resident 285's behavior of screaming should be addressed. SSD further confirmed the IDT did not discuss their plan of care about Resident 285's behavior.</p> <p>During a review of the facility's undated policy and procedure titled, Behavior Assessment, Intervention and Monitoring, indicated, Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of medical record and general observations. The nursing staff will identify, document, and inform the physician about the specific details regarding changes in an individual's mental status, behavior, and cognition. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. The care plan will incorporate findings from the comprehensive assessment. The resident and family or representative will be involved in the development and implementation of the care plan.</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583</p> <p>Based on observation, interview, and record review, the facility failed to provide an appropriate social services (SS) support for four of six residents (Residents 61, 63, 75 and 285) when:</p> <ol style="list-style-type: none"> 1. There was no documentation of timely SS support following Resident 61's complaint of missing money; 2. There was no SS support following an alleged abuse to Resident 63 and no documentation on SS follow up to address Resident 63's psychosocial needs; 3. There was no SS support following an alleged abuse to Resident 75 and no documentation on SS follow up to address Resident 75's psychosocial needs; and 4. There was no SS follow up to address Resident 285's behavior. <p>These failures resulted in a lack of timely social services interventions and had the potential not to address Residents 61, 63, 75, and 285's psychosocial needs.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Resident 61's face sheet (summary page of a patient's important information) indicated, Resident 61 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (COPD, a disease that affects airflow in the lungs and makes it difficult to breathe), unspecified asthma (inflammatory disease of the airway that often causes wheezing, coughing, and shortness of breath), and pain in right shoulder. <p>Review of Resident 61's admission minimum data set (MDS, an assessment tool) dated 4/21/2024, indicated Resident 61's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 12 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</p> <p>Review of Resident 61's SBAR-GENERAL [Situation, Background, Assessment, and Recommendation - an assessment tool used to facilitate prompt and appropriate communication of a problem] dated 6/10/2024, indicated Resident 61 was angry and stated someone stole his money from his wallet.</p> <p>Review of the IDT note for Resident 61's missing money, dated 6/11/2024, indicated, the IDT discussed Resident 61's missing money. Further review indicated, IDT will continue to monitor and follow up with plan of care as needed.</p> <p>During an interview with Resident 61 on 6/17/2024 at 3:50 p.m., Resident 61 reported someone stole his money worth \$260. Resident 61 stated, I don't want to know who took it.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with social services director (SSD) on 6/19/2024 at 10:10 a.m., SSD stated she received a report about Resident 61's missing money on 6/10/2024. SSD confirmed she was not able to monitor and follow up Resident 61 to address possible psychosocial effects of the missing money.</p> <p>During a concurrent interview with director of nursing (DON) and record review on 6/19/2024 at 11:19 a.m., DON reviewed SSD's progress notes. DON confirmed SSD's follow up documentations about Resident 61's missing money was just dated 6/19/2024 for both 6/10 and 6/11/2024 follow up. This surveyor started the investigation of Resident 61's missing money on 6/17/2024.</p> <p>2. Review of Resident 63's face sheet indicated, Resident 63 was admitted to the facility with diagnoses including sepsis (blood poisoning due to an infection, causing the organs to work poorly), candidiasis (an infection caused by an overgrowth of yeast [Candida]), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and multiple sclerosis (a disabling disease of the brain and spinal cord).</p> <p>Review of Resident 63's admission MDS dated [DATE], indicated Resident 63's BIMS score was 15 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</p> <p>Review of Resident 63's SBAR-GENERAL dated 6/19/2024, indicated, Resident alleged roommate verbally abused her.</p> <p>Review of the IDT note for Resident 63's allegation of abuse by roommate dated 6/19/2024, indicated, IDT recommends and SOC 41 filed, notification to sheriff, ombudsman and CDPH, SBAR, COC, alert charting for emotional distress x (for) 72 hours, SSD (social services director) to follow up with residents, psych [psychological or psychiatric] eval [evaluation], and on monitoring for emotional distress, resident was offered a room change but declined.</p> <p>During a concurrent observation and interview on 6/20/2024 at 1:27 p.m., inside Resident 63's room, Resident 63 was in bed, eating lunch. Resident 63 confirmed her roommate (Resident 75) called her very bad words. Resident 63 stated, she's (Resident 75) just very aggressive, verbally but not physically.</p> <p>During an interview with SSD on 6/21/2024 at 9:58 a.m., SSD stated her role as the SSD of the facility was to look after the psychosocial wellbeing of the residents. SSD further stated, her other role was to put out fire, and did some problem solving.</p> <p>During a concurrent interview with SSD and record review on 6/21/2024 at 10:41 a.m., SSD reviewed the IDT note on Resident 63's allegation of abuse by roommate dated 6/19/2024. SSD confirmed she did not implement the plan of care which was to follow up with Resident 63 for psych eval and on monitoring for emotional distress. SSD stated she should have followed up with Resident 63 as soon as she received the report on alleged abuse.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3a. Review of Resident 75's face sheet indicated, Resident 75 was admitted to the facility with diagnoses including fracture (broken bone) of left femur (thighbone), complete traumatic amputation (the loss of a body part, usually a finger, toe, arm, or leg, that occurs as a result of an accident or injury) of two or more left lesser toes, person injured in unspecified motor-vehicle accident, traffic, nontraumatic subarachnoid hemorrhage (bleeding in the space that surrounds the brain) and nontraumatic subdural hemorrhage (a type of bleeding in which a collection of blood gathers between the inner layer of the meninges [the three thin layers that cover and protect the brain and spinal cord] surrounding the brain).</p> <p>Review of Resident 75's admission MDS dated [DATE], indicated Resident 75's BIMS score was 13 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</p> <p>Review of Resident 75's SBAR-GENERAL dated 6/13/2024, indicated, Allegation of Physical Abuse. Further review of the SBAR indicated, Resident 75 reported to staff a certified nursing assistant (CNA), threw her in her wheelchair and that he verbally abused her telling her she is loud and an old lady that talks to much. The SBAR indicated, the incident happened on 6/5/2024.</p> <p>Review of the IDT notes related to alleged physical and verbal abuse, dated 6/13/2024, indicated some recommendations, will continue and intervene accordingly .</p> <p>During a concurrent interview with SSD and record review on 6/19/2024 at 9:51 a.m., SSD reviewed her documentations related to the incident. SSD confirmed there was no documentation of SS three day follow up with Resident 75.</p> <p>During a concurrent interview with DON and record review on 6/19/2024 at 11:15 a.m. DON reviewed Resident 75's clinical records. DON confirmed there was no SS follow up with Resident 75's alleged abuse. DON stated, there should be SS follow up to check if Resident 75 was having emotional distress.</p> <p>3b. Review of Resident 75's SBAR-GENERAL dated 6/14/2024, indicated, Alleged financial abuse. Per resident she had \$1000 in her purse in a wallet and last seen it at 1100 am, she went to take money out of her wallet at 1700 and money was missing .</p> <p>During a concurrent observation and interview with Resident 75 on 6/18/2024 at 8:59 a.m., in the patio outside Resident 75's room, Resident 75 was having breakfast. Resident 75 had anger outburst (a sudden violent expression of strong feeling) to this surveyor, and stated they robbed me, they're incompetent .</p> <p>Review of Resident 75's clinical records, it did not indicate any SS follow up regarding the alleged financial abuse.</p> <p>3c. Review of Resident 75's SBAR-GENERAL dated 6/19/2024, indicated, Resident 75 was accused of being verbally abusive and went through her roommate's belongings.</p> <p>Review of the IDT notes related to Resident 75's being accused of verbally abusive to roommate, dated 6/19/2024, indicated, SSD to follow up with residents, psych eval.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview with Resident 75 on 6/18/2024 at 8:59 a.m., in the patio outside Resident 75's room, Resident 75 was having breakfast. Resident 75 had anger outburst (a sudden violent expression of strong feeling) to this surveyor, and stated they robbed me, they're incompetent .</p> <p>During an interview with SSD on 6/21/2024 at 10:44 a.m., SSD confirmed she did not follow up with Resident 75 about the accusation of being verbally abusive to her roommate (Resident 63).</p> <p>4. During an observation on 6/17/2024 at 10:29 a.m., inside Resident 285's room, Resident 285 was lying in bed and her bed had two upper bed rails in upright position. Resident 285 was awake and quiet at this time.</p> <p>During a concurrent observation and interview on 6/17/2024 at 12:44 p.m., inside Resident 19's room, Resident 19 was sitting at the edge of her bed. Resident 19 complained about the screamer, pointing towards Resident 285's room. Resident 19 stated, it was hard for her to sleep at night because of the screamer.</p> <p>During a concurrent observation and interview on 6/17/2024 at 3:50 p.m., inside Resident 61's room, Resident 61 was seated on his four wheeled walker and heard Resident 285 screamed. Resident 61 sounded irritated from the sound of Resident 285's scream and stated, Can you please make that person stop?</p> <p>During an observation on 6/18/2024 at 9:40 a.m., in Station AA's hallway, Resident 285 could be heard screaming and sounded like a baby crying. Resident 285 was screaming continuously.</p> <p>Review of Resident 285's face sheet ((summary page of a patient's important information), indicated, Resident 285 was admitted on [DATE] with diagnoses including sepsis (blood poisoning due to an infection), anemia (a condition in which the body does not have enough healthy red blood cells), type 2 diabetes mellitus with diabetic polyneuropathy (occurs when the body is unable to regulate glucose [sugar] in the blood, with nerve damage), unspecified dementia (a group of symptoms affecting thinking and social abilities interfering with daily functioning), dysphagia (difficulty swallowing), and gastrostomy status (G-tube or GT, a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach).</p> <p>Review of Resident 285's admission minimum data set (MDS, an assessment tool) dated 6/18/2024, indicated Resident 285 was usually understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time) and usually understands (misses some part/intent of message but comprehends most conversation). Further review of Resident 285's MDS indicated, Resident 285's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 6 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</p> <p>During a concurrent observation and interview with licensed vocational nurse D (LVN D) on 6/19/2024, in Station AA's hallway, Resident 285 could be heard screaming intermittently. LVN D confirmed Resident 285 had periods of screaming. LVN D stated, Resident D screamed mostly when she wanted to eat. LVN D confirmed Resident 285 had GT and her next feeding would be at 12:00 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview with director of nursing (DON) and record review on 6/20/2024 at 10:26 a.m., DON reviewed Resident 285's clinical records. DON confirmed the following: Resident 285 did not have an admission care conference, the behavior was not addressed, care plan regarding the behavior was not developed, and a risk meeting was done by the interdisciplinary team (IDT, a group of health care professionals from diverse fields who work toward a common goal for residents), but they did not address the behavior. DON stated Resident 285's behavior should have been monitored and managed with a plan of care.</p> <p>During an interview with the social services director (SSD) on 6/21/2024 at 10:50 a.m., SSD confirmed Resident 285's behavior of screaming should be addressed. SSD further confirmed the IDT did not discuss their plan of care about Resident 285's behavior. SSD stated she did not address Resident 285's behavior issue. SSD further stated the only assessment and conversation she did for Resident 285 was related to possible long term stay at the facility.</p> <p>During a review of the facility's undated job description titled, SOCIAL SERVICES - SALARIED, indicated, Has administrative authority and accountability for the provision of psychosocial needs of the residents and patients. Acts as a Resident Advocate. ESSENTIAL DUTIES AND RESPONSIBILITIES include the following. Other duties may be assigned .Collects and assesses data relevant to patients' psychosocial needs, risk factors for psychosocial deterioration and responses to interventions. Implements social service interventions that achieve treatment goals, address resident needs, link social supports, physical care and physical environment to enhance quality of life.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>48935</p> <p>Based on observation, interview, and record review, the facility failed to provide appropriate pharmacy pharmaceutical services when:</p> <ol style="list-style-type: none"> 1. A medication, Lamictal (a medication used to treat conditions such as bipolar disorder and seizure disorders) 200 milligrams (mg, unit of measure), was not available for one out of six residents (Resident 8), 2. There were discrepancies between the controlled drug (those with high potential for abuse and addiction) record (CDR, an inventory/accountability sheet) and the medication administration record (MAR) for four out of four residents (Residents 3, 22, 40, and 51), 3. A controlled substance medication was wasted without a witness for Resident 41, 4. The controlled substances medication destruction records did not have a registered nurse (RN) signature for three out of three residents (Residents 82, 335, and 336), and, 5. There was no CDR started for two controlled substances for Resident 47. <p>These failures had the potential for Resident 8 to suffer from withdrawal symptoms; and resulted in the facility not having accurate accountability of controlled medications, which had the potential for misuse or diversion.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a medication pass observation on 6/17/24 at 9:47 AM with Licensed Vocational Nurse (LVN) A, LVN A stated she did not have Lamictal 200 mg on hand to give to Resident 8. During the administration, LVN A administered two 25 mg tablets (50 mg total) to Resident 8 but did not administer a 200 mg tablet. <p>During a concurrent interview and inspection of the medication cart with LVN A on 6/17/24 at 10:01 AM, LVN A stated the Lamictal 200 mg dosage was not in stock, and that she reordered the medication from pharmacy the previous day. LVN A also stated only one dose of the medication was missed, which was today's dose.</p> <p>A review of Resident 8's physician orders, dated 06/15/2023, indicated Resident 8 was to receive Lamictal, one 200 mg tablet plus 50 mg (total of 250 mg) once a day at 9:00 AM for bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).</p> <p>During a follow-up interview and cart inspection with LVN E on 6/18/24 at 10:01 AM, LVN E stated Lamictal 200 mg was still not available yet, and that pharmacy will send the refill today, I'm holding them to it.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 8's June 2024 MAR indicated the resident did not receive Lamictal 200 mg dose at 9 AM on 6/17/24 and 6/18/24.</p> <p>A review of the facility's policy titled Pharmaceutical Services, dated 1/9/24, indicated: Medications shall be administered in a safe and timely manner, and as prescribed.</p> <p>2. During the survey, four random CDRs for four residents (Residents 3, 22, 40 and 51) were requested for review. On 6/18/24 at 10:19 AM, a review of the residents' physician orders, the CDRs and MARs indicated the following:</p> <p>a. Resident 3 had a physician order, dated 3/25/24 for hydrocodone-acetaminophen (Norco, a potent narcotic for pain) 5 mg-325 mg 1 tablet every 6 hours PRN (as needed). Resident 3 had six instances which were recorded in the CDR but not documented as given in the MAR: on 4/7/24 at 12:00 AM, 4/14 at 8:21 AM, 4/26 at 10:30 AM, 5/31 at 12:00 PM, 6/11/24 at 1:00 AM and 11:00 PM.</p> <p>b. Resident 22 had a physician order, dated 6/17/24, for oxycodone (a potent narcotic for pain) 10 mg 1/2 tablet every 8 hours PRN. Resident 22 had three instances which were recorded in the CDR but not documented as given in the MAR: on 5/31/24 at 11:00 AM, 6/5/24 at 11:08 AM, and 6/12/24 at 5:00 AM.</p> <p>c. Resident 40 had a physician order, dated 3/14/24, for oxycodone 5 mg 1 tablet every 12 hours PRN. Resident 40 had six instances which were recorded in the CDR but not documented as given in the MAR: 5/19/24 at 6:00 AM, 5/25/24 at 5:45 AM, 5/29/24 at 1:05 PM, 6/5/24 at 9:00 AM, 6/11/24 at 6:30 PM and 6/15/24 at 9:00 AM.</p> <p>d. Resident 51 had a physician order, dated 3/14/24, for hydrocodone-acetaminophen (Norco) 5 mg-325 mg 1 tablet every 8 hours PRN. Resident 51 had six instances which were recorded in the CDR but not documented as given in the MAR: 5/19/24 at 1:00 AM, 5/21/24 at 12:30 AM, 6/1/24 at 10:00 AM, 6/5/24 at 2:30 PM, 6/14/24 at 9:15 AM, and 6/15/24 at 7:30 AM.</p> <p>During a concurrent interview and record review with the director of nursing (DON) on 6/18/24 at 10:53 AM, the DON reviewed the residents' respective CDRs and MARs and verified the above findings, and stated she expected the nurses to sign out a medication in the CDR and record administration of the medication in the MAR. The DON also stated, It is important to document in both places because you don't want to be questioned by anyone about a mismatch, and to do it right.</p> <p>During an interview with Licensed Vocational Nurse (LVN A) on 6/19/24 at 10:50 AM, LVN A stated four out of six signatures on the CDR were hers for Resident 51, Resident 40, and Resident 3, and two out of three signatures were hers for Resident 22. LVN A also stated We have to be doing both, documenting controlled substance medication on the count sheet and the MAR.</p> <p>During an interview with LVN D on 6/19/24 at 11:02 AM, LVN D stated one out of three signatures on the CDR were hers for Resident 22, and one out of six signatures were hers for Resident 51 and Resident 40. LVN D also stated I was in a hurry. I can't really excuse not recording it in the MAR. I am usually pretty careful with that.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility policy titled Medication Administration-Controlled Substances, dated November 2017 indicated 4. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from controlled storage: a. Date and time of administration b. Amount administered c. Signature of the nurse administering the dose. 5. Administer the controlled medication and document dose administration on the MAR.</p> <p>3. During an interview on 6/18/24 at 10:53 AM, the DON stated two licensed nurses must sign off that a controlled substance medication was wasted, and both nurses must destroy the medication before disposing.</p> <p>During a concurrent interview and record review on 6/18/24 at 3:51 PM with the DON, the DON stated Resident 41 had a blister pack of Norco 5mg/325 mg for 10 doses. One dose was wasted on 5/18/24 at 5:00 PM, with the signature of only one registered nurse (RN). The DON verified that there should have been two nurses' signatures when a controlled medication is wasted</p> <p>Review of facility policy titled Medication Administration-Controlled Substances, dated November 2017, indicated When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It must be destroyed according to policy and the disposal documented on the accountability record on the line representing that dose.</p> <p>4. A review of three randomly chosen controlled drug record (CDR) papers for Residents 82, 335, and 336 indicated their respective controlled medications were destroyed on 5/14/24 but there were no signatures from a registered nurse (RN) There were only signatures from the consulting pharmacist (CP).</p> <p>During an interview with the DON on 6/19/24 at 10:38 AM, the DON verified that the CDR did not contain a RN signature for Residents 82, 335 and 336. The DON also stated either she can sign the Disposition of Remaining Doses with the CP or the NS can sign it.</p> <p>Review of Resident 82's physician orders dated from 4/1/24 to 4/8/24 indicated oxycodone 5 mg 2 tablets every 4 hours PRN (as needed).</p> <p>Review of Resident 335's physician orders dated from 4/25/24 to 5/1/24 indicated lorazepam 0.5 mg 1 tablet every 8 hours PRN.</p> <p>Review of Resident 336's physician orders indicated no active order. Review of the CDR indicated a past order for Oxycontin ER 10 mg 1 tablet twice daily.</p> <p>A review of facility policy last revised in January 2024 titled Disposal of Medications, Syringes and Needles-Disposal of Medications indicated .these controlled substances shall be disposed of by the nursing care center in the presence of appropriately titled professionals .Licensed nurse employed by the nursing care center and a pharmacist .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. During a concurrent medication cart inspection and interview with LVN C on 6/17/24 at 10:05 AM, a vial containing 10 tablets of lorazepam (a controlled medication for anxiety) 0.5 mg and a 30-mL bottle containing morphine 20 mg/milliliter (mL) were identified in the locked compartment of the medication cart. LVN C reviewed the binder containing the CDRs for controlled medications and stated they did not have the CDRs for Resident 47's lorazepam and morphine. LVN C stated a CDR sheet should have been put in the log to keep count of the medications.</p> <p>During an interview with the DON on 6/18/24 at 10:53, the DON stated controlled medications must be signed out in the CDR and administration must be recorded in the MAR.</p> <p>Review of Resident 47's physician orders indicated lorazepam 0.5 mg 1 tablet every six hours PRN and morphine concentrate 100 mg/5 mL 0.25 mL every three hours PRN.</p> <p>Review of facility policy, dated November 2017 titled Medication Administration-Controlled Substances indicated, When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from controlled storage .a. Date and time of administration. b. Amount administered. c. Signature of the nurse administering the dose .</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>27000</p> <p>Based on interview and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported drug irregularities during the monthly medication regimen review (MRR); and that there was documented clinical rationale when the physician disagreed with the CP's recommendation, for two of 18 sampled residents (Resident 2 and 29).</p> <p>The failure resulted in Resident 29 receiving concomitant use of two medications in the same therapeutic class, the loop diuretics (a type of medication that exerts its action on certain part of the kidneys; used in the management and treatment of fluid overload conditions such as heart failure and high blood pressure), for over a year; and Resident 2 receiving five psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) without the documented clinical rationale to support continued use.</p> <p>Findings:</p> <p>1. A review of Resident 29's medical record indicated he was admitted to the facility with diagnoses including congestive heart failure (long-term condition that happens when your heart can not pump blood well enough to give your body a normal supply) and hypertension (high blood pressure).</p> <p>A review of Resident 29's physicians orders included the following orders:</p> <ul style="list-style-type: none"> - Furosemide (a loop diuretic) 40 milligrams (mg, unit of measurement) twice daily for hypertension, dated 5/23/2023 - Torsemide (a loop diuretic) 40 mg once daily for hypertension, dated 6/7/2023 <p>There was no documented risk/benefit assessment or clinical rationale indicating why Resident 29 was receiving two loop diuretics at the same time since 6/7/23, more than a year ago.</p> <p>During a concurrent interview and record review with the director of nursing (DON) on 6/19/24 at 4:03 PM, she stated she could not find the clinical rationale why Resident 29 was receiving two loop diuretics at the same time.</p> <p>During an interview with the CP on 6/20/24 at 9:54 AM, the CP stated Resident 29 was on furosemide for short term for edema [fluid retention], and when the resident had another episode, they put her back on it. She stated there are no current standards of practice to use double loop diuretics at the same time for treatment of the same or different medical conditions. The CP stated she did not identify this duplicate therapy as an irregularity during her monthly MRR for Resident 29, and confirmed she should have.</p> <p>A review of the facility's policy and procedure titled Medication Monitoring Medication Regimen Review and Reporting, dated 9/2018, indicated the CP reviews the medication regimen of each resident to prevent, identify, report, and resolve medication-related problems or other irregularities.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. A review of Resident 2's medical record indicated she was admitted to the facility with diagnoses including bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and brief psychotic disorder (sudden onset of psychotic behavior that lasts less than one month followed by complete remission with possible future relapses).</p> <p>A review of Resident 2's physicians orders indicated the following psychotropic medications:</p> <p>a. Clonazepam (a medication to treat agitation and anxiety) 0.5 milligrams (mg, unit of measure) at bedtime for anxiety manifested by (m/b) inability to relax such as repetitive calling out since 8/18/22 (almost 2 years ago);</p> <p>b. Fanapt (iloperidone, an antipsychotic medication) 2 mg twice daily for schizoaffective disorder (a mental illness that can affect your thoughts, mood and behavior) manifested by (m/b) thinking that someone is after her, since 8/18/2022;</p> <p>c. Divaproex (Depakote, medication to treat mood disorder) 500 mg twice a day for bipolar disorder m/b (manifested by) mood swings since 8/18/23 (almost a year ago);</p> <p>d. Lamictal (lamotrigine, a medication for mood disorder) 100 mg, 1 tablet twice daily for Mood stabilization since 8/18/2023;</p> <p>e. Zolof (sertraline, an antidepressant) 150 mg once daily for depression m/b sad facial expressions, dated 05/19/2023.</p> <p>A review of the monthly psychotropic medication evaluations, dated 1/31/24, 4/3/24, 5/3/24, and 6/2/24, indicated Resident 2 had zero (0) behaviors for the previous months. In other words, during a 6-month period from December 2023 to May 2024, the Resident 2 had not exhibited any behaviors for which the above medications were indicated.</p> <p>During the survey, Resident 2 was observed on 6/20/24 at 10:15 AM and 06/20/24 at 11:52 AM during which she was very pleasant, quiet, and without any agitation or distress.</p> <p>During an interview with Certified Nursing Assistant (CNA) F on 6/20/24 at 11:39 AM, she stated Resident 2 was often confused but had no mood changes, calling out, or anxiety/inability to relax.</p> <p>During an interview with Licensed Vocational Nurse (LVN) C on 6/20/24 at 11:47 AM, she stated Resident mumbles when she talks . makes noises and asks for help when she doesn't need help but had no mood changes or anxiety/inability to relax.</p> <p>In an interview with CNA G on 6/6/20/24 at 12:06 PM, she stated she had never observed Resident 2 with mood changes or anxiety, or any delusion thinking that someone is after her.</p> <p>During an interview with CNA H on 6/20/24 at 12:47 PM, she stated Resident 2 sometimes cries but not often. She stated she never witnessed Resident 2 exhibiting mood changes or thinking someone is after her.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Despite the lack of behaviors, there were no documented evidence in the medical record the facility attempted the GDR (GDR, gradual dose reduction, a tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) for any of the medications since their respective ordered dates.</p> <p>A review of the physician's progress notes, written by Resident 2's physician (MD), indicated the following statements on the following dates:</p> <ul style="list-style-type: none"> - 12/07/2023, The patient was seen for psychotropic meeting. The patient is on clonazepam, valproic, Fanapt, lamotrigine, sertraline. GDR is contraindicated. We will continue at this point. - 3/27/2024, The patient was seen for the psychotropic gradual drug reduction. GDR was contraindicated, clonazepam, valproic, Vimpat [an anticonvulsant which is also used for mood disorder], lamotrigine and sertraline. - 5/22/2024, The patient was seen for psychotropic meeting. GDR is contraindicated. <p>A review of the CP's MRR, dated 2/12/24, indicated the CP asking the MD for an evaluation and consideration of a dose reduction of five medications above. In response, the MD checked the box DISAGREE and signed the document without offering a clinical rationale for the disagreement.</p> <p>During a concurrent interview and record review with the director of nursing (DON) and the nursing supervisor (NS) on 6/20/24 at 4:06 PM, they confirmed the MD did not provide a clinical rationale of why she disagreed with the CP's recommendations.</p> <p>A review of the facility's policy and procedure titled Medication Monitoring Medication Regimen Review and Reporting, dated 9/2018, indicated in part, Resident-specific MRR recommendations and findings are documented and acted upon by the nursing center and/or physician . For those issues that require physician intervention, the attending physician either accepts . or rejects all or some of the report and should document his or her rationale of why the recommendation is rejected in the resident's medical record.</p> <p>48935</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48935</p> <p>Based on interview and record review, the facility failed to ensure that one out of 18 sampled residents (Resident 29) was not receiving two medications of the same therapeutic class for over one year. This deficient practice had the potential for Resident 29 to receive unnecessary medication from duplicate therapy and increased risk of adverse effects from the medications.</p> <p>Findings:</p> <p>A review of Resident 29's clinical record indicated he was admitted on [DATE] with diagnoses including paroxysmal atrial fibrillation (an irregular heart rhythm), type 2 diabetes mellitus (poor control of blood sugar levels) and chronic congestive heart failure (failure of the heart caused by enlargement).</p> <p>A review of Resident 29's physician orders indicated Resident 29 had an order, dated 5/23/2023, for furosemide 40 mg 1 tablet twice a day at 9:00 AM and 5:00 PM. Review also indicated Resident 29 had an order, dated 6/7/2024, for torsemide 20 mg 2 tablets once a day at 9:00 AM. Both medications are considered loop diuretics, medications which act on the filtration loops in the kidneys.</p> <p>During a phone interview with the consulting pharmacist (CP) on 6/19/24 at 4:15 PM, CP stated she was not sure why the resident was on both furosemide and torsemide, and that she would follow up on that question.</p> <p>During an in-person interview with the CP on 6/20/24 at 9:55 AM, the CP stated Resident 29 was on furosemide for short term for edema [fluid retention], and when the resident had another episode, they put her back on it. She also stated there are no current standards of practice to use double loop diuretics at the same time for treatment of the same or different medical conditions.</p> <p>A review of the facility's policy titled Pharmaceutical Services, dated 1/9/24, indicated, Medications shall be administered in a safe . manner. Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27000</p> <p>Based on observation, interviews and record review, the facility failed to ensure 3 of 18 sampled residents (Residents 2, 41, and 59) were free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behaviors) when:</p> <ol style="list-style-type: none"> 1. Resident 2 received five psychotropic medications without a gradual dose reduction (GDR, a tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) and without documented clinical rationale why the GDR was contraindicated (advised against in specified cases or under specified conditions); 2. Resident 41 received Seroquel (generic name: quetiapine, an antipsychotic medication) without specific and documented indication, and without an initial AIMS (abnormal involuntary movement scale, a rating scale designed to measure involuntary movements known as tardive dyskinesia, a disorder that sometimes develops as a side effect of long-term treatment with antipsychotic medications) assessment; and 3. For Resident 59, the GDR assessment for the use of Seroquel did not have a physician-documented clinical rationale why the GDR was contraindicated. <p>The failures resulted in unnecessary medications for the residents, which had the potential for increased risks associated with psychotropic medication use that include but not limited to sedation, respiratory depression, falls, constipation, anxiety, agitation, abnormal involuntary movements, and memory loss.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 2's medical record indicated she was admitted to the facility with diagnoses including bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and brief psychotic disorder (sudden onset of psychotic behavior that lasts less than one month followed by complete remission with possible future relapses). <p>A review of Resident 2's physicians orders indicated the following psychotropic medications:</p> <ol style="list-style-type: none"> a. Clonazepam (a medication to treat agitation and anxiety) 0.5 milligrams (mg, unit of measure) at bedtime for anxiety manifested by inability to relax such as repetitive calling out since 8/18/22 (almost 2 years ago); b. Fanapt (iloperidone, an antipsychotic medication) 2 mg twice daily for schizoaffective disorder (a mental illness that can affect your thoughts, mood and behavior) manifested by (m/b) thinking that someone is after her, since 8/18/2022; c. Divaproex (Depakote, medication to treat mood disorder) 500 mg twice a day for bipolar disorder m/b mood swings since 8/18/23 (almost a year ago); <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. Lamictal (lamotrigine, a medication for mood disorder) 100 mg, 1 tablet twice daily for Mood stabilization since 8/18/2023;</p> <p>e. Zoloft (sertraline, an antidepressant) 150 mg once daily for depression m/b sad facial expressions, dated 05/19/2023.</p> <p>A review of the monthly psychotropic medication evaluations, dated 1/31/24, 4/3/24, 5/3/24, and 6/2/24, indicated Resident 2 had zero (0) behaviors for the previous months. In other words, during a 6-month period from December 2023 to May 2024, the Resident 2 had not exhibited any behaviors for which the above medications were indicated.</p> <p>During the survey, Resident 2 was observed on 6/20/24 at 10:15 AM and 06/20/24 at 11:52 AM during which she was very pleasant, quiet, and without any agitation or distress.</p> <p>During an interview with Certified Nursing Assistant (CNA) F on 6/20/24 at 11:39 AM, she stated Resident 2 was often confused but had no mood changes, calling out, or anxiety/inability to relax.</p> <p>During an interview with Licensed Vocational Nurse (LVN) C on 6/20/24 at 11:47 AM, she stated Resident mumbles when she talks . makes noises and asks for help when she doesn't need help but had no mood changes or anxiety/inability to relax.</p> <p>In an interview with CNA G on 6/6/20/24 at 12:06 PM, she stated she had never observed Resident 2 with mood changes or anxiety, or any delusion thinking that someone is after her.</p> <p>During an interview with CNA H on 6/20/24 at 12:47 PM, she stated Resident 2 sometimes cries but not often. She stated she never witnessed Resident 2 exhibiting mood changes or thinking someone is after her.</p> <p>Despite the lack of behaviors, there were no documented evidence in the medical record the facility attempted the GDR for any of the medications since their respective ordered dates.</p> <p>A review of the physician's progress notes, written by Resident 2's physician (MD), indicated the following statements on the following dates:</p> <ul style="list-style-type: none"> - 12/07/2023, The patient was seen for psychotropic meeting. The patient is on clonazepam, valproic, Fanapt, lamotrigine, sertraline. GDR is contraindicated. We will continue at this point. - 3/27/2024, The patient was seen for the psychotropic gradual drug reduction. GDR was contraindicated, clonazepam, valproic, Vimpat [an anticonvulsant which is also used for mood disorder], lamotrigine and sertraline. - 5/22/2024, The patient was seen for psychotropic meeting. GDR is contraindicated. <p>During a concurrent interview and record review with the director of nursing (DON) and the nursing supervisor (NS) on 6/20/24 at 4:06 PM, they confirmed there had been no GDR attempts for the above medications since their respective ordered dates. They also confirmed there were no documented risk versus benefit assessment why the resident did not benefit from a GDR, nor was there a clinically pertinent explanation for why the GDR is contraindicated.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's undated policy and procedure titled Psychotropic Medication Assessment and Monitoring indicated:</p> <p>Dosage reduction or re-evaluations are provided (follow regulations)</p> <p>- Reductions or re-evaluations are not necessary if, within the last reduction time frame, the resident has had a gradual dose reduction and the dose has been reduced to the lowest possible dose to control the symptoms, and the physician documents this information.</p> <p>In the facility-provided undated document titled Gradual Dose Reduction: Implication for Prescribers, it indicated the GDR for psychotropic medications may be contraindicated if the continued use is in accordance with relevant current standards of practice AND the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would likely impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.</p> <p>48935</p> <p>2. Review of Resident 41's clinical document titled Resident Face Sheet indicated Resident 41 was admitted on [DATE] with diagnoses including periprosthetic fracture (broken bone) around internal left hip joint, unspecified dementia (a disease that negatively affects brain function), and hypothyroidism (diseased caused by low thyroid hormone).</p> <p>Review of Resident 41's physician order dated 6/14/24 indicated quetiapine 25 mg 1 tablet at 7:00 PM. The indication given was Psychotic Disorder.</p> <p>According to the National Library of Medicine, psychotic disorders are severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality. They include mental illnesses such as schizophrenia, schizoaffective disorder, bipolar disorder, etc. (https://medlineplus.gov/psychoticdisorders.html; accessed 6/26/24)</p> <p>Review of Resident 41's medical record indicated there was no AIMS measurement documented anywhere in the electronic chart.</p> <p>During a concurrent interview with the DON on 6/19/24 at 1:39 PM, the DON stated the diagnosis of psychotic disorder is not specific indication as it could mean any serious mental illness. She also stated the AIMS is done on initiation and then every 6 months after that. The DON also stated that she could not find a documented AIMS in Resident 41's medical record.</p> <p>Review of facility undated policy titled Antipsychotic Medication Use indicated Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat specific condition as diagnosed and documented in the clinical record . Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident.</p> <p>3. A review of Resident 59's clinical document titled Resident Face Sheet indicated Resident 59 was admitted on [DATE] with diagnoses including history of traumatic brain injury, unspecified mood disorder and type 2 diabetes (disorder in regulation of blood sugar levels).</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 59's physician order, dated 1/16/24, indicated for quetiapine 50 mg 1 tablet at 9:00 AM; and another order, dated 3/27/24, for quetiapine 200 mg 1 tablet at 9:00 PM for psychosis.</p> <p>Review of the medical director (MD)'s progress note dated 5/22/24 indicated The patient was seen for psychotropic meeting. On Seroquel 50 mg q.a.m. and 200 mg q.h.s. [at bedtime]. GDR is contraindicated.</p> <p>During an interview with the DON on 6/20/24 at 1:02 PM, the DON stated there needs to be a given reason for why a gradual dose reduction (GDR) is contraindicated. The DON also stated, I argued with [MD] about the contraindication for gradual dose reduction, about how she should write why it is contraindicated. Because how can I explain to the family?</p> <p>Review of facility undated policy titled Antipsychotic Medication Use indicated The physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweighs the risks or suspected or confirmed adverse consequences.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>48935</p> <p>Based on observation, interview and record review, the facility had a medication error rate of 7.41% when two medication errors occurred out of 27 opportunities during medication administration for one out of six residents (Resident 8). This failure resulted in medication not given in accordance with the prescriber's order and facility policy and procedure (P&P), which resulted in resident not receiving the full therapeutic effects of the medications.</p> <p>Findings:</p> <p>1. During a medication pass observation on 6/17/24 at 9:47 AM with Licensed Vocational Nurse (LVN) A, LVN A stated she did not have Lamictal (a medication used to treat conditions such as bipolar disorder and seizure disorders) 200 milligrams (mg, unit of measure) on hand to give to Resident 8. During the administration, LVN A administered two 25 mg tablets (50 mg total) to Resident 8 but did not administer a 200 mg tablet.</p> <p>During a concurrent interview and inspection of the medication cart with LVN A on 6/17/24 at 10:01 AM, LVN A stated the Lamictal 200 mg dosage was not in stock, and that she reordered the medication from pharmacy the previous day. LVN A also stated, Only one dose of the medication was missed, which was today's dose.</p> <p>A review of Resident 8's physician orders, dated 06/15/2023, indicated Resident 8 was to receive Lamictal, one 200 mg tablet plus 50 mg (total of 250 mg) once a day at 9:00 AM for bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).</p> <p>During a follow-up interview and cart inspection with LVN E on 6/18/24 at 10:01 AM, LVN E stated Lamictal 200 mg was still not available yet, and that pharmacy will send the refill today, I'm holding them to it. LVN E also stated, It's important to not skip administration of this medication because it can cause a rebound effect.</p> <p>A review of the facility's P&P titled Medication Administration General Guidelines, dated 1/2021, indicated, Medications are administered in accordance with written orders of the prescriber.</p> <p>2. During a medication pass observation on 6/17/24 at 9:47 AM with LVN A, LVN A administered olopatadine 0.1% (an eye drop medication used to treat irritation and swelling in the eyes), one eye drop in each eye by directly dropping it in the eye without putting in the conjunctival sac (a pouch in the lower eye lid of an eye). LVN A also did not have the resident slowly close their eyes after administering one drop in each eye, or compress the inner corner of each eye for one minute.</p> <p>During an interview with LVN A at 10:01 AM, LVN A stated Resident 8 doesn't like her eyes getting pulled when asked administering the eye drops to Resident 8. When asked about closing the eyes and holding the tear ducts closed, LVN A stated I did not know it had to be done that way.</p> <p>During an interview with the director of nursing (DON) on 6/17/24 at 3:54 PM, the DON stated eye drops have to be applied to the conjunctiva sac, and she expects the nursing staff to apply pressure to the lacrimal gland after administering eye drops.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 8's physician order, dated 4/16/2023, indicated Resident 8 was to receive olopatadine 0.1% eye drops, one eye drop in both eyes, once a day at 9:00 AM, for left eye swelling.</p> <p>Review of facility's policy titled Medication Administration-Eye Drops, last revised in May 2016, indicated, With a gloved finger, gently pull down lower eyelid to form pouch while instructing resident to look up . and Instruct resident to close eyes slowly to allow for even distribution over the surface of the eye, and While the eye is closed, use one finger to compress the tear duct in the inner corner (inner canthus) of the eye for 1-2 minutes. This reduces systemic absorption of the medication.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48935</p> <p>Based on observation, interview and record review, the facility failed to ensure medications and biologicals were stored appropriately when:</p> <ol style="list-style-type: none"> 1. An emergency medication kit (e-kit, a kit/box containing medications for immediate use during a medical emergency) contained an expired medication in it. This had the potential for residents to be given expired medications in an emergency, which would be ineffective for their treatment. 2. A treatment cart with wound care supplies was left unlocked, and the cart's drawer was left opened. This had the potential for access to medications and supplies by unauthorized persons such as residents and visitors <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent medication storage inspection and interview with Licensed Vocational Nurse (LVN) C on 6/17/24 at 10:05 AM, one e-kit containing 8 tablets of lorazepam (medication to treat agitation or anxiety) 0.5 milligrams (unit of measurement) was observed with the expiration date of 04/2024. LVN C confirmed the expiration date of the lorazepam and stated, It should have been replaced. <p>A review of the facility's policy titled Medication Storage, dated 1/2024, indicated in part, Outdated . medications .are immediately removed from stock .and reordered from the pharmacy.</p> <p>37409</p> <ol style="list-style-type: none"> 2. Review of Resident 64's Admission Record indicated he was admitted to the facility on [DATE]. <p>Review of Resident 64's 6/2024 Treatment Administration Record (TAR) indicated he had wounds on his left and right gluteal folds (the horizontal skin crease that forms below the buttocks, separating the upper thigh from the buttocks).</p> <p>During an observation on the treatment for Resident 64's wounds with registered nurse K (RN K) on 6/20/24, at 11:12 a.m., while providing the treatment for Resident 64's wounds, RN K realized that she forgot to bring the skin protectant packet with her. RN K went back to the treatment cart, opened the treatment cart and the drawer to get the skin protectant packet, came back into Resident 64's room, continued the treatment, and left the treatment cart unlocked and the drawer opened in the hallway.</p> <p>During an observation on the treatment cart and interview with RN K on 6/20/24 at 11:24 a.m., RN K confirmed her treatment cart was unlocked and the drawer was opened. RN K stated the treatment cart, and the drawer should be locked.</p> <p>(continued on next page)</p>		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's 2007 policy, Medication Storage - Storage of Medication, indicated . 3. medication supplies should remain locked when not in use or attended to by persons with authorized access.		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>38087</p> <p>Based on observation and interview the facility failed to ensure food served was palatable and attractive. This failure had the potential to affect the amount of food residents consume, which could decrease their food intake and lead to poor nutrition and health outcomes.</p> <p>Findings:</p> <p>As a result of multiple resident complaints about the food, in particular complaints about the meats served being hard and dry, a test tray evaluation was conducted during the lunch service on 6/18/24 at 1:35 p.m. The consultant dietary manager (CDM) was in attendance when the test tray contents were sampled by four surveyors. One meat item served on the test tray was a breaded chicken fillet. The fillet was thin and covered in a breading crust. The breaded chicken fillet was very hard and difficult to cut. The breading was dark brown and appeared to be overcooked. The meat inside was dry. All 4 of the surveyors who tasted the chicken concurred that the meat was hard, dry, and overcooked. The CDM stated the chicken tasted fine.</p> <p>A review of the facility document titled, Job Description: Cook, revised 4/30/17, indicated the cook prepares palatable, nourishing, well-balanced meals to meet the daily nutritional and special dietary needs for each resident.</p> <p>A review of the facility document titled, Job Description: Registered Dietician, undated, indicated the essential duties and responsibilities may include supervising food preparation using techniques that conserve nutritional value, flavor, and appearance.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>38087</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident food preferences were honored when Resident 46 disliked the planned lunch entree. This failure had the potential to result in decreased food intake and potential weight loss.</p> <p>Findings:</p> <p>A review of Resident 46's tray card indicated she had a pureed diet ordered. The tray card indicated that she disliked fish.</p> <p>A review of the facility's lunch menu for 6/18/24 indicated the entree to be served was breaded fish and baked potato wedges.</p> <p>During a tray line observation in the kitchen on 6/18/24 at 12:35 p.m., [NAME] J was observed plating Resident 46's lunch meal. [NAME] J placed one scoop of pureed fish onto the plate in addition to the other menu items. The kitchen aide covered the plate and placed the entire tray in the food delivery cart. When the cart was ready to be taken out of the kitchen for delivery to the dining room, the registered dietician (RD) was asked to view Resident 46's meal tray and compare it to the diet card of Resident 46. The RD confirmed Resident 46's tray card indicated she disliked fish and confirmed the presence of pureed fish on Resident 46's lunch tray. The RD stated the fish should not be served if a resident dislikes fish and confirmed Resident 46 should have an alternate entree item served instead of the fish.</p> <p>A review of the facility's policy, Nutrition Care-Resident Food Preferences dated 2023, indicated the resident food preference should be placed on the profile card and identified on the tray card. The policy further indicated all residents must be offered a substitute food item when an item they dislike is on the menu. Substitutes must be foods of similar nutrient value.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583</p> <p>Based on observation, interview, and record review, the facility failed to ensure snacks was in accordance with resident's needs, preferences, and requests for one (Resident 288) of seven sampled residents (residents who attended the resident council's meeting). This failure resulted in Resident 288's needs and preferences not being met. This failure had the potential for other residents not to have snacks in their requested times.</p> <p>Findings:</p> <p>During an interview in the resident council meeting on 6/19/2024 at 11:01 a.m., Resident 288 stated he was on antibiotics (a drug used to treat infections caused by bacteria and other microorganisms) which made his stomach upset. Resident 288 further stated the staff at night did not have crackers when he requested and so he stopped taking his antibiotics.</p> <p>Review of Resident 288's face sheet (summary page of a patient's important information) indicated, Resident 288 was admitted to the facility on [DATE] with diagnoses including acute on chronic systolic heart failure (damage in the heart, which may have developed over time), hypertension (high blood pressure), and gastro-esophageal reflux disease (GERD, a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, called the esophagus).</p> <p>Review of Resident 288's admission/5-day scheduled minimum data set (MDS, an assessment tool) assessment dated [DATE], indicated Resident 288's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 14 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</p> <p>Review of Resident 288's physician order report dated 5/21/2024-6/21/2024, indicated Resident 288 was on cephalexin (an antibiotic medication) 500 milligrams (mg, unit of measurement), one capsule by mouth every eight hours for urinary tract infection (UTI, an infection in any part of the urinary system). Further review of the physician order report, it indicated the cephalexin was started on 6/14/2024 and ended on 6/19/2024.</p> <p>Review of Resident 288's medication administration record (MAR) dated 6/1/2024-6/21/2024, indicated, Resident 288 refused the cephalexin on 6/18/2024, 2:00 p.m. dose, 6/19/2024, 6:00 a.m. and 2:00 p.m. doses.</p> <p>During a concurrent observation and interview with registered nurse P (RN P) on 6/21/2024 at 1:20 p.m., inside the medication room in Station AA, the refrigerator did not have any snacks except a nutritional supplement and apple sauce were observed. There were no dried snacks stored in Station AA. RN P confirmed the observation. RN P stated they have a scheduled snacks provided by the kitchen at 10 a.m., 2 p.m. and at bedtime.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the nursing supervisor (NS) on 6/21/2024 at 1:26 p.m., NS stated they did not store crackers or any dried snacks at the nurse stations or medication rooms. NS further stated, kitchen staff would leave a tray of sandwiches, fruits, yogurt, pudding, and crackers for evening snacks and will discard them in the morning.</p> <p>During an interview with Resident 288 on 6/21/2024 at 2:52 p.m., Resident 288 stated he often had upset stomach and he needed to have some food to relieve his upset stomach. Resident 288 further stated nobody followed up with his food preferences since he got admitted at the facility. Resident 288 confirmed he never had snacks, and nobody offered him to have snacks since admission. Resident 288 stated, he had to ride a cab one day and went to a store to get some snacks (this statement was confirmed in record review on Resident 288's nurse progress note dated 6/19/2024).</p> <p>During an interview with director of nursing (DON) on 6/21/2024 at 3:05 p.m., DON confirmed they did not store snacks. DON stated they asked the kitchen staff for snacks if needed. Nobody had a key to the kitchen if they ran out of the kitchen provided evening snacks. DON further stated dietary supervisor (DS) should have done the assessment upon admission to determine residents' food preferences.</p> <p>During a concurrent interview with registered dietitian (RD) and record review on 6/21/2024 at 3:30 p.m., RD reviewed Resident 288's assessment record. RD confirmed there were no documentation that the DS did his assessment about Resident 288's food preferences and RD did not do Resident 288's nutrition assessment.</p> <p>During a review of the facility's undated policy and procedure titled, Food Alternates, indicated, If planned alternates are refused, additional items may be designated to be available at all times, e.g. (stands for <i>exempli gratia</i>, meaning for example), peanut butter, cottage cheese, crackers, sandwiches, cold cereal, juice, ice cream.</p> <p>During a review of the facility's undated policy and procedure titled, Nutritional Assessment, indicated, Food History: complete the Diet History/Food Preference List Form to obtain food preferences and nutrition history information within 48 hours of admission.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38087</p> <p>Based on observation, interview and record review, the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food safety when:</p> <ol style="list-style-type: none"> 1. Pans and a bowls used for food preparation and food service were stacked and stored wet; 2. A cup was left inside the sugar container; 3. Unpasteurized eggs were used during a breakfast meal service. <p>These failures had the potential to cause food contamination and food-borne illness to 79 of 79 residents who received their food from the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an observation on 6/17/24 at 9:16 a.m., there were 4 metal pans of various sizes observed to be stacked on a metal wire rack. The pans were stacked upside down inside of one another and were wet inside and outside of the pan's surfaces. There were 2 large metal bowls stacked upside down on top of each other and were wet on the inside and outside of the bowls. The consultant dietary manager (CDM) confirmed the pans and bowls were wet and she stated they should have been air dried before being stacked and stored. <p>Review of the facility's undated policy titled Machine Dishwashing Raking Procedure indicated to Air dry dishes. Do not wipe with a dish towel. Stack when dry.</p> <ol style="list-style-type: none"> 2. During an observation on 6/17/24 at 9:32 a.m., there was a large plastic bin containing sugar with a Styrofoam cup inside the bin. The cup was touching the sugar. The dietary supervisor (DS) confirmed the cup was inside the bin of sugar and stated staff should not leave any scoops or cups inside the bin. The DS further stated scoops should be brought to the bin for each use and should not be stored inside the bin. 3. During an observation in the walk-in refrigerator, on 6/17/24 at 10:00 a.m., a metal pan containing 7 eggs, one cardboard flat of 25 eggs, and an open box containing multiple flats of eggs were observed on the metal shelves of the refrigerator. All of the eggs were white with no outer markings on the shell to indicate if they were pasteurized. The cardboard box was labeled 15 dozen eggs but had no indication if they were pasteurized eggs. <p>During a concurrent interview with the CDM she stated the facility should be using pasteurized eggs. She confirmed there was no indication the loose eggs or the box of eggs could be identified as pasteurized. She stated the eggs need to be labeled or identified as pasteurized.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the [NAME] J (Cook J) on 6/17/24 at 10:11 a. m. he was asked if the eggs in the walk-in refrigerator were pasteurized. He stated he did not know and did not know how to tell if they were pasteurized or unpasteurized. When asked if he served residents eggs out of the shell during the morning's breakfast service, the [NAME] J stated he had served about 20 eggs, fried and over easy, this morning at breakfast.</p> <p>The facility's breakfast tray cards for 6/17/24, provided by the RD, were reviewed for 79 residents. There were preferences identified as fried eggs and over easy eggs for 10 residents. Further review of the diet tray cards indicated Resident 15 and Resident 42 preference was for 2 fried eggs. Over easy eggs were identified as a preference for Residents 4, 7, 34, 48, 53, 54, 61, and 75.</p> <p>During an interview with the registered dietician (RD) on 6/17/24 at 2:25 p.m., he stated the eggs in the refrigerator are not pasteurized. The RD stated the facility usually orders pasteurized eggs and confirmed shell eggs should not be prepared for residents unless pasteurized eggs are used. The RD stated the facility will order a supply of pasteurized eggs.</p> <p>A review of the facility's undated policy titled Egg Cooking indicated It is best to use pasteurized egg products when feeding the elderly due to increased susceptibility to foodborne illnesses.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>44583</p> <p>Based on observation, interview, and document review, the facility failed to ensure the dumpster lid was kept closed. This failure had the potential to attract pests in the facility.</p> <p>Findings:</p> <p>During an observation on 6/19/2024 at 11:15 a.m., inside the director of nursing's (DON's) office, the facility's dumpster could be observed through a window. The dumpster was located at the back of the facility. One staff opened the dumpster's lid and threw a garbage. The staff left the dumpster lid open.</p> <p>During a follow up observation on 6/19/2024 at 11:29 a.m., through the DON's office window, the same dumpster lid was still left open.</p> <p>During a concurrent observation and interview with dietary supervisor (DS) on 6/20/2024 at 10:53 a.m., at the back of the facility, the blue dumpster was overflowing with cartons of boxes which kept the lid open. DS confirmed the observation. DS stated all the dumpsters' lids should be kept closed to prevent from attracting some pests.</p> <p>During a review of the facility's undated policy and procedure titled, Food Handling Practices, indicated, 12. Follow proper food waste disposal practices .Keep lids/doors to dumpsters closed when not dumping garbage.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37409</p> <p>Based on observation, interview, and record review, the facility failed to implement infection control practices when:</p> <ol style="list-style-type: none"> 1. The registered dietician (RD) walked in the hallway to the big dining room with gloves on; 2. The rehab director (RHD) checked the residents' lunch tickets on the lunch trays, passed lunch trays to certified nursing assistant N (CNA N) and certified nursing assistant O (CNA O) to bring to the residents in their rooms without sanitizing her hands; CNA N and CNA O carried lunch trays to the residents without sanitizing their hands; licensed vocational nurse A (LVN A) checked the residents' lunch tickets on the lunch trays and opened the lids of the lunch trays to check on the food without sanitizing her hands; and the infection preventionist (IP) checked the residents' lunch tickets on the lunch trays, opened the lids of the lunch trays to check on the food, and passed the lunch trays to CNAs to bring them to the residents in their rooms without sanitizing her hands; 3. The activity director (AD) and certified nursing assistant L (CNA L) went into the isolation room for Coronavirus disease (COVID-19, an infectious disease caused by the SARS-CoV-2 virus which can spread from an infected person's mouth or nose in small liquid particles when they cough, sneeze, speak, sing or breathe) wearing surgical mask, and certified nursing assistant M (CNA M) went in the isolation room for COVID-19 not wearing a gown; 4. Resident 38's oxygen tubing was undated, and Resident 38's and Resident 72's filters of oxygen concentrators were dusty; 5. Registered nurse K (RN K) picked up sterile Alginate dressing (highly absorbent dressing) and clean gauzes with her contaminated gloved hands when doing the treatment for Resident 64's wounds; 6. Restorative nurse assistant (RNA) did not perform hand hygiene in between Resident 2 and Resident 4's meal assistance; 7. Certified nursing assistant Q (CNA Q) did not wear a face mask when she entered the facility with COVID-19 outbreak; and 8. CNA O touched the shared bathroom doorknob with dirty gloves, in Resident 31's room, placed the clean washcloth in the sink, used the same washcloth during incontinent care with Resident 31 and used dirty gloves to place a clean disposable brief on Resident 31. <p>These failures had the potential to spread infection in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an observation on 6/17/24, at 12:37 p.m., the registered dietician (RD) was walking in the hallway to the big dining room with gloves on. <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent interview, the RD stated he just came out of the kitchen and forgot to remove the gloves. The RD acknowledged that he should remove gloves before walking out in the hallway.</p> <p>During an interview with the director of nursing (DON) on 6/24/24, at 1:45 p.m., she stated the RD talked to her about that, and she told him that he should remove gloves before walking out in the hallway.</p> <p>Review of the facility's undated policy, Standard Precautions, indicated Remove gloves promptly after use, and wash hands immediately .</p> <p>2. During an observation on 6/17/24, at 12:45 p.m., the rehab director (RHD) came to lunch cart 1, checked the residents' lunch tickets on the lunch trays, passed lunch trays to certified nursing assistant N (CNA N) and certified nursing assistant O (CNA O) to bring to the residents in their rooms without sanitizing her hands, and CNA N and CNA O carried lunch trays to the residents without sanitizing their hands.</p> <p>During an interview with the RHD, CNA N, and CNA O on 6/17/24, at 1:06 p.m., the RHD acknowledged that she should sanitize her hands before checking the tickets on the lunch trays and passing the lunch trays to CNAs to bring to the residents; CNA N and CNA O stated they should sanitize their hands before carrying the lunch trays to the residents.</p> <p>During an observation on 6/17/24, at 1 p.m., licensed vocational nurse A (LVN A) came to lunch cart 1, checked a resident' lunch ticket on the lunch tray and opened the lid of the lunch plate to check on the food without sanitizing her hands.</p> <p>During an interview with LVN A on 6/17/24, at 1:14 p.m., she acknowledged that she should sanitize her hands before checking the lunch ticket on the lunch tray and opening the lid of the lunch plate to check on the food.</p> <p>During an observation on 6/17/24, at 1:35 p.m., the infection preventionist (IP) pushed the lunch cart 2 over, opened the lunch cart 2, checked residents' lunch tickets on the lunch trays, opened the lids of the lunch plates to check on the food, and passed the lunch trays to the CNAs to bring to the residents in their rooms without sanitizing her hands.</p> <p>During an interview with the IP on 6/17/24, at 1:44 p.m., the IP stated she should sanitize her hands before checking residents' lunch tickets on the lunch trays, opening the lids of the lunch plates to check on the food, and passing the lunch trays to the CNAs to bring to the residents.</p> <p>During an interview with the director of nursing (DON) on 6/24/24, at 1:45 p.m., the DON stated staff should sanitize their hands before checking the meal ticket on the meal tray, opening the lid of the meal plate to check on the food, passing the meal tray to the CNA, and carrying the meal tray to the resident.</p> <p>3. During an observation on 6/17/24, at 10:15 a.m., the activity director (AD) went in Resident 33's room which was a COVID-19 isolation room to answer his call light wearing a surgical mask.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent interview, the AD stated she should wear a N95 mask (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) instead of a surgical mask when entering a COVID-19 isolation room.</p> <p>During an observation on 6/17/24, at 11:12 a.m., certified nursing assistant M (CNA M) went in Resident 58's room which was a COVID-19 isolation room to give him ice water without wearing a gown (a personal protective equipment used to provide broad barrier protection).</p> <p>During a concurrent interview, CNA M acknowledged she should put on a gown before entering Resident 58's room.</p> <p>During an observation on 6/17/24, at 11:40 a.m., CNA L went in Resident 54's room which was a COVID-19 isolation room wearing a surgical mask.</p> <p>During a concurrent interview, CNA L stated she should wear a N95 mask instead of a surgical mask when entering Resident 54's room.</p> <p>During an interview with the infection preventionist (IP) on 6/17/24, at 10:15 a.m., she stated staff should wear N95 when entering COVID-19 isolation room, and on 6/18/24, at 10:10 a.m., the IP stated staff should put on a gown before entering COVID-19 isolation room.</p> <p>Review of the facility's undated policy, COVID-19 Using Personal Protective Equipment (PPE), indicated . 3. a. Personnel who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection adhere to enhanced transmission-based precautions and use a N95 or equivalent or higher-level respirator, gown, gloves, and eye protection.</p> <p>4. Review of Resident 38's Admission Record indicated she was admitted to the facility on [DATE] with dependence on supplemental oxygen diagnosis.</p> <p>Review of Resident 38's physician order indicated she had an order, started on 1/5/24, for continuous oxygen at 3 liters (L, a metric unit of volume) per minute.</p> <p>During an observation and interview with the infection preventionist (IP) on 6/17/24, at 1:25 p.m., Resident 38 was on supplemental oxygen. Her oxygen tubing was undated, and the filter of her oxygen concentrator was dusty. The IP stated the oxygen tubing should be dated and changed every week, and the filter of the oxygen concentrator should be kept clean.</p> <p>Review of Resident 72's Admission Record indicated he was admitted to the facility on [DATE] with chronic obstructive pulmonary disease (COPD, lung diseases that block airflow and make it difficult to breathe) diagnosis.</p> <p>Review of Resident 72's physician order indicated he had an order, started on 3/21/24, for continuous oxygen at 3 L per minute.</p> <p>During an observation and interview with the infection preventionist (IP) on 6/17/24, at 1:30 p.m., Resident 72 was on supplemental oxygen, and the filter of his oxygen concentrator was dusty. The IP stated the filter of the oxygen concentrator should be kept clean.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview with the IP on 6/17/24, at 4:40 p.m., she stated the filter of oxygen concentrator should be cleansed every week.</p> <p>Review of the facility's undated policy, Cleaning Respiratory Equipment, indicated Supplies: 1. Replace masks and/or cannulas used by an individual resident within 7 days, . Oxygen Tanks, Connectors, and Concentrators: . 2. Clean oxygen concentrator filters weekly.</p> <p>5. Review of Resident 64's Admission Record indicated he was admitted to the facility on [DATE].</p> <p>Review of Resident 64's 6/2024 Treatment Administration Record (TAR) indicated he had wounds on his left and right gluteal folds (the horizontal skin crease that forms below the buttocks, separating the upper thigh from the buttocks).</p> <p>During an observation on the treatment for Resident 64's wounds with registered nurse K (RN K) on 6/20/24, at 11:12 a.m., RN K prepared the supplies for the treatment. RN K washed her hands, put on gloves, opened the treatment cart, opened the drawers looking for supplies, got the treatment creams to the medication cups, then opened the Alginate dressing packet and picked up the sterile Alginate dressing and picked up the clean gauzes with the same gloved hands that she opened the treatment cart, opened the drawers looking for supplies, and got the treatment creams to the medication cups.</p> <p>During an interview with RN K on 6/20/24, at 11:45 a.m., she acknowledged that she should not picked up the sterile Alginate dressing and clean gauzes with her contaminated gloved hands.</p> <p>Review of the facility's undated policy, Standard Precautions, indicated . 4. Gloves: . Remove gloves promptly after use, and wash hands immediately before touching non-contaminated items .</p> <p>44583</p> <p>6. During lunch observation on 6/18/2024 at 1:02 p.m., inside the big dining room, RNA was observed seated between Resident 2 and Resident 4. RNA touched Resident 2's adaptive utensils, which was already used by Resident 2, and handed them to Resident 2's hands. RNA turned to her right-side assisted Resident 4 in opening his drinks without performing hand hygiene.</p> <p>During an interview with RNA on 6/18/2024 at 1:24 p.m., RNA confirmed above observations. RNA stated she should have performed hand hygiene in between meal assistance with two residents.</p> <p>During an interview with DON on 6/24/2024 at 12:02 p.m., DON stated staff should perform hand hygiene in between residents' meal assistance.</p> <p>During review of the facility's undated policy and procedure titled, Assisting the Resident to Eat, indicated, Wash your hands if you will be assisting the resident to eat.</p> <p>Review of the Centers for Disease Control and Prevention's (CDC) guidelines, titled, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/24/2024, indicated, All healthcare personnel should understand how to care for and clean their hands .Know when to clean your hands .After touching patient or patient's surroundings .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Driftwood Healthcare Center - Santa Cruz		STREET ADDRESS, CITY, STATE, ZIP CODE 675 24th Avenue Santa Cruz, CA 95062	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>7. During a concurrent observation and interview with CNA Q on 6/18/2024 at 1:15 p.m., inside Resident 41's room, CNA Q was observed assisting Resident 41 with meals without wearing a face mask. When Resident 41 was finished with lunch, CNA Q went out of Resident 41's room, without a face mask, walked towards the empty lunch cart which was passed nurse Station AA and went back to Resident 41's room. CNA Q confirmed above observation and stated she should have worn a face mask upon entry to the facility because they were having some COVID-19 cases.</p> <p>During an interview with receptionist (RECP) on 6/18/2024 at 1:19 p.m., RECP stated staff should grab a mask before entering the facility. RECP further stated all staff should wear a face mask because their facility had COVID-19 outbreak.</p> <p>During an interview with DON on 6/20/2024 at 10:36 a.m., DON stated, staff should wear surgical mask or N95 (a mask or device worn over the mouth and nose to protect the respiratory system by filtering out dangerous substances [such as dusts, fumes, or bacterial] from inhaled air) since we have COVID-19.</p> <p>During a review of the facility's undated policy and procedure titled, COVID-19 Using Personal Protective Equipment (PPE), indicated, One of the following is worn for source control while in the facility and for protection during resident care encounters: (1) An N95 respirator .(3) A well-fitting facemask .</p> <p>8a. During an observation on 6/24/2024 at 9:31 a.m., inside Resident 31's room, Resident 31 was positioned on his left side lying facing CNA O. CNA O opened Resident 31's disposable brief and noticed Resident 31 had a bowel movement. RN K started cleaning Resident 31 with CNA O's assistance. RN K asked CNA O to get clean washcloths because the disposable wipes were not enough to remove the sticky stool from Resident 31's skin. CNA O grabbed the bathroom doorknob with dirty gloves to open it, then removed her dirty gloves inside the bathroom.</p> <p>8b. During a follow up incontinent care observation on 6/24/2024 at 9:37 a.m., inside Resident 31's room, CNA O went back inside Resident 31's room with clean washcloths. CNA O placed the clean washcloths on top of the shared residents' sink, beside the faucet and turned on the faucet. The contaminated washcloths were used to clean Resident 31.</p> <p>8c. During the same observation on 6/24/2024 at 9:40 a.m., CNA O tried to use the wet washcloth to remove some dried stool from Resident 31's scrotal area. CNA O was observed rolling and folding the same washcloth to remove more dried stool on Resident 31's scrotal area. After cleaning Resident 31, CNA O put on a new disposable brief on Resident 31 with the same dirty gloves.</p> <p>During an interview with CNA O on 6/24/2024 at 10:20 a.m., CNA O confirmed above observations. CNA O stated she preferred to use disposable wipes during incontinent care.</p> <p>During an interview with DON on 6/24/2024 at 12:02 p.m., DON stated clean wash cloth should not be placed on top of the sink. DON confirmed staff should not touch anything with dirty gloves. DON stated staff should remove their dirty gloves, wash their hands before touching any resident surface or belongings. DON mentioned staff should change used wet wash cloth and they should not fold the used washcloth and used it again.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the facility's undated policy and procedure titled, Standard Precautions, indicated, All employees are expected to practice standard precautions to reduce both the risk of transmitting infections . Wash hands after touching or coming in contact with blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed, before and after resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents or environments .Handle resident care equipment that is soiled with .excretions in a manner that prevent skin and mucous membrane exposure .transfer of microorganisms to other residents and environment.</p> <p>48935</p>

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>44583</p> <p>Based on observation, interview, and document review, the facility failed to provide a safe, and comfortable environment for one of six residents (Resident 81) when Resident 81's headboard and footboard of bed were loose and wobbly. This failure had a potential to compromise residents' safety, well-being, and health.</p> <p>Findings:</p> <p>During a concurrent observation and interview with director of nursing (DON) and Resident 81 on 6/20/2024 at 10:05 a.m., inside Resident 81's room, Resident 81 was seated on a wheelchair. The following were observed: the wooden headboard of Resident 81's bed tilted to the left side and one screw on the right side was about to come off, and the footboard of Resident 81's bed was leaning forward and wobbly when touched. DON and Resident 81 confirmed above observations.</p> <p>During an interview with licensed vocational nurse A (LVN A) on 6/20/2024 at 3:58 p.m., LVN A stated staff should write any faulty equipment like bed not working, broken call light, or toilet not flushing to the maintenance log located at the nurse station. LVN A further stated staff should follow up with maintenance staff if the work order was not completed.</p> <p>During an interview with director of operations (DO) on 6/24/2024 at 1:14 p.m., DO stated faulty equipment inside residents' room should be recorded in the maintenance binder. DO further stated the maintenance binder should be checked by maintenance staff daily.</p> <p>Review of the maintenance log located at nurse station AA, revealed there was no work order regarding Resident 81's bed and there was no work order entered for the month of June 2024.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583</p> <p>Based on observation, interview, and record review, the facility failed to ensure call buttons (a red button used by residents to request assistance) were easily accessible for use for seven of 18 sampled residents (Residents 285, 286, 6, 80, 40, 13, and 49). This failure had the potential to cause delays in attending to Residents 285, 286, 6, 80, 40, 13, and 49's needs which could affect their physical and psychosocial well-being.</p> <p>Findings:</p> <p>1. Review of Resident 285's face sheet (summary page of a patient's important information), indicated, Resident 285 was admitted on [DATE] with diagnoses including sepsis (blood poisoning due to an infection), anemia (a condition in which the body does not have enough healthy red blood cells), type 2 diabetes mellitus with diabetic polyneuropathy (DM, occurs when the body is unable to regulate glucose [sugar] in the blood, with nerve damage), unspecified dementia (a group of symptoms affecting thinking and social abilities interfering with daily functioning), dysphagia (difficulty swallowing), and gastrostomy status (G-tube or GT, a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach).</p> <p>Review of Resident 285's admission minimum data set (MDS, an assessment tool) dated 6/18/2024, indicated Resident 285 was usually understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time) and usually understands (misses some part/intent of message but comprehends most conversation). Further review of Resident 285's MDS indicated, Resident 285's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 6 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</p> <p>During an observation inside Resident 285's room on 6/17/2024 at 10:29 a.m., Resident 285 was lying in bed. The call button cord was at the right upper head of bed, caught in between the mattress and the right bed rail which caused the call button to faced down the floor. Resident 285 tried to reach for the call button with the used of her right hand, when asked by this surveyor, but she had a hard time reaching for it.</p> <p>During a concurrent observation and interview with certified nursing assistant O (CNA O) on 6/17/2024 at 12:19 p.m., inside Resident 285's room, CNA O confirmed above observation. CNA O stated call button should be within resident's reach for use.</p> <p>2. Review of Resident 286's face sheet indicated, Resident 286 was admitted to the facility with diagnoses including alcohol abuse, and bipolar disorder (mental disorder characterized by periods of elevated mood and depression, often with poor decision-making).</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 286's admission/5-day MDS assessment, dated 6/9/2024, indicated Resident 286 was usually understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time) and usually understands (misses some part/intent of message but comprehends most conversation). Further review of Resident 286's MDS indicated her BIMS score was 5 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</p> <p>During an observation on 6/17/2024 at 10:33 a.m., inside Resident 286's bed, Resident 286 was lying in bed and her call button was placed on top of the left bed side drawer. The call button was covered by some towels, and non-skid socks.</p> <p>During a concurrent observation and interview with CNA O on 6/17/2024 at 12:19 p.m., inside Resident 286's room, CNA O confirmed above observation.</p> <p>3. Review of Resident 6's face sheet indicated, Resident 6 was admitted to the facility with diagnoses including cerebral infarction (also known as stroke), unspecified lack of expected normal physiological development in childhood-developmental delay, unspecified dementia (a group of symptoms affecting thinking and social abilities interfering with daily functioning), unspecified severity, with other behavioral disturbance and parkinsonism (a disease that include symptoms of slowness of movements, muscle rigidity, involuntary tremors/shaking and impaired balance and posture).</p> <p>Review of Resident 6's admission/5-day MDS assessment, dated 5/20/2024, indicated Resident 6 had the ability to express ideas and wants (both verbally and non-verbal expressions) and she had the ability to understand others. Further review of the MDS indicated Resident 6's BIMS score was 1 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</p> <p>During concurrent observation and interview with Resident 6's caregiver (CG), on 6/17/2024 at 10:57 a.m., inside Resident 6's room, Resident 6 was seated on her wheelchair positioned at the end of the bed. Resident 6's call button was positioned top of her pillow which was located at the head of bed. CG confirmed the call button was too far from Resident 6. CG stated, the call button was already clipped on Resident 6's pillow when she got there at 9:00 a.m. CG further stated, Resident 6 would use the call button when she needed help.</p> <p>During a concurrent observation and interview with CNA O on 6/17/2024 at 12:28 p.m., inside Resident 6's room, CNA O confirmed Resident 6's call light was far from Resident 6 to use.</p> <p>4. Review of Resident 80's face sheet indicated, Resident 80 was admitted to the facility with diagnoses including type 2 diabetes mellitus, alcohol dependence, and other cerebral infarction.</p> <p>Review of Resident 80's admission MDS assessment, dated 5/29/2024, indicated, Resident 80 had the ability to express ideas and wants (both verbally and non-verbal expressions) and she had the ability to understand others. Further review of Resident 80's MDS indicated, Resident 80's BIMS score was 5 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 6/17/2024 at 11:05 a.m., inside Resident 80's room, Resident 80 was seated on his wheelchair, located at the right side of the bed, near the door. Resident 80's call light was observed located at the left side of the bed faced down to the floor. Resident 80 tried to reach for his call button but to no success.</p> <p>During a concurrent observation and interview with CNA O on 6/17/2024 at 12:26 p.m., Resident 80 was lying in bed, and his call button was hanged to the left side of the bed, already touching the floor. CNA O confirmed the observation. CNA O stated the call button was not within Resident 80's reach for use.</p> <p>5. Review of Resident 40's face sheet, indicated, Resident 40 was admitted to the facility with diagnoses including paroxysmal (sudden increase or recurrence of symptoms) atrial fibrillation (a type of irregular heartbeat), hyperlipidemia (high cholesterol), and hypertension (high blood pressure).</p> <p>Review of Resident 40's quarterly MDS assessment, dated 3/28/2024, indicated, Resident 40 had the ability to express ideas and wants (both verbally and non-verbal expressions) and she had the ability to understand others. Further review of Resident 40's MDS indicated, Resident 40's BIMS score was 10 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</p> <p>During an observation on 6/17/2024 at 3:39 p.m., inside Resident 40's room, Resident 40 was lying in bed, her call button cord was hanging at the right side of her bed, while the call button was on the floor.</p> <p>During a concurrent observation and interview with registered nurse R (RN R) on 6/17/2024 at 3:44 p.m., inside Resident 40's room, resident 40's call button was still in the same position. RN A confirmed Resident 40's call button was not within Resident 40's reach for use. RN R stated the location of the call button would be impossible for Resident 40 to reach.</p> <p>6. Review of Resident 13's face sheet, indicated, Resident 13 was admitted to the facility with diagnoses including degenerative disease of nervous system (occur when nerve cells in the brain or peripheral nervous system [a network of nerves that runs throughout the head, neck, and body] lose function over time), dysphagia following cerebral infarction and dementia.</p> <p>Review of Resident 13's annual MDS assessment dated [DATE], indicated, indicated, Resident 13 had the ability to express ideas and wants (both verbally and non-verbal expressions) and she had the ability to understand others. Further review of Resident 13's MDS indicated, Resident 13's BIMS score was 3 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</p> <p>During an observation on 6/17/2024 at 3:40 p.m., inside Resident 13's room, Resident 13 was seated on a wheelchair and positioned at the foot part of the bed. Resident 13's call button was located at the head part of the bed.</p> <p>During a concurrent observation and interview with RN R on 6/17/2024 at 3:48 p.m., RN R confirmed above observation. RN R stated Resident 13's call button was too far from her. RN R further stated residents' call button should always be within residents' reach for use.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with director of nursing (DON) on 6/20/2024 at 10:36 a.m., DON stated all call buttons should always be within residents' reach for use.</p> <p>During a review of the facility's undated policy and procedure titled, Call Lights-Answering Of, indicated, Facility staff will provide an environment that helps meet the Resident's needs . When leaving the room, ensure that the call light is placed within the Resident's reach.</p> <p>38087</p> <p>7. Review of Resident 49's clinical record indicated she was admitted to the facility on [DATE] with diagnoses including osteoarthritis of left knee (a degenerative joint disease in which the tissues in the joint break down over time causing pain and stiffness)), and contractures (shortening and hardening of muscles, tendons, and other tissues leading to deformity and rigidity of joints) of the right and left lower leg.</p> <p>Review of Resident 49's minimum data set (MDS, an assessment tool) dated 3/21/24, indicated she needed maximal assistance from staff for toileting, dressing, bathing, and personal hygiene.</p> <p>During an observation in Resident 49's room on 6/17/24 at 2:02 p.m., Resident 49 was lying in bed and her call light was on the floor behind the bedside dresser, out of reach of Resident 49.</p> <p>During a concurrent observation and interview with certified nursing assistant I (CNA I) on 6/17/24 at 2:08 p. m., he confirmed the above observation and stated Resident 49 cannot reach the call light that was on the floor. CNA I further stated residents should always have their call lights within their reach.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>37409</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for the residents when:</p> <ol style="list-style-type: none"> 1. Resident 59's room had bent window screens, a big hole on the wall, and the pipe at the toilet in his restroom was leaking every time the toilet was flushed; and 2. The walls at the heads of the beds of Resident 29 and Resident 72 were peeled off and the dry wall was exposed. <p>These failures had the potential to adversely affect the health and safety and to create a poor quality of life for the residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an observation and interview with Resident 59 in his room, on 6/17/24, at 10:39 a.m. the two window screens were bent; the wall next to the restroom door had a big hole; and the pipe at the toilet in the restroom which was shared by four residents was leaking every time the toilet was flushed. Resident 59 stated the bent window screens created spaces, and the bugs came in the room all the times. Resident 59 also stated the toilet pipe leaked and wet the floor, so he had to ask staff for the towels and place them on the wet floor. He told staff about all of these, but they were not fixed. 2. During an observation on 6/17/24 at 11:28 a.m., the wall above Resident 29's head of bed and the wall on the right side of Resident 72's head of bed had big areas with peeled off wall and the dry wall was exposed. <p>During an observation and interview with the regional maintenance director (RMD) on 6/19/24, at 4:36 p.m., the RMD stated the bent window screens, the big hole on the wall, the leaking pipe in Resident 59's room, and the peeled off wall in Resident 29 and 72's room should have been fixed, and he would fix them right away.</p>