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 _____	C 03/06/2025

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DRIFTWOOD HEALTHCARE CENTER	4109 EMERALD ST TORRANCE, CA 90503

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint and a Facility Reported Incident (FRI). Complaint Number: CA00949679 Facility Reported Incident Number: CA00946759 The inspection was limited to the specific Complaint and Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. No deficiency was identified for the complaint number: CA00949679 Two deficiencies were identified for Facility Reported Incident Number: CA00946759 (see Ftags 660 and 689)	F 000	**Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law.**	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.	F 660	**Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix)** **Corrective action:** • Resident 1 no longer resides in the facility. • Notice of Proposed transfer & Discharge was corrected on 3/6/25 and Faxed to Ombudsman. • Late Entry for telephone order and documentation was done by RN supervisor 2 on 3/6/25.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3/24/25

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.

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F 660	Continued From page 1 (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not	F 660	• SSD called Texas Police on 3/26/25 to do a wellness check regarding Resident 1. They were unable to provide information regarding the resident's whereabouts. There wasn't anyone home at the time of their visit. **How to identify potentially affected other:** • On 3/21/25 Medical Records conducted an audit for Discharges from January 01, 2025, to March 21, 2025, for completion of Discharge order, Notice of Proposed Transfer, Discharge Planning, EInteract (If applicable) and Discharge notes. No other resident was found affected with the same deficient practice. **Measures/Systemic change:** • RN supervisor 3 was given Disciplinary Action and 1:1 in-service On 3/5/25 by DON giving emphasis on making sure that Steps for Discharge	

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F 660	Continued From page 2 limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of two sampled resident's (Resident 1) discharge planning and discharge procedures were implemented and documented prior to and when was Resident 1 was discharged from the facility (2/27/2025). This deficient practice resulted in Resident 1 being discharged from the facility with without prior discharge planning or documentation that he received discharge instructions when he left the facility on 2/27/2025. This deficient practice had the for Resident 1 to be unaware of his care needs and follow up appointments. Findings:	F 660	Process is done with instruction, Health teachings and Verbalization of understanding with resident's signature or Responsible Party. • RN Supervisor 2 was given Disciplinary Action and 1:1 In-service on 3/6/25 by DON Regarding Discharge Process giving emphasis on documenting and writing Telephone Order per MD's instruction for Discharges. To make sure Discharge Planning will be initiated. • License Nurses were given in-service and Re-education by Director of Nursing regarding Discharge Process on 3/6/25, 3/7/25, 3/8/25, 3/11/25 and 3/12/25 with emphasis on appropriate documentation on proposed Transfer, making sure that resident or Responsible Party will sign Discharge Instructions with Health Teachings Provided upon Discharge. • QAPI was initiated on 3/6/25 regarding Transfer and Discharges. • License nurse was given in-services by DON regarding QAPI on 3/6/25, 3/7/25, 3/8/25,3/11/25 and 3/12/25.	

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F 660	Continued From page 3 During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility 2/3/2025 with diagnosis including paraplegia (when a person is unable to move their lower body), anxiety disorder (a condition that involves persistent and excessive worry that interferes with daily activities), major depressive disorder ([MDD] a mood disorder that causes a persistent feeling of sadness and loss of interest), cannabis (marijuana) dependence and psychoactive substance induced psychotic disorder (a mental health condition in which the onset of psychotic disorder symptoms can be traced to starting or stopping using alcohol or a drug). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 2/10/2025, the MDS indicated Resident 1 was able to make decisions that were reasonable and consistent, he had behavioral episodes of physical and verbal symptoms directed towards others such as hitting, cursing, threatening and screaming, he required a one person assist to complete his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily) and transferring from bed/chair to chair. During a review of Resident 1's History and Physical (H&P), dated 2/4/2025 and timed at 2:19 p.m., the H&P indicated Resident 1 had the capacity to understand and make medical decisions.	F 660	• The Administrator gave 1:1 in-service to Medical Records Director regarding audit on all Discharge charts on 3/7/25. • The Administrator gave 1:1 in-service to SSD on 3/24/25 regarding Discharge Process giving emphasis in Initiating Discharge Planning, Documentation and follow up with Discharge Resident. **Monitoring:** • **Medical Records Designee will audit the PCC, daily Discharges for charting and documentation for completion weekly. Findings will be discussed in daily clinical meeting for necessary action.** • DON will review the Discharge Audit report for accuracy. Any negative trends will be discussed and reported in the monthly QA & A meeting for further intervention and compliance. **Completed on 3/26/25**	

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F 660	Continued From page 4 A review of Resident 1's medical record indicated discharge planning had not occurred prior to Resident 1's discharge from the facility or that discharge instructions were provided to Resident 1 on discharge from the facility (2/27/2025) During a review of the Resident 1's Notice of Proposed Transfer and Discharge form dated 2/17/2025, the Notice of Proposed Transfer and Discharge form indicated Resident 1 was self-responsible and was discharged to home and/or was going to another State (no specific address was indicated). The Notice of Proposed Transfer and Discharge form was not signed by Resident 1. During a review of Resident 1's Social Service Progress Note dated 3/3/20205 with a late entry date of 2/27/2025, the Social Service Progress Note indicated the facility helped Resident 1 purchase a bus ticket but Resident 1 did not leave any family information. The Social Service Progress Notes indicated Resident 1 was discharged from the facility with no medication, per Resident 1's physician. During a telephone interview on 3/5/2025 at 1:20 p.m., Registered Nurse Supervisor 2 (RNS 2) stated on 2/27/2025 she received an order from Resident 1's nurse practitioner to discharge Resident 1 home with no medications. RNS 2 stated she endorsed the discharge instructions to the incoming shift (3 p.m. to 11 p.m.) RNS 3. RNS 2 stated she instructed Resident 1 that there was an order to discharge him without his	F 660		

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F 660	Continued From page 5	F 660		

medications and to follow up with his physician in one week. RNS 2 stated Resident 1 wanted to leave the facility, so she prepared the Notice of Transfer and Discharge form but Resident 1 refused to sign it. RNS 2 stated she did not document on the Notice of Transfer and Discharge form or in Resident 1's clinical record her communication with him or his refusal to sign the form.

During a telephone interview on 3/5/2025 at 2:03 p.m., RNS 3 stated Resident 1's discharge was unplanned, and he (Resident 1) insisted on leaving the facility despite being discharged without his medications. RNS 3 stated thought all of Resident 1's discharge papers were given to Resident 1 by RNS 2 during the at 7 a.m. to 3 p.m. shift (2/27/2025) and she (RNS 3) discharged Resident 1 on 2/27/2025 at 7 p.m.

During an interview on 3/5/2025 at 2:26 p.m., the Social Service Director (SSD) stated Resident 1 requested to leave the facility with a bus ticket to his home (out of state) and wanted to leave even if his physician discharged him with no medications. The SSD stated there was no discharge planning started or documented in Resident 1's medical record.

During an interview on 3/5/2025 at 3:32 p.m., RNS 1 stated Resident 1's discharge planning process should have been initiated when he was admitted to the facility. RNS 1 stated discharge instructions should have been prepared and explained to Resident 1 and a copy given to him before he was discharged from the facility. RNS

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F 660	Continued From page 6 1 stated it was important for Resident 1 to have a copy of his discharge instructions, a list of his medications and/or prescriptions, follow up appointments and if ordered, provision of his care at home to ensure his overall health and well-being. During an interview on 3/6/2025 at 3:10 p.m., the Director of Nursing (DON) stated if the facility and its interdisciplinary team was not able to implement a thorough discharge plan for a resident, then the resident will not be prepared and safely discharged. The DON stated the actual discharge process should involve the nursing and social services department and must work hand in hand to ensure the resident safely transition from the facility to the community to be able to thrive. During an interview on 3/6/2025 at 3:50 p.m., the Administrator (ADM) stated all resident's discharge preparation and procedures should be documented in the resident's chart. During a review of the facility's policy and procedure (P/P) titled, "NP03 Discharge and Transfer of Residents" revised 12/21/2023, the P/P indicated the facility must ensure the discharge planning of the residents must be complete and appropriate, and that necessary information is communicated to the resident and/or the continuing care provider. During a review of the facility's P/P titled, "P-NP03 Discharge and Transfer of Residents revised	F 660		

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F 660	Continued From page 7 12/21/2023, the P/P indicated: 1. The residents' discharge planning shall begin on the residents' admission to the facility 2. The primary physician and the interdisciplinary team will review the resident's progress and determine a possible discharge date 3. Prior to discharge, the facility will provide the resident/resident representative with a Notice of Proposed Transfer and Discharge Document and copy of a signed/completed form will be placed in the resident's medical record.	F 660		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 5) was supervised by the facility staff while smoking. This deficient practice resulted in Resident 5	F 689	**Free of Accident Hazard / Supervision / Devices CFR(s): 483.25(d)(1)(2)** **Corrective action:** • The body check was done on Resident 5 on 3/6/25 RN Supervisor and Tx nurse with no indication of cigarette burns and other skin issues associated with smoking. • SSD spoke with Resident 5 and Brother on 3/7/25 regarding Smoking Policies giving emphasis that cigarettes and lighter will be kept by LN, smoking schedule that is supervised by staff. **How to identify potentially affected other:**	

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F 689	Continued From page 8 smoking unsupervised on/near the facility's parking lot with the use of a cigarette lighter, without wearing a smoking apron, or having a receptacle to safely dispose of his used cigarette(s). This deficient practice had the potential for Resident 5 to sustain burn injuries. Findings: During a review of Resident 5's Admission Record (Face Sheet), the Face Sheet indicated Resident 5 was admitted to the facility on 2/4/2013 with diagnosis including cerebrovascular disease ([stroke] a condition that affects the blood flow to the brain), right side hemiplegia (complete paralysis of one side of the body), and glaucoma (an eye condition that damages the optic nerve that can lead to vision loss or blindness). During a review of Resident 5's Minimum Data Set ([MDS] a resident assessment tool) dated 2/7/2025, the MDS indicated Resident 5 was forgetful and was not able to make reasonable decisions, had an impairment on side of his upper extremities (the region of the body that includes the arm, forearm, wrist and hand) and required a one person assist to complete his 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 5/25/2023, the H&P indicated Resident 5 was pleasantly demented,	F 689	• RN supervisor made rounds on 3/6/25 and there was no other resident smoking. • Medical Records audited current residents who desired to smoke and non-compliance regarding facility's smoking policy was audited on 3/21/25 to ensure that smoking assessment & care plan are updated and revised in resident's record. No issues were identified. **Measures/Systemic change:** • License Nurses and Certified Nurse Assistant was given in-service by Director of Nursing regarding Smoking Resident on 3/6/25 , 3/7/25, 3/7/25, 3/8/25 , 3/11/25 and 3/12/25 giving emphasis on following smoking schedule, making sure that all cigarette & lighter should be kept by LN , • smoking resident should be assessed with care plan and should be supervised by assigned staff at all times. • IDT was done on 3/24/25 by SSD to all current resident who smokes giving emphasis on smoking schedule with staff to supervised and all cigarette & lighter should be kept by LN .	

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F 689	Continued From page 9 and conversational but did not have the capacity to understand and make decisions. During a review of Resident 5's Care Plan on "Potential for Safety Hazard and Injury Related to Smoking" dated 7/18/2023, the Care Plan indicated Resident 5 refused to wear a protective smoking apron while smoking. The Care Plan's goal was for Resident 5 to have no injury to himself, others and no property damage. The interventions included allowing Resident 5 to smoke in designated smoking areas, the nursing personnel would keep smoking materials at the nursing station and return the materials to the nursing station after smoke break. During an observation on 3/6/2025 at 8:55 a.m., Resident 5 was observed sitting in his wheelchair in front of two large trash bins by the facility's parking lot with no staff present, without a smoking apron on or ashtray to dispose of cigarette ashes or used cigarette(s). Resident 5 was observed lighting a cigarette that was in his mouth with a cigarette lighter, and then placed the cigarette lighter inside the pocket of his coat. Resident 5 shrugged his left shoulder, moved his head from side to side, pointed to the smoking patio when asked why he was smoking alone in the facility's parking lot. During an interview on 3/6/2025 at 9:50 a.m., Licensed Vocational Nurse 4 (LVN 4) stated Resident 5 loved to go outside of the facility to get fresh air and to smoke. LVN 4 stated the licensed nurses keep residents' smoking supplies and they were only provided to residents when they wanted	F 689	**Monitoring:** • **Nursing staff will monitor daily rounds on their shift to ensure "no cigarette lighter permitted in the resident's room for the resident who desire to smoke. Any issues identified will be corrected.** • The SSD will conduct random weekly rounds for 1 month, then 3 months and then quarterly thereafter or until compliance is reached and ongoing as needed to ensure the appropriate storing of cigarette, lighter for the resident who desired to smoke. Any issues identified will be corrected. • DON and or designee will randomly check for compliance. Audit review the Smoking progress report, will be discussed and reported in the monthly QA & A meeting for further intervention and compliance. Completion Date : 3/26/25	

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F 689	Continued From page 10 to smoke. During an interview on 3/6/2025 at 10:07 a.m., Certified Nursing Assistant 5 (CNA 5) stated she was busy caring for other residents, and she did not know Resident 5 was outside of the facility smoking by himself. CNA 5 stated Resident 5 needed supervision when he was smoking because he did not always understand directions. During an interview on 3/6/2025 at 3:10 p.m., the Director of Nursing (DON) stated all staff were responsible to ensure residents' were safe and supervised when they were smoking. During a review of the facility's policy and procedure (P/P) titled, " NP132 Smoking by Residents" revised 7/27/2023, the P/P indicated the facility that accommodate residents who smoke will take reasonable precautions by providing a safe environment for the residents. During a review of the facility's policy and procedure (P/P) titled, "P-NP132 Smoking Residents" revised 7/27/2023, the P/P indicated the following: a. Smoking by the residents is allowed outside of the facility in designated, marked smoking areas with ashtrays made of safe and non-combustible material, metal containers with self-closing covers in which the ashtrays can be emptied, portable extinguisher and a fire retardant blanket,	F 689		

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F 689	Continued From page 11 b. The facility may develop a smoking schedule to ensure a safe environment for the residents, and During a review of the facility's P/P titled, "Resident Safety" revised 4/15/2021, the P/P indicated: a. The facility shall provide the residents a safe and hazard free environment	F 689		