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	06/23/2026

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 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** Based on interview, medical record review, facility document, and facility P&P review, the facility failed to protect the resident's rights to be free from physical abuse by another resident for one of 10 sampled residents (Resident 1). * The facility failed to ensure Resident 1 was free from abuse when the CNA heard yelling and slapping noise and observed Resident 2 pushed Resident 1 on the shoulder out the door. This failure posed a risk for the resident to sustain an injury and experience negative psychosocial outcome. Findings: Review of the facility's P&P titled Abuse, Neglect and Exploitation revised 12/2022 showed it is the policy for this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. The P&P further showed willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Review of the facility's SOC-341 dated 6/15/26, showed Resident 2 allegedly hit Resident 1 when Resident 1 entered the room. The CNA heard slapping sound while she was tending to another resident. The SOC-341 further showed Resident 1 complained of right sided head pain. a. Medical record review for Resident 1 was initiated on 6/19/26. Resident 1 was admitted to the facility on [DATE], and readmitted [DATE]. Review of Resident 1's H&P examination dated 5/5/26, showed Resident 1 had fluctuating capacity to understand and make medical decisions. Review of Resident 1's Progress Note dated 6/15/25 at 0445 hours, showed Resident 1 was propelling herself in the wheelchair in reverse direction into Room A. While the CNA was providing care to another resident in Room A-Bed B, she heard yelling and then a slapping noise. The notes further showed the CNA immediately opened the curtain and observed Resident 2 placed both hands on Resident 1's shoulder pushing Resident 1 out the door. The notes further showed upon interview of Resident 1, Resident 1 stated, Resident 2 shoved her head. b. Medical record review for Resident 2 was initiated on 6/19/26. Resident 2 was admitted to the facility on [DATE] and readmitted [DATE]. Review of Resident 2's H&P examination dated 6/1/26, showed Resident 1's decision making capacity was capable. Review of Resident 2's Progress Notes dated 6/15/26 at 0445 hours, showed Resident 1 was propelling herself in the wheelchair in reverse direction into Room A. While the CNA was providing care to another resident in Room A- Bed B, she heard yelling and then a slapping noise. The notes further showed the CNA immediately opened the curtain and observed Resident 2 placed both hands on Resident 1's shoulder pushing Resident 1 out the door. The notes further showed upon interview with Resident 2, Resident 2 stated, I only pushed her. On 6/19/26 at 1251 hours, an interview was conducted with Resident 2. Resident 2 stated Resident 1 came in her room on her wheelchair and I (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pushed her out. Resident 2 denied hitting or touching Resident 1's head; however, Resident 2 stated she touched Resident 1's shoulder during the interaction. On 6/23/26 at 1415 hours, an interview was conducted with CNA 1. CNA 1 stated she was present during the interaction between Residents 1 and 2. CNA 1 stated while helping with the resident in Room A-Bed B with the curtains closed, she heard the interaction between Residents 1 and 2 after Resident 2 entered Resident 1's room. On 6/23/26 at 1642 hours, an interview was conducted with the DON. The DON stated after speaking to Resident 2, Resident 2 was very remorseful and apologetic of the incident. The DON stated the goal of the facility was the residents' safety. On 6/23/26 at 1730 hours, an interview was conducted with the Administrator and DON. The Administrator and the DON was made aware and acknowledged the above findings.

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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 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** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for one of 10 sampled residents (Resident 4) investigated for abuse. * The facility failed to report Resident 4's allegation of feeling her rights were disregarded and when Resident 5 was being rude to her. This failure posed a risk for the abuse allegation to go unreported and uninvestigated, and put the residents at risk for further abuse.Findings: Review of the facility's P&P titled Abuse, Neglect and Exploitation revised 12/2022 showed it is the policy for this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. The P&P further shows possible indicators of abuse include, but are not limited to:1. Resident, staff or family report of abuse;8. Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning and positioning; and10. sudden or unexplained changes in behaviors and/or activities such as fear of a person or place, or feelings of guilt or shame. Moreover, the P&P showed reporting and response includes analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences. The administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the result of the investigation when final within 5 (five) working days of the incident, as required by state agencies. Review of the facility's document titled Grievance Reporting Form dated 6/2/26, showed Resident 4 had a grievance against roommate Resident 5. Review of the Administrator's interview showed the following:- Resident 4 felt Resident 5 did not want her in the room and was being very rude and feels her rights are disregarded; and - Resident 5 feels disrespected by Resident 4 and stays out of her way. Resident 5 stated Resident 4 is very rude and mean and talks down to her. a. Closed medical record review for Resident 4 was initiated on 6/19/26. Resident 4 was admitted to the facility on [DATE], and discharged on 6/7/26. Review of Resident 4's H&P examination dated 5/8/26, showed Resident 4's decision making capacity was capable. b. Medical record review for Resident 5 was initiated on 6/19/26. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's H&P examination dated 5/12/25, showed Resident 5 had the capacity to understand and make decisions. On 6/19/26 at 1405 hours, an interview was conducted with Resident 5. Resident 5 stated her previous roommate Resident 4 was just all and all mean and she just tried to ignore her. Resident 5 stated since Resident 4 has been discharged , she has been happy with her current roommate. On 6/23/26 at 1500 hours, an interview with LVN 1 was conducted. LVN 1 stated Residents 4 and 5 were roommates and during the time they were roommates, both residents would speak to her privately without the other resident present and would call each other the B word. When asked how many times Residents 4 and 5 call each other the B word, LVN 1 stated it happened two to three times during her shift. When asked if she notified the Administrator or DON of both residents, LVN 1 stated she could not recall. LVN 1 further stated it should have been reported as it could be a verbal abuse and could cause mental anguish or depression and/or anxiety for the residents. LVN 1 stated if a resident felt disrespected or was being rude with another resident, it should be reported. On 6/23/26 at 1621 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours, an interview and facility document review was conducted with the SSD. The SSD verified the Grievance Reporting Form between Resident 4 and Resident 5 was initiated on 6/2/26, after Resident 4 spoke with her stating she and Resident 5 did not get along. The SSD then stated she would report if the residents called each other the B word, even if not directly to each other. The SSD stated it should have been reported immediately to the Administrator and DON. On 6/23/26 at 1655 hours, an interview with the Administrator was conducted. The Administrator stated Residents 4 and 5 did not feel threatened by each other and neither wanted to move rooms when offered; however, the Administrator acknowledged Resident 4 verbalized her rights were not being recognized and Resident 5 verbalized Resident 4 was being rude and mean to her. On 6/23/26 at 1730 hours, an interview was conducted with the Administrator and DON. The Administrator and the DON was made aware and acknowledged the above findings.