STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555797	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gordon Lane Care Center	1821 E Chapman Ave Fullerton, CA 92831

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 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 37726 Based on interview, medical record review, and facility P&P review, the facility failed to develop the plan of care to reflect the individual care needs for one of seven final sampled residents (Resident 1). * The facility failed to develop a care plan to address Resident 1's risk for impaired cognition. This failure posed the risk for not providing appropriate and individualized care to the resident. Findings: Review of the facility's P&P titled Comprehensive Care Plans dated 12/19/22, showed it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The care planning process will include an assessment of the resident's strengths and needs. Medical record review for Resident 1 was initiated on 6/6/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's physician's progress note dated 4/23/24, showed Resident 1's primary issues include mild cognitive impairment likely vascular dementia. Resident 1's secondary issues included frailty syndrome. With Resident 1's age and comorbidities, Resident 1 was vulnerable to cognitive decline including periods of delirium, in the setting of cognitive impairment and/or dementia. Review of Resident 1's Order Summary Report showed an order dated 4/24/24, for a follow-up appointment with Physician 1 for a neurology consult for dementia. Further review of Resident 1's plan of care failed to show a comprehensive and individualized care plan problem to address Resident 1's mild cognitive impairment likely due to vascular dementia and vulnerability to cognitive decline. (continued on next page)

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

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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 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	On 6/25/24 at 1145 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 1's plan of care failed to show a comprehensive and individualized care plan specific to Resident 1's mild cognitive impairment likely due to vascular dementia and vulnerability to cognitive decline.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of seven sampled residents (Resident 1) attended the scheduled neurology consultation appointment for * Resident 1 had a telemedicine neurology consultation for dementia. Resident 1's appointment was scheduled to take place at the facility utilizing Resident 1's telephone. However, at the time of Resident 1's appointment, no staff were present to assist Resident 1 with her appointment via telephone. As a result, Resident 1 did not attend her scheduled neurology appointment. This failure had the potential to delay Resident 1's plan of care. Findings: Review of the facility's P&P titled Accommodation of Needs dated 12/19/22, showed the facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a resident. Based on individual needs and preferences, the facility will assist the resident as much as possible in maintaining and/or achieving independent functioning, dignity, and well being to the extend possible. Medical record review for Resident 1 was initiated on 6/6/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's physician's progress note dated 4/23/24, showed Resident 1's primary issues included mild cognitive impairment likely vascular dementia. Resident 1's secondary issues included frailty syndrome. With Resident 1's age and comorbidities, Resident 1 was vulnerable to cognitive decline including periods of delirium, in the setting of cognitive impairment and/or dementia. Review of Resident 1's Order Summary Report showed an order dated 4/24/24, for a follow-up appointment with Physician 1 for a neurology consult for dementia. Review of Resident 1's Case Management Progress Note dated 4/26/24 at 1603 hours, showed Resident 1's neurology consult was scheduled for 5/21/24 at 0815 hours,via telemedicine. Further review of Resident 1's medical record show no documented evidence Resident 1 had attended her scheduled neurology consult scheduled for 5/21/24 at 0815 hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/24 at 1317 hours, an interview and concurrent medical record review was conducted with the Case Manager. The Case Manager verified Resident 1 had a scheduled neurology consult appointment for dementia, scheduled for 5/21/24 at 0815 hours. The Case Manager stated on the morning of 5/21/24, before Resident 1's scheduled neurology appointment, the Case Manager went to Resident 1's room and reminded Resident 1 that she had a scheduled telephone neurology appointment scheduled for 0815 hours. The Case Manager stated she was not available at the actual time (0815 hours) of Resident 1's scheduled appointment and was unable to be present in Resident 1's room at 0815 hours, nor did she delegate this task to another staff member, to ensure Resident 1 attended her neurology consult appointment for dementia. The Case Manager was then asked if Resident 1 had attended her neurology consult appointment for dementia. The Case Manager stated Resident 1 had not attended her appointment. The Case Manager stated her normal practice would to be present in Resident 1's room, at the time of Resident 1's telemedicine neurology appointment, to ensure Resident 1 received the necessary assistance to attend her appointment. The Case Manager stated she was unable to be present in Resident 1's room at the time of her neurology appointment as she was with other residents. The Case Manager stated she subsequently rescheduled Resident 1's neurology appointment for 6/18/24. On 6/25/24 at 1145 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 1's physician's progress note dated 4/23/24, showed Resident 1's primary issues included mild cognitive impairment likely vascular dementia. Resident 1's secondary issues included frailty syndrome and with Resident 1's age and comorbidities, Resident 1 was vulnerable to cognitive decline, including periods of delirium in the setting of cognitive impairment and/or dementia. The DON stated her expectation was for a staff member to be present in Resident 1's room at the time of her neurology consult appointment for dementia, to provide Resident 1 with any assistance she may have needed to attend her scheduled appointment. Cross reference to F656.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on interview, medical record review, and facility P&P review, the facility failed to maintain an accurate medical record for one of seven sampled residents (Resident 1). * The facility failed to ensure the licensed nurse documented her initials on Resident 1's TAR (indicating the treatment was provided) as per the facility's P&P. This failure had the potential for the resident's needs not being met as the medical information was incomplete. Findings: Review of the facility's P&P titled Documentation in Medical Record dated 12/19/22, showed the licensed staff shall document all services provided in the resident's medical record in accordance with state law and facility policy. Medical record review for Resident 1 was initiated on 6/6/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed an order dated 5/20/24, to apply a warm compress to Resident 1's right groin area for 20 minutes four times a day for five days. Review of Resident 1's TAR for May 2024 showed the licensed nurse failed to document her initials on the TAR for the application of Resident 1's warm compress to the right groin area for 20 minutes on 5/21/24 at 0900 and 1300 hours. On 6/25/24 at 1035 hours, an interview and concurrent medical record review was conducted with LVN 4. LVN 4 verified she was assigned to care for Resident 1 on 5/21/24, duringthe morning shift (0700 to 1500 hours). LVN 4 verified Resident 1's TAR failed to show documentation (licensed nurse's initials) Resident 1's warm compress to the right groin was applied on 5/21/24 at 0900 and 1300 hours. LVN 4 stated the treatment nurse who administered Resident 1's warm compress was responsible for documenting (on the TAR) the warm compress was applied. LVN 4 stated the purpose of documenting the licensed nurse's initials on the resident's TARwas to indicate the resident's treatment was provided as ordered by the physician and applied at the time the treatment was ordered by the physician. On 6/25/24 at 1145 hours, an interview was conducted with the DON. The DON was asked about the facility's policy specific to documentation of the resident'streatments. The DON stated after a licensed nurse administered a treatment, the licensed nurse was required to document on the resident's TAR to show the treatment was administered in accordance with the physician's order.