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	02/05/2025

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 0761 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on observation, interview, and facility P&P review, the facility failed to ensure the medications were stored in a safe and secure manner as evidence by: * Resident 7 had a bottle of One a Day Multivitamin/Multimineral (supplement) on the top of the bedside table. * A Hibiclens (antiseptic skin cleanser) was observed on top of the grab bars unattended inside Shower room [ROOM NUMBER]. These failuresposed the risk for non-licensed staff and visitors to have access to the medications. Findings: Review of the facility's P&P titled Resident Self Administration of Medication revised 12/2022 showed it is the policy of this facility to support each resident's right to self-administer the medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective. b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy. Review of the facility's P&P titled Resident Showers revised 12/2022 showed help the resident back to their room and return personal hygiene products to their designated spot. 1. Medical record review for Resident 7 was initiated on 1/29/25. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Potential for minimal harm Residents Affected - Some	On 1/29/25 at 1044 hours, an observation was conducted in Resident 7's room. A bottle of One a Day Multivitamin/Multimineral was observed on the top of the bedside table. On 1/29/25 at 1558 hours, an observation conducted inResident 7's room. A bottle of One a Day Multivitamin/Multimineral was observed on the top of the bedside table. Another resident was observed self-propelling in a wheelchair inside the room. Review of Resident 7's medical record failed to show a Self-Administration of Medication assessment was completed. On 1/29/25 at 1637 hours, an interview and concurrent observation was conducted with RN 1. RN 1 verified Resident 7 had a bottle of One a Day Multivitamin/Multimineral on the top of the bedside table. RN 1 discussed with Resident 7 regarding having the medications at the bedside and proceeded to remove the bottle of the multivitamin from Resident 7's room. RN 1 stated the medications were not kept at bedside and stored in the medication cart. RN 1 stated the process to have any medications at the resident's bedside would include a notification to the physician, a resident assessment for self-administration of medications, and implement the orders recommended by the physician. RN 1 verified the assessment to self-administer the medications was not completed for Resident 7. 2. On 1/30/25 at 0931 hours, an interview and concurrent observation of Shower room [ROOM NUMBER] was conducted with CNA 1. A bottle of Hibiclens antiseptic skin cleanser was observed on top of the grab bars. CNA 1 stated the cleanser was not supposed to be left in the shower room. The bottle of the Hibiclens antiseptic skin cleanser showed an active ingredient of chlorhexidine gluconate solution (a substance that slows or stops the growth of microorganism). On 2/5/25 at 1253 hours, an interview with the DON was conducted. The DON stated the Hibiclens should not be left unattended in the shower room. On 2/5/25 at 1640 hours, the Administrator and the DON wasmade aware and acknowledged the findings.