STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ellison John Transitional Care Center	43830 10th Street West Lancaster, CA 93534

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50961 Based on observation, interview, and record review, the facility failed to ensure the room of one of four sampled residents (Resident 3) was free from clutter. This failure had the potential to negatively impact Resident 3's psychosocial well-being (refers to a resident's overall mental, emotional, and social health, encompassing aspects like happiness, life satisfaction, self-esteem, social functioning, and a sense of purpose). Findings: During a review of Resident 3's Admission Record, the Admission Record indicated Resident 1 was admitted on [DATE], and readmitted on [DATE], with diagnoses of epilepsy (a condition with sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares and loss of consciousness), schizophrenia (a mental illness that is characterized by disturbances in thoughts), and muscle weakness. During a review of Resident 3's Minimum Data Set (MDS-a resident assessment tool), dated 1/25/2024, the MDS indicated Resident 3 had severely impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS also indicated Resident 3 required maximal assistance on lower body dressing, and dependent on eating, personal hygiene, and toilet transfers. During a review of Resident 3's Care Plan (CP), dated 2/10/2025, the CP indicated Resident 3 had high risk for falls and injuries due to the following risk factors: impaired cognition, disorder of brain, epilepsy, decrease in functional status. The CP indicated to keep Resident 3's environment free from obstruction. During a review of Resident 3's History and Physical (H&P), dated 3/21/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Care Plan (CP), dated 4/21/2025, the CP indicated Resident 3 had an Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) Self Care performance deficit. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/21/2025 at 12:10 a.m. with Licensed Vocational Nurse (LVN) 3 in Resident 3's room, three boxes and two bags covered with 3 blankets and clothing were observed next to the right side of Resident 3's room entrance. On the left side of Resident 3's room entrance multiple folded cardboard boxes were observed in a single cardboard box next to side table with multiple bottles and plastic bags. LVN 3 stated all the boxes, bags and clothing belong to Resident 3's roommate. During an interview on 4/22/2025 at 1:46 p.m. with the Director of Nursing (DON), the DON stated Resident 3 was cognitively impaired. The DON also stated that any reasonable person would not feel comfortable in a cluttered room. The DON stated the facility failed to provide a homelike environment for Resident 3. During a review of the facility-provided policy and procedure (P&P) titled, Homelike Environment, last revised on 1/2025, the P&P indicated, The facility strives to provide a personalized, homelike environment which recognizes the individuality and autonomy of the residents It is the responsibility of all facility staff to create a homelike environment and promptly address any cleaning needs.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50961 Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice to meet the resident's physical, mental, and psychosocial (relating to the interrelation of social factors and individual thoughts and behavior) needs by failing to administer medications and treatments as ordered by the physician for one of four sampled residents (Resident 1). This deficient practice had the potential to delay Resident 1's care causing him to experience prolonged, unrelieved muscle spasms (a sudden involuntary muscular contraction, twitch). Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted on [DATE] with diagnoses of neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), malignant melanoma (type of a skin cancer), hypothyroidism (a condition where the thyroid gland located int eh lower part of the neck doesn't produce enough hormone), and muscle weakness. During a review of Resident 1's History and Physical (H&P), dated 4/9/2025, the H&P indicated, Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 4/15/2025, the MDS indicated Resident 1's cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks) was intact. During a review of Resident 1's Order Summary Report, the report indicated the following physician's order: -4/16/2025: Baclofen (a medication that relaxes muscles and reduces muscle stiffness) tablet to give 5 milligram (mg-unit of measurement) by mouth three times a day for muscle spasms. -4/21/2025: Cyclobenzaprine HCl (a medication that relaxes muscles and reduces muscle stiffness) tablet 10 mg to give 1 tablet by mouth every 8 hours as needed for muscle spasms. During a concurrent observation and interview on 4/22/2025 at 10:45 a.m. with Licensed Vocational Nurse (LVN) 1 in Resident 1's room, Resident 1 was observed in bed, awake and alert. Resident 1 stated he was uncomfortable in bed and was experiencing muscle spasms. Resident 1 stated he had not received his muscle spasm medication since last night and asked the LVN 1 to administer his muscle spasm medication. LVN 1 stated Resident 1's order of Baclofen was discontinued by the physician and there was no new medication ordered for muscle spasms. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/25/2025 at 2:08 p.m. with LVN 1, Resident 1's Medication Administration Record (MAR), dated April 2025 was reviewed. The MAR indicated the medication order of Baclofen table 5 mg was discontinued on 4/21/2025 at 6:07 p.m. The MAR also indicated Resident 1 had an order for Cyclobenzaprine HCL 10 mg as needed for muscle spasms ordered on 4/21/2025 at 6:15 p. m. LVN 1 stated she was not aware that Resident 1 had a new medication order, and she did not check Resident 1's complete order summary. LVN 1 stated Cyclobenzaprine was already available in the medication cart, and she should have administered the medication when resident complained of muscle spasms. During a review of Resident 1's MAR, dated 4/2025, the MAR indicated Cyclobenzaprine was administered to Resident 1 on 4/22/2025 at 2:30 p.m. During an interview on 4/22/2025 at 2:54 p.m. with the Director of Nursing (DON), the DON stated facility failed to administer Resident 1's medications and treatments as ordered by the physician. The DON stated LVN 1 should have reviewed Resident 1's complete order summary and administered the medication when Resident 1 complained of experiencing muscle spasm. The DON stated the failure caused a delay in Resident 1's care. During a review of the facility-provided policy and procedure (P&P) titled, Medication administration-General Guidelines, last reviewed on 12/3/2024, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices.The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions B. 2) Medications are administered in accordance with written orders of the prescriber.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50961 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases (illness that can be transmitted from one person to another) and infections by failing to ensure a sign was posted near the isolation room (a specialized room designed to separate residents with communicable disease to prevent the spread of infection) indicating the type of precaution and personal protective equipment (PPE, specialized clothing or gear worn to minimize exposure to hazards taht can cause serious illnesses) a resident required for one of four sampled residents (Resident 2). The deficient practices had a potential to spread infections and illnesses among residents. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted on [DATE] with the diagnoses of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, anemia (a condition where the body does not have enough healthy red blood cells), and resistance to multiple antimicrobial drugs (drugs that kill or slow the growth of microorganisms like bacteria and viruses). During a review of Resident 2's History and Physical (H&P), dated 4/11/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 2's Order Summary Report, the report indicated the following physician's order: - 4/17/2025: Contact Isolation (an isolation method used to prevent the spread of germs through direct or indirect contact with a patient or their environment) for diagnoses of E.Coli (a bacteria that can cause infection of the urine)/ multidrug-resistant organism (MDRO) infection of urine every shift. During a review of Resident 2's Care Plan (CP), initiated on 4/17/2024, the CP indicated Resident 1 had urinary tract infection/E. Coli of urine. The CP also indicated Resident 2 was on Isolation/Contact Precaution (an infection control intervention designed to reduce transmission of MDRO) for E.Coli of urine. The CP interventions indicated to maintain contact precautions and post precaution sign in front of room/door per facility's policy. During an observation on 4/21/2025 at 8:30a.m. near Resident 2's room, an isolation caddy (a small storage containing PPE) was observed secured on the door. There was no isolation sign posted on Resident 2's door indicating the type of precautions and PPE required to enter the Resident 2's room. During an interview on 4/21/2025 at 9:07a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated an isolation sign should have been posted near Resident 2's room to indicate the type of PPE required to enter Resident 2's room. LVN 2 stated the lack of isolation sign could lead to the spread of infection among staff and residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/2025 at 12:06 p.m. with the Infection Preventionist (IP) Assistant, the IP Assistant stated an isolation sign should have been placed near Resident 2's room to indicate the type of PPE required to enter the Resident 2's room. The IP Assistant stated the failure to place an isolation sign near Resident 2's room could have led to staff and visitors not using the proper PPE prior to entering Resident 2's room leading to the spread of infection to staff and other residents. During an interview on 4/22/2025 at 2:54 p.m. with the Director of Nursing (DON), the DON stated an isolation sign should have been posted on Resident 2's room to indicate the type of PPE required to enter Resident 2's room and to prevent the spread of infection to staff and other residents in the facility. During a review of the facility-provided policy and procedure (P&P) titled, Resident Isolation-Categories of Transmission-Based Precautions, last revised on 12/3/2024, the P&P indicated, Contact precautions are implemented for residents known or suspected to be infected or colonized with microorganisms that are transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. i. The Facility alerts staff to the type of precaution a resident requires