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	06/11/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the personal belongs for one of two sampled resident's (Resident 1), who was discharged from the facility on 1/17/2025, were made available to Resident 1 and/or Resident 1's Responsible Party (RP) and/or Family Member (FM). This deficient practice resulted in Resident 1's being discharged to a Board and Care ([B&C] a type of small, residential facility that provides housing and personal care services to individuals who need assistance with ADLs) facility without her personal belongings and had the potential for Resident 1 to feel detached in her new environment. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of dementia a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 12/13/2024, the MDS indicated Resident 1 was unable to make decisions that were consistent and reasonable. During a review of Resident 1's History and Physical (H&P) dated 10/2/2023, the H&P indicated Resident 1 does not have the capacity to understand and make decisions because of dementia and her family member is the surrogate (a substitute) decision maker for her care needs and medical decisions. During a review of Resident 1's Inventory of Personal Effects dated 9/29/2023, the Inventory of Personal Effects indicated a blank/unsigned receipt on discharge by Resident 1 and/or Resident 1's RP/FM. The Inventory of Personal Effects indicated Resident 1 had the following items at the facility: a. four blouses (no description) b. one underpants (no description) c. one coat (no description) d. two short pants (no description) e. four pairs of slippers (no description) (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. two sweaters (no description) g. six undershirts (no description) h. six pairs of socks (no description) i. two pillows (no description) j. two blankets (no description) k. two pairs of glasses (no description) l. two perfume bottles (no description) m. one black cellular phone During a telephone interview on 6/5/2025 at 10:48 a.m., Resident 1's FM stated she was called by the facility's Social Services Worker Director (SSD) on 1/17/2025 (time unspecified) informing her that Resident 1 would be discharged from the facility later that day. The FM stated on 5/27/2025, she received a call from the County Public Administrator's Office notifying her that Resident 1 passed away at an ([ECF] a healthcare institution that provides ongoing medical care, rehabilitation services, and assistance with ADLs to individuals who require prolonged or specialized attention) and when she contacted the owner of ECF she was told that Resident 1 arrived there (2/2025) with the clothes she had on, a top and bottom, a list of medication and an insurance card. The FM stated Resident 1 was subjected to an undignified situation at the ECP and lived the rest of her life without her personal belongings that were necessary for a comfortable life. During a telephone interview on 6/6/2025 at 2:28 p.m., Resident 1's RP stated he did not know about and had not been involved in any discharge plans for Resident 1 until 1/17/2025 when the facility's SSD called to inform him that Resident 1 would be discharged to a B&C facility that day. The RP stated the facility did not call him when Resident 1 was discharged from the facility nor was not told anything about Resident 1's personal belongings. During a telephone interview on 6/9/2025 at 8:27 a.m., the Extended Care Owner (ECO) stated she was contacted by a person from a B&C facility (information unknown) and asked if she had an available female room. The ECO stated the first week of 2/2025 Resident 1 came to her facility in a car and was dropped off, she (Resident 1) had no personal belongings, only the clothes she wore, a list of medications and an insurance card. During an interview and record review on 6/9/2025 at 9:49 a.m., the Social Service Director (SSD) stated Resident 1's Inventory of Personal Effects did not indicate disposal of personal belongings upon discharge. During an interview and record review on 6/9/2025 at 1:11 p.m., the Director of Nursing Services (DON) stated it was the responsibility of the facility's registered nurse supervisor (RNS) on duty and the SSD to ensure Resident 1's RP and/or FM are notified regarding the disposition of the resident's belongings on discharge from the facility. (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 0557 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, Discharge and Transfer of Residents revised 2/2018, the P/P indicated the facility must ensure the facility staff will prepare the resident's inventory at the time of discharge and the facility will provide the resident and their representative a copy of the Resident's Inventory and have the recipient sign. During a review of the facility's P/P titled, Personal Property revised 7/14/2017, the P/P indicated the facility shall take reasonable steps to protect the residents' personal property by returning inventories personal items to the residents or their representatives upon discharge in a timely manner and take reasonable steps to safeguard the belongings of the resident in the interim.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1), who was diagnosed with dementia (a progressive state of decline in mental abilities), and who lacked the capacity to understand and make decisions was discharged appropriately from the facility. This deficient practice resulted in Resident 1 being discharged to a Board and Care ([B&C] (a type of small, residential facility that provides housing and personal care services to individuals who need assistance with ADLs) facility on [DATE] without an Interdisciplinary Team (IDT) a team comprised of healthcare professionals from different discipline collaborating to develop and coordinate the residents' care plans such as a discharge plan with a goal to optimize the resident outcomes) discharge meeting, prior discharge planning, Resident 1's Responsible Party (RP) and/or Family Member (FM) provided with a Notice of Proposed Discharge/Transfer 30 days prior to the resident's transfer, assessment of the resident on transfer to the B&C, confirmation that the resident's contact information was received at the B&C, a list of the resident's medication or an inventory list with Resident 1's personal affects sent with her. Resident 1 was transferred from the B&C to an Extended Care facility ([ECF] a healthcare institution that provides ongoing medical care, rehabilitation services, and assistance with ADLs to individuals who require prolonged or specialized attention) sometime in 2/2025 and expired at the Extended Care facility on [DATE] without the RP and/or FM's knowledge. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of dementia, and depression (a mood disorder that causes persistent feelings of sadness and loss of interest in activities). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated [DATE], the MDS indicated Resident 1 was unable to make decisions that were consistent and reasonable, and required a one person assist to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's History and Physical (H&P) dated [DATE], the H&P indicated Resident 1 did not have the capacity to understand and make decisions because of dementia. The H&P indicated her family member was the surrogate (a substitute) decision maker for her care needs and medical decisions. During a review of Resident 1's untitled Care Plan dated [DATE], the Care Plan indicated Resident 1 had impaired cognitive function (having difficulty with thinking, learning and remembering) and impaired thought processes related to dementia. The Care Plan's goals was for Resident 1 to maintain her current level of cognitive function and to develop skills to cope with cognitive decline and maintain safety, with interventions that included communicating with Resident 1 and her family and/or caregivers regarding Resident 1's needs and capabilities. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Physician's Progress Notes dated [DATE], the Physician's Progress Notes indicated Resident 1's physician communicated with the nursing staff and the case management/discharge planner that Resident 1's discharge plans and procedures be discussed/notified/permitted by Resident 1 and her family to ensure Resident 1's safe discharge from the facility. During a review of Resident 1's Medical Record, the Medical Record indicated there was no documented evidence the facility conducted a discharge planning IDT that involved Resident 1 and her RP/FM. During a review of the Social Service Progress Notes dated [DATE] (the corrected date was [DATE]), the Social Service Progress Notes indicated Resident 1 was to be discharged to a B&C facility on that same day ([DATE]) and Resident 1's RP was informed via a telephone call. During a review of Resident 1's Medical Record, the Medical Record indicated there was no documented evidence that a Notice of Proposed Transfer and Discharge was completed 30 days prior to Resident 1's discharge to the B&C facility on [DATE]. During a review of Resident 1's Discharge Planning Review Form dated [DATE] and timed at 4:38 p.m., the Discharge Planning Review Form indicated the following: No reason for Resident 1's discharge A Post discharge medication list was discussed with the resident/family then contradicted the previous documentation to say the reconciled medication list was not provided to the resident family and/or care giver. A walker (front wheel walker [FWW] a mobility aid with two wheels a the front and two legs with glides or rubber tips at the back) was provided to Resident 1 Medications were sent with Resident 1 Contact information to include the name, relation and phone numbers of Resident 1's RP were provided Continued review of the Discharge Planning Review Form indicated there were no signatures of Resident 1 and/or the RP to indicate that either one of them understood the discharge instructions. During a review of Resident 1's Medical Records, the Medical Records indicated there was no documented evidence that Resident 1's status on discharge form the facility ([DATE]) was assessed. During a review of Resident 1's Inventory of Personal Effects dated [DATE], the Inventory of Personal Effects indicated a blank/unsigned receipt on discharge by Resident 1 and/or Resident 1's RP/FM. The Inventory of Personal Effects indicated Resident 1 had the following items at the facility: a. four blouses (no description) b. one underpants (no description) c. one coat (no description) (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. two short pants (no description) e. four pairs of slippers (no description) f. two sweaters (no description) g. six undershirts (no description) h. six pairs of socks (no description) i. two pillows (no description) j. two blankets (no description) k. two pairs of glasses (no description) l. two perfume bottles (no description) m. one black cellular phone During a telephone interview on [DATE] at 10:48 a.m., Resident 1's FM stated she was called by the facility's Social Services Worker Director (SSD) on [DATE] (time unspecified) informing her that Resident 1 would be discharged from the facility later that day. The FM stated the SSD did not provide her with information where Resident 1 would be going because she (FM) was not the RP. The FM stated she contacted the RP a few days after Resident 1 was discharged from the facility ([DATE]) to ask him about Resident 1's discharge location but the RP had no information about Resident 1's location. The FM stated on [DATE], she received a call from the County Public Administrator's Office notifying her that Resident 1 passed away at an ECF. The FM stated she was devastated that the facility discharged Resident 1 from the facility without providing her location to the RP and no one knew where in the community she (Resident 1) was. The FM stated Resident 1's condition was unknown, and she (Resident 1) died alone without the presence of her family and was not given the proper respect/compassion during her last days. During a telephone interview on [DATE] at 2:28 p.m., Resident 1's RP stated he did not know about and had not been involved in any discharge plans for Resident 1 until [DATE] when the facility's SSD called to inform him that Resident 1 would be discharged to a B&C facility that day. The RP stated he told the SSD to notify Resident 1's FM of Resident 1's discharge information. The RP stated the facility did not call him when Resident 1 was being discharged from the facility. The RP stated the end of 5/2025 he received a letter form the County Public Administrator's Office, when he called the County Public Administrator's Office, he was informed that Resident 1 passed away at an ECF. The RP stated he was dismayed that Resident 1 was alone after her discharge from the facility up until the time she took her last breath. The RP stated this could have been avoided if the facility had notified him (RP) and Resident 1's FM where Resident 1 was discharged to. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 8:27 a.m., the Extended Care Owner (ECO) stated she was contacted by a person from a B&C facility (information unknown) and asked if she had an available female room. The ECO stated the first week of 2/2025 Resident 1 came to her facility in a car and was dropped off, she (Resident 1) had no personal belongings, only the clothes she wore, a list of medications and an insurance card. The ECO stated the contact person from the B&C told her Resident 1 had no family. The ECO stated Resident 1 expired on [DATE] in her sleep and she (ECO) called a local funeral home to pick up Resident 1's body. During an interview on [DATE] at 9:49 a.m., the SSD stated there was no Notice of Proposed Transfer and Discharge completed by the facility for Resident 1 prior to being discharged to a lower level of care. During a subsequent interview on [DATE] at 2:50 p.m., the SSD stated the facility had not conducted a discharge planning IDT meeting with Resident 1 and/or her RP before Resident 1 was discharged from the facility on [DATE] and Resident 1's inventory list was not signed for receipt by Resident 1 and/or her RP on discharge from the facility. The SSD stated she faxed Resident 1's information to the B&C facility prior to her discharge on [DATE] but there was no confirmation receipt that the B&C facility received the documents. The SSD stated she should have confirmed with the B&C facility that Resident 1's information was received prior to her discharge from the facility and documented her communication with the B&C in Resident 1's medical record. During a telephone interview on [DATE] at 11:02 a.m., Registered Nurse Supervisor (RNS) 2 stated on [DATE] during the 7 a.m. to 3 p.m. shift, she prepared and signed Resident 1's discharge planning review form (discharge instructions) in preparation for Resident 1's discharge to a B&C facility. RNS 2 stated Resident 1 was not transferred to the B&C during her shift, and she did not call Resident 1's RP or FM regarding Resident 1's discharge information/instructions. RNS 2 stated she did not prepare and complete Resident 1's Notice of Transfer and Discharge Form because that was SSD's responsibility to complete the form. During a telephone interview on [DATE] at 3:36 p.m., the Funeral Director (FD) of a cremation company stated Resident 1 arrived at the funeral home with a top and bottom on, and two metal rings on her fingers. The FD stated he called the County Public Administrator's (CPA) office because Resident 1 did not have family to take charge of Resident 1's remains, per the ECO. During a telephone interview on [DATE] at 11 a.m., the CPA stated the cremation company referred Resident 1's remains to their office to locate Resident 1's family. The CPA stated Resident 1's RP and FM were not estranged from Resident 1. During an interview and record review on [DATE] at 1:11 p.m., the Director of Nursing Services (DON) stated Resident 1 was not able to make medical decisions for herself and there was no Notice of Proposed Transfer and Discharge Form signed by Resident 1's RP on file. The DON stated it was the responsibility of the facility's and SSD to ensure Resident 1's RP and/or FM were involved in the actual discharge process to ensure Resident 1's safe transition to the community. During an interview on [DATE] at 12:30 p.m., the Administrator (ADM) stated the residents' discharge plan, discharge instructions and discharge process should involve not only the resident but also the resident's RP and/or FM to ensure the resident's safe discharge to the community. During a review of the facility's Policy and Procedure (P/P) titled, Discharge and Transfer of Residents revised 2/2018, the P/P indicated the facility must ensure: (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The resident's discharge planning is complete and appropriate, and the necessary information is communicated to the continuing care provider b. The resident/resident representative will be provided with a Notice of Proposed Transfer and Discharge 30 days prior to discharge or as soon as practicable. c. The IDT will complete a discharge summary/post discharge plan of care when a resident is near a planned discharge and a copy of the discharge plan of care and/or discharge summary be provided to the resident, resident representative or the receiving facility. d. The social services or the nursing department must provide the resident and their representative with the Notice of Proposed Transfer and Discharge document and the social service department will provide a copy of the same document to the resident and their representative and a copy shall be placed in the resident's medical record. e. The Discharge Summary/Post Discharge Plan should include the resident's discharge destination including the address and phone number and the resident's representative and/or family contact information f. The resident's actual discharge must be documented in the resident's medical record to indicate the following: g. The date, time, and condition of the resident upon discharge h. Condition and diagnoses of the resident upon discharge or final disposition i. Discharge planning notes; and j. The resident's medications shall be reconciled and the disposition of the resident's drugs during discharge should be prepared, labelled and endorsed to the resident and/or the responsible party and/or to the representative of the incoming facility, according to the orders of the resident's primary care physician. During a review of the facility's P/P titled, NP03 Discharge and Transfer of Residents revised [DATE], the P/P indicated the facility shall ensure the residents' discharge planning is complete and appropriate and that necessary information is communicated to the continuing care provider to prevent inappropriate, unnecessary and untimely transfer and discharges.