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	11/21/2024

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 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50003 Based on observation, interview, and medical record review, the facility failed to ensure the comprehensive plan of care was revised to reflect the resident's current wound care treatment and interventions as ordered for one of three sampled residents (Resident 2). * Resident 2's care plan was not revised to address the use of wound vac for the pressure ulcer of the sacrococcyx area. This failure posed the risk of not providing the resident with individualized and person-centered care. Findings: Closed medical record review for Resident 2 was initiated on 11/21/24. Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 2's physician's order dated 6/8/22 to 9/15/22, showed to perform the following wound care to the pressure ulcer of the sacrococcyx site: clean with normal saline, pat dry, apply a granulating foam on wound bed, seal with a transparent dressing, and connect to wound vac at 150 mmHg setting every day shift on Mondays, Wednesdays, and Fridays for 30 days. Review of Resident 2's plan of care dated 7/8/22, showed the wound management goal and interventions for the pressure ulcer of the sacrococcyx site to include the following wound care: apply the skin protectant as ordered, elevate the lower extremities when in bed, handle gently during care, keep clean and dry, perform the laboratory tests as ordered, medicate as ordered, monitor for any signs and symptoms of infection, and reposition every two hours. However, the care plan failed to include the use of wound vac every Monday, Wednesday, and Friday on the day shifts for 30 days as ordered. On 11/15/24 at 1620 hours, a concurrent interview and closed medical record review for Resident 2 was conducted with RN 1. RN 1 stated the care plan should be individualized and updated to reflect the current treatment and interventions for the pressure ulcer of the sacrococcyx site. On 11/21/24 at 1615 hours, the DON acknowledged the findings.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50003 Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement the infection control practices designed to provide the safe and sanitary environment to prevent the transmission of diseases and infections in the facility. * The facility failed to ensure the staff practiced the EBP during the high contact-care for one of three sampled residents (Resident 3). This failure posed the risk for the transmission of diseases and infections. Findings: According to the CDC, EBP promotes the use of PPE to include donning of gown and gloves during high-contact resident care activities that can provide the opportunities for transmission of MDROs to others. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include the following: - Dressing - Bathing/showering - Transferring - Providing hygiene - Changing linens - Changing briefs or assisting with toileting - Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator - Wound care: any skin opening requiring a dressing Review of the facility's EBP signage showed everyone must clean hands before entering and after leaving room. Providers and staff also wear gloves and a gown for the high contact resident care activities such as: - Activities of Daily Living: Dressing, Bathing/Showering, Changing Linens, Feedings - Caring for Devices: Central Line, Urinary Catheter, Feeding Tube, Tracheostomy and Giving Medical Treatment - Toileting and Changing Incontinence Briefs - Wound Care: any skin opening requiring a dressing (continued on next page)

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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 0880 Level of Harm - Potential for minimal harm Residents Affected - Some	- Mobility Assistance, Transferring and preparing to leave room - Cleaning Environment Medical record review for Resident 3 was initiated on 11/21/24. Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 3's physician order summary dated 11/21/24, showed Resident 3 was on EBP for the indwelling medical device and left buttock wound. On 11/21/24 at 1033 hours, an EBP signage was observed posted on Resident 3's door. The signage showed EBP, everyone must perform hand hygiene before entering the room, providers and staff must also wear gloves and a gown for the high contact resident care activities such as: - Activities of Daily Living: Dressing, Bathing/Showering, Changing Linens, Feedings - Caring for Devices: Central Line, Urinary Catheter, Feeding Tube, Tracheostomy and Giving Medical Treatment - Toileting and Changing Incontinence Briefs - Wound Care: any skin opening requiring a dressing - Mobility Assistance, Transferring and preparing to leave room - Cleaning Environment On 11/21/24 at 1035 hours, a wound care observation for Resident 3 was conducted with the Treatment Nurse. The Treatment Nurse was observed providing the wound treatment to the left medial buttock pressure injury without donning a gown. After the completion of the wound treatment, the Treatment Nurse also failed to perform hand hygiene prior to pressing the feeding pump to resume the tube feeding. The Treatment Nurse verified she should have worn a gown before providing the wound treatment and performed hand hygiene after the wound treatment was completed for infection prevention. On 11/21/24 at 1620 hours, the DON verified the findings and stated the staff were expected to perform hand hygiene and don gloves and gown when providing the high contact resident care activities, including the wound treatment to prevent the transmission of diseases.