| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555797 | A. Building<br>B. Wing | 08/04/2025 |

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| Gordon Lane Care Center | 1821 E Chapman Ave<br>Fullerton, CA 92831 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain proper infection control practices. * The facility failed to ensure one laundry rolling rack with clean residents' clothing was appropriately covered when it was transported through the hallways and was left unattended. * The facility failed to ensure the local public health department was informed of Resident 63's unresolved scabies. Additionally, the facility failed to place Resident 63 on proper contact isolation for the unresolved scabies. * The facility failed to ensure CNA 7 did not use the same pair of gloves and gown when providing care to Resident 48 on EBP and then to Resident 105 who was not on EBP. This posed the risk of cross-contamination and spread of infection. * The facility failed to ensure Resident 36's indwelling urinary drainage bag was not touching the floor. This failure had the potential to put the resident at risk for urinary infection. * The facility failed to ensure Resident 1's tubing of negative pressure wound therapy (a therapeutic technique that uses controlled negative pressure to promote wound healing) was not touching the floor.Findings:<br><br>1. Review of the facility’s P&P titled Handling Clean Linen revised 12/2022 showed it is the policy of the facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection. The P&P further showed linen can become contaminated with pathogens from contact with intact skin or body substances or form environmental contaminants or contaminated hands. Moreover, the P&P showed clean linen shall be delivered to resident care units on covered linen carts with covers down. Nothing shall be kept on top of linen carts.<br><br>On 7/31/25 at 1320 hours, during an observation, one laundry rolling rack with the clean residents’ clothing was transported down the hallway from room [ROOM NUMBER] to room [ROOM NUMBER]. The laundry rolling rack was uncovered and passed by several residents and staff. Further observation showed the laundry rolling rack was left unattended and uncovered in between rooms [ROOM NUMBERS].<br><br>On 7/31/25 at 1323 hours, an observation and concurrent interview was conducted with Janitor 1. Janitor 1 returned to the laundry rolling rack and verified the findings. Janitor 1 stated the clean residents' clothes should not be left unattended and uncovered for infection control.<br><br>On 8/1/25 at 1021 hours, an interview with the DON was conducted. The DON acknowledged the findings and stated the residents’ clean linen cart should be covered when transporting down the hallway and when left unattended to maintain infection control.<br><br>On 8/4/25 at 1406 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of the facility’s P&P titled Head Lice and Scabies Exposure and Treatment revised 12/2022 showed the facility ensures the residents who contract scabies or head lice are treated according to current standards of practice to eradicate the infestation and prevent further exposure and transmission. Human scabies are caused by the human itch mite. It is contagious and can be transmitted by direct, prolonged skin to skin contact with an affected person. The P&P further showed proper treatment and infection control measures should be utilized to prevent outbreaks within the facility. The infested resident will be placed in a single occupancy room away from other residents to avoid transmission.<br><br>Review of the facility's document obtained from The Public Health Nurse titled Prevention and Control of Scabies in California Healthcare Settings, California Department of Public Health Division of Communicable Disease Control in Consultation with Center for Health Care Quality Healthcare-Associated Infections Program dated 8/2020 showed the residents with atypical or crusted scabies often require several scabicides to completely kill all the mites. The document further showed for all optional treatment plans, at least three skin scrapings performed at least one week after the completion of the selected treatment should be negative before scabies is declared cured.<br><br>Medical record review for Resident 63 was initiated on 7/29/25. Resident 63 was admitted to the facility on [DATE], and readmitted back on 1/19/25.<br><br>Review of Resident 63’s Quarterly MDS assessment dated [DATE], showed resident had a BIMS score of 3, indicating severe cognitive impairment.<br><br>Review of Resident 63’s Order Summary Report for August 2025 showed the following physician’s orders:<br><br>- order dated 6/16/25, for Elimite External Cream 5% apply to the neck, foot, abdominal folds topically for one day and may rinse off after eight hours.<br><br>- order dated 6/23/25, for Elimite External Cream 5% (medication to treat parasites) apply to the neck, foot, abdominal folds topically for one day and may rinse off after eight hours.<br><br>- order dated 7/3/25, for Ivermectin (medication to treat parasites) 6 mg give two tablets by mouth one time a day every Friday for scabies until 8/1/25.<br><br>Review of Resident 63’s Lab Results Report dated 6/18/25, showed the resident was with Sarcoptes scabiei (a parasitic mite that burrows into the skin causes scabies). Further review of Resident 63’s medical record failed to show documented evidence a follow up labs or a skin test were completed after 6/18/25, and prior to the physician’s order for the Ivermectin medication on 7/4/25.<br><br>On 7/30/25 at 1530 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 verified the above findings. LVN 6 stated although Resident 63 received the Elimite cream as ordered on 6/16 and 6/23/25, the resident’s skin condition did not improve. LVN 6 stated the Medical Director was notified of Resident 63’s unresolved rash and increase itchiness. LVN 6 stated the Medical Director ordered Ivermectin medication on 7/4/25 until 8/1/25. LVN 6 further verified Resident 63 was not on the contact isolation after the Ivermectin medication was ordered, and the resident has been outside her room multiple times.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/31/25 at 1446 hours, a telephone interview was conducted with the Public Health Nurse. The Public Health Nurse stated the recommendations for the residents with scabies were to be treated with Elimite cream and can be taken off contact isolation after the treatment; however, the Public Health Nurse stated, if the resident has atypical rashes (crusty rashes), then the resident should be placed on the contact isolation and re-tested for scabies.<br><br>On 8/4/25 at 0924 hours, an interview and concurrent medical record review was conducted with the IP. The IP verified the above findings. The IP stated Resident 63 was treated with the Elimite cream; however, the resident’s rash was not healing and described the rash as “generalized,” “pimple-like with whiteheads,” “crusty on the edge,” “clustered,” and “skin redness” due to the increased itchiness. The IP verified Resident 63 was last seen by the wound physician on 6/19/25, and was not seen by the wound physician or a dermatologist after the resident still presented with unresolved rashes and itchiness. The IP verified the facility did not do another skin test after the initial lab result dated 6/18/25 was done. The IP stated another testing of the skin would have allowed information of whether Resident 63’s unresolved skin concern was related to a positive scabies result. Moreover, the IP verified the facility did not inform the Public Health Nurse of Resident 63’s unresolved skin rash and increased itchiness. The IP stated the facility should have informed the Public Health Nurse to obtain further recommendations and instructions on the care of Resident 63 and to reduce the potential exposure of scabies to other residents, visitors, and staff.<br><br>On 8/4/25 at 1024 hours, a telephone interview with the Medical Director was conducted. The Medical Director verified he ordered the Ivermectin medication for Resident 63. When the Medical Director was informed the facility did not inform the Public Health Nurse of Resident 63’s unresolved rashes and increased itchiness, the Medical Director stated he was not aware of that. The Medical Director also stated the type of strain the resident had would indicate if the resident would need to be placed on the contact isolation. However, the Medical Director was informed there were no other skin scrape tests or dermatologist follow up to determine what type of strain the resident had. The Medical Director was informed and acknowledged the findings.<br><br>On 8/4/25 at 1406 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.<br><br>Cross Reference with F684.<br><br>3. According to CDC’s The Basics of Standards Precautions (undated), wear a gown when contact between clothing or skin with resident blood or body substances is expected, and to not wear the same gown between residents.<br><br>Review of the facility’s EBP sign showed everyone must clean hands, including before entering and when leaving the room, and the providers and staff also wear gloves and gown for the high contact resident care activities: ADLs care, caring for the devices, toileting and changing incontinence briefs, wound care, mobility assistance, transferring and preparing to leave room, and cleaning environment.<br><br>On 8/1/25 at 0607 hours, an EBP sign was observed posted outside Room A, and a number “6” was observed by Resident 48’s name by the door. The following was observed:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - CNA 7 was observed inside the room with gloves and gown on. Resident 48 was awake and in bed. When asked about Resident 48’s call light, CNA 7 looked for the call light. CNA 7 placed the call light within Resident 48’s reach, repositioned Resident 48 by touching his head, back and arms, and then repositioned Resident 47’s pillow.<br><br>- Without removing the gown and gloves used for Resident 48, CNA 7 untangled Resident 105’s call light cord and placed the call light button on Resident 105’s stomach area. CNA 7 then offered water to Resident 105 and touched the resident’s water pitcher and cup. CNA 7 emptied Resident 105’s urinal.<br><br>On 8/1/25 at 0620 hours, an interview was conducted with CNA 7. CNA 7 verified the above findings. CNA 7 acknowledged she used the same gown and gloves to reposition Resident 48 and then assisted Resident 105.<br><br>On 8/4/25 at 0912 hours, an interview was conducted with the IP. The IP stated the number “6” by the resident’s name meant the resident in the room was on EBP. The IP stated the staff cannot wear the same gown and gloves in caring for different residents.<br><br>4. According to the CDC guidelines for the Prevention of Catheter-Associated Urinary Tract Infection dated 2009 under the Proper Techniques for Urinary Catheter Maintenance section showed to keep the collecting bag below the level of the bladder at all times and do not rest on the floor.<br><br>Medical record review for Resident 36 was initiated on 7/29/25. Resident 36 was admitted to the facility on [DATE].<br><br>Review of Resident 36's H&P examination dated 4/1/25, showed Resident 36 had the capacity to understand and make decisions.<br><br>Review of Resident’s 36 MDS quarterly assessment dated [DATE], showed the resident had a BIMS score of 13 (meaning cognitively intact) and had an indwelling urinary catheter.<br><br>Review of Resident 36's Physician Order Summary showed a physician's order dated 7/30/25, for indwelling urinary foley catheter size French 16/5 ml for obstructive uropathy (a urinary tract disorder that occurs when urine flow is obstructed).<br><br>On 7/29/25 at 0935 hours, during the initial tour of the facility, an observation was conducted in Resident's 36 room. Resident 36 was lying in bed with an indwelling urinary catheter, with the tubing attached to a drainage bag. The drainage bag was observed touching the floor.<br><br>On 7/29/25 at 1002 hours, an observation and concurrent interview for Resident 36 was conducted with CNA 1. CNA 1 verified Resident 36's indwelling urinary catheter drainage bag was touching the floor.<br><br>On 7/29/25 at 1005 hours, an observation and concurrent interview for Resident 36 was conducted with LVN 4. LVN 4 verified the above findings.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 8/4/25 at 0834 hours, an interview was conducted with the DON. The DON acknowledged the above findings and stated the indwelling urinary catheter drainage bag should not be touching the floor to prevent infection.<br><br>Cross reference to F550<br><br>5. Review of the facility’s P&P titled Negative Pressure Wound Therapy dated 12/19/22, showed to promote wound healing of various types of wounds, it is the policy of the facility to provide evidence- based treatment in accordance with current standards of practice and physician wounds. Further review of the P&P showed clean technique shall be utilized unless otherwise specified by the physician.<br><br>Medical record review for Resident 1 was initiated on 7/29/25. Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE].<br><br>Review of Resident 1’s Order Summary Report showed an order dated 7/8/25, for negative pressure wound therapy, wound location sacrum, continuous intensity, low pressure 125 mm/Hg, and to change dressing on every day shift, Monday, Wednesday, and Friday. Further review of the physician's order showed to cleanse the wound with normal saline, pat dry, apply foam, and cover with transparent dressing.<br><br>On 7/29/25 at 1120 hours, Resident 1 was observed in bed and the negative pressure wound therapy was connected to Resident 1's wound. The tubing of Resident 1’s negative wound pressure therapy was touching the floor.<br><br>On 7/29/25 at 1249 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 verified the observation and stated the negative pressure wound therapy tubing should not be touching the floor.<br><br>On 7/30/25 at 1452 hours, Resident 1 was observed in bed and the negative pressure wound therapy was connected to Resident 1’s wound. The tubing of Resident 1’s negative wound pressure therapy was observed touching the floor.<br><br>On 7/30/25 at 1332 hours, an observation and interview was conducted with LVN 6. LVN 6 stated he provided wound care treatment to the residents in the facility. LVN 6 verified the tubing of Resident 1’s negative wound pressure therapy was observed touching the floor. LVN 6 stated the negative wound pressure therapy tubing should not touch the floor to prevent contamination and wound infection.<br><br>On 8/1/25 at 1243 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, facility document review, and facility P&P review, the facility failed to monitor and address the use of the antibiotics when the resident's condition did not meet McGeer's criteria for two of five residents (Residents 4 and 53) reviewed for antibiotic stewardship. This failure had the potential for the antibiotics to be used when it was not indicated and the development of antibiotic-resistant bacteria.Findings: Review of the facility's P&P titled Antibiotic Stewardship Program revised 12/19/22, showed it is the policy of the facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The program included antibiotic use protocols as a system to monitor antibiotic use.the facility uses the (CDC's NHSN Surveillance Definition, updated McGeer's criteria, or other surveillance tool) to define infection. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics. 1. Medical record review for Resident 4 was initiated on 7/29/25. Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the facility's untitled document showed Resident 4 had wound infection and was prescribed piperacillin sodium tazobactam (an antibiotics) intravenous solution 4.5 gm. Further review of the document did not show if Resident 4's infection met the McGeer's criteria for a true infection or Loeb's minimum criteria to treat the infection with antibiotics. Review of Resident 4's Infection Screening Evaluation dated 7/9/25, showed Resident 4 had a repeated temperature more than 99 degree Fahrenheit. Further review of the Infection Screening Evaluation failed to show if the symptoms experienced by Resident 4 met the McGeer's criteria for true infection or Loeb's minimum criteria to treat the infection with antibiotics. Review of Resident 4's Antibiotic Time Out dated 7/12/25, showed Resident 4 was prescribed with piperacillin sodium tazobactam intravenous solution 4.5 gm, intravenously every eight hours. The presenting symptoms showed fever, abdominal pain or tenderness, and diarrhea. Under the section for the Narrative note showed the criteria was met, reviewed antibiotic stewardship program and clinical status of the resident with the medical doctor, and as per medical doctor, to continue with the antibiotic treatment as ordered from the acute care hospital. Further review of Resident 4's medical records failed to show if Resident 4 had fever, abdominal pain tenderness, and diarrhea in the facility. On 7/31/25 at 1412 hours, an interview and concurrent medical record review for Resident 4 was conducted with the IP. The IP stated the facility used the McGeer's criteria. The IP stated if a resident did not meet the criteria for a true infection using the McGeer's criteria, the physician would be notified. The IP verified Resident 4 did not have a fever, abdominal pain or tenderness, and diarrhea in the facility. The IP further stated Resident 4's infection did not meet the McGeer criteria for infection. The IP stated she should have accurately notified the physician regarding Resident 4's symptoms that did not meet the McGeer's Criteria for a true infection when the IV antibiotic was ordered. 2. Medical record review for Resident 53 was initiated on 7/31/25. Resident 53 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the facility's untitled document showed Resident 53 had a pneumonia and was prescribed with doxycycline hyclate (an antibiotic) 100 mg. Further review of the document did not show if Resident 53's infection met the McGeer's criteria for a true infection or Loeb's minimum criteria to treat the infection with the antibiotic. Review of the Resident 53's Infection Screening Evaluation dated 7/25/25, showed Resident 53 had new or changed lung exam abnormalities and unproductive cough. Further review of the Infection Screening Evaluation did not show if the above symptoms met the McGeer's criteria for a true infection or Loeb's minimum criteria to treat the infection with antibiotics. Review of the Resident 53's Antibiotic Time Out dated 7/28/25, showed Resident 53 was receiving doxycycline hyclate oral tablet 100 mg medication, by mouth two times a day. Further review of the Antibiotic Time Out showed Resident 53 had presenting symptoms of chest x-ray with pneumonia (a lung infection) or a new infiltrate (the abnormal presence of substances within tissues or cells, often in a way that is not normal), new or changed lung exam abnormalities, and acute functional decline. Under the section for the Narrative note showed the criteria met per McGeer's, reviewed antibiotic stewardship program and clinical status of the resident with the medical doctor, per the medical doctor, to continue with the antibiotic as ordered. Review of Resident 53's chest x-ray dated 7/25/25, showed mild parabronchial thickening, suggestive of respiratory bronchiolitis (an inflammation of the small airways in the lungs), and no focal infiltrates. Further review of Resident 53's medical records failed to show if Resident 53 had a chest X-ray result showing pneumonia or a new infiltrate, and if Resident |