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	04/30/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on observation, interview, and record review the facility failed to ensure one of four sampled residents (Resident 1) who was observed with a discoloration on her forehead, black eye and eye swelling was reported to California Department of Public Health (CDPH). This failure resulted in CDPH being unable to investigate Resident 1's injury of unknown origin in a timely manner Findings: During a review of Resident 1's Admission Record, the Admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses of chronic kidney disease (a long term condition where the kidneys gradually lose their ability to filter waste and extra fluid from the blood), abnormalities of gait and mobility, dementia (a progressive state of decline in mental abilities) hypertension (HTN-high blood pressure) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's History and Physical (H&P), dated 4/26/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set,(MDS - a resident assessment tool), dated 1/31/2025, the MDS indicated Resident 1 was dependent on nursing staff for oral hygiene, toileting, showering, and dressing. The MDS indicated Resident 1 needed substantial to maximal nursing assistance with eating and transferring to a chair. The MDS indicated Resident 1 needed partial to moderate nursing assistance with rolling from left to right, sitting, lying in bed and walking. During a review of Resident 1's Change in Condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) Evaluation, dated 3/20/2025, the COC indicated, on 3/20/2025 at 7:30 am Resident 1 was sitting on the bed with her side rails up, on and off agitation noted and the CNA observed that Resident 1 had skin discoloration to the forehead (color was not indicated). The COC indicated Resident 1's medical doctor and family member were notified. The COC indicated Resident 1's MD ordered a skull x-ray and skin monitoring. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Physician Orders, dated 3/20/2025, the Physician Orders indicated, to monitor Resident 1's forehead for skin discoloration, and for skin management. The Physician Orders indicated a skull x-ray for Resident 1. During a review of Resident 1's Physician Orders, dated 3/21/2025, the Physician Orders indicated, neurological checks (examination of mental status, motor function, sensory) every two hours for 72 hours every shift for eye swelling. During a review of Resident 1's Physician Orders, dated 3/21/2025, the Physician Orders indicated, to instill Pataday Ophthalmic Solution, two drops in both eyes two times a day for eye irritation. During a review of Resident 1's Physician Progress Notes, dated 3/24/2025, the Physician Progress Notes indicated, Resident 1 had a bump on the forehead, with swelling and bruising over the left eye. During an observation on 4/29/2025 at 1:10 pm in Resident 1's room, observed Resident 1 lying in bed with a pillow covering her head mumbling. Observed Resident 1 bruising to the left forehead, a black eye and swelling to the forehead. Licensed Vocational Nurse (LVN) 1 came to assist Resident 1 with the help from other staff and pulled Resident 1 up in bed and elevated the head of the bed. During an interview on 4/29/2025 at 1:15 p.m., with Resident 2. Resident 2 stated she has been the roommate of Resident 1 for a year. Resident 2 stated one day (unknown date) in the morning before breakfast Resident 1 was sitting in the wheelchair outside of the room in front of the door and leaned forward and the whole wheelchair tipped forward. Resident 2 stated Resident 1 injured her eye. Resident 2 stated Resident 1's eye had redness and swelling. Resident 2 stated the nurses came to help Resident 1. Resident 2 stated Resident 1 fell while trying to stand. Resident 2 stated she heard the charge nurse tell Resident 1's family member she hit her head on the bed railing. During an interview on 4/30/2025 at 12:35 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated she worked the night shift (11 p.m. to 7 a.m.) on 3/19/2025. CNA 1 stated she provided total care, diaper change and linen change for Resident 1. CNA 1 stated she did not observe any discoloration on Resident 1's forehead or left eye. During an interview on 4/30/2025 at 12:42 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated she works the 11 pm to 7 am shift. RNS 1 stated Resident 1 requires maximal assistance with activities of daily living such as feeding, bathing, and toileting. RNS 1 stated Resident 1 was being fed by the CNAs and probably (unwitnessed) hit her left forehead on the side rails. RNS 1 stated she assessed Resident 1 for pain. RNS 1 stated when she assessed Resident 1's forehead Resident 1 grimaced (a facial expression usually of disgust, disapproval, or pain) on 3/20/2025. RNS 1 stated Resident 1's forehead was tender to touch. RNS 1 stated Resident 1 was given icepacks for comfort. During an interview on 4/302025 at 1:02 p.m., with Certified Nursing Assistant (CNA) 2 , CNA 2 stated she saw Resident 1 at around 7 am on 3/20/2025. CNA 2 stated Resident 1 had bruising on the forehead. CNA 2 stated she asked CNA 3 what happened to Resident 1. CNA 2 stated CNA 3 stated she does not know, CNA 2 stated she reported to the charge nurse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/2025 at 1:11 p.m., with CNA 3. CNA 3 stated he saw Resident 1 on 3/20/2025 at 7 a.m. CNA 3 stated he asked CNA 2 for help to pull Resident 1 up in bed. CNA 3 stated Resident 1 had swelling and discoloration on the left eye. CNA 3 stated he did not know how the injury to Resident 1's left eye happened. During an interview on 4/30/2025 at 1:29 p.m., with Registered Nurse Supervisor (RNS) 2. RNS 2 stated on 3/21/2025 she noticed Resident 1 had a swollen eye with discoloration. RNS 2 stated she informed the Nurse Practitioner. RNS 2 stated the Nurse Practitioner ordered cold compresses for 20 minutes for 3 days and eye drop for eye irritation. RNS 2 stated she did not know how the resident received the injury to the left head. RNS 2 stated she did not receive any report on how Resident 1 injured her head. RNS 2 stated there was no documentation of what happened to Resident 1 on 3/20/2025. RNS 2 stated that when a resident has an injury and no one knows what happened a Change of Condition should be done, the doctor and family member were informed. RNS 2 stated the injury was monitored to see if it was getting worse. RN 2 stated then the DON was notified. RNS stated that the injury should also be reported to the ombudsman, police and CDPH. RNS 2 stated that the injury was reportable because it could be abused. During an interview on 4/30/2025 at 2:35 pm with RNS 3, RNS 3 stated on 3/20/2025 at 7 am, RNS 1 told her Resident 1 had discoloration on the forehead. RNS 3 stated she asked RNS 1 what happened to Resident 1. RNS 1 stated RNS 3 said Resident 1 probably hit her head on the side rails (but no witness). RNS 3 stated an injury of unknown origin or unknown cause like Resident 1's discoloration on the forehead and swelling of eye, needs to be investigated and reported within one hour to the police, state agency, the Administrator and the Director of Nursing. RNS 3 stated the DON does the investigation of the incident. RNS 3 stated an investigation should be done to determine the cause of the injury and to prevent it from happening again. During a concurrent interview and record review on 4/30/2025 at 3:48 pm with the Director of Nursing (DON), reviewed the facility's Policy and Procedure (P&P) titled Abuse & Neglect, date revised 5/30/2024 which indicated Injury of unknown source is defined as an injury that meets both of the following conditions: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time, or the incidence of injuries over time. The DON stated she did not know she had to report this. The DON stated at the change of shift on 3/20/2025 CNA 1 noticed Resident 1's eye. The DON stated she was not clear what shift the injury happened on. The DON stated Resident 1 might have hit herself while in bed but was not witnessed by staff. The DON stated Resident 1 was observed with the discoloration on the left forehead and left eye. The DON stated an x-ray was done to make sure Resident 1 did not have a fracture. The DON stated Resident 1 had a black eye with discoloration. During a review of the facility's policy and procedure (P&P) titled, Abuse & Neglect, date revised 5/3/2024. The P&P indicated, Injury of Unknown source is defined as an injury that meets both the following conditions: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury, the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time, or the incidence of injuries over time. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Unusual Occurrence Reporting, date revised 5/30/2024. The P&P indicated, The facility reports the following events by phone and in writing to the appropriate State or Federal agencies; .major accidents, allegations of abuse . other occurrences that interfere with facility operations and affect the welfare, safety, or health of residents, employees, or visitors. Unusual occurrences are reported to the appropriate agency within 24 hours by telephone and then confirmed in writing. The facility conducts documents timely and thorough investigations into all unusual occurrences and takes corrective action as appropriate. The investigation should include but not limited to interviews with residents, staff, and other witnesses.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure one of four sampled residents (Resident 1) who was observed with discoloration on her forehead, black eye and eye swelling on 3/20/2025 was investigated into the history of her injury and to rule out abuse and neglect. This deficient practice had the potential to result in unidentified abuse and/or neglect in the facility and the failure to protect residents from abuse and neglect. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses of chronic kidney disease (a long term condition where the kidneys gradually lose their ability to filter waste and extra fluid from the blood), abnormalities of gait and mobility, dementia (a progressive state of decline in mental abilities) hypertension (HTN-high blood pressure) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1 ' s History and Physical (H&P), dated 4/26/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set,(MDS - a resident assessment tool), dated 1/31/2025, the MDS indicated Resident 1 was dependent on nursing staff for oral hygiene, toileting, showering, and dressing. The MDS indicated Resident 1 needed substantial to maximal nursing assistance with eating and transferring to a chair. The MDS indicated Resident 1 needed partial to moderate nursing assistance with rolling from left to right, sitting, lying in bed and walking. During a review of Resident 1 ' s Change in Condition ([COC]a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) Evaluation, dated 3/20/2025, the COC indicated, on 3/20/2025 at 7:30 am Resident 1 was sitting on the bed with her side rails up, on and off agitation noted and the CNA observed that Resident 1 had skin discoloration to the forehead (color was not indicated). The COC indicated Resident 1 ' s medical doctor and family member were notified. The COC indicated Resident 1 ' s MD ordered a skull x-ray and skin monitoring. During a review of Resident 1 ' s Physician Orders, dated 3/20/2025, the Physician Orders indicated, to monitor Resident 1 ' s forehead for skin discoloration, and for skin management. The Physician Orders indicated a skull x-ray for Resident 1. During a review of Resident 1 ' s Physician Orders, dated 3/21/2025, the Physician Orders indicated, neurological checks (examination of mental status, motor function, sensory) every two hours for 72 hours every shift for eye swelling. During a review of Resident 1 ' s Physician Orders, dated 3/21/2025, the Physician Orders indicated, to instill Pataday Ophthalmic Solution, two drops in both eyes two times a day for eye irritation. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Physician Progress Notes, dated 3/24/2025, the Physician Progress Notes indicated, Resident 1 had a bump on the forehead, with swelling and bruising over the left eye. During an interview on 4/30/2025 at 2:35 pm with RNS 3, RNS 3 stated on 3/20/2025 at 7 am, RNS 1 told her Resident 1 had discoloration on the forehead. RNS 3 stated she asked RNS 1 what happened to Resident 1. RNS 1 stated RNS 3 said Resident 1 probably hit her head on the side rails (but no witness). RNS 3 stated an injury of unknown origin or unknown cause like Resident 1 ' s discoloration on the forehead and swelling of eye, needs to be investigated and reported within one hour to the police, state agency, the Administrator and the Director of Nursing. RNS 3 stated the DON does the investigation of the incident. RNS 3 stated an investigation should be done to determine the cause of the injury, rule out abuse, and to prevent it from happening again. During an interview on 4/30/2025 at 3:48 pm with the Director of Nursing (DON), the DON stated a certified nursing assistant (CNA) noticed Resident 1 had discoloration on the forehead. The DON stated she was not sure when the injury happened. The DON stated it was not clear what happened to Resident 1. The DON stated Resident 1, possibly might have hit herself with the side rails (unwitnessed). The DON stated Resident 1 had a black eye with discoloration. The DON stated no investigation was carried out into how Resident 1 incurred the injury. During a review of the facility ' s Policy and Procedure (P&P), titled Abuse & Neglect, date revised 5/30/2024 was reviewed. The P&P indicated When the Administrator or designated representative receives a report of an allegation of resident abuse, mistreatment, neglect, abuse facilitated or enabled by technology, exploitation or injuries of an unknown source, or suspicion of a crime, the Administrator or designated representative, will initiate an investigation immediately. During a review of the facility ' s P&P titled, Unusual Occurrence Reporting, date revised 5/30/2024. The P&P indicated, The facility reports the following events by phone and in writing to the appropriate State or Federal agencies; .major accidents, allegations of abuse . other occurrences that interfere with facility operations and affect the welfare, safety, or health of residents, employees, or visitors. Unusual occurrences are reported to the appropriate agency within 24 hours by telephone and then confirmed in writing. The facility conducts documents timely and thorough investigations into all unusual occurrences and takes corrective action as appropriate. The investigation should include but not limited to interviews with residents, staff, and other witnesses.