

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555533	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/22/2026
NAME OF PROVIDER OR SUPPLIER  Driftwood Healthcare Center - Hayward		STREET ADDRESS, CITY, STATE, ZIP CODE  19700 Hesperian Boulevard Hayward, CA 94541	
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 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record reviews, the facility failed to ensure immediate interventions during a resident-to-resident altercation for two sampled residents (Resident 1 and Resident 2) when a verbal altercation between Resident 1 and Resident 2 escalated into a physical altercation without timely staff separation. This failure placed Resident 1 and Resident 2 at risk for escalation of aggressive behaviors, physical injury, and emotional distress. During a review Resident 1's Face Sheet, printed on 1/22/26, the Face Sheet indicated Resident 1 was admitted to the facility in November 2023 with diagnoses of acute respiratory syndrome (life-threatening lung injury that allows fluid to leak into the lungs) and anxiety disorder (a mental health condition causing excessive and persistent fear or worry). During a review of Resident 1's Brief Interview for Mental Status (BIMS, is a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information. A BIMS score of thirteen to fifteen is an indication of intact cognitive status.) dated 9/30/25 showed Resident 1's BIMS score of 15. During a review of Resident 1's Care Plan dated 11/12/24, the Care Plan showed Resident 1 had a history of Aggressive behavior towards other resident with interventions including emphasizing responsibility of physical aggression and description of possible outcome to self and others and neutralize the situation by separating involved parties. During a review of Resident 2's Face Sheet, printed on 1/22/26, the Face Sheet indicated Resident 2 was admitted to the facility in June 2025 with diagnosis of late-onset cerebellar ataxia (gradual loss of muscle coordination). During a review of Resident 2's BIMS record dated 9/26/25, Resident 2's BIMS score of 12. (A BIMS score of eight to twelve is an indication of moderate impairment of cognitive status) During an interview on 1/22/26 at 12:46 p.m. with Resident 2, Resident 2 stated the altercation with Resident 1 happened last November 2025. Resident 2 stated it occurred early in the morning when Resident 2 used the shared bathroom and heard another resident yelling loudly in the adjacent room. Resident 2 stated they entered the room through the shared bathroom door to address the yelling. Resident 2 stated a staff member was present in the room and that Resident 2 told the staff to address the resident's yelling. Resident 2 stated Resident 1 began yelling and instructed Resident 2 to leave the room. Resident 2 stated they approached Resident 1 and a verbal argument occurred. Resident 2 stated they were challenging each other and that the argument escalated to physical altercation when Resident 1 struck Resident 2 on the head with a cane. When asked if the staff who was present in the room intervened during the altercation, Resident 2 stated I don't think so. Resident 2 further stated they were separated from each other only after the physical altercation had occurred by male nursing staff. During an interview on 1/22/26 at 2:05 p.m. with CNA 1, CNA 1 stated she was providing care to Resident 1's roommate in room [ROOM NUMBER] when Resident 2 entered the room through the shared bathroom and told her to make Resident 1's roommate to stop yelling. CNA 1 stated she was unfamiliar with the residents as it was her first time working at the</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  555533	Facility ID:  555533  If continuation sheet Page 1 of 2

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>facility. CNA 1 stated she did not know Resident 2 was assigned to another room and informed Resident 2 she was almost finished providing care to Resident 1's roommate. CNA 1 stated Resident 1 became upset and began arguing with Resident 2 and was telling Resident 2 to get out of the room. CNA 1 stated she also instructed Resident 2 to leave the room; however, Resident 1 and Resident 2 continued to yell at each other. CNA 1 stated Resident 1 got up from the bed, and Resident 1 and Resident 2 began shoving each other. CNA 1 stated she did not intervene physically as she did not want to get in the middle of Resident 1 and Resident 2. CNA 1 stated she attempted to de-escalate the situation verbally by telling them to calm down, and stated she was keeping an eye on them while Resident 1 and Resident 2 continued to argue. CNA 1 stated she witnessed Resident 1 grab a cane and hit Resident 2 on the head and that was the time she called for assistance. CNA 1 stated a couple of male nursing staff entered the room and assisted with separating Resident 1 and Resident 2. CNA 1 further stated she believed the incident could have been prevented if she had been informed of potential conflicts between Resident 1 and Resident 2 and behaviors that could lead to aggression. During an interview on 1/22/26 at 2:48 p.m. with the Director of Nursing (DON), DON stated during a resident-to-resident altercation, facility staff, including registry (personnel supplied by an agency) staff, were expected to immediately separate the residents as soon as a verbal altercation occurs. DON further stated if a staff member was unable to handle the safely manage the situation, the staff member was expected to immediately call for assistance to prevent escalation to a physical altercation. During a review of the facility's policy and procedure (P&amp;P), titled, Abuse Prevention Program, dated on 5/12/25, the P&amp;P indicated, Our residents have the right to be free from abuse. This includes but is not limited to freedom from verbal or physical abuse. 1. Protect our residents from abuse by anyone including, but not necessarily limited to facility staff, other residents. 4. Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse and handling verbally or physically aggressive resident behavior. Follow the required training frequency and requirements by regulatory agencies. During a review of the facility's undated P&amp;P, titled, Resident-to-Resident Altercations, the P&amp;P indicated, 2. If two residents are involved in an altercation, staff will: a. Separate the residents, and institute measures to calm the situation.</p>		