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 _____	C 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GORDON LANE CARE CENTER	1821 E CHAPMAN AVE FULLERTON, CA 92831

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the Abbreviated Survey for Complaint Numbers: CA00959739, CA00962241, CA00964563, and CA00965123, Complaint and Facility Reported Incident (FRI) Numbers: CA00959745 and CA00961997, and FRI Number: CA00963367. The survey team entered the facility on 5/13/25 at 1128 hours. The facility identified the census as 91. The survey sample size was 5. Inspection was limited to the specific complaints and FRIs investigated and did not represent the findings of a full inspection of the facility. * FOR COMPLAINT NUMBER: CA00959739, NO DEFICIENCIES WERE IDENTIFIED. * FOR COMPLAINT NUMBER: CA00962241, DEFICIENCIES WERE IDENTIFIED AND CITED AT F755. * FOR COMPLAINT NUMBER: CA00964563, NO DEFICIENCIES WERE IDENTIFIED. * FOR COMPLAINT NUMBER: CA00965123, DEFICIENCIES WERE IDENTIFIED AND CITED AT F610. * FOR COMPLAINT AND FRI NUMBER: CA00959745, NO DEFICIENCIES WERE IDENTIFIED.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Administrator — (X6) DATE 6/13/25

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.

Poc ok 6/17/25

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F 000	Continued From page 1 * FOR COMPLAINT AND FRI NUMBER: CA00961997, NO DEFICIENCIES WERE IDENTIFIED. * FOR FRI NUMBER: CA00963367, NO DEFICIENCIES WERE IDENTIFIED. GLOSSARY AND DEFINITIONS: BIMS - Brief Interview for Mental Status CDPH - California Department of Public Health CNA - Certified Nursing Assistant DON - Director of Nursing DSD - Director of Staff Development H&P - History and Physical HTN - Hypertension (high blood pressure) L&C - Licensing and Certification LVN - Licensed Vocational Nurse MDS - Minimum Data Set (an assessment tool) mcg - microgram(s) mg - milligram(s) ml - milliliter(s) mmHg - millimeter(s) of mercury P&P - Policy and Procedure	F 000		

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F 000	Continued From page 2 SBP - Systolic Blood Pressure (it is one of the two numbers that make up a blood pressure reading, and represents the pressure in your arteries when your heart beats and is pumping blood) SSD - Social Services Director	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility P&P review, the facility failed to ensure the allegation of abuse was reported within the required time frame, the resident's responsible party was notified of the allegation, the investigation was initiated after the abuse allegation was identified, and the staff were provided an in-service regarding the code of conduct and sexual abuse prevention for one of	F 610		

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F 610	Continued From page 3 five sampled residents (Resident 4). * CNA 11 witnessed CNA 10 in Resident 4's room. CNA 10's top scrub was lifted in front of Resident 4. This failure posed the risk for Resident 4 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 Abuse, Neglect and Exploitation dated 12/19/22, showed the facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies within specified time frame. The P&P further showed reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involves abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. On 5/30/25, the CDPH, L&C program received a complaint alleging CNA 10 was topless and braless in Resident 4's room. The complaint further showed there was no police report, nor was the ombudsman notified. Additionally, there were two staff members who were present during	F 610		

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F 610	Continued From page 4 the incident. Medical record review for Resident 4 was initiated on 6/2/25. Resident 4 was admitted to the facility on 5/6/24. Review of Resident 4's H&P examination dated 2/4/25, showed the resident was not able to make decisions. Review of Resident 4's MDS dated 5/2/25, showed the resident was rarely/ never understood thus BIMS was not conducted. Review of Resident 4's medical record failed to show documented evidence the abuse allegation was reported within the required time frame, the resident's responsible party was notified of the allegation, an abuse investigation was initiated, the resident was monitored for the clinical/psychosocial status after the alleged incident occurred from 5/25 to 6/1/25. Additionally, there was no care plan initiated for the alleged incident. On 5/30/25 at 1540 hours, an interview was conducted with the SSD. The SSD stated she was not aware of the incident until now. The SSD verified Resident 4's responsible party was not notified of the incident. On 5/30/25 at 1614 hours, a telephone interview was conducted with CNA 10. CNA 10 stated while she was walking down the hall, her bra came undone. CNA 10 went into Resident 4's room to fix it. CNA 10 stated CNA 11 walked in the room and saw her scrub top was lifted. CNA 10 stated she jokingly told CNA 11 she was flashing the resident. CNA 10 further stated she knew she	F 610		

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F 610	Continued From page 5 made a huge mistake and was being childish about the joke. CNA 10 verified her scrub top was up, and her bra was down by her waist. CNA 10 verified her breasts were exposed. CNA 10 verified Resident 4 was awake. On 5/30/25 at 1647 hours, an interview was conducted with the Administrator. The Administrator verified there was no report made to CDPH, ombudsman, law enforcement or the physician. The Administrator stated for an allegation to be deemed sexual, there had to be contact. On 6/2/25 at 0750 hours, an interview was conducted with the Administrator. The Administratorstated the alleged incident was reported to her right after it occurred. The Administrator stated on 5/24/25, the alleged CNA (CNA 10) had a wardrobe malfunction and went inside Resident 4's room. The alleged CNA was sent home immediately pending an investigation. The Administratorstated the alleged incident was not reported to CDPH because it was considered a code of conduct issue rather than an abuse allegation. On 6/2/25 at 1000 hours, an interview was conducted with the DSD. The DSD stated the alleged incident occurred on 5/24/25, during the evening shift. The DSD was asked why was not reported. The DSD responded, "it was just a report of an employee, and it was just a rumor. " The DSD verified there was no in-service given to facility staff regarding the code of conduct or sexual abuse prevention, after the allegation was reported. On 6/2/25 at 1200 hours, a phone interview was	F 610		

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F 610	Continued From page 6 conducted with CNA 12. CNA 12 stated she saw CNAs 10 and 11 talking right by Resident 4's room. CNA 12 stated she observed CNA 11's facial expression and noted something was wrong. CNA 12 further stated CNA 11 informed her CNA 10's scrub top was up when CNA 11 opened the door. CNA 11 informed CNA 12, CNA 10 stated she wanted to give Resident 4 something special because it was his birthday, seeing the balloons, she flashed her breasts. On 6/2/25 at 1340 hours, a telephone interview was conducted with CNA 11. CNA 11 stated on 5/24/25, she had finished providing care to her assigned residents. CNA 11 stated she wondered why Resident 4's door was closed. CNA 11 stated she knocked on the door and saw CNA 10 lifting her scrub top in front of Resident 4. CNA 11 stated she got scared and closed the door. CNA 10 immediately followed CNA 11 and stated it was Resident 4's birthday so she flashed her breast. CNA 11 stated CNA 10 told her she did not know what was on her mind at that moment. CNA 11 further stated CNA 10 apologized to her and immediately reported the incident to the supervisor on duty. When asked if she had witnessed this incident before, CNA 11 stated no but CNA 10 told her she had exposed her breasts to Resident 4 before. On 6/2/25 at 1449 hours, a telephone interview was conducted with CNA 10. CNA 10 stated as she was walking down the hallway, she felt the clip of her bra was off and quickly went inside Resident 4's room to fix it. CNA 10 stated CNA 11 walked in the room and saw her scrub top was lifted up. CNA 10 stated she jokingly told CNA 11 she was flashing the resident. CNA 10 further stated she was not even in the room for 2-3	F 610		

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F 610	Continued From page 7 minutes, and she was not sure what she thought CNA 11 thought she was doing. CNA 10 further stated she should have gone to the bathroom and denied exposing her breasts to the resident. CNA 10 stated she was sent home immediately after the incident.	F 610		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		

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F 755	Continued From page 8 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility document review, the facility failed to ensure the medications were administered as ordered for one of five sampled residents (Resident 2). * Resident 2 did not receive the prescribed medications upon admission as ordered by the physician. This failure had the potential to negatively impact Resident 2's medical condition. Findings: Medical record review for Resident 2 was initiated on 5/28/35. Resident 2 was readmitted to the facility on 5/12/25. Review of Resident 2's Order Summary Report dated 5/27/25 showed the following physician orders: - dated 5/14/25, omeprazole (medication to treat heart burn) DR (delayed release) 20 mg capsule to give one capsule by mouth one time a day - dated 5/14/25, venlafaxine HCL (antidepressant medication) ER (extended release) 150 mg capsule, two capsules by mouth one time a day - dated 5/12/25, lamotrigine (antiseizure medication) oral tablet 150 mg, one tablet by mouth two times a day - dated 5/12/25, lisinopril (antihypertensive medication) oral tablet 10 mg, one tablet by	F 755		

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F 755	Continued From page 9 mouth one time a day - dated 5/12/25, metformin (medication to treat diabetes) HCL oral tablet 500 mg, one tablet by mouth two times a day - dated 5/12/25, metoprolol tartrate oral tablet 25 mg, one tablet by mouth two times a day - dated 5/13/25, vitamin C (supplement) oral tablet 500 mg, one tablet by mouth one time a day - dated 5/12/25, acetaminophen (pain reliever) oral tablet 325 mg, two tablets by mouth every four hours as needed for mild pain - dated 5/12/25, magnesium hydroxide (laxative medication) oral suspension, 30 ml by mouth as needed for constipation for 60 Days - dated 5/12/25, gabapentin (nerve pain medication) oral capsule 300 mg, one capsule by mouth one time a day - dated 5/12/25, vitamin B-12 (supplement) oral tablet 1000 mcg, one tablet by mouth one time a day - dated 5/12/25, clonidine HCl (antihypertensive medication) oral tablet 0.1 mg, one tablet by mouth every eight hours as needed for HTN for 60 Days SBP greater than 160 mmHg - dated 5/12/25, dextromethorphan-guaifenesin (medication for cough) oral syrup 10-100 mg/5ml, 10 ml by mouth every six hours as needed for cough and congestion	F 755		

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F 755	Continued From page 10 On 5/28/25 at 0908 hours, an interview was conducted with LVN 1. LVN 1 stated on 5/13/25, as he was giving medications, LVN 1 noted Resident 2's medications were not delivered except for one (gabapentin medication). LVN 1 stated he contacted the pharmacy and refaxed the orders to the pharmacy. LVN 1 stated the nursing supervisor, and the physician were notified the resident's medications were not delivered upon readmission. LVN 1 stated the resident's medications were still not delivered on the following day. LVN 1 called the pharmacy, refaxed the orders and notified the DON. LVN 1 verified the medications were not available from 5/13 until he came to work on 5/15/25. On 5/29/25 at 1414 hours, an interview and concurrent facility document review was conducted with the Pharmacy Manager. The Pharmacy Manager stated Resident 4's orders were electronically misfiled to an unknown folder instead of filing it to the admission file. The Pharmacy Manager further stated Resident 4's readmission orders, were not reviewed and medications were not processed. Review of the pharmacy's tracking log showed the following: - 5/12/25 at 1910 hours, received fax - 5/13/25 at 2125 hours, received fax for Ascorbic Acid (Vitamin C) - 5/13/25 at 1700 hours, guaifenesin, clonidine, Vitamin B-12, gabapentin, magnesium, Tylenol (acetaminophen) orders received - 5/13/25 at 0650 hours, clonidine and gabapentin	F 755		

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F 755	Continued From page 11 were sent to the facility. - 5/14/25 at 1323 hours, phone call received from the DON, medications not received; - Medications were delivered on the evening of 5/14/25 at 1746 hours. The Pharmacy Manager verified the above findings. On 6/2/25 at 1635 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and verified the above findings.	F 755		

PLAN OF CORRECTION

FACILITY: GORDON LANE

DATE OF SURVEY: 6/2/2025

SUBMISSION DATE: 6/16/2025

DATE OF SUBSTANTIAL COMPLIANCE: 7/2/2025

This Plan of Correction is submitted in response to the Statement of Deficiencies from the survey completed on 6/2/2025. The facility's plan to correct the alleged deficiencies and the date it will be accomplished does not constitute an admission or agreement with the findings of the survey. This plan is submitted as evidence of the facility's continuing compliance with all applicable regulations.

F 610 Investigate/Prevent/Correct Alleged Violation SS=D

Corrective Action To Correct Deficiency:

- On 5/24/25, upon being made aware of the allegation, CNA 10 was immediately suspended pending the outcome of an investigation and has since been terminated.
- On 5/30/25, Resident 4 was assessed by the licensed nurse for any adverse clinical or psychosocial effects related to the incident, with none noted.
- On 5/30/25, the facility initiated a formal investigation into the allegation of abuse.
- On 5/30/25, Resident 4's physician and responsible party were notified of the incident and the investigation.
- On 5/30/25, the incident was reported to the California Department of Public Health (CDPH), the long-term care ombudsman, and local law enforcement.
- On 5/30/25, a care plan was initiated for Resident 4 to include interventions for psychosocial monitoring by licensed nurses and social services.

Identify Any Other Residents Who May Have Been Affected By the Deficient Practice:

- On 6/13/25, the Administrator and Director of Nursing (DON) initiated a facility-wide audit of all residents to identify any unreported allegations of abuse, neglect, or mistreatment. No other residents were found to be affected.

Systemic Change To Prevent Recurrence:

- On 6/10/25, the Administrator and DON were provided 1:1 in-servicing by the Regional Director regarding the facility's Abuse Prevention policy and procedure (P&P), with specific focus on the definitions of abuse and the mandatory reporting requirements and timelines.
- Beginning 6/17/25, the Director of Staff Development (DSD) will provide mandatory in-service training to all facility staff on the Abuse Prevention P&P, Code of Conduct, and the immediate reporting of all allegations to a supervisor. This training will be completed by 7/2/25.
- By 7/2/25, the Administrator will provide in-service training to all licensed nurses and department heads on how to conduct a thorough and timely investigation into any allegation of abuse, neglect, or mistreatment.

Monitoring And Evaluation Plan:

- Beginning 7/3/25, the Administrator or designee will conduct a weekly audit of all reported staff and resident incidents to ensure that any potential allegation of abuse is identified, immediately investigated, and reported in accordance with facility policy and state/federal regulations.
- These weekly audits will continue for 3 months, at which point the frequency will be re-evaluated by the Quality Assurance (QA) committee.

- The results of these audits will be presented by the Administrator at the monthly QA meeting for review and any necessary recommendations.

F 755 Pharmacy Srvcs/Procedures/Pharmacist/Records SS=D

Corrective Action To Correct Deficiency:

- On 5/14/25, all of Resident 2's medications were received from the pharmacy and administered per physician orders.
- On 5/14/25, Resident 2 was assessed by a licensed nurse for any adverse signs or symptoms related to the delayed medication administration. The resident's physician was notified, and no adverse effects were identified.

Identify Any Other Residents Who May Have Been Affected By the Deficient Practice:

- On 6/13/25, the DON initiated a full audit of all new admissions and readmissions from 5/12/25 to 6/13/25 to verify that all admission medication orders were received from the pharmacy and administered in a timely manner. No other residents were identified as being affected by a similar issue.

Systemic Change To Prevent Recurrence:

- On 6/11/25, licensed nursing staff were re-educated by the DON on the facility's Medication Reconciliation P&P for new admissions and readmissions. The training emphasized the process for verifying receipt of medications from the pharmacy within 24 hours of admission.
- Effective 6/12/25, a new verification process was implemented. The nursing unit manager or designee on each shift is now required to use a "New Admission/Readmission Pharmacy Checklist" to verify that all new medication orders have been faxed to the

pharmacy and that confirmation of receipt has been obtained from the pharmacy. This checklist is then co-signed by the DON within 24 hours.

- On 6/10/25, the Administrator and DON met with the Pharmacy Manager to review the breakdown in process and reinforce the communication protocol for confirming receipt of all new admission order faxes.

Monitoring And Evaluation Plan:

- Beginning 6/16/25, the DON or designee will conduct daily audits of the "New Admission/Readmission Pharmacy Checklist" for all new and re-admitted residents to ensure 100% compliance with the verification process.
- This daily audit will continue for 2 weeks, then transition to a weekly audit of 5 checklists for 3 months, or until substantial compliance is achieved.
- The DON will report the findings of these audits at the monthly QA meeting for ongoing oversight and recommendations.