

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/12/2025
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)		
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview and record review, the facility failed to ensure the proper use of bed rail (or side rail, adjustable rigid bars attached to the side of a bed) for 12 of 15 residents (64,11, 80, 51, 71, 8, 9, 14, 17, 26, 35, and 36) when there were no documented evidence that the side rail entrapment risk assessments for the 12 residents were completed.This failure had the potential to place the residents at risk of entrapment and serious injury. Findings: During an observation on 12/8/25 at 10:34 a.m., in Resident 64's room, Resident 64 had the bilateral (both) side rails in upright position. During a concurrent observation and interview with the Director of Nursing (DON) on 12/9/25 at 10:23 a.m., in Resident 64's room, Resident 64 had the bilateral upper side rails in upright position. The DON confirmed the observation. Review of Resident 64's Physician's order, dated 6/26/24, indicated Half side rails up bilateral when in bed to enable independent repositioning and transfers. Review of Resident 64's Side Rail Evaluation dated 4/5/25, with the DON on 12/12/25 at 12:46 p.m., the DON confirmed that the entrapment risk assessment was not done. The DON confirmed that the Siderail Evaluation does not indicate how the risk of entrapment was assessed. The DON also stated that maintenance staff does the entrapment risk assessment quarterly. During a concurrent observation and interview with the DON on 12/9/25 at 10:29 a.m., in Resident 71's room, Resident 71 had the bilateral side rails (grab bars) in upright position. The DON confirmed the observation. Review of Resident 71's Physician's order, dated 12/5/25, indicated Bil grab bars up when in bed to enable independent repositioning and transfers. During a concurrent interview and record review with the Maintenance Supervisor (MS), on 12/12/25 at 1:53 p.m., the MS stated Resident 71's entrapment risk assessment was not done. During a concurrent observation and interview with the DON on 12/9/25 at 10:24 a.m., in Resident 11's room, Resident 11 had the bilateral upper side rails in upright position. The DON confirmed the observation. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 11's Physician's order, dated 2/24/25, indicated Half side rails up both when in bed to enable independent repositioning and transfers. Review of Resident 11's Side Rail Evaluation with the DON on 12/12/15 at 12:53 p.m., dated 3/11/25, the DON confirmed that the entrapment risk assessment was not done. During a concurrent observation and interview with the DON on 12/9/25 at 10:26 a.m., in Resident 80's room, Resident 80 had the bilateral side rails (grab bars) in upright position. The DON confirmed the observation. Review of Resident 80's Physician's order, dated 12/8/25, indicated Grab bar side rails up both when in bed to enable independent repositioning and transfers. During a concurrent interview and record with the DON, on 12/12/25 at 12:57 p.m., the DON stated side rail evaluation for Resident 80 was not done because grab bars was considered less restrictive. During a concurrent observation and interview with the DON on 12/9/25 at 10:28 a.m., in Resident 51's room, Resident 51 has the bilateral side rails in upright position. The DON confirmed the observation. Review of Resident 51's Physician's order, dated 12/10/25, indicated Half side rails up bil when in bed to enable independent repositioning and transfers. Review of Resident 51's Side Rail Evaluation, dated 10/21/25, with the DON on 12/12/25 at 1:02 p.m., indicated the resident does not require the use of side rails at the time of evaluation. No documented evidence of risk of entrapment assessment done on 12/5/25. During an interview with the MS on 12/12/25 at 2:43 p.m., the MS stated he does the entrapment risk assessment for all bed with or without residents annually. The MS also stated that he will attach the side rails for a new resident once nursing staff informed him. The MS further stated he will not do the entrapment risk assessment for the new resident after the side rails were attached. During an interview with Registered Nurse (RN) A on 12/12/25 at 4:25 p.m., RN A stated there was no checklist or form to fill out for entrapment risk assessment. RN A also stated they only check if the hand does not get trapped in the side rail or if the side rail restrict their movement. According to Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals, Nursing Homes and Home Health: The Facts, dated 12/11/2017, indicated potential risks of bed rails may include: strangling, suffocating, bodily injury or death when patients or part of their body are caught between rails or between the bed rails and mattress. According to FDA's Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings, date 2003, indicated In creating a safe bed environment, the following general principles should be applied: Inspect, evaluate, maintain, and upgrade equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards. Re-assess the patient's needs and re-evaluate. During an initial observation visit on 12/8/25 (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. at 10:05 a.m. Resident 35's bed was observed with 1 side rail; b. at 10:08 a.m. Resident 14's bed was observed with 2 side rails; c. at 10:09 a.m. Resident 9's bed was observed with 2 side rails; d. at 10:10 a.m. Resident 36's bed was observed with 2 side rails; e. at 10:12 a.m. Resident 26's bed was observed with 1 side rail; f. at 10:20 a.m. Resident 6's bed was observed with 2 side rails; g. at 10:40 a.m. Resident 17's bed was observed with 1 side rail. During a concurrent interview and record review on 12/12/25 at 2:45 p.m. with the Director of Nursing (DON), Resident 35's Medical Record (EMR) was reviewed. The side rail documents were reviewed. Resident 35's order dated 8/7/25 indicated start date 8/7/25 End date: open ended. Half side rails up. Resident 35's Side rail Evaluation dated 2/3/25, indicated, Entrapment Risk completed. Side rail Evaluation dated 5/11/25 indicated, Entrapment Risk not completed. Side rail Evaluation dated 8/7/25, indicated, Entrapment Risk completed. The DON stated the Entrapment risk is completed by maintenance yearly. Side rail Evaluation dated 11/8/25 indicated, Does the Resident require side rails at this time. No. Entrapment Risk: not applicable. The DON stated, there was no orders to discontinue or gap in orders for side rail use. Review of the side rail (non-restraint) care plan (CP), dated 8/5/25, the CP indicated, Check for any gaps between the bedside rail/rails and the bed mattress for the risk of entrapment and refer to maintenance staff for interventions. During a concurrent interview and record review on 12/12/25 at 2:50 p.m. with DON, Resident 14's Medical Record (EMR) was reviewed. The side rail documents were reviewed. Resident 14's order dated 9/17/25 indicated start date 9/17/25 End date: open ended. Transfer rails. Resident 14's Side rail Evaluation dated 3/4/25 indicated, Entrapment risk completed. Side rail Evaluation dated 5/31/25 indicated, Entrapment risk completed. Resident 14's Side rail Evaluation dated 8/7/25 indicated, Entrapment risk completed. Resident 14's Side rail Evaluation dated 8/31/25 indicated, Entrapment risk not applicable. Resident 14's Side rail Evaluation dated 11/29/25 indicated, Entrapment risk not completed. Review of the side rail (non-restraint) care plan, dated 12/2/24, the CP indicated, Check for any gaps between the transfer rails and the bed mattress for the risk of entrapment and refer to maintenance staff for interventions. During a concurrent interview and record review on 12/12/25 at 2:55 p.m. with DON, Resident 9's Medical Record (EMR) was reviewed. The side rail documents were reviewed. Resident 9's order dated 7/15/24 indicated start date 7/15/24 End date: open ended. Half side rails up both. Resident 9's Side rail Evaluation dated 2/3/25 indicated, Entrapment risk: completed. Side rail Evaluation, dated 5/4/25 Entrapment Risk not completed. Side rail Evaluation, dated 8/7/25 Entrapment Risk: completed. Side rail Evaluation dated 11/1/25 indicated, No side rails and Entrapment risk: not applicable. Review of the side rail (non-restraint) care plan, dated 9/17/25, the CP indicated, Check for any gaps between the bedside rail/rails and the bed mattress for the risk of entrapment and refer to maintenance staff for interventions. During a concurrent interview and record review on 12/12/25 at 2:58 p.m. with DON, Resident 36's Medical Record (EMR) was reviewed. The side rail documents were reviewed. Resident 36's order (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 7/1/25 indicated start date 7/1/25 End date: open ended. Half side rails up both. Resident 36's Side rail Evaluation , dated 2/24/25 indicated Entrapment risk completed. Side rail Evaluation , dated 3/11/25 indicated Entrapment risk completed. Side rail Evaluation , dated 8/7/25 indicated Entrapment risk completed. Side rail Evaluation , dated 12/8/25 indicated Entrapment risk completed. Review of the side rail (non-restraint) care plan, dated 8/5/25, the CP indicated, Check for any gaps between the bedside rail/rails and the bed mattress for the risk of entrapment and refer to maintenance staff for interventions. During a concurrent interview and record review on 12/12/25 at 3:00 p.m. with DON, Resident 26's Medical Record (EMR) was reviewed. The side rail documents were reviewed. Resident 26's order dated 9/24/24 indicated start date 9/24/24 End date: open ended. Half side rails up both. Resident 26's Side rail Evaluation dated 1/14/25 indicated, Entrapment risk: completed. Resident 26's Side rail Evaluation dated 4/1/25 [observed- completed 7/3/25] indicated, Entrapment risk: completed. Resident 26's Side rail Evaluation dated 7/4/25 indicated, Entrapment risk: not completed. Resident 26's Side rail Evaluation dated 8/7/25 indicated, Entrapment risk: completed. Resident 26's Side rail Evaluation dated 9/13/25 indicated, Entrapment risk: completed. Review of the side rail (non-restraint) care plan, dated 6/21/24, the CP indicated, Check for any gaps between the bedside rail/rails and the bed mattress for the risk of entrapment and refer to maintenance staff for interventions. During a concurrent interview and record review on 12/12/25 at 3:10 p.m. with DON, Resident 6's Medical Record (EMR) was reviewed. The side rail documents were reviewed. Resident 6's order dated 12/8/25 indicated start date 12/8/25 End date: open ended. Half side rails up both. Resident 6's Side rail Evaluation dated 3/4/25 indicated, Entrapment risk: completed. Resident 6's Side rail Evaluation dated 5/31/25 indicated, Entrapment risk: completed. Resident 6's Side rail Evaluation dated 8/7/25 indicated, Entrapment risk: completed. Resident 6's Side rail Evaluation dated 8/31/25 indicated, Entrapment risk: completed. Resident 6's Side rail Evaluation dated 11/29/25 indicated, Entrapment risk: completed. Review of the side rail (non-restraint) care plan, dated 4/5/24, the CP indicated, Check for any gaps between the bedside rail/rails and the bed mattress for the risk of entrapment and refer to maintenance staff for interventions. During a concurrent interview and record review on 12/12/25 at 3:15 p.m. with DON, Resident 17's Medical Record (EMR) was reviewed. The side rail documents were reviewed. Resident 17's order dated 10/3/24 indicated start date 10/3/25 End date: open ended. Half side rails up both. Resident 17's Side rail Evaluation dated 2/24/25 indicated, Entrapment risk: completed. Resident 17's Side rail Evaluation dated 3/26/25 indicated, Entrapment risk: completed. Resident 17's Side rail Evaluation dated 6/7/25 indicated, Entrapment risk: completed. Resident 17's Side rail Evaluation dated 8/7/25 indicated, Entrapment risk: completed. Resident 17's Side rail Evaluation dated 9/13/25 indicated, Entrapment risk: completed. Review of the side rail (non-restraint) care plan, dated 10/3/24, the CP indicated, Check for any gaps between the bedside rail/rails and the bed mattress for the risk of entrapment and refer to maintenance staff for interventions. During an interview on 12/12/25 at 4:10 p.m. with the Maintenance Supervisor (MS), the MS indicated the entrapment assessment is completed by nursing, he completed the yearly maintenance checks and maintenance as needed. During an interview on 12/12/25 at 4:20 p.m. with Registered Nurse A (RN), RN A stated there are no resources for checking Residents for entrapment from side rails. RN A was not able to provide evidence of what specific assessments are included in the entrapment assessments. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/25 at 4:27 p.m. with Registered Nurse D (RN), RN D stated, maintenance places the side rails and a supervising nurse will do the entrapment assessment. No evidence provided on what is included in the entrapment assessment.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to ensure four of five Residents (8,18,40,44) eye drops medications were appropriately stored and labeled. This failure placed residents at potential risk for receiving the wrong medication and expired medications, which could lead to medication ineffectiveness and medication adverse reaction. Findings: During an observation and concurrent interview on 12/11/25 at 2:15 p.m. with Registered Nurse (RN) D, medication carts one, two and three were inspected. In medication cart one there were three of four bottles of artificial tears (over-the-counter eye drops, gels, or ointments that mimic natural tears to add moisture, lubricate, and soothe dry, irritated eyes) (Resident 18, 40, 44) with the box identified with the name, date opened and room number, no Resident identifiers on the bottle. In medication cart three there was one box of artificial tears (Resident 8) with only a room number identifier and date opened on the box and no identifier on the bottle. During a follow up interview on 12/12/25 at 8:57 a.m. with RN D, RN D confirmed, there is a potential for error with only the boxes having Resident identifiers. During an interview on 12/12/25 at 2:28 p.m. with the Pharmacist (RPH), the RPH stated, [eyedrops] should have a label on the container in case the box is lost and for infection prevention so not using the wrong [eyedrops] container on Residents. During a review of the facility's policy and procedure (P&P) titled, Guidelines for Labeling and Disposing Multi-Dose Medications, not dated, the P&P indicated, . Each multi-dose container must have: the resident's name, the medication name, dose, route dispensing pharmacy label, expiration date .		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure puree food recipes were followed during cooking for 14 of 84 residents. This failure had the potential to compromise the health and safety of 14 residents who receive pureed diets. During an observation in the kitchen on December 9, 2025, at 11:39 a.m., [NAME] A was observed adding hot water from the kitchen faucet to the blender to prepare pureed bread without measuring the amount added. During an observation in the kitchen on December 9, 2025, at approximately 11:50 a.m., [NAME] A was observed adding 1 scoop (4 ounce) of food thickener to the pureed Brussels sprouts and adding approximately 2 1/2 scoops (10 ounce) of food thickener to the pureed bread. During an interview with [NAME] A on December 10, 2025, at 11:54 a.m., [NAME] A confirmed that he added water from the kitchen faucet instead of using a measuring cup and used a 4-ounce scoop to add food thickener. He further confirmed that he added approximately 2 1/2 scoops (10 ounces) of thickener to the pureed bread and approximately 1 scoop (4 ounces) of thickener to the pureed Brussels sprouts. [NAME] A admitted that he added more thickener than required by the recipe and acknowledged that he should have followed the recipe when preparing pureed foods. During a concurrent interview and record review with the Registered Dietitian (RD) on December 10, 2025, at 4:00 p.m., the RD reviewed the recipe titled Wheat Bread Conv PU and confirmed that, according to the recipe for 14 residents (15-serving recipe), the preparation required a total of 1 3/4 cups plus 2 tablespoons [15 ounces (units of mass, weight, or volume)] of water and 3 tablespoons plus 2 1/2 teaspoons (approximately 1.9 ounces) of food thickener. The RD stated that [NAME] A added approximately 10 ounces of thickener to the pureed bread, which was not consistent with the recipe. The RD further reviewed the recipe titled Brussels Sprouts FZN PU and confirmed that, according to the recipe for 14 residents (15-serving recipe), the preparation required a total of 1/4 cup plus 1 tablespoon of food thickener. The RD stated that [NAME] A added 4 ounces of food thickener, which exceeded the amount required by the recipe. A review of the facility's policy and procedure titled Nutrition Therapy Essentials, Inc. Food Service Policy and Procedures, Manual 2023, indicated: .pureed food preparation (follow menu recipes). pureed foods should be prepared to the consistency and thickness of mashed potatoes rather than a gravy or watery texture. use product guidelines for thickening to achieve appropriate consistency .		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure that food was stored, prepared, and served under sanitary conditions and failed to follow infection control protocols when:1. Five food items were not labeled with an open date, and three food items were expired in the walk-in refrigerator; 2. One food item in the dry storage room was not labeled with an open date; 3. Two trash cans in the kitchen were observed without lids when not in use; 4. Kitchen staff used contaminated gloved hands to touch the blender blade assembly; 5. Kitchen staff did not wash or replace the blender lid after it fell into the sink and continued to use it to prepare pureed Brussels sprouts; 6. Kitchen staff did not use tongs to distribute bread and instead used gloved hands that had touched multiple surfaces; and7. The ice machine was not cleaned properly according to the manufacturer's instructions.These failures had the potential to cause food contamination and spread foodborne illness (illness resulting from contaminated food) to 84 of 85 residents who received their food from the kitchen. During an observation on December 8, 2025, at 9:52 a.m., accompanied by the Dietary Services Manager (DSM), the kitchen walk-in refrigerator was inspected. It was identified that 5 items were not labeled with an open date, and 3 items were expired.Items without open dates:a. A jar of premium sweet pickle relish, received 11/20/2025b. A can of horseradish, received 11/10/2025c. A jar of Italian dressing, received 11/28/2025d. A bottle of base BBQ sauce, received 11/26/2025e. A Jar of heavy-duty mayonnaise, no open date and no received dateExpired items:f. A bottle of vinaigrette dressing, expired 11/11/2025g. A Jar of tartar sauce, expired 12/3/2025h. A Jar of honey mustard dressing, expired 10/8/2025During an interview with the DSM on December 8, 2025, at 10:14 a.m., the DSM confirmed the above observations and stated that all opened food items should be labeled with an open date and that expired items should be removed from the refrigerator to ensure food safety.2. During an observation on December 8, 2025, at 10:18 a.m., accompanied by the DSM, the dry storage room was inspected. One partially used bag of corn flakes was identified without an open date.During an interview with the DSM on December 8, 2025, at 10:22 a.m., the DSM confirmed the above observation and stated that the opened bag of corn flakes should have been labeled with the open date.3. During a concurrent observation and interview in the kitchen with the DSM on December 8, 2025, at 10:25 a.m., two trash cans were observed without lids while not in use. The DSM confirmed the observation and stated that all trash cans should be covered with lids to help prevent the spread of infection.During an interview with the Registered Dietitian (RD) on December 8, 2025, at 3:00 p.m., the RD stated that all food items in the refrigerator should be labeled with received, opened, and use-by dates. In addition, the opened bag of cornflakes should also be labeled with the open date to ensure food safety. the RD further stated that the trash can should have a lid for sanitation purposes. A review of the facility's policy and procedure titled Nutrition Therapy Essentials, inc. Food Service Policy and Procedures , Manual 2023, indicated . Refrigerators and Freezers .all food should be dated and labeled with received, open, and use by dates. this to assure that food is safe for consumption and any food-borne illness can be avoided . Garbage containers should always be closed .storage room .all food bins should be clean, labeled .4.During an observation on December 9, 2025, at 11:25 a.m., [NAME] A was observed wearing a pair of black gloves. He used the same gloves to touch a spoon, a knife, and the handle of the blender (an electric kitchen appliance used to mix, chop, puree, or liquefy food and liquids). He then placed the blade assembly (the removable component inside a blender that contains the cutting blades and the parts that hold them in place) into the blender, using the same gloves to handle the cooked chicken and add it to the blender to prepare finely chopped chicken.During an observation on December 9, 2025, at 11:31 a.m., in the kitchen, [NAME] A used the same pair of gloves after touching a spoon and a knife, and after placing the blender on the machine. He then used the same gloves to touch the blade assembly and add Brussels sprouts into the blender to prepare pureed brussels sprouts.During an observation on (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	December 9, 2025, at 11:39 a.m., in the kitchen [NAME] A continued to use the same gloves after touching multiple items and did not change gloves before handling bread and placing it into the blender to prepare pureed bread. During a concurrent observation and interview with the Registered Dietitian (RD) on December 9, 2025, at 11:57 a.m., the RD confirmed the above observations and removed three trays of contaminated food from the tray line, including finely chopped chicken, pureed bread, and pureed brussels sprouts. 5. During an observation in the kitchen on December 9, 2025, at 11:38 a.m., the DSM took over for [NAME] A and continued blending brussels sprouts. During this process, the blender lid fell into the sink. The DSM placed the lid back on the blender without washing or replacing it and continued preparing the pureed brussels sprouts. The DSM confirmed this observation. During an interview with the Infection Preventionist (IP) on December 9, 2025, at 12:39 p.m., the IP stated that the cook should have changed to a new pair of gloves before and after directly touching the blade assembly to prevent infection. The IP further stated that if a blender lid falls into the sink, kitchen staff should replace it because the sink may contain contaminants, posing a risk for infection and cross-contamination. During an interview with the Registered Dietitian (RD) on December 9, 2025, at 2:10 p.m., the RD confirmed that the finely chopped chicken was prepared for eight residents and the pureed food was prepared for fourteen residents. The RD stated that all food equipment must be clean and sanitized, and staff should change to a new pair of gloves before directly touching food and food-contact equipment. The RD also stated that the blender lid that fell into the sink should be cleaned and sanitized, or replaced, before contacting food to prevent infection and food contamination. A review of the facility's undated policy and procedure titled Food Handling Practices indicated that .change plastic gloves as frequently as handwashing would indicate. change gloves before and after non-food contact and between contacts with raw and cooked food .6. During a tray line observation with the Registered Dietitian (RD) on December 10, 2025, at 12:03 p.m., [NAME] B was observed wearing a pair of gloves and touching multiple utensil handles. [NAME] B then used the same gloved hands to grab bread and place it on residents' lunch trays. The RD subsequently removed four trays containing bread. During an interview with the RD on December 10, 2025, at 4:00 p.m., the RD confirmed the above observations and stated that approximately 40 residents were scheduled to receive the bread. The RD further stated that the cook should have used tongs (a handheld kitchen utensil used to grip, pick up, and transfer food without directly touching it by hand) to distribute the bread rather than gloved hands that had already touched multiple other items and were no longer considered clean. A review of the facility's undated policy and procedure titled Food Handling Practices indicated that . use tongs in meal service to portion meats, bread, garnishes, baked potatoes, cookies, etc .7. During an observation on December 9, 2025, at approximately 3:00 p.m., in the kitchen, accompanied by the Registered Dietitian (RD) and the Maintenance Supervisor (MS), the facility's ice machine was inspected. The MS stated that the manufacturer's service staff are scheduled to clean the ice machine with chemicals every six months. Since the ice machine was newly installed in August 2025, the manufacturer's cleaning service had not yet occurred. The MS further stated that he cleans the ice machine monthly by spraying it with hot water and wiping it. During a concurrent interview and record review with the MS on December 9, 2025, at 4:00 p.m., the MS reviewed the ice machine's Installation, Operation, and Maintenance Manual and stated that he had used hot water to clean the ice machine. The MS acknowledged that, per the manufacturer's instructions, he should use three gallons (a unit of liquid volume) of warm water mixed with two ounces (units of mass, weight, or volume) sanitizer to properly clean the ice machine. A review of the facility's Ice Machine Monthly Cleaning Log indicated that the MS cleaned the ice machine on August 6, 2025; September 10, 2025; October 10, 2025; and November 10, 2025. A review of the facility's undated ice machine cleaning policy and procedure, titled Cleaning& Maintaining Ice Machines, indicated . following the manufacturer's guidelines for cleaning .A review of the ice machine's installation, operation and maintenance Manual, revision 11/12/2023, indicated mix a solution of sanitizer and lukewarm water (3 gal of water mixed with 2 oz of sanitizer), use half of the (continued on next page)		

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Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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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	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sanitizer/water solution to sanitize all removed components .use half of the sanitizer/water solution to sanitize all food zone surfaces of the ice machine and bin (or dispenser) .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure proper infection prevention techniques were followed when: - For one of three residents (Resident 36) the licensed nurse failed to wear gloves when giving an injection - The Certified Nursing Assistant (CNA) B failed to wear the proper Personal Protective Equipment (PPE, equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) when providing care to one of seven residents (Resident 71) on Enhanced Barrier Precautions (EBP, infection control guidelines, primarily for nursing homes, that require staff to wear gowns and gloves during high-contact resident care activities to prevent the spread of multidrug-resistant organisms [MDROs, microorganisms that are resistant to many common antibiotics]). - The Licensed Vocational Nurse (LVN) C failed to change gloves during tube feeding for 1 of 1 resident (Resident 11). These deficient practices had the potential for contamination and spread of infection. Findings: 1. During a medication pass observation on 12/10/25 at 11:52 a.m., with Licensed Vocational Nurse (LVN) F, LVN F was observed giving Resident 36 an injection without wearing gloves. During a concurrent interview at 11:55 a.m. LVN F stated, usually I wear gloves. During a review of the facility's policy and procedure (P&P) titled, Subcutaneous Injection, dated (undated), indicated .Procedure: .put on gloves. 2. Review of Resident 71's Physician's order, dated 12/8/25, indicated Place resident on Enhanced Barrier Precautions (EBP) due to use of medical device (IV to left hand). Wear gloves, mask, gown for contact and resident activities: Dressing, bathing, device, showering, transferring, changing linens, providing hygiene, changing briefs and assist with toileting. During an observation on 12/9/25 at 9:41 a.m., in Resident 71's room, Resident 71 was lying in bed when CNA B removed the blanket and heel booties (heel protectors) of the resident. CNA B was not wearing the yellow gown. During a concurrent observation and interview with the Medical Records Director (MRD), in the hallway outside of Resident 71's room, on 12/9/25 at 9:47 a.m., the MRD pointed with his hand to the PPE hanging by the door of Resident 71 and stated something in Spanish to CNA B. The MRD confirmed that he did point at the PPE and that CNA B was not wearing yellow gown. The MRD stated that CNA B was getting ready to do patient care and reminded her to wear the PPE. During an interview with CNA B, on 12/9/25 at 10:21 a.m., CNA B confirmed that she was not wearing the yellow gown when she started providing care to Resident 71. CNA B stated should wear the yellow gown. During an interview with the Infection Preventionist (IP), on 12/9/25 at 12:40 p.m., the IP stated the staff have to put on the PPE for any type of patient care for residents on EBP. The IP also stated the staff have to wear the mask, gloves and yellow gown when removing the socks or heel booties of residents. 3. Review of Resident 11's Physician's order, dated 11/12/25, indicated Formula: Twocal HN (a high-calorie, high-protein nutritionally complete liquid formula used for tube feeding [liquid nutrients given through a tube inserted in the stomach] via enteral pump (a medical device that delivers liquid nutrition via a feeding tube). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 11's Physician's order, dated 6/18/25, indicated Enhanced barrier precautions due to presence of indwelling device: GT feeding. Wear gloves and gowns for the ff: High-contact resident care activities: Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. Device care: central line, urinary catheters, feeding tube and wound care. During a concurrent observation and interview with LVN C, on 12/10/25 at 2:45 p.m., LVN C was performing tube feeding on Resident 11. LVN C put on gloves and yellow gown. Then prepared the tube feeding formula and the enteral pump. LVN C then changed the gloves and pulled up Resident 11's dress and checked the residual amount (the amount of formula or fluid left in the stomach). LVN C then flushed the G-tube (gently pushing water through the Gastrostomy tube, a feeding tube inserted through the abdomen directly into the stomach with a syringe to keep it clear of blockages), turned on the enteral pump and entered the settings. Then LVN C primed the enteral pump tubing (filling the line with fluid to flush out the air before connecting to the patient) and connected it to the G-tube. LVN C then started the pump and then removed the gloves. LVN C confirmed she did not change the gloves before checking the residual and before connecting the pump tubing to the G-tube. LVN C also stated she should have changed gloves. During an interview with the IP, on 12/11/25 at 4:01 p.m., the IP stated the LVN should change the gloves before checking the residual and again before connecting the tubing to the G-tube because the LVN touched other things. During a review of the facility's Policy and Procedures (P&P), titled Enhanced Barrier Precautions (EBP), undated, indicated EBP shall be used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning of gown and gloves during high-contact resident care activities that may result in transfer of MDROs to staff hands and clothing .For residents for whom EBP are indicated, EBP shall also be used when performing the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, e.g., central line, urinary catheter, feeding tube .		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure accurate documentation of the administration of controlled medications (narcotics, including potential opioids for pain management) for two of eight sampled residents (Resident 7, 37), by failing to document the administration and refusal of Resident 7's and 37's medications on the Medication Administration Record (MAR - a report detailing the medications administered to a resident by the licensed nurse in the facility). This deficient practice had the potential to result in medication errors and/or drug diversion (illegal distribution or abuse of prescription drug). Findings: On 12/10/25 at 12:52 p.m., during the inspection of Medication cart 1, with Licensed Vocational Nurse C (LVN C), an audit of controlled drug records and medication administration records was completed. During the concurrent interview and record review on 12/10/25 at 12:52 p.m., with LVN C Resident 7's Controlled Drug Record (CDR) (a record of narcotic medication counts) for hydrocodone-apap (generic for Norco, a potent opioid for pain management) 5-325 milligram (mg a unit of measure) was reviewed. The CDR indicated a dose of Norco was removed on 12/10/25 at 8:28 a.m. However, a concurrent count of the medication package indicated the Norco medication was still in the package and therefore not administered to Resident 7. Review of Resident 7's MAR for December 2025 indicated the medication [Norco] was administered 12/10/25 at 8:28 a.m. During a follow up interview, on 12/10/25 at 3:27 p.m. with LVN C, LVN C stated, she had forgotten the resident refused the medication, she gave all the other medications, and signed them all off as given, she should have signed off the Norco as refused. During a concurrent interview and record review on 12/11/25 at 11:41 a.m. with the Director of Nursing (DON), Resident 37's CDR for Oxycodone HCL 5 mg and MAR dated 9/2025 was reviewed. The CDR indicated a dose of Oxycodone HCL 5 mg was removed on 9/1/25 at 12 MN and 9/25/25 at 2:00 p.m. However, a review of Resident 37's 9/2025 MAR indicated there was no evidence documented that Resident 37 was administered the medication Oxycodone HCL 5 mg. During a review of Resident 37's physician orders dated 8/4/25 for Oxycodone 5 mg indicated Oxycodone HCL 5 mg, Give 1 tablet every 6 hours as needed for moderate to severe pain. During a review of the facility's policy and procedures (P&P), titled Medication Pass Guidelines, undated, indicated .Record the results of medication administration as necessary. Record the name, dose, route, and time of medication on the Medication Administration Record [MAR]. initial the record after the medication is administered to the resident. Use the electronic health record system. During a review of the facility's policy and procedures (P&P), titled Refusal of Treatment, undated, indicated .Refusal of treatment includes, but is not limited to, refusal of the following: Medications. At a minimum, the following must be recorded in the nursing progress notes: the date and time the treatment/medication administration was attempted; the treatment/medication administration attempted; the residents response and reasons for refusal. documentation each time the resident refused .treatment/medication.		