STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555114	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Driftwood Healthcare Center	4109 Emerald St Torrance, CA 90503

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on interview and record review, the facility failed to provide a copy of medical records upon written request from an authorized legal representative ([LR] a person who is legally authorized to act on behalf of another) for one of five sampled residents (Resident 2) within two working days. This deficient practice violated Resident 2 ' s right to obtain a copy of their medical record and delayed their appeal to Health Insurance Provider (HIP) ' s decision to deny Resident 2 covered (paid for by insurance) stay at the facility. Findings: During a review of Resident 2 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), generalized muscle weakness, abnormalities with gait (a person ' s manner of walking) and mobility (the ability to move freely or lack thereof), and Charcot ' s arthropathy (a rare disorder that causes the bones and joints in the foot and ankle to become unstable and deformed). During a review of Resident 2 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/22/2024, the MDS indicated Resident 2 was cognitively intact (ability to think and reason). The MDS indicated Resident 2 required supervising and touching assistance for showering/bathing and dressing the upper body. The MDS indicated Resident 2 required moderate assistance (helper does less than half the effort) with personal hygiene, dressing the lower body, and putting on/taking off footwear. During a review of Resident 2 ' s Resident Request for Access to Protected Health Information ([Request for Access of PHI] any information in the medical record or designated record set 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) dated 6/3/2024, the Request for Access of PHI indicated Resident 2 signed a release of medical records authorizing LR 1 access to Health Insurance Provider (HIP) authorization (a request form and clinical records to support the approval or denial of the insurance company ' s decision to continue to pay for resident ' s stay at the facility) records. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s Request for Access of PHI dated 10/2/2024, the Request for Access of PHI indicated Resident 2 signed a release of medical records authorizing LR 1 records from 2/23/2024. During a review of an email dated 10/1/2024 from LR 1 to the Medical Records Director (MRD), the email indicated LR 1 requested a copy of Resident 2 ' s monthly HIP authorizations, supporting clinical documents sent to HIP, and Resident 2 ' s outside provider clinical notes from endocrinology (hormone physician specialist), ophthalmology (eye physician specialist), podiatry (foot physician specialist), and the wound care physician. During an interview on 10/9/2024 at 8:40 a.m., LR 1 stated she had requested records the facility sent to HIP since 5/2024 on numerous occasions starting 6/2024 because she believed the facility is omitting information that could support Resident 2 ' s stay at the facility. LR 1 stated she had not yet received what supporting documents the facility had sent to HIP. During an interview on 10/9/2024 at 12:03 p.m., Resident 2 stated she authorized LR 1 to request her records to see what the facility was submitting to the HIP for her to appeal HIP ' s decision of denial of coverage. Resident 2 stated the facility had been omitting information to HIP that would allow to her stay covered, such as her inability to administer insulin herself, and her infected foot wounds that needed to be amputated. Resident 2 stated her and LR 1 had been requesting records the facility sent to HIP since 6/2024 but still had not received them. Resident 2 stated she believed the facility was sending incomplete and incorrect information to HIP to force her out of the facility and purposely try to delay her right to appeal. During an interview on 10/9/2024 at 1:39 p.m., Social Worker Representative (SWR) stated she was responsible for submitting clinical records to HIP to approve authorizations. SWR stated Resident 2 and LR 1 had requested Resident 2 ' s clinical records she had sent to HIP in the past, but those documents are confidential. SWR stated she did not release to LR 1 and SWR clinical records or authorizations she submitted to HIP. SWR stated she would need to ask HIP if she could disclose those records but had not done so yet. During an interview on 10/9/2024 at 2:25 p.m. the Medical Records Director (MRD) stated when a resident or their legal authorized representative requests records the facility have 48 hours to submit the request. MRD stated LR 1 requested records submitted to HIP on 6/3/2024 but he did not have access to what SWR submitted to HIP. MRD stated he spoke to SWR 10/9/2024 to follow up on LR 1 ' s request of what was submitted to HIP, but SWR had informed him she did not have a copy of what she sent to HIP. During an interview on 10/10/2024 at 1:00 p.m., with the Administrator (ADM), the ADM stated when residents or legal authorized representatives request medical records it should be released within 42 hours upon written request. During an interview on 10/18/2024 at 1:00 p.m., the Social Worker Director (SWD) stated their Disclosure of Protected Health Information policy did not indicate a timeframe in which records are to be submitted to authorized requestors such as a resident or legal authorized representative. The SWD stated Disclosure of Protected Health Information was the only policy the facility had on release of information. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled Disclosure of Protected Health Information dated 12/1/2012, the P&P did not indicate a timeframe in which records are to be submitted to authorized requestors such as a resident or legal authorized representative.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on observation, interview, and record review, the facility failed to ensure two out of five sampled residents (Resident 3 and Resident 4), who were high-risk for falls, had wheelchairs that locked. This deficient practice had the potential to cause Resident ' s 3 and Resident 4 to sustain falls and injuries resulting from the fall such as a hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel), fractures (broken bones), hospitalization , and possible death resulting from complications of the fall. Findings: a. During a review of Resident 3 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including paroxysmal atrial fibrillation (a heart condition that causes an irregular and often rapid heartbeat in the upper chambers of the heart), thrombophilia (a condition which the body has a high probability of creating blood clots), functional quadriplegia, generalized muscle weakness, abnormalities of gait (a person ' s manner of walking) and mobility (the ability to move freely or lack thereof). During a review of Resident 3 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/13/2024, the MDS indicated Resident 3 had moderate cognitive impairment (ability to think and reason). The MDS indicated Resident 3 required moderate assistance (helper does less than half the effort) with sit to stand, transferring from chair to bed, and walking. During a review of Resident 3 ' s at risk for falls care plan dated 8/4/2024, the care plan indicated Resident 3 had a history of falls prior to admission to the facility and needed assistance with transferring and mobility. The care plan goal included Resident 3 will demonstrate the ability to use assistive devices (wheelchairs, walkers, and canes) safely. During a concurrent observation and interview on 10/8/2024 at 9:54 a.m., CNA 1 locked Resident 3 ' s wheelchair on the left and right side then assisted Resident 3 in standing up and transferring her to her bed. CNA 1 stated he was not aware that the left lock was not working and should have checked to make sure it was locked by seeing if the wheels would move or not to prevent Resident 3 from potentially falling if the wheelchair moved unexpectedly. During an interview on 10/8/2024 at 9:48 a.m., the AD stated one week ago Resident 3 let her know her wheelchair was not locking, and she reported it to the Director of Maintenance (DOM) that same day. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/8/2024 at 9:54 a.m., CNA 1 locked Resident 3 ' s wheelchair on the left and right side then assisted Resident 3 in standing up and transferring her to her bed. CNA 1 stated he was not aware that the left lock was not working and should have checked to make sure it was locked by seeing if the wheels would move or not to prevent Resident 3 from potentially falling if the wheelchair moved unexpectedly. During a concurrent interview and record review on 10/8/2024 at 1:30 p.m., with Registered Nurse (RN) 1, Fall Risk Evaluation dated 9/16/2024 was reviewed, which indicated Resident 3 was a high fall risk. RN 1 stated Resident 3 was a high fall risk and needed assistance to transfer from her bed to her chair and vice versa. RN 1 stated she was not working on 10/3/2024 when Resident 3 ' s broken wheelchair was discussed during the morning meetings with staff and did not return to work until 10/7/2024. RN 1 stated she was not aware Resident 3 ' s wheelchair was broken and did not hear about it during change of shift report. RN 1 stated when it was discovered Resident 3 ' s wheelchair breaks were not working it should have been fixed within 24 hours because she could fall. b. During a review of Resident 4 ' s Face Sheet, the Face Sheet indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including parkinsonism (a clinical syndrome usually caused by long-term medication side effects characterized by involuntary movements, tremors, muscle stiffness, and inability to maintain balance), unsteadiness (loss of balance) on feet, and dementia (a progressive state of decline in mental abilities). During a review of Resident 4 ' s MDS dated [DATE], the MDS indicated Resident 4 had severe cognitively impairment. During a review of Resident 4 ' s Fall Risk Evaluation dated 8/30/2024, the Fall Risk Evaluation indicated Resident 4 was at high risk for falls. During a review of Resident 4 ' s impaired mobility care plan dated 8/30/2023, the care plan indicated the goal was for Resident 4 to have no falls or injuries. The care plan interventions for Resident 4 included use of an assistive device for ambulation to prevent fall or injury, to be up in a wheelchair daily as tolerated, and to always monitor Resident 4 for safety. During an interview on 10/8/2024 at 9:35 a.m., Resident 1 stated she was concerned about Resident 3 (her roommate) because she had fallen in the past and the brakes on the wheelchair she currently uses do not lock. During a concurrent observation and interview on 10/8/2024 at 10:07 a.m., Resident 4 was pushing his wheelchair while ambulating (walking) accompanied by Licensed Vocational Nurse (LVN) 1 who was walking beside him to direct him back to his room. Inside Resident 4 ' s room LVN 1 attempted to lock the wheelchair but was not able to lock the right side with substantial force and effort. LVN 1 stated the right lock on Resident 4 ' s wheelchair was stuck, and she was unable to lock it. LVN 1 stated she was going to take Resident 4 and his wheelchair to the exercise room to see if someone from the rehabilitation department can fix it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/8/2024 at 10:15 a.m., Physical Therapist (PT) 1 locked the left lock of Resident 4 ' s wheelchair with ease but had to use substantial force and effort to lock the right side. The wheelchair ' s left side locked in the opposite direction than the right side; the left lock had to be pushed forward to lock whereas the right lock had to be forcefully pushed backward to lock. PT 1 attempted to educate Resident 4 verbally and by demonstration on how to lock his wheelchair, but Resident 4 was not able to lock the right side. PT 1 informed the Director of Rehab (DOR) Resident 4 ' s wheelchair was too difficult and confusing for him to lock. The DOR stated she would inform the maintenances supervisor (The Director of Maintenance). During an interview on 10/8/2024 at 10:37 a.m., CNA 2 stated when she made rounds earlier Resident 4 was already in her wheelchair, and she was not aware that it was not locking properly. During a concurrent interview and record review on 10/8/2024 at 11:05 a.m., with the Director of Maintenance (DOM), the facility Morning Meeting record dated 10/3/2024 was reviewed, indicating Resident 3 ' s wheelchair needed to be fixed. The DOM stated he attended the 10/3/2024 morning meeting and was informed Resident 3 ' s wheelchair needed to be fixed but forgot. The DOR stated he received a follow up text 10/8/2024 (same day at the time of interview) reminding him to fix Resident 3 ' s chair. The DOM stated he was also made aware 10/8/2024 Resident 4 had a wheelchair with breaks that needed to be fixed. During a concurrent interview and record review on 10/8/2024 at 2:11 p.m., with RN 1, Change of Condition Evaluation, dated 10/4/2024 was reviewed, which indicated Resident 4 had fell when trying to open the door while walking and pushing his wheelchair, landing on his buttocks. RN 1 stated Resident 4 was evaluated as being a high fall risk prior to his fall on 10/4/2024. During an interview on 10/8/2024 at 2:41 p.m., the DOR stated she evaluated Resident 4 on 10/4/2024 after he fell . The DOR stated although Resident 4 had a steady gait because he had a history of falls and dementia, she tried to give him a rollator (a walker with four legs) but Resident 4 was confused on how to use it, so she continued to let him use the wheelchair. The DOR stated she did not recall if she checked the wheelchair locks to see if they work upon assessment on 10/4/2024 when she evaluated Resident 4 for a fall. During an interview on 10/8/2024 at 3:32 p.m., the Administrator (ADM) stated when equipment such as a wheelchair is broken it should be communicated to the DOM to be fixed within 24 hours, and in the interim while Resident 3 ' s chair was being repaired should have received another wheelchair. The ADM stated he believed it was sufficient for nursing staff to assume the locks on a wheelchair work and it was unreasonable to expect nursing to make sure Resident 3 ' s wheelchair was immovable prior to transferring Resident 3. During an interview on 10/9/2024 at 12:18 p.m., the Director of Nursing (DON) stated nursing should ensure wheelchairs are locked by checking to see if they move because Resident 3, or any elderly resident, could potentially fall and result in a head injury or a hip fracture (breaking the hip bone) which would require hospitalization . The DON stated she had witnessed an elderly person break their hip from a fall in the past. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure (P&P) titled Wheelchairs, dated 1/2012, the Wheelchairs P&P indicated wheels are to be locked while transferring a resident from a bed to wheelchair, and defective wheelchairs will be reported to the maintenance department for repair. The P&P did not indicate a plan for residents in the interim while chairs are being repaired, and not did indicate a timeframe in which maintenance will respond to the needed repair. The P&P did not indicate to exercise [NAME] in ensuring the wheelchair is immovable prior to transfers or use.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47092 Based on interview and record review the facility failed to retain, accurately document, systematically organize, and have readily accessible medical records for one of five sampled residents (Resident 2) according to the facility ' s policy and procedure (P&P) titled, Documentation Retention. This deficient practice had the potential Resident 2 to have unnecessary stress and fear of being kicked out of the facility due to Health Insurance Provider (HIP) not being given the clinical documents needed to support her continued insurance coverage to stay at the facility. Findings: During a review of Resident 2 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), generalized muscle weakness, abnormalities with gait (a person ' s manner of walking) and mobility (the ability to move freely or lack thereof), and Charcot ' s arthropathy (a rare disorder that causes the bones and joints in the foot and ankle to become unstable and deformed). During a review of Resident 2 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/22/2024, the MDS indicated Resident 2 was cognitively intact (ability to think and reason). The MDS indicated Resident 2 required supervising and touching assistance for showering/bathing and dressing the upper body. The MDS indicated Resident 2 required moderate assistance (helper does less than half the effort) with personal hygiene, dressing the lower body, and putting on/taking off footwear. During a review of an email from Health Insurance Provider (HIP) to the Social Services representative (SSR) dated 6/24/2024, the email indicated HIP requested documentation indicating if Resident 2 can self-administer insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication). During a review of Resident 2 ' s Physician ' s Order dated 7/24/2024, the Physician ' s Order indicated Resident 2 had an appointment with the Endocrinologist ([MD] a physician that specializes in diabetes and other hormonal disorders) 1 on 8/29/2024. During a review of Resident 2 ' s Endocrinology Assessment and Plan dated 8/29/2024, the Assessment and Plan indicated Resident 2 had a severe diabetic right foot infection and may need debridement (removal of dead or unhealthy tissue) or amputation (removal of appendages) next month. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s After Visit Summary dated 8/29/2024, the After Visit Summary indicated per MD 1 ' s assessment Resident 2 was unable to self-administer insulin due to severe neuropathy (a chronic condition that can cause pain, numbness, weakness, and a pins-and-needles sensation), and a new order for Lantus (a long-acting insulin also known as Glargine) 20 units (a unit of measurement) at 9:30 a.m., and to be decreased by 2 units if Resident 2 skips breakfast or has a blood sugar is below 70 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount)/deciliter (dL - a metric unit of capacity). During a review of Resident 2 ' s Physician ' s Order dated 8/30/2024, the Physician ' s Order indicated inject 20 units of Lantus subcutaneously (fat tissue) in the morning for Diabetes Mellitus, to give after breakfast, and to decrease dose by 2 units if Resident 2 skips breakfast or had a blood sugar below 70. During a review of Resident 2 ' s Interdisciplinary Team Conference Record (IDT Record) dated 8/29/2024, the IDT Record indicated Resident 2 did not want discharge planning and HIP may deny her due to discharge planning refusal. The IDT record indicated Resident 2 wanted her medical record from her Endocrinologist. During a review of Resident 2 ' s Physician ' s Order dated 9/6/2024, the Physician ' s Order indicated: wound care daily for right foot, fifth toe by cleaning with normal saline (0.9 % sodium chloride and water solution), pat dry, apply Mupirocin (antibiotic) ointment, cover with pressure pad and dry gauze, and secure with tape. During a review of Notice of Action (from HIP) dated 10/2/2024, the Notice of Action indicated Resident 2 was denied approval of payment for continued stay at the facility starting 10/1/2024 because it was not medically necessary. The Notice of Action indicated Resident 2 ' s facility stay was for diabetes, and did not meet the requirements due to: a. Blood pressure was stable. b. Breathing was baseline. c. Level of consciousness was baseline. d. Resident 2 did not need help with activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). e. Resident 2 not willing to make any discharge plans. f. There were no wound care needs. During a review of Notice of Action (from HIP) dated 10/3/2024 indicated Resident 2 was denied approval of payment for continued stay at the facility starting 10/1/2024 because it was not medically necessary. The Notice of Action indicated the request was denied because: a. The medical need is not met. b. Resident 2 has high blood sugar levels. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Resident 2 ' s health has improved. d. Resident 2 is ready to go to a lower level of care. During a review of Resident 2 ' s Request for Access of PHI dated 10/2/2024, the Request for Access of PHI indicated Resident 2 signed a release of medical records authorizing LR 1 records from 2/23/2024. During a review of an email dated 10/1/2024 from Resident 2 ' s Legal Representative (LR - a person who is legally authorized to act on behalf of another) 1 to the Medical Records Director (MRD), the email indicated LR 1 requested a copy of Resident 2 ' s monthly HIP authorizations, supporting clinical documents sent to HIP, and Resident 2 ' s outside provider clinical notes from endocrinology, ophthalmology (eye physician specialist), podiatry (foot physician specialist), and the wound care physician. During an interview on 10/9/2024 at 8:40 a.m., LR 1 stated she had requested records the facility sent to HIP since 5/2024 on numerous occasions starting 6/2024 because she believed the facility is omitting information that could support Resident 2 ' s stay at the facility. LR 1 stated she had not yet received what supporting documents the facility had sent to HIP. During an interview on 10/9/2024 at 12:03 p.m., Resident 2 stated she authorized LR 1 to request her records to see what the facility was submitting to HIP for her to appeal HIP ' s decision of denial of coverage. Resident 2 stated the facility had been omitting information to HIP that would allow to her stay covered, such as her inability to administer insulin herself, and her infected right foot wound that needed to be amputated. Resident 2 stated her and LR 1 had been requesting records the facility sent to HIP since 6/2024 but still had not received them. Resident 2 stated she believed the facility was sending incomplete and incorrect information to HIP to force her out of the facility and purposely try to delay her right to appeal. During a concurrent interview and record review on 10/9/2024 at 12:15 p.m. with Resident 2 the endocrinology After Visit Summary dated 8/29/2024 was reviewed. The After Visit Summary indicated Resident 2 was unable to self-administer insulin due to severe neuropathy. Resident 2 stated she had given the After Visit Summary to one of the nurses on 8/29/2024 upon return from her appointment and was given a copy. Resident 2 stated she had not been refusing to administer her insulin but was not able due to her inability to feel normally in her fingers and hands. Resident 2 stated the stress and fear of the facility not believing her disability and trying to kick her out makes her want to die. Resident 2 stated since she was admitted she was never able to self-administer her own insulin. During an interview on 10/9/2024 at 12:47 p.m. Licensed Vocational Nurse (LVN) 1 stated Resident 2 needed assistance with showering, changing clothes, and putting on her shoes. LVN 1 stated three months ago she attempted to teach Resident 2 on how to self-administer insulin who was willing to try but was unable to push the insulin pen (a device used to inject insulin). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/9/2024 at 1:39 p.m., Social Services Representative (SSR) stated she was responsible for submitting clinical records to HIP to approve authorizations. SSR stated Resident 2 and LR 1 had requested Resident 2 ' s clinical records she had sent to HIP in the past, but those documents are confidential. SSR stated she did not release to LR 1 and SSR clinical records or authorizations she submitted to HIP. SSR stated she would need to ask HIP if she could disclose those records but had not done so yet. During an interview on 10/9/2024 at 1:47 p.m. SSR stated the last clinical notes she submitted to HIP regarding Resident 2 ' s wound care was on 7/19/2024, and she did not submit the endocrinology After Visit Summary dated 8/29/2024 to HIP which indicated Resident 2 was unable to administer insulin due to severe neuropathy. SSR stated she did not understand how to interpret the clinical notes but sent what she believed HIP requested. During an interview on 10/9/2024 at 2:25 p.m. the Medical Records Director (MRD) stated when a resident or their legal authorized representative requests records the facility have 48 hours to submit the request. MRD stated LR 1 requested records submitted to HIP on 6/3/2024 but he did not have access to what SSR submitted to HIP. MRD stated he spoke to SSR 10/9/2024 to follow up on LR 1 ' s request of what was submitted to HIP, but SSR had informed him she did not have a copy of what she sent to HIP. During an interview on 10/9/2024 at 2:39 p.m. Business Office Assistant (BA) 1 stated she submitted a request for authorization for Resident 2 on 9/24/2024 starting 10/1/2024. BA 1 stated she submitted a Face Sheet and the most recent MDS. BA 1 stated the only clinical notes she would send to HIP was the Face Sheet, MDS, and Preadmission Screening and Resident Review ([PASARR] A federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide appropriate care). BA 1 stated the SSR was responsible for submitting clinical notes to HIP. During an interview on 10/9/2024 at 2:57 p.m., MRD stated when residents come back from appointments they would give the nurses papers from the appointments, but if the resident did not have any paperwork the SSR or MRD was responsible to reach out to the outside facility to get the notes to ensure they are in the chart to update orders or instructions. MRD stated the facility did not have the endocrinology After Visit Summary note from 8/29/2024 but should. During an interview on 10/10/2024 at 11:01 a.m. the Director of Nursing (DON) stated she had not been involved in submission of records to HIP regarding Resident 2. The DON stated if SSR did not understand how to interpret medical records she was obtaining to submit to HIP she should have consulted with a registered nurse or herself to ensure they are submitting accurate supporting documentation to HIP. During a concurrent interview and record review on 10/10/2024 at 11:37 a.m. with the DON the endocrinology After Visit Summary dated 8/29/2024 was reviewed, indicating Resident 2 was unable to self-administer insulin due to severe neuropathy. The DON stated if the After Visit Summary was submitted to HIP it may have supported their decision in approving her authorization. The DON stated Resident 2 is not forgetful and would have likely given the After Visit Summary to the facility upon return from her appointment on 8/29/2024, but the facility should have called the Endocrinologist to get a copy if they did not have it in Resident 2 ' s chart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555114	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Driftwood Healthcare Center	4109 Emerald St Torrance, CA 90503

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/2024 at 1:13 p.m. the Administrator (ADM) stated when residents go to appointments typically the records will be sent to the facility which will have pertinent follow up information meant to be shared with nursing. The ADM stated SSR was a rehabilitation aide (an assistant who assists residents in improving their motor skills and daily functioning) but changed roles earlier this year to a social services representative. The ADM stated SSR ' s responsibility to communicate to HIP acting as a liaison (communication or cooperation which facilitates a close working relationship between people or organizations) but was supervised by Social Services Director (SSD) who is part-time. The ADM stated SSR also consulted with nursing before sending out records to HIP and was not aware of anyone else doing so. During an interview on 10/11/2024 at 10:12 a.m. SSR stated she did not know why HIP denied Resident 2 authorization, but she thinks it because Resident 2 is able to administer her own insulin. SSR stated she was not aware of the 8/29/2024 endocrinology notes. SSR stated the DON was the only person assisting her with this case (refer to 10/10/2024 interview with the DON who stated she was not involved in this case). The SSR stated she was the liaison between Resident 2 and HIP. During an interview on 10/11/2024 at 1:08 p.m. LVN 2 stated on 8/29/2024 Resident 2 came back from her endocrinology appointment and gave her notes she received from the Endocrinologist (MD 1). LVN 2 stated she noted new insulin orders which she transcribed into Resident 2 ' s electronic medical record ([EMR] a digital version of a resident ' s medical records). LVN 2 stated she gave Resident 2 a copy and put the original in her physical chart. LVN 2 stated the medical records department will take it from the chart and upload it into the EMR. LVN 2 stated there was no notes progress notes documented on upon return from her endocrinology appointment on 8/29/2024. LVN 2 stated Resident 2 ' s return from appointment should have been documented with updated instructions, orders, and other pertinent information for accurate communication amongst the team. During an interview on 10/11/2024 at 1:23 p.m. MRD stated biweekly they review charts that are too thick, and then scan documents into the electronic medical record. MRD stated he checked Resident 2 ' s paper chart and EMR, and the facility did not possess Resident 2 ' s endocrinology After Visit Summary notes date 8/29/2024. MRD stated LR 1 wanted to send him a copy of Resident 2 ' s medical record, but he cannot accept it from her and needed to directly reach out to MD 1 to obtain the After Visit Summary from 8/29/2024. During a review of the facility ' s policy and procedure (P&P) titled Documentation Retention dated 1/1/2012, the P&P indicated the facility will retain records for a period of ten (10) years from the creation of the document, or ten years from the date the document was last in effect.