

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Driftwood Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident 2's Responsible Party (RP) choices were upheld regarding medication consent and dosing for one of three sampled Residents (Resident 2) who was prescribed Trazodone (medication used to treat major depressive disorder [a mood disorder that causes a persistent feeling of sadness and loss of interest] 50 milligrams ([mg] unit of measurement) at bedtime for insomnia. This deficient practice resulted in the Resident 2 receiving treatment inconsistent with the RPs directive. Resident 2 continued to receive Trazadone 50 mg on 7/2/2026, 7/3/2026, 7/4/2026 and 7/5/2026 despite the RP consenting to decrease the Trazodone to 25 mg. This failure resulted in Resident 2 experiencing increased lethargy on 7/2/2026 and had the potential to result in excessive sedation, increased fall risk, and cognitive impairment. Findings: During a review of Resident 2's Face Sheet (front page of the chart that contains the summary of basic information about the resident), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 had diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), and anxiety (excessive worry) disorder. During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 6/22/2026, the MDS indicated Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. During a review of Resident 2's untitled Care Plan, initiated 3/31/2026, the Care Plan indicated Resident 2 had an episode of walking back and forth in the hall and had an angry outburst. The Care Plan's goal indicated Resident 2 will have improved sleep pattern by reporting adequate rest or fewer episodes of insomnia. The Care Plan's interventions included monitoring/recording Resident 2's mood, assessing whether any changes were related to external factors or current medications and treatments, and reporting any acute changes; particularly alterations in sleep patterns, to the physician as required. During a review of Resident 2's Psychiatric Evaluation Report, dated 6/19/2026, the report indicated Resident 2's plan of care included continued monitoring of mood, anxiety, cognition, and sleep. During a review of Resident 2's Order Summary Report (physician's orders), dated 6/29/2026, the Order Summary Report indicated an order was placed for Resident 2 to receive Trazadone Hydrochloride (HCL) 50 mg by mouth at bedtime for insomnia and the inability to sleep at nighttime. During a review of Resident 2's Psychotherapeutic Drug Informed Consent Form (voluntary agreement to accept treatment after receiving education regarding the risks, benefits and alternatives offered), dated 6/29/2026, the Consent Form indicated Resident 2 was to receive Trazadone 50 mg every night at bedtime due to Resident 2's inability to sleep due to insomnia and the RP was who would be the one consenting for treatment on Resident 2's behalf. The Consent Form indicated the area where did the prescribers' name, signature and date was blank. The Consent Form indicated that if the signature of the RP cannot be obtained, a licensed (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse must sign the form, by signing the form, the licensed nurse confirming that the RP gave their consent to the treatment with the psychotherapeutic drug on 6/29/2026. The Consent Form indicated Registered Nurse (RN) 1 and Licensed Vocational Nurse (LVN) 1 signed and dated the consent on 6/29/2026 and there was documentation indicating the RP refused to sign the consent on 7/2/2026. During a review of Resident 2's Psychotherapeutic Drug informed Consent Form, dated 7/2/2026, the Consent Form indicated Resident 2 was to receive Trazadone 25 mg at night due to Resident 2's inability to sleep due to insomnia and the RP was who would be the one consenting for treatment on Resident 2's behalf. The Consent Form indicated the area where the prescribers' name, signature and date was blank. The Consent Form indicated the RP signed the consent on 7/2/2026. During a review of Resident 2's Medication Administration Record (MAR) a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 6/1/2026 through 6/30/2026, the MAR indicated Resident 2 received Trazadone HCL Tablet 50 mg on 6/29/2026 and 6/30/2026. During a review of Resident 2's MAR, dated 7/1/2026 through 7/31/2026, the MAR indicated Resident 2 received Trazadone HCL Tablet 50 mg from 7/1/2026 to 7/5/2026. During a review of Resident 2's untitled Care Plan, initiated 7/7/2026, the Care Plan indicated Resident 2 has episodes of insomnia. The Care Plan's goal indicated Resident 2 will show positive response to medication, minimizing side effects with intervention. During a telephone interview on 7/8/2026 at 10:30 a.m., Resident 2's RP stated during the first week of June 2026, nursing staff informed her that Resident 2 was often awake at night, pacing the hallway or sitting at the nurses' station. The RP stated that after receiving this information, she requested that Resident 2 be assessed by the psychiatrist due to her disrupted sleep patterns. She stated she consistently asked nursing staff for a status update on the psychiatrist's visit. The RP stated staff did not discuss with her any interventions nursing staff would attempt to address Resident 2's insomnia. RP stated she wanted to know if Resident 2 was provided opportunities for increased daytime activity to promote improved nighttime sleep but was not given information. The RP stated she was never informed whether the psychiatrist evaluated Resident 2. The RP recalled that the nursing staff contacted her on 6/29/2026 via telephone to consent for Trazodone 25 mg to be administered at bedtime. The RP stated this occurred several weeks after her initial request for a psychiatric consultation. The RP stated she was not aware of any non-pharmacological approaches attempted prior to initiating Trazodone. The RP stated she visited Resident 2 on 7/2/2026 sometime after lunch and observed Resident 2 to be very lethargic. The RP asked a licensed nurse how if Resident 2 was given any other medications in addition to the Trazadone. The RP stated she was surprised to learn that Resident 2 was being administered 50 mg of Trazadone. The RP stated she understood that she only agreed to Resident 2 receiving 25 mg once a day at bedtime. The RP stated she immediately asked for the Trazadone dosage to be decreased from 50 mg to 25 mg. RP stated she signed a new informed consent indicating she provided consent for Trazadone 25 mg at bedtime instead of 50 mg. RP state she was frustrated as she still had not received a call from the psychiatrist and the licensed nursing staff could not provide an answer on when the psychiatrist would see Resident 2. RP state she felt frustrated and distrustful of the facility not following her wishes for Resident 2's best interest. During an interview on 7/8/2026 at 12:44 p.m., RN 1 stated on 6/29/2026, the previous shift had endorsed to her indicating a telephone order was received from Resident 2's physician to initiate Trazadone. RN 1 stated she was not informed of the reason for initiating Trazadone aside for the indication of insomnia. RN 1 stated she did not review Resident 2's medical records to determine what interventions per attempted prior to Resident 2 being initiated on Trazadone. RN 1 stated she was following the physician's orders. RN 1 stated she called the RP to obtain informed consent for (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Trazadone 50 mg at bedtime. RN 1 stated she called LVN 1 as a witness to the telephone consent. During an interview on 7/8/2026 at 1 p.m., LVN 1 stated that on 6/29/2026, RN 1 asked her to serve as the second witness for obtaining informed telephone consent from Resident 2's RP. LVN 1 stated she verified that the RP agreed to administer Trazodone 50 mg at bedtime to Resident 2 and stated she confirmed the RP's agreement during the telephone call. During an interview on 7/8/2026 at 1:35 p.m., the Director of Nursing (DON) stated she is responsible for reviewing the residents' clinical documents to ensure all residents ' receive appropriate care and treatment. The DON stated that based on her review of Resident 2's clinical documents, the records indicated that on 7/2/2026, Resident 2's RP provided informed consent indicated Trazadone 25 mg. The DON stated there was another consent, dated 6/29/2026, indicating informed consent for Trazadone 50 mg, witnessed by two licensed nurses. The DON stated the physician's order indicated Trazadone 50 mg at bedside, with a start date of 6/29/2026. The DON stated Resident 2's MARs indicated Resident 2 received Trazadone on 7/2/2026, 7/3/2026, 7/4/2026 and 7/5/2026 despite the RP revising the consent on 7/2/2026 for Trazadone 25 mg. The DON stated there was no documentation indicating the nursing staff called Resident 2's physician to inform the physician of RP's directive to change the Resident 2's Trazadone dose. The DON stated the nursing staff should have called the physician to discuss the medication regimen instead of continuing to administer Trazadone 50 mg to Resident 2. During a review of the facility's policy and procedure (P&P) titled, Resident's Rights, dated 01/01/2012, the P&P indicated residents have the freedom of choice, about how they wish to live their everyday life and receive care, subject to the facility's rules and regulations and applicable state and federal laws governing the protection of resident health and safety. During a review of the facility's P&P titled, Informed Consent, dated 01/03/2024, the P&P indicated the facility except in emergencies, informed consent must be obtained prior to the proposed treatment or procedure, where possible, consent should be obtained sufficiently in advance to allow the resident or their surrogate decision-maker time to consider and make an informed decision. During a review of the facility's P&P titled, Person-Centered Care Planning, dated 5/22/2025, the P&P indicated the facility focuses on the resident as the center of control and supports each resident in making her own choices.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 2) whose Responsible Party (RP) verbalized quality of care concerns to facility staff, was informed of and helped in completing a Grievance/Complaint Investigation Report. This failure resulted in Resident 2 and RP 2 not receiving timely or formal communication regarding the outcome or resolution of the complaint, which led to distrust toward the facility. This failure had the potential to delay necessary care and services to Resident 2 and could negatively impact Resident 2's mental health and emotional well-being. Findings: During a review of Resident 2's Face Sheet (front page of the chart that contains the summary of basic information about the resident), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 had diagnosis including schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (dementia (progressive state of decline in mental abilities) and anxiety (worry) disorder. During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 6/22/2026, the MDS indicated Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired and required substantial to maximum assistance (helper does more than half the effort) from staff for her activities of daily living ([ADLs] activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 2's Social Service Notes, dated 6/23/2026, the Social Service Notes indicated Resident 2's RP was dissatisfied with the current room situation and stated she (RP) called the local Long-Term Care (LTC) Ombudsman department and the department of Social Services to report the Social Services Director (SSD). The Social Service Note indicated the SSD reminded RP that it is her right as the RP to contact the Department of Health and the Department of Social Services with any concerns. There was no documentation in the Social Service Note indicating that the SSD identified or addressed RPs concerns. During a telephone interview on 7/7/2026 at 12 p.m., Resident 2's RP stated that over the last couple of months, she had informed the SSD and nursing staff of her quality-of-care concerns and of her most recent concern involved an incident in which she requested that Resident 4's (Resident 2's roommate) bedside commode, which had a foul smelling odor, be moved to another area on Resident 4's side of the room instead of near Resident 2's bed. The RP stated she had asked multiple staff members to move the commode, but staff took no action. The RP stated due to her frustration waiting for staff to address the issue, she asked facility staff for permission to move the commode herself. She stated that when she moved the commode, Resident 4 became audibly upset. She stated staff heard the commotion, came to the room, and informed her not to move the commode. She stated the incident caused a misunderstanding between herself and Resident 4. She stated she felt reprimanded by the facility for moving the commode, even though she had permission to do so. The RP stated she brought her concerns to the social worker regarding Resident 2's right to have a homelike and safe environment free from foul odors from Resident 4's commode. She stated this was one example of the facility not following up on her concerns. The RP stated another issue occurred about a month prior, when she notified facility staff that Resident 2 had a physician's appointment the following day and requested that staff ensure Resident 2 was awake, prepared, and ready on time. She stated that when she arrived at the facility around 8 a.m. that day, Resident 2 was still asleep. She stated she asked CNA 2, Resident 2's assigned CNA, why Resident 2 was not awake and ready yet. She stated CNA 2 had not been notified of Resident 2's appointment. She stated she assisted in (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	getting Resident 2 ready to avoid missing the appointment. She stated this delay in care caused Resident 2 to almost miss the physician's appointment. She stated she brought her concerns to the nursing staff that day but did not receive follow up. She stated she remained concerned that this could happen again. The RP stated she was not provided with education or the option to file an official grievance. During an interview on 7/8/2026 at 11 a.m. the SSD stated she is the facility's grievance officer and is responsible for ensuring all grievances are logged. The SSD stated she was not aware of any outstanding grievances from 5/2026 to 7/2026. The SSD stated all grievances have been entered into the grievance log and stated if there are any concerns regarding care, residents and family members can file a grievance and it can be initiated by any staff member. During a subsequent interview on 7/8/2026 at 11:30 a.m., the SSD stated she had initiated a grievance for Resident 4 (Resident 2's roommate) because Resident 2's RP moved Resident 4's commode and opened a window, causing Resident 4 to feel upset that her right rights were violated. The SSD stated Resident 2's RP also verbalized frustration and stated she moved the Resident 4's commode because it was too close to Resident 2's area of the room. The SSD stated she offered a room change to Resident 2 and Resident 2's RP, but the RP refused the room change. The SSD stated she did not further investigate why the RP moved the commode. The SSD stated she informed the RP that she could make a complaint to the office of the LTC Ombudsman or the Department of Health, but she did not think to create a grievance to address or investigate the underlying issue. The SSD stated both residents in the room had the right to equal treatment and to have their room concerns addressed. The SSD stated she was not aware that Resident 2 almost missed an appointment due to delayed ADL care. The SSD stated that when staff became aware of that concern, a grievance should be initiated to track the concern, ensure it is resolved, and provide updates to the complainant to ensure the instance doesn't happen again. The SSD stated failure to follow the policy increases the chances of delay in care and lead to feelings of distrust toward the facility from the resident or the RP. During an interview on 7/8/2026 at 12 p.m., CNA 2 stated she recalled an incident about a month prior when Resident 2's RP arrived at the facility at approximately 8 a.m. CNA 2 stated the RP planned to take Resident 2 to a doctor's appointment that morning. CNA 2 stated she did not know Resident 2 had an early appointment, and when the RP arrived, Resident 2 was still in bed, had not eaten, and was not prepared to leave for her appointment. CNA 2 stated Resident 2 experienced a delay in care, and she was not sure if the RP's concerns were noted or addressed. During an interview on 7/8/2026 at 4 p.m., The Director of Nursing (DON) stated facility policy require staff to investigate and resolve all grievances and clearly communicate outcomes to residents and their representatives. The DON stated failure to address grievances can delay care and cause frustration and distrust among residents and families. During a review of the facility's policy and procedure (P&P) titled, Grievances and Complaints, revised 11/14/2025 the P&P indicated when the facility staff member overhears or receives a grievance/complaint from a resident, a responsible representative, family member, the facility staff member encourages and offers to facilitate the completion of a Grievance/Complaint investigation report. Upon receiving the grievance/complaint report, the grievance officer or designee provides a copy of the report to the appropriate department manager to being the investigation and subsequent resolution. The Grievance Official will be provided with a completed Resident Grievance/Complaint Investigation Report withing five business days of the start of the investigation. the facility will inform the resident and his RP with a summary of findings and corrective action if applicable. the disposition of all written grievances and/or complaints is recorded on the Resident Grievance/complaint log.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident (Resident 2) who had insomnia (trouble falling asleep or staying asleep) staff implemented Care Plan interventions which included behavioral monitoring to determine changes in sleep patterns and received resident-directed care and treatment consistent with the residents Care Plan prior to the initiation of Trazadone (a medication used to treat prescription medication prescribed to treat major depressive disorder [a mood disorder that causes a persistent feeling of sadness and loss of interest]) for one of three sampled residents (Resident 2). This deficient practice resulted in nursing staff failing to adequately assess and monitor Resident 2's sleep patterns per the Care Plan and resulted in nursing staff to be unaware of the clinical indications that lead to the physician's order for Trazodone. This deficient practice had the potential to delay in identifying and providing needed care and services to Resident 2. Findings: During a review of Resident 2's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 had diagnoses including with diagnoses schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities) and anxiety (excessive worry) disorder. During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 6/22/2026, the MDS indicated Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. During a review of Resident 2's untitled Care Plan, initiated 3/31/2026, the Care Plan indicated Resident 2 had an episode of walking back and forth in the hall and had an angry outburst. The Care Plan's goal indicated Resident 2 will have improved sleep pattern by reporting adequate rest or fewer episodes of insomnia. The Care Plan's interventions included monitoring/recording Resident 2's mood, assessing whether any changes were related to external factors or current medications and treatments, and reporting any acute changes; particularly alterations in sleep patterns, to the physician as required. During a review of Resident 2's Psychiatric Evaluation Report, dated 6/19/2026, the Psychiatric Evaluation Report indicated Resident 2's plan of care included continued monitoring of mood, anxiety, cognition, and sleep. During a review of Resident 2's Order Summary Report (physician's orders), dated 6/29/2026, the Order Summary Report indicated an order was placed for Resident 2 to receive Trazadone Hydrochloride (HCL) Tablet 50 milligrams ([mg] unit of measurement) by mouth at bedtime for insomnia and the inability to sleep at nighttime. During a telephone interview on 7/8/2026 at 10:30 a.m., Resident 2's RP stated that during the first week of June 2026, nursing staff informed her that Resident 2 was often awake at night, pacing the hallway or sitting at the nurses' station. The RP stated that after receiving this information, she requested that Resident 2 be assessed by the psychiatrist due to her disrupted sleep patterns. She stated she consistently asked nursing staff for a status update on the psychiatrist's visit. The RP stated staff did not discuss with her any interventions nursing staff would attempt to address Resident 2's insomnia. She stated she would have wanted to know if Resident 2 was provided opportunities for increased daytime activity to promote improved nighttime sleep. The RP stated she was never informed whether the psychiatrist evaluated Resident 2. She recalled that nursing staff contacted her on 6/29/2026 to sign a consent for Trazodone, several weeks after her initial request for a psychiatric consultation. She stated she was not aware of any non-pharmacological approaches attempted prior to initiating Trazodone. During an interview on (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/8/2026 at 1:28 p.m., Registered Nurse (RN) 1 stated on June 29,2026, the previous shift had endorsed a telephone order from Resident 2's physician to initiate Trazadone. RN 1 stated she was not informed of the reason for initiating Trazadone aside for the indication of insomnia. RN 1 stated she did not review Resident 2's medical records to determine what interventions per attempted prior to Resident 2 being initiated on Trazadone. RN 1 stated she was following the physician's orders.During an interview on 7/8/2026 at 1:35 p.m., the Director of Nursing (DON) stated she is responsible for reviewing the residents' clinical documents to ensure all residents receive appropriate care and treatment. The DON stated based on review of Resident 2's Care Plan, Resident 2's Care Plan interventions included required monitoring and documentation sleep patterns and any signs of insomnia. The DON stated that her review of Resident 2's clinical documents showed no documentation indicating Resident 2's sleep-related behaviors were monitored or assessed. The DON stated that the failure to monitor and document these behaviors prevented nursing staff from developing or revising the care plan which would include implementing non-pharmacological interventions before initiating Trazodone. The DON further stated that, based on the available documentation, she could not determine the clinical indications that led to Resident 2 being prescribed Trazodone. During a review of the facility's policy and procedure (P&P) titled, Person-Centered Care Planning, dated 5/22/2025, the P&P indicated the facility must develop and implement a comprehensive person- centered care plan for each resident consistent with the resident rights, that includes measurable objectives, and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.		