| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555904 | A. Building<br>B. Wing | 11/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Ellison John Transitional Care Center | 43830 10th Street West<br>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.

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|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately notify the primary physician regarding a decision to transfer the resident and a need to alter treatment significantly (a need to stop or commence a new form of treatment to deal with a problem) for one of four sampled residents (Resident 1) when on 8/26/2025 Family Member (FM) 1 refused immediate emergent 911 (phone number called to summon emergency services) transfer of Resident 1 to the General Acute Care Hospital (GACH) after Resident 1 sustained a fall resulting in injuries including swelling to the forehead, a skin tear to the left arm, swelling to the right upper arm, and a change in status of mobility. This deficient practice resulted in a delay of placing an emergent 911 call for approximately 30 minutes potentially resulting in further harm to the resident including internal bleeding and death. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included displaced intertrochanteric (a hip fracture that occurs between the greater [large bony prominence on the outer side of the femur {thighbone} and lesser trochanters {smaller projection on the inner side of the femur}, which are bony protrusions {sticks out} on the upper part of the femur) fracture of the left femur, pain, bacterial pneumonia (an infection/inflammation in the lungs), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life) of unspecified severity, age-related osteoporosis (weak and brittle bones), muscle weakness, and history of falling. During a review of Resident 1's History and Physical (H&P) dated 8/22/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/26/2025, the MDS indicated Resident 1 was able to understand others and able to make herself understood. The MDS further indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with personal hygiene and upper body dressing; and substantial/maximal assistance (helper does more than half the effort) with bathing, lower body dressing, toileting, rolling left to right, moving from sitting to lying, and moving lying to sitting on the side of the bed. During a review of Resident 1's care plan (CP) titled Actual Fall: The resident had an unwitnessed fall related to poor balance, unsteady gait. Resident observed with bruise and swelling to left forehead, skin tear to left forearm, swelling to right arm. Resident stated that (Resident 1) cannot lift (Resident 1's) right arm , initiated 8/26/2025, the CP indicated to perform neuro checks for 72 hours as ordered. During a review of Resident 1's Physician Orders, the Physician Orders indicated an order to send Resident 1 out via 911 due to possible fracture status post fall, dated 8/26/2025. During a review of Resident 1's Situation, Background, Assessment, Recommendations (SBAR) - Communication for Changes in Condition (COC) form (document used when a sudden, significant, or important deviation from a resident's baseline health, physical, functional, or cognitive state that may require intervention), dated 8/27/2025, the SBAR-COC form indicated the following timeline of events on 8/26/2025:- At 9:25 p.m., Companion 1 notified the LVN that Resident 1 had a fall near bedside. The RN assessed Resident 1 and the physician was notified with an order to transfer to the hospital via 911. FM 1 was notified, refused transfer to GACH 1, and requested to wait to call 911 until FM 1 arrived at the facility. -At 9:50 p.m. FM 1 arrived at the facility.-At 9:55 p.m., 911 was called.-At 10:05 p.m., paramedics arrived at the facility. -At 10:25 p.m., Resident 1 was transferred to GACH 1. During a concurrent interview and record review on 11/7/2025 at 1:35 p.m. with the Minimum Data Set Coordinator (MDSC), the MDSC reviewed Resident 1's SBAR COC form dated 8/27/2025, Physician's Orders, H&P dated 8/22/2025, Advance Directive (a legal document indicating resident preference on end-of-life treatment) dated 12/18/2024, and Progress Notes for 8/2025. The MDSC stated the facility process is when a physician or staff determines that 911 should be called, then 911 is called immediately. The MDSC stated on 8/26/2025 at 9:25 p.m. Resident 1 had a fall that resulted in injury to the head and arm, the physician was notified and placed an order to send Resident 1 via 911 to the hospital for possible fracture. The MDSC stated 911 should have been called immediately because there was a doctor's order and it was in the best interest and safety of the resident. The MDSC stated Resident 1's most recent H&P indicated the resident had the capacity to make decisions and there was no documented evidence that Resident 1 refused to transfer via 911. The MDSC stated Resident 1 also had an AD that indicated the resident did not have the capacity to make decisions. The MDSC stated there was a delay of approximately 30 minutes before 911 was called because FM 1 did not want Resident 1 to transfer to GACH 1. The MDSC stated there should not be a delay of calling 911 in an |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on interview and record review, the facility failed to report an allegation of employee-to-resident abuse to the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) as per its policy on abuse for one of five sampled residents (Resident 3). This failure had the potential to place Resident 3 at risk for not having an advocate. Findings: During a review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 11/2/2025, with diagnoses including Parkinson Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition characterized by weakness on one side of the body, affecting the arm, leg, hand, and or face) following cerebral infarction (a condition where brain tissue dies due to a lack of blood supply). During a review of Resident 3's History and Physical (H&P), dated 11/3/2025, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (a resident assessment tool), dated 11/2/2025, the MDS indicated Resident 3 had intact cognition (normal mental abilities that allow someone to effectively handle the day-to-day demands of life). During a review of Resident 3's Situation Background Assessment Recommendation (SBAR, technique that provides a framework for communication between members of the health care team about a resident ' s condition): Change of Condition Form, dated 11/3/2025, the SBAR indicated on 11/3/2025, at 8 p.m., Resident 3 reported to Registered Nurse (RN) 1 that Resident 2 was hit by the certified nursing assistant (CNA, name not indicated) assigned to her at around 3 a.m. while providing hygiene care and repositioning and was assisted by another CNA (name not indicated). The SBAR indicated CNA 3 notified RN 1 and the physician ordered to monitor the vital signs. During a review of Resident 3's Social Services Notes, dated 11/4/2025, the Social Services Notes indicated that Resident 3 did not have visible signs of distress and stated she was fine. The Social Services notes further indicated the alleged incident happened the night before and that two CNAs walked in to change her and proceeded to slap her, but Resident 3 was unable to remember when or where the incident happened and already forgot about the incident until she was asked by Social Services Coordinator (SSC) 1. During an interview on 11/4/2025 at 12:39 p.m. with Registered Nurse (RN) 1, RN 1 stated that Certified Nursing Assistant (CNA) 3 reported to her that Resident 3 Family Member (FM) 1 that 2 CNAs hit her the night that she was admitted to the facility. RN 1 stated for any allegations of abuse, it has to be reported immediately to the Administrator (ADM) and fax a report to the SSA, local law enforcement office, and the Ombudsman. RN 1 stated she reported the incident to the department of public health and local law enforcement within 2 hours, but she forgot to report to the Ombudsman. RN 1 stated she should have reported the allegation of abuse by Resident 3 to the Ombudsman within 2 hours of the alleged incident as it can place Resident 3 at risk for further potential abuse. RN 1 stated the Ombudsman is the advocate for residents in long term care settings to ensure they are safe and getting proper treatment to maintain their quality of life. During an interview on 11/6/2025 at 10:35 a.m., with the Director of Nursing (DON), the DON stated the Ombudsman was not notified by RN 1. The DON stated she is the acting abuse coordinator in the absence of the ADM. The DON stated the facility is supposed to report any allegation of abuse to the SSA, local law enforcement, and the Ombudsman thru a phone call within 2 hours of the incident and followed by a faxed report to the same agencies within 24 hours per facility policy and state and federal regulations. The DON stated the Ombudsman is an advocate for long term care residents to ensure they are safe in the facility, and that they are getting the respect and dignity they deserve to help maintain their quality of life. The DON stated that RN 1 should have reported Resident 3's allegation of abuse to the Ombudsman within 2 hours thru a phone call and the facility should have faxed the written report within 24 hours as it placed Resident 3 at risk for further potential abuse. During a review of the facility's policy and procedure (P&P) titled, Abuse Prohibition and Prevention Program, last reviewed on 12/3/2024, the P&P indicated that the facility shall ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of property, are reported immediately, but no later than 2 hours after the allegation is made, or not later than 24 hours to the administrator of the facility and to other officials including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities in accordance with the state law through established procedures. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: 1. Ensure the resident who was repeatedly attempting to get out of bed unassisted, did not fall out of bed and sustained injury for one of four sampled residents (Resident 1). The facility failed to: 1a. Ensure Licensed Vocational Nurse (LVN) 3 responded to Resident 1's family provided caregiver (Companion) 1's report that Resident 1 repeatedly attempted to get out of bed unassisted on 8/26/2025. 1b. Ensure LVN 3 notified Registered Nurse (RN) 2 regarding Companion 1's report that Resident 1 repeatedly attempted to get out of bed unassisted on 8/26/2025. 1c. Ensure Resident 1's bed's pad alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) was plugged-in and functioning when Resident 1 was attempting to get out of bed unassisted on 8/26/2025. 1d. Ensure LVN 3 and Certified Nursing Assistant (CNA) 3 did not move Resident 1 back to bed without a registered nurse (RN) assessing the resident for safe transfer to bed after Resident 1's fall on 8/26/2025. These deficient practices resulted in Resident 1 having an unwitnessed fall on 8/26/2025 at 9:21 p.m. and was transferred to the General Acute Care Hospital (GACH) for possible fracture (broken bone). At the GACH, Resident 1 was diagnosed with a right angulated (bent), displaced (the bone cracks or breaks and does not retain proper alignment) oblique (slanting or diagonal) fracture of the distal (away from the center of the body) humerus (a severe elbow fracture where the broken bone fragments have shifted out of alignment and are angled) requiring surgery with the placement of metallic hardware (device implanted into the body to provide support), blunt head trauma (injury caused by a sudden impact), and mild left frontal scalp (the skin covering the head) and periorbital (around the eye) soft tissue swelling / hematoma (bruise). 2. Ensure Resident 2's pad alarm was plugged in and functioning. This deficient practice had the potential to result in falls with injury to Resident 2. Findings: a. During a review of Resident 1's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included displaced intertrochanteric (a hip fracture that occurs between the greater [large bony prominence on the outer side of the femur {thighbone} and lesser trochanters {smaller projection on the inner side of the femur}, which are bony protrusions {sticks out} on the upper part of the femur) fracture of the left femur, pain, bacterial pneumonia (an infection/inflammation in the lungs), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life) of unspecified severity, age-related osteoporosis (weak and brittle bones), muscle weakness, and history of falling. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/26/2025, the MDS indicated Resident 1 was able to understand others and able to make herself understood. The MDS further indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with personal hygiene and upper body dressing; and substantial/maximal assistance (helper does more than half the effort) with bathing, lower body dressing, toileting, rolling left to right, moving from sitting to lying, and moving lying to sitting on the side of the bed. During a review of Resident 1's Fall Risk Evaluation (FRE), dated 8/19/2025, the FRE indicated the resident had a history of one to two falls in the past three months, had balance problems while standing / walking, was regularly incontinent (having no or insufficient voluntary control over urination or defecation [the discharge of feces from the body]) of unspecified bladder or bowel, and was a high risk for falls. During a review of Resident 1's care plan (CP) titled Risk for fall: Resident is at risk for recurrent falls and spontaneous injuries related to history of falling, muscle weakness, left intertrochanteric fracture due to fall., initiated 8/20/2025, the CP indicated a goal for the resident was to minimize risk of injury from falls. The CP interventions included anticipating and meeting the resident's needs, promoting a safe environment, and that the resident needs activities that minimize the potential for falls while providing diversion and distraction. During a review of Resident 1's CP titled Bed Alarm: Resident is at risk for recurrent fall and spontaneous injury due to impaired safety awareness, cognitive impairment and getting out of bed unassisted, history of fall and poor follow through, initiated 8/19/2025, the CP indicated a goal for Resident 1 was to maintain optimal safety by ensuring the bed alarm is used consistently, and that staff respond appropriately to prevent falls. The CP indicated interventions included to place a functioning bed alarm on Resident 1's bed, ensure the bed alarm was securely attached, and training staff how to properly use the bed alarm. During a review of Resident 1's Physician Orders, the Physician Orders indicated the following: -Place a pad alarm in bed, monitor for placement and function every shift, dated 8/19/2025 - Transfer Resident 1 out via 911 (phone |