

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/05/2025
NAME OF PROVIDER OR SUPPLIER The Ellison John Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>43878</p> <p>Based on interview and record review, the facility failed to obtain weekly weights for one of three sampled residents (Resident 1) after Resident 1 was noted with a Change in Condition (COC) on 3/21/2025 regarding a weight loss of 15 pounds (lbs.- a unit of measurement) in one week.</p> <p>This deficient practice had the potential for Resident 1 to have a delay in care.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 1/5/2024 and readmitted the resident on 3/11/2025 with diagnoses including hypertensive heart disease with heart failure (long-term high blood pressure [HTN-hypertension] has weakened the heart muscle to the point where it can't pump enough blood, leading to heart failure), muscle weakness (generalized), and polyneuropathy (damage to multiple peripheral nerves in the body, causing symptoms like numbness, tingling, and pain, often in the hands and feet).</p> <p>During a review of Resident 1's Weights and Vital Summary, the Summary indicated:</p> <p>- 3/12/2025 157 lbs.</p> <p>- 3/20/2025 142 lbs. (weight loss of 15 lbs - 9.6%)</p> <p>During a review of Resident 1's care plan created on 3/17/2025 and revised on 3/27/2025 for nutritional risk secondary to weight fluctuation related fluid shifts and diagnosis of heart failure, the care plan indicated interventions that included diet as ordered and weekly weights as ordered.</p> <p>During a review of Resident 1's SBAR (Situation-Background-Assessment-Recommendation, a structured communication tool used in healthcare to improve information sharing and resident safety, especially during critical situations: Change in Condition (COC), dated 3/21/2025 at 9:08 a.m., the SBAR indicated weight loss. The assessment details indicated Resident 1 noted with weight loss: -15 lbs. in one week.</p> <p>During a review of Resident 1's care plan created on 3/21/2025 for weight loss of 15 lbs. in one week, the care plan indicated interventions that included notifying the doctor of any COC, and weekly weight as ordered.</p> <p>(continued on next page)</p>

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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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Interdisciplinary Team (IDT- a group of professionals from different fields who work together to achieve a common goal, often related to a patient's care or a specific project) Progress Notes Weight Variance & Nutritional Condition, dated 3/27/2025 at 6:33 p.m., the IDT Progress Notes indicated Resident 1 was observed with loss of 15 lbs. in one week. The IDT agreed to continue weekly weights, will continue to monitor and refer to doctor for any COC.</p> <p>During a review of Resident 1's Progress Notes, dated 4/2/2025 at 4:15 p.m., the Progress Notes indicated Resident 1 was noted with edema (a condition where excess fluid accumulates in the body's tissues, causing swelling) of the bilateral (both) lower extremities (limbs of the body) and upper arms.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/2/2025, the MDS indicated Resident 1's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. The MDS indicated Resident 1 required supervision or touch assistance (helper provides verbal cues, and or touching, steadying and or contact guard assistance as resident completes activities) with toileting, showering, lower body dressing, putting on and taking off footwear and personal hygiene.</p> <p>During a concurrent interview and record review, Resident 1's IDT Progress Notes Weight Variance & Nutritional Condition, dated 3/27/2025 on 5/5/2025 at 12:28 p.m. was reviewed with the Assistant Director of Nursing (ADON). The ADON stated for newly admitted residents we do weekly weights for four weeks then if there is any significant weight loss the facility will review the resident and determine the need to continue with the weekly weight for another four weeks. The ADON reviewed Resident 1's IDT Progress Notes Weight Variance & Nutritional Condition dated 3/27/2025 and stated it indicated to continue weekly weights. The ADON reviewed Resident 1's weights and stated last weight was on 3/20/2025, next weight should have been on 3/27/2025. The ADON stated Resident 1 was weighed on 4/2/2025 with a weight of 194 lbs. but it was not recorded, because we wanted to verify the accuracy, but Resident 1 was later discharged . The ADON stated the weight increase was an increase of 52 lbs. The ADON reviewed Resident 1's progress notes dated 4/2/2025 at 4:15 p.m. indicating Resident 1 had edema, the ADON stated the edema could potentially have been a factor for Resident 1's weight gain. The ADON stated Resident 1 should have been weighed weekly, the ADON stated not weighing Resident 1 weekly could potentially cause a delay in care.</p> <p>During an interview on 5/5/2025 at 4 p.m. with the Director of Nursing (DON), the DON stated for new admissions the facility checks weights weekly for four weeks, then it will change to monthly if weights are stable but if within the first month there are issues with weight gain or weight loss we continue with the weekly weights. The DON stated reviewed Resident 1's weights and the facility did not do weekly weights for a new admission as Resident 1 was a new admission. The DON stated Resident 1 had a COC on 3/21/2025 for weight loss of 15 lbs. and there should have been another weight check on 3/28/2025. The DON stated Resident 1 was weighed on 4/2/2025 with an increase in weight of 56 lbs. this was a large discrepancy. The DON stated the doctor assessed and cleared Resident 1 to be discharged . The DON stated if the facility had been doing the weekly weights the facility could have caught the weight gain, not sure if it was the food or something else that caused the weight increase.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Policy and Procedure (P&P) titled, Weight Management, last reviewed on 12/3/2024, the P&P indicated weight will be recorded monthly unless ordered more or less frequently by the physician or upon the discretion of the IDT. Resident monitored during the weekly weight management meeting may be weighed weekly until his or her condition stabilizes or as determined by the IDT evaluation of resident needs.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>43878</p> <p>Based on interview and record review, the facility failed to provide laboratory (lab) services for one of three sampled residents (Resident 1) on 3/18/2025. On 4/2/2025 Resident 1 was discharged without the ordered labs being completed.</p> <p>This deficient practice had the potential for a delay in care and treatment.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 1/5/2024 and readmitted the resident on 3/11/2025 with diagnoses including hypertensive heart disease with heart failure (long-term high blood pressure [HTN-hypertension] has weakened the heart muscle to the point where it can't pump enough blood, leading to heart failure), muscle weakness (generalized), and polyneuropathy (damage to multiple peripheral nerves in the body, causing symptoms like numbness, tingling, and pain, often in the hands and feet).</p> <p>During a review of Resident 1's SBAR (Situation-Background-Assessment-Recommendation, a structured communication tool used in healthcare to improve information sharing and resident safety, especially during critical situations: Change in Condition (COC), dated 3/14/2025 at 6:15p.m., the SBAR indicated Resident 1 had dysuria. The doctor (MD) was notified with new orders for urinalysis (UA- a test of your urine, used to detect any urinary tract infections [UTI-an infection in the bladder/urinary tract]), culture and sensitivity (CS- a lab test to check for bacteria or other germs in a urine sample)</p> <p>During a review of Resident 1's Physician Order dated 3/14/2025, the Physician Order indicated UA and CS one time only for 2 days.</p> <p>During a review of Resident 1's Progress Notes dated 3/18/2025 at 3/18/2025 at 12:44 p.m., the Progress Notes indicated urine specimen culture results is insufficient, new order to collect urine specimen for repeat UA and CS, one time only until 3/19/2025.</p> <p>During a review of Resident 1's Physician Order dated 3/18/2025, the Physician Order indicated to collect urine specimen for repeat urine test one time only until 3/19/2025</p> <p>During a review of Resident 1's Progress Notes dated 3/18/2025 at 10:24 p.m., the Progress Notes indicated Attempted to collect UA. Unsuccessful attempt. Next shift to made aware and re-attempt.</p> <p>During a review of Resident 1's Order Workflow, Patient Order History dated 3/19/2025, the Patient Order History indicated incomplete specimen, not ready for pick up. For the UA & C/S- clean catch.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/2/2025, the MDS indicated Resident 1 cognition was intact. The MDS indicated Resident 1 required supervision or touch assistance (helper provides verbal cues, and or touching, steadying and or contact guard assistance as resident completes activities) with toileting, showering, lower body dressing, putting on and taking off footwear and personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/5/2025 at 2:35 p.m. with the Director of Nursing (DON), the DON stated Licensed Vocational Nurse (LVN) 1 collected Resident 1's UA on 3/19/2025 and placed it in the facility's refrigerator for the lab to pick up but the lab had already come in the morning. The DON stated cannot verify anyone came to pick up the UA, and the order fell off the tracker and no one verified it was done. The DON stated staff should have called the lab to inform them that UA was done and ready for pick up and staff should have called lab to follow up on results.</p> <p>During an interview on 5/5/2025 at 3:37 p.m. with LVN 1, LVN1 stated collected Resident 1's UA on 3/19/2025. LVN 1 stated she labeled the UA, did not call the lab to inform them that the specimen was ready to be picked up, worked the following day, did not see the specimen in the facility specimen refrigerator, and assumed the lab had picked up Resident 1's UA. LVN1 stated she did not call the lab to follow up on the results of the UA. LVN 1 stated UA and C/S should have been done to determine what antibiotics the resident needs to be on. LVN 1 stated the potential negative outcome is that we will not know if the resident has an infection, and we will not be able to treat the infection. LVN 1 stated it can possibly lead to a delay in the care and treatment if the resident has an infection.</p> <p>During an interview on 5/5/2025 at 4 p.m. with the DON, the DON stated for labs we get an order, enter it, and when the lab sees the order, they come in and pick it up. The DON stated when lab came in and the specimen was not ready the ball was dropped (someone made a mistake or missed an opportunity at a critical moment). The DON stated if there is a pending infection, and the C/S is not done then we will not know what antibiotics the resident will need to be prescribed. The DON stated we did not see the result, and no one had followed up to see what the result was.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Laboratory Services ordering and Prompt Reporting, last reviewed on 12/3/2024, the P&P indicated the facility shall provide or obtain lab services and promptly report abnormal results in accordance with physician order.</p> <p>During a review of the facility's P&P titled, Laboratory Services, last reviewed on 12/3/2024, the P&P indicated laboratory, radiology, or other diagnostic services ordered by the physician will be completed in a timely manner; and abnormal results will be reported to the physician in a timely manner to ensure results can be acted upon quickly.</p>		