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	09/11/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to notify the physician on 9/5/2025 when Resident 1 complained of weakness/numbness (a loss of feeling or sensation in an area of the body) to the right side the face for one of three samples Residents (Resident 1). This deficient practice had the potential to result in a lack of necessary care and treatment to Resident 1.Findings: A record review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE] and readmitted on [DATE] and 6/28/2025 with diagnosis including chronic respiratory failure (a condition where the lungs are unable to adequately exchange oxygen), type 2 diabetes (the body's inability to process sugar), dependence on ventilator (a mechanical life-support machine that helps patients breathe), and hypertensive heart disease (a long-term condition that develops from chronic high blood pressure). A record review of Resident 1's Minimum Data Set (An assessment tool) dated 9/10/2025, indicated Resident 1 was cognitively intact. Resident 1 was dependent on staff for activities of daily living. During an interview with Resident 1 on 9/11/2025 at 10:10 a.m., Resident 1 stated that on 9/5/2025 at around 6:30 p.m., she reported to the Registered Nurse (RN 2) that she was having numbness and weakness to the right side of her face. Resident 1 stated the Registered Nurse assessed her (Resident 1), however she (RN 2) did not notify her (Resident 1) Medical Doctor. Resident 1 stated she (Resident 1) continued to have numbness to the right side of her (Resident 2) face over the weekend. Resident 1 stated she (Resident 1) complained again on 9/7/2025 to a different registered nurse (RN 1). Resident 1 stated RN 1 then proceeded to call the Medical Doctor, and she (Resident 1) was transferred to the emergency department. Resident 1 stated she does not know why it took two days for the facility to finally listen to her (Resident 1). Resident 1 stated she (Resident 1) was diagnosed in the Emergency Department with Bell's Palsy (a sudden weakness in the muscles on one half of the face). During a record review of Resident 1's Progress Notes dated 9/5/2024 at 6:40 p.m., the Progress Notes indicated Resident 1 requested a Registered Nurse (RN 2) present in her (Resident 1) room and stated she (Resident 1) feels like her mouth is tilting to one side. RN 2 assessed Resident 1 for any signs of stroke (damage to the brain from interruption of blood supply) but noted none at the time. RN 2 educated Resident 1 on signs and symptoms of stroke. RN 2 asked Resident 1 to stay calm and relax for a better assessment to be done. Resident 1 was reassessed after 5 to 10 minutes when Resident 1 was calm and no abnormalities noted. During an interview with Registered Nurse (RN 2) on 9/11/2025 at 1:57 p.m., RN 2 stated, she was called to assess Resident 1. RN 2 stated when she went into Resident 2's room, she noted Resident 1 crying, and she (Resident 1) stated she was experiencing numbness and weakness to the right side of her face. RN 2 stated she did not notice any weakness to Resident 1's right side of the face, and she did not notify Resident 1's Medical Doctor. RN 2 stated, she later realized that she should have called the Medical Doctor, but she failed to do so. During an interview with Assistant Director of Nurses (ADON) on 9/11/2025 at 2:30 p.m., ADON stated, Registered Nurse (RN 2) needed to call Resident 1's Medical Doctor to notify of Resident 1's change of condition immediately. ADON stated, there was a delay in care and treatment of Resident 1. ADON stated, the facility should have called the Medical Doctor to obtain orders for Resident 1. ADON stated, it should not have taken two days to respond to Resident 1's right facial numbness. During a record review of the facility's Policy and Procedure titled, Notification of Changes dated November 2017, indicated the facility informs the resident's physician, and resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status in either life-threatening condition of clinical complications. The Attending Physician will be notified timely with a resident's change in condition.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services for one of three sampled residents (Resident 8) by failing to ensure the resident's medications were not left unattended at bedside. This deficient practice had the potential to cause medication errors and could possibly lead to Resident 8's discomfort.Findings: During a review of Resident 8's admission Record (undated), the admission Record indicated the facility admitted the resident on 9/8/2025 with diagnoses that included acute respiratory failure (a serious condition that makes it difficult to breathe on your own), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), and benign prostatic hyperplasia (BPH - a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream). During a review of Resident 8's Physician Order, dated 9/8/2025, the Physician Order indicated polyethylene glycol 3350 powder (a medication used to relieve constipation) 17 grams (unit of measurement) mixed with eight ounces (oz - unit of measurement) of water, one time a day for bowel management. During a review of Resident 8's History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 9/9/2025, the H&P indicated Resident 8 had the capacity to understand and make decisions. During a concurrent observation and interview on 9/10/2025 at 10:30 a.m. with Licensed Vocational Nurse (LVN) 2, observed LVN 2 left Resident 8's room and went to the nurse station. LVN 2 left Resident 8's water mixed with polyethylene glycol 3350 powder on the bedside table unattended. LVN 2 returned to Resident 8's room and stood at the door. LVN 2 stated she gave all of Resident 8's scheduled medications and was going to document the medications as given. The surveyor clarified with LVN 2 if Resident 8's scheduled medications were administered and LVN 2 stated she gave all of Resident 8's scheduled medications. LVN 2 looked in Resident 8's room and stated that she forgot to give the resident's water mixed with polyethylene glycol 3350 powder. LVN 2 stated that she should not leave medications unattended. LVN 2 stated that medications left unattended had the potential for other residents to take the medications or for Resident 8 to not take the medication and result in discomfort and constipation. During an interview on 9/10/2025 at 3:03 p.m. with Registered Nurse (RN) 1, RN 1 stated Resident 8's medication should not be left unattended. RN 1 stated other residents had the potential to drink Resident 8's medication on the bedside table thinking it was regular water. RN 1 stated the facility failed to ensure Resident 8's medication was not left unattended and failed to ensure Resident 8 received all the scheduled medications before leaving the resident's room. During a review of the facility's policy and procedure (PnP) titled, Administering Medications, last reviewed on 12/3/2024, the PnP indicated the purpose to provide employees with guidelines for the safe and timely administration of medications per physician order. The PnP indicated following verification of the resident and scheduled medication, the licensed nurse follows the pour, pass, chart standard of practice.