STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555114	A. BUILDING _____ B. WING _____	**04/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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** Based on interview and record review, the facility failed to report an abuse allegation to the Department of Health Services (DHS), for one of three sampled residents (Resident 1), who alleged that she was physically abused by one of the staffs. This deficient practice placed Resident 1 and other residents in the facility at risk for abuse and neglect. Findings: During a review of Resident 1's Admission Face sheet indicated the resident was admitted to the facility, on [DATE]. Resident 1's [DIAGNOSES REDACTED]. During a review of Resident 1's history and physical (H/P) report dated 1/22/2020 indicated the resident have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ((MDS) an assessment and care screening tool) dated 1/28/2020, indicated the resident was able to understand and be understood by others. According to the MDS, Resident 1 required extensive assistance from staff with bed mobility, transferring from a bed and chair to a standing position, moving from one location in the facility to another, dressing, eating toilet use and personal hygiene. The MDS also indicated Resident 1 used a wheelchair (w/c) for ambulation and was incontinent (inability to control) of bowel and bladder functions. During a review of a care plan dated 1/12/2020 indicated Resident 1 requires assist with bed mobility, transfer, dressing, personal hygiene, toilet use, bathing and walking. The staff interventions include to assist resident with turning and repositioning, remind resident to use call light when needs assistance, provide good skin and perineal care and kept resident clean dry and comfortable. During an interview with Resident 1 on 3/11/2020 at 10:04 a.m., Resident 1 stated she woke up at about 5 am in the morning and she was soaked wet with urine, she turned on the call light for help. Resident 1 stated she pointed her finger in CNA 1's face. During an interview with Administrator on 3/11/2020 at 11:20 a.m., Administrator stated he did not call in and report the abuse allegation because he was informed about it four days later. Administrator stated he is still investigation the incident and he had spoke with Resident 1, she stated that she does not want to get anyone in trouble resident stated she feel safe and will like to continue living in the facility. During an interview with CNA 1 on 4/8/2020 at 8:02 a.m., CNA 1 stated she did not hit Resident 1, she only re-directed resident by moving away her finger from her face. Resident 1 was talking to her and pointing her finger on her face. CNA 1 stated that she responded to Resident 1 call light and told her give her few minutes because she was busy with another resident, Resident 1 was angry saying that she asked to be changed earlier and was told that she was not wet and now she is soaked and wet and wants to be change. CNA 1 stated that she moved resident 1's hand away from her face telling her to have patient that she is not the only Cinderella here. CNA 1 stated she went back to Resident 1 and apologize to her for calling her Cinderella. They both made up. A review of a policy titled Abuse Reporting and Investigation, date of 3/18 indicated the facility would protect the health, safety and welfare of Facility residents by ensuring that all reports of abuse, mistreatment, neglect, exploitation and injuries of unknown source and suspicion of crimes are promptly reported and thoroughly investigated. The facility will report all allegations of abuse and criminal activity as required by law and regulations to the appropriate agencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.