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	09/03/2024

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 0557 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the resident personal belongings were properly recorded for two of 10 sampled residents (Residents 2 and 6). This failure had the potential for the residents' personal belongings being lost or stolen. Findings: Review of the facility's P&P titled Resident Personal Belongings revised 12/2022 showed all residents personal items will be inventoried at the time of admission by the social services designee, or another designated staff member and documentation shall be retained in the medical record. Additional possessions brought in during the duration of the individual's stay shall be added to the existing personal belongings inventory listing. Following the discharge or death of a resident, all personal clothing and items of a customized personal nature are to be given to the designated resident representative. Review of the facility's P&P titled Theft and Loss Program revised 12/2022 showed the following under policy interpretation and implementation: upon admission, residents/responsible parties will be informed of the facility's theft and loss program policies and procedures. A resident property inventory will be completed to identify personal property the resident brought with him/her to the facility. The items will be listed on a two part form; Resident's Clothing and Possessions. After completing the admission section of the Resident's Clothing and Possessions form, the resident/surrogate will sign the form. The yellow copy of the form is then given to the resident/surrogate and the white copy becomes part of the resident's medical record. 1. Medical record review for Resident 2 was initiated on 8/29/24. Resident 2 was readmitted to the facility on [DATE]. Review of Resident 2's Clothing and Possessions form failed to show a date and signature from the resident or responsible party. There were personal belongings listed on the form. (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 0557 Level of Harm - Potential for minimal harm Residents Affected - Some	On 8/29/24 at 1017 hours, a concurrent interview and facility document review was conducted with LVN 1. LVN 1 stated the resident's inventory list was done upon the resident's admission. LVN 1 stated Resident 2 was readmitted to the facility on [DATE]. LVN 1 verified Resident 2's Clothing and Possessions form was incomplete and there was no documented evidence a Resident 2's Clothing and Possessions form was completed on 8/19/24, upon Resident 2's readmission. 2. Medical record review for Resident 6 was initiated on 8/29/24. Resident 6 was admitted to the facility on [DATE]. On 8/29/24 at 0925 hours, a concurrent observation and interview was conducted with Resident 6. Resident 6 stated she had all her personal belongings on her nightstand and one dress in her closet. When asked if the staff inventoried her personal belongings upon admission, Resident 6 stated she did not know and they kept her bag with her. On 8/29/24 at 0951 hours, a concurrent observation, interview, and medical record review was conducted with LVN 2. LVN 2 stated on admission, a CNA will do the inventory for the resident and the resident or family will sign the form. LVN 2 reviewed Resident 6's Resident's Clothing and Possessions form. The form showed there was no signature from the resident or responsible party. LVN 2 verified Resident 6's Clothing and Possessions form was incomplete. An inventory check of Resident 6's personal belongings was performed. Upon the inventory check, LVN 2 verified there were personal belongings not listed on the form and Resident 6's clothing was unlabeled. On 9/3/24 at 0959 hours, the DON acknowledged the above findings.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844 Based on interview, medical record review, and facility P&P review, the facility failed to protect the resident's rights to be free from the verbal abuse by a staff for one of 10 sampled residents (Resident 1). * Resident 1 was asking for help and CNA 3 answered Resident 1 in a foul language in Spanish. This failure had the potential to negatively impact Resident 1's well-being. Findings: Review of the facility's P&P titled Abuse, Neglect and Exploitation revised on 12/19/22, showed it is the policy of the facility to provide protections for the health, welfare and rights of each resident. Review of the facility's SOC 341 form dated 8/30/24, showed a student nurse witnessed CNA 3 using a foul language in Spanish to Resident 1. Review of the facility's conclusion letter dated 9/3/24, showed the facility substantiated the incident as verbal abuse. Medical record review for Resident 1 was initiated on 9/3/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS dated [DATE], showed Resident 1 was severely cognitively impaired. On 9/3/24 at 1415 hours, an interview was conducted with Resident 1. Resident 1 was unable to remember the incident. Review of the facility's investigation conclusion report showed the facility had substantiated the incident as verbal abuse. On 9/3/24 at 1503 hours, a telephone interview was conducted with the student nurse. The student nurse and CNA 3 were changing the resident next to Resident 1 when Resident 1 started to ask for help. CNA 3 answered in Hispanic ya callate pinche [NAME] which translated to a foul language in English. The student nurse immediately reported the incident to the clinical instructor. On 9/3/24 at 1541 hours, an interview was conducted with the Administrator. The Administrator stated other residents assigned to CNA 3 were interviewed and stated CNA 3 was not verbally abusive to the residents. The student nurse was interviewed and stated together with CNA 3, they were changing the resident next to Resident 1. Resident 1 started to ask for help and CNA 3 answered in a foul language in Spanish. CNA 3 was immediately suspended.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on interview, medical record review, and facility P&P review, the facility failed to maintain the infection control practices designed to provide the safe and sanitary environment and help prevent the development and transmission of diseases and infections. * Resident 8 who was positive for COVID-19 and required isolation precautions, was cohorted with Resident 9 who was negative for COVID-19. This failure posed the risk of infection and transmission of COVID-19 and other disease-causing microorganisms. Findings: According to the CDC's Infection Control Guidance: SARS-CoV-2, under section 2, Recommended infection prevention and control practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection, showed to place a patient with confirmed SARS-CoV-2 infection in a single person room .if cohorting, only patients with the same respiratory pathogen should be housed in the same room. Review of the facility document titled [NAME] Lane Care Center dated 8/12/24, showed the census admissions. Under the admissions showed Resident 8 was admitted to the facility at 1723 hours, and Resident 9 was admitted to the facility at 2148 hours. Both residents were admitted to Room A. Medical record review for Resident 8 was initiated on 9/3/24. Resident 8 was readmitted to the facility on [DATE], to Room A. Review of Resident 8's COVID-19 Rapid Test dated 8/6/24 at 0612 hours, showed Resident 8 was positive for COVID-19. Review of Resident 8's Change in Condition Evaluation dated 8/6/24, showed Resident 8's physician ordered for Resident 8 to be transferred to the acute care hospital for positive COVID, shortness of breath, and congestion. Review of Resident 8's ADV Clinical admitted d 8/12/24, showed Resident 8 was currently on azithromycin (antibiotic) for diagnosis of COVID-19 positive. Review of Resident 8's Order Summary Report dated 9/3/24, showed a physician's ordered dated 8/12/24, for contract droplet precautions every shift for COVID positive for 5 days starting 8/12/24, and ending on 8/16/24. Review of Resident 8's Notification of Room/Bed/Roommate Change dated 8/12/24 at 1954 hours, showed Resident 8's room was changed from Room B to Room A due to a medical necessity. Review of Resident 8's Notification of Room/Bed/Roommate Change dated 8/13/24, showed Resident 8's room was changed from Room A to Room C due to a medical necessity. Medical record review for Resident 9 was initiated on 9/3/24. Resident 9 was readmitted to the facility on [DATE], to Room A. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 9's COVID-19 Rapid Test dated 8/12/24 at 2143 hours, showed Resident 9 was negative for COVID-19. On 9/3/24 at 1355 hours, an interview and concurrent medical record review was conducted with the IP. The IP verified the above findings. The IP verified Resident 9 tested negative for COVID-19 and was placed in a room with Resident 8 who was tested positive for COVID-19 and required isolation precautions. The IP verified it was not the facility's policy to cohort the positive tested COVID-19 residents with negative tested COVID-19 residents. The IP stated she found out Residents 8 and 9 were cohorting together the next day on 8/13/24, and moved Resident 8 once she saw Resident 8 was taking medications for COVID-19. The IP stated there was a miscommunication with admissions and they were unaware that Resident 8 was COVID positive. The IP verified Resident 9 was at high risk for developing a respiratory infection.