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	07/22/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to follow the facility's policy and procedure on fall management for one of three sampled residents (Resident 1), when Resident 1 who was admitted to the facility with history of falls, was not assessed for fall risk upon admission. This failure had the potential to place Resident 1 at an increased risk of falls. Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 6/7/2025 with diagnoses of diabetes mellitus, muscle weakness, history of falling, and anemia. During a review of Resident 1's History and Physical (H&P), dated 6/29/2025, the H&P indicated Resident 1 had the capacity to make decisions. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 6/14/2025, the MDS indicated Resident 1 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS further indicated Resident 1 required moderate assistance from staff with eating, oral hygiene, personal hygiene. The MDS indicated Resident 1 required maximal assistance from staff for transfers from chair to bed and had a history of falls. During a review of Resident 1s Care Plan (CP) for risk of falls, last revised on 7/15/2025, the CP indicated Resident 1 was at risk for recurrent falls and spontaneous injury related to deconditioning, gate and balance problems. During a concurrent interview and record review on 7/22/2025 at 12:19p.m. with Registered Nurse (RN) 1, Resident 1's Fall Risk Assessment, dated 7/14/2025 was reviewed. The Fall Risk Assessment indicated Resident 1 was at high risk for falls. RN 1 stated Resident 1's fall risk assessment upon admission was not completed. RN 1 further stated the purpose of the fall risk assessment was to identify fall risk residents and initiate appropriate fall prevention interventions. RN 1 stated this failure had the potential for Resident 1 to experience a fall incident. During an interview on 7/22/2025 at 2:13p.m. with the Director of Nursing (DON), the DON stated the purpose of the fall risk assessment was for the facility to identify the risk of fall and develop a personalized care plan. The DON further stated the failure to complete the fall risk assessment had the potential to increase the likelihood of accidents and falls for Resident 1. During a review of the facility-provided policy and procedure (P&P) titled, Fall Management Program, last reviewed on 12/3/2024, the P&P indicated, Each resident entering the facility shall have a fall risk evaluation completed within 2 hours, and no more than 24 hours of admission. Residents at risk for falling shall have a care plan that identified individual risk factors and person-centered interventions, based on the risk factors.

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