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	10/02/2024

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 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** 48844 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their P&P for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when the facility failed to report in a timely manner an allegation of staff-to-resident abuse to the CDPH, L&C Program for one of two sampled residents (Resident 1). This failure had the potential for the abuse allegation going unreported and uninvestigated. Findings: Review of the facility's P&P titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation revised 12/19/22, showed it is the policy of the facility to report the allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. Closed medical record review for Resident 1 was initiated on 10/1/24. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had a BIMS score of 14, indicating Resident 1's cognition was intact. Review of Resident 1's Progress Notes showed an entry dated 9/17/24, by the SSD. The SSD documented the police came to the facility regarding a call made by Resident 1 alleging CNA 1 was rough with Resident 1 during brief change. On 10/1/24 at 1549 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were both aware Resident 1 called 911 (emergency call number) regarding an allegation of abuse. The Administrator and DON both acknowledged no report regarding the incident was sent to CDPH, L&C Program. On 10/2/24 at 1033 hours, a telephone interview was conducted with CNA 1. CNA 1 stated he was accused of rough handling by Resident 1. CNA 1 further stated he reported the incident to the charge nurse. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 1339 hours, an interview was conducted with the SSD. The SSD stated the police came to the facility on [DATE], at around noontime regarding a 911 call from Resident 1. The SSD stated Resident 1 alleged CNA 1 was rough during care. The SSD verified no report was sent to CDPH, L&C Program on 9/17/24.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their abuse P&P related to the investigation of the physical abuse for one of two sampled residents (Resident 1). * The facility failed to remove the alleged employee from resident care areas while the facility was investigating the abuse allegation. * The facility failed to send the result of the abuse investigation to the CDPH L&C Program. These failures posed the risk of Residents 1 to not be protected against the alleged abuse and placed other vulnerable residents at risk for abuse. Findings: Review of the facility's P&P titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation revised 12/19/22, showed when the suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the licensed nurse will remove the accused employee from resident care areas. The Administrator or designee will obtain statements from direct care staff, suspend the accused employee pending completion of the investigation and within five working days of the incident, report sufficient information to describe the results of the investigation. Closed medical record review for Resident 1 was initiated on 10/1/24. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had a BIMS score of 14, indicating Resident 1's cognition was intact. Review of Resident 1's Progress Notes showed an entry dated 9/17/24, by the SSD. The SSD documented the police department came to the facility regarding a call made by Resident 1 alleging CNA 1 was rough with Resident 1 during brief change. a. Review of CNA 1's Timesheet dated 9/17/24, showed CNA 1 worked from 0655 to 1103 hours, 1135 to 1600 hours, and 1630 to 2330 hours. CNA 1 had a meal break from 1103 to 1135 hours and 1600 to 1630 hours. Review of Resident 1's Behavior Monitoring & Interventions for September 2024 showed a documentation entry of NB (no behavior observed) by the CNA 1 on 9/17/24 at 1442 hours. On 10/1/24 at 1549 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were both aware that Resident 1 called 911 (emergency call number) regarding an allegation of abuse. The Administrator and DON was asked if an investigation was done, the Administrator and DON stated the internal investigation was done while the police were in the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Review of the facility's Investigation Summary dated 9/17/24, showed the facility conducted and concluded the internal investigation of Resident 1's abuse allegation against CNA 1. However, there was no documented evidence the Investigative Summary was sent to CDPH L&C Program. On 10/2/24 at 1504 hours, a concurrent interview and facility document review was conducted with the Administrator. When asked regarding Resident 1's abuse allegation, the Administrator stated the DSD started to investigate on 9/17/24. The DSD interviewed CNAs 1 and 2. The SSD interviewed Resident 2 and another resident. The Administrator was asked when the investigation was concluded, the Administrator stated she signed and dated the Investigation Summary on 9/17/24. The Administrator was asked if CNA 1 was suspended from work, the Administrator stated CNA 1 was not suspended because the police stated the allegation was unsubstantiated. The Administrator stated the DSD only changed the CNA assigned to the Resident 1. Cross reference to F609.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of two sampled residents (Resident 1) was free from the unnecessary psychotropic medications (any drug that affects brain activity). * The facility failed to obtain the informed consent from Resident 1 or surrogate for the use of Seroquel (brand name for quetiapine fumarate, a drug to treat bipolar disorder) * The facility failed to ensure Resident 1's behavior was monitored for the use of citalopram (to treat depression), quetiapine fumarate, divalproex sodium (to treat the manic phase of bipolar disorder) and lorazepam (to treat anxiety disorder) medications. * The facility failed to ensure Resident 1 was monitored for side effects and/or adverse effects related to the use of citalopram, quetiapine fumarate, divalproex sodium and lorazepam medications. * The facility failed to ensure Resident 1 was provided with the non-pharmacologic intervention for the use of the citalopram, quetiapine fumarate, divalproex sodium and lorazepam medications. These failures have the potential to negatively affect Resident 1's well-being. Findings: Review of the facility's P&P titled Use of Psychotropic Medication revised 12/19/22, showed the residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. Closed medical record review for Resident 1 was initiated on 10/1/24. Resident was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 1's Order Summary Report showed a physician's order dated 9/17/24, to administer the following medications: - citalopram 20 mg tablet one time a day for bipolar disorder manifested by constant yelling out. - divalproex sodium 250 mg tablet two times a day for bipolar disorder manifested by false accusations. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's MAR for September 2024 showed Resident 1 had a physician's order and was administered the following medications: - citalopram 20 mg tablet one time a day for bipolar disorder on 9/10, 9/11, 9/12, 9/14, 9/15, 9/16, and 9/17/24; - divalproex sodium delayed release 250 mg tablets two times a day for bipolar disorder on 9/10, 9/11, 9/12, 9/14, 9/15, and 9/17/24; - quetiapine fumarate 50 mg tablet by mouth at bedtime for bipolar disorder on 9/10, 9/12, 9/13, 9/14, 9/15, and 9/17/24; and - lorazepam 0.5 mg every six hours as needed for anxiety manifested by verbalization of feeling anxious on 9/12/24 at 1700 hours, 9/13/24 at 1900 hours, 9/14/24 at 0800 and 1700 hours, 9/15/24 at 1700 and 2346 hours, and 9/17/24 at 0800 hours. a. Review of Resident 1's Physician Documentation of Informed Consent showed an informed consent was obtained from the surrogate for the following medications: - citalopram 20 mg for bipolar disorder manifested by constant yelling; - divalproex 250 mg for bipolar disorder manifested by false accusation; and - lorazepam 0.5 mg as needed for anxiety manifested by verbalization of feeling anxious. However, there was no documentation of an informed consent obtained from Resident 1 or surrogate for quetiapine medication use. b. Review of Resident 1's Behavior Monitoring & Interventions for September 2024 showed to monitor Resident 1 for bipolar disorder manifested by constant yelling out and false accusations and anxiety manifested by verbalization of feeling anxious. The monitoring sheet showed Resident 1's behavior was monitored on 9/17 - 9/19/24. However, Resident 1's medical record showed no behavior monitoring and interventions for 9/9/24 to 9/16/24. c. Review of the facility's P&P titled Use of Psychotropic Medication revised 12/19/22, showed the resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. Review of Resident 1's Plan of Care initiated on 9/11/24, showed a care plan problem addressing Resident 1's use of the following: - psychotropic medication related to bipolar disorder. The interventions included to monitor for side effects and monitor/document/report PRN any adverse reaction of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking) dry mouth, constipation, blurred vision, disorientation, confusion, difficulty urination, hypertension, dark urine, yellow skin, nausea and vomiting, lethargy, and drooling; and (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- antianxiety medication due to anxiety disorder. The interventions included to monitor for side effects and monitor/document/report PRN any adverse reactions to anti-anxiety therapy of drowsiness, slurred speech, dizziness, nausea, and aggressive or impulsive behavior. Review of Resident 1's medical record failed to show documented evidence Resident 1 was monitored for the side effects and/or adverse effects of psychotropic and antianxiety medications. d. Review of the facility's P&P titled Use of Psychotropic Medication revised 12/19/22, showed the residents who use psychotropic drugs shall also receive non-pharmacologic interventions to facilitate reduction or discontinuation of the psychotropic drugs. Review of Resident 1's MAR for September 2024 showed Resident 1 was administered the following medications: - citalopram 20 mg tablet one time a day for bipolar disorder on 9/10, 9/11, 9/12, 9/14, 9/15, 9/16, and 9/17/24; - divalproex sodium delayed release 250 mg tablets two times a day for bipolar disorder on 9/10, 9/11, 9/12, 9/14, 9/15, and 9/17/24; - quetiapine fumarate 50 mg tablet by mouth at bedtime for bipolar disorder on 9/10, 9/12, 9/13, 9/14, 9/15, and 9/17/24 ; and - lorazepam 0.5 mg every six hours as needed for anxiety manifested by verbalization of feeling anxious on 9/12/24 at 1700 hours, 9/13/24 at 1900 hours, 9/14/24 at 0800 and 1700 hours, 9/15/24 at 1700 and 2346 hours, and 9/17/24 at 0800 hours. Review of Resident 1's medical record failed to show documented evidence Resident 1 was provided with the non-pharmacologic interventions for the psychotropic medication use. On 10/2/24 at 0930 hours, a concurrent interview and medical record review was conducted with LVNs 1 and 2. LVN 1 stated Resident 1 was calm on admission; however, following the day of admission, Resident 1 started to be aggressive and calling out names. LVN 1 stated Resident 1 was on divalproex, Seroquel, and citalopram. LVN 1 was asked if there was any non-pharmacological intervention provided to Resident 1, LVN 1 was unable to provide documentation. LVN 2 was asked if there was any psychotropic medications monitoring, LVN 2 confirmed there was no physician's order for the monitoring of the psychotropic medications. LVN 2 further confirmed there was no monitoring record for the psychotropic medications in the MAR for September 2024. On 10/2/24 at 1523 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 verified there was no informed consent obtained from Resident 1 for the use of Seroquel medication. RN 1 also verified there was no physician's order for the monitoring of the side effects, and no documentation of the non-pharmacological interventions provided to Resident 1 for the use of the psychotropic medications. Furthermore, RN 1 stated the monitoring of the side effects of the psychotropic medications should be in the MAR to keep in track on the documentation. On 10/2/24 at 1531 hours, an interview was conducted with the Administrator. The Administrator was made aware and acknowledged the above findings.