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	12/01/2025

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan (a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs) for one of three sampled residents (Resident 2) regarding Resident 1's two right abdominal Jackson Pratt drains (JP drain-a surgical drain that uses gentle suction to remove fluid from a surgical site to promote healing, consisting of a tube in the body connected to a squeezable bulb reservoir that creates constant suction when compressed). This deficient practice placed Resident 2 at risk for insufficient provision of care and services related to the JP drain care. Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 10/28/2025, with diagnoses including cellulitis of lower extremity (a bacterial skin infection, typically presenting as a red, swollen, warm, tender, and painful area on the leg requiring prompt antibiotic treatment to prevent serious complications), malignant neoplasm of colon (a cancerous tumor that develops in the colon lining and can spread to other parts of the body), and heart failure (a condition where the heart can't pump enough blood to meet the body's needs, causing symptoms like fatigue, shortness of breath, and swelling). During a review of Resident 2's Minimum Data Set, dated [DATE], the MDS indicated Resident 2 had intact cognitive functioning. The MDS indicated Resident 2 required maximal assistance from the facility staff for personal hygiene, showers, and lower body dressing. During a concurrent interview and record review on 12/1/2025 at 10:36 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's Admit/Readmit Evaluation form, dated 10/28/2025 was reviewed. The Admit/Readmit Evaluation form indicated the facility admitted Resident 2 on 10/28/2025 with two right abdominal JP drains. LVN 1 stated the purpose of the Care Plan was to make sure all departments are aware of the plan of care for the resident. LVN 1 stated Care Plan should be resident-centered and include resident-specific goals and interventions. LVN 1 stated the failure to address Resident 2's JP drains in the Care Plan had the potential for Resident 2's goals not to be met. During an interview on 12/1/2025 at 3:20 p.m. with the Director of Nursing (DON), the DON stated the facility staff failed to address Resident 2's JP drains in the Care Plan. The DON stated the purpose of the care plan is to provide step by step instruction on how to address each resident specific condition. The DON stated there was a potential for inaccurate plan of care for Resident 2. During a review of the facility-provided policy and procedure (P&P) titled, Develop-Implement Comprehensive Care-Plans, last revised on 12/3/2024, the P&P indicated, The facility develops a person-centered comprehensive care plan that are culturally competent and trauma-informed, developed and implemented to meet each resident's preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. During a review of the facility-provided policy and procedure (P&P) titled, Comprehensive Care Plans-Timing, last revised on 12/3/2024, the P&P indicated, Each resident has a person-centered, comprehensive care plan, developed, reviewed, and revised by the facility interdisciplinary team including the resident and resident representative, if applicable.

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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(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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 for two of three sampled residents (Residents 1 and 2) by failing to: 1. Administer medications to Resident 1 as ordered by the physician. 2. Provide Resident 1 with the correct size of incontinent briefs (a type of absorbent undergarment, essentially an adult diaper with adjustable tabs, designed for individuals who experience incontinence). 3. Notify Resident 2's physician regarding lack of peripheral intravenous (PIV catheter- a thin, flexible plastic tube inserted into a vein to deliver fluids, medications, blood, or nutrition, using a needle for placement that's then removed, leaving just the tube) access and missed Ertapenem Sodium Injection Solution (antibiotics-medication to treat bacterial infection administered as an intravenous solution) doses. These deficient practices had had the potential to delay care for Residents 1 and 2, negatively affecting Residents 1 and 2's well-being. Findings: a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 11/4/2025, with diagnoses including nontraumatic intracerebral hemorrhage (bleeding within the brain tissue that is not caused by a head injury), diabetes mellitus type two (DM II-a disorder characterized by difficulty in blood sugar control and poor wound healing), and glaucoma (a group of eye diseases often due to increased pressure inside the eye, leading to irreversible vision loss and blindness if untreated). During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 11/11/2025, the MDS indicated Resident 1 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1's vision was highly impaired. The MDS indicated Resident 1 frequently incontinent of bladder and bowel. The MDS indicated Resident 1 required maximal assistance (helper does more than half of the effort) from the facility staff for personal hygiene, toileting hygiene, showers, and lower body dressing. a.1. During a review of Resident 1's Care Plan (not titled), initiated on 11/4/2025, the Care plan indicated Resident 1 had impaired visual functioning. The Care Plan interventions indicated to administer Resident 1's eye drops as ordered by the physician. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following physician's order: -11/4/2025: Brimonidine Tartrate Ophthalmic Solution (an eye drop used primarily to lower high pressure inside the eye from glaucoma, and for redness from minor irritation) 0.2 percent (%-unit of measurement). Instill one drop in both eyes twice a day for glaucoma. -11/4/2025: Dorzolamide Hydrochloride-Timolol Ophthalmic Solution (an eye drop used to lower high pressure inside the eye, treating glaucoma, and preventing vision loss by reducing fluid production in the eye) 2-0.5%. Instill one drop in both eyes two times a day for glaucoma. -11/10/2025: Brimonidine Tartrate Ophthalmic Solution 0.2%. Instill one drop in both eyes three times a day for glaucoma. During a concurrent interview and record review on 12/1/2025 at 3:20 p.m. with the Director of Nursing (DON), Resident 1's Medication Administration Audit Report (MAAR), dated 11/2025 was reviewed. The MAAR indicated Dorzolamide Hydrochloride-Timolol Ophthalmic Solution and Brimonidine Tartrate Ophthalmic Solution were administered as follows:Dorzolamide Hydrochloride-Timolol Ophthalmic Solution-11/5/2025: scheduled time: 9 a.m.-administration time 2:37 p.m.11/12/2025: scheduled time 9 a.m. -administration time 11:04 a.m.11/15/2025: scheduled time 9 a.m. -administration time 11:52 a.m. Brimonidine Tartrate Ophthalmic Solution-11/5/2025: scheduled time 9 a.m.-administration time 2:37 p.m. -11/12/2025: scheduled time 9 a.m.-administration time 11:04 a.m. The DON stated Resident 1's medications should have been administered at the correct time as ordered by the physician. The DON stated Resident 1's treatment was delayed, and Resident 1 had the potential to experience discomfort. During a review of the facility-provided policy and procedure (P&P) titled, Administering Medications, last revised on 12/3/2024, the P&P indicated, Medications must be administered in accordance with the orders. Medications must be administered in accordance with state and federal guidelines. During a review of the facility-provided policy and procedure (P&P) titled, Medication Errors, last revised on 12/3/2024, the P&P indicated, The facility ensures that its residents are free of any significant medication errors. Medication Error: The observed or identified preparation or administration of medication or biologicals which is not in accordance with: a. The prescriber's order. d. Accepted professional standards and principles include the various practice regulations in each State, and current commonly accepted health standards established by national organizations

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of three sampled residents (Residents 1 and 2) were free from significant medication error (means the identified administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards), by failing to: 1. Administer Bisacodyl rectal suppository (a fast-acting stimulant laxative inserted into the rectum used for short-term relief of occasional constipation) to Resident 1 by the correct route. 2. Ensure Resident 2 received full course of Ertapenem Sodium Injection Solution (antibiotics-medication to treat bacterial infection administered as an intravenous solution) as ordered by the physician. These deficient practices had the potential to cause adverse effects (a harmful, unintended, and undesirable response to a medication) and negatively affect Resident 1's and Resident 2's well-being. Findings: a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 11/4/2025, with diagnoses including nontraumatic intracerebral hemorrhage (bleeding within the brain tissue that is not caused by a head injury), diabetes mellitus type two (DM II-a disorder characterized by difficulty in blood sugar control and poor wound healing), and glaucoma (a group of eye diseases often due to increased pressure inside the eye, leading to irreversible vision loss and blindness if untreated). During a review of Resident 1's Care Plan (a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs), initiated on 11/10/2025, the Care plan indicated Resident 1 was at risk for adverse reactions secondary to medication error due to Bisacodyl suppository inserted into the vagina (the internal muscular canal that connects the cervix to the outside of the body.) During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 11/11/2025, the MDS indicated Resident 1 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 required maximal assistance (helper does more than half of the effort) from the facility staff for personal hygiene, toileting hygiene, showers, and lower body dressing. During a review of Resident 1's Order Summary Report, the report indicated the following physician's order: -11/4/2025: Bisacodyl Rectal Suppository ten milligram (MG-unit of measurement). Insert one suppository rectally every 12 hours as needed for constipation (having infrequent bowel movement with hard, dry stools that are difficult to pass, causing straining and bloating). During a concurrent interview and record review on 12/1/2025 at 3:20 p.m. with the Director of Nursing (DON), Resident 1's Change of Condition (COC -major decline or improvement in a resident's status that will not resolve without intervention) form, dated 11/10/2025 was reviewed. The COC form indicated that during the administration of bisacodyl suppository Resident 1 stated that she (Resident 1) felt that the suppository went into the wrong orifice (opening or hole) and not the anus as indicated. The DON stated the failure to administer a medication by the correct route as ordered by the physician is a medication error. The DON stated the failure to administer Resident 1's suppository by the correct route had the potential to delay treatment and cause pain to Resident 1. b. During a review of Resident '2s admission Record, the admission Record indicated the facility admitted Resident 2 on 10/28/2025, with diagnoses of cellulitis of lower extremity (a bacterial skin infection, typically presenting as a red, swollen, warm, tender, and painful area on the leg requiring prompt antibiotic treatment to prevent serious complications), malignant neoplasm of bladder (a cancerous tumor that develops in the bladder lining and can spread to other parts of the body), and heart failure (a condition where the heart can't pump enough blood to meet the body's needs, causing symptoms like fatigue, shortness of breath, and swelling). During a review of Resident 2's Care Plan, initiated on 10/29/2025, the Care Plan indicated Resident 2 was receiving antibiotic therapy for left lower leg cellulitis. The Care Plan interventions indicated to administer medications as ordered. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had intact cognitive functioning. The MDS indicated Resident 2 required maximal assistance from the facility staff for personal hygiene, showers, and lower body dressing. During a review of Resident 2's Order Summary Report, the report indicated the following physician's order: -10/28/2025: Ertapenem Sodium Injection Solution reconstituted 1 gram (GM-unit of measurement). Use one gram intravenously in the morning for left leg cellulitis for 14 days. During a concurrent interview and record review on 12/1/2025 at 11:34 a.m. with the Infection Preventionist (IP), Resident 2's Medication Administration Record (MAR), dated 11/2025 was reviewed. The MAR indicated, on 11/7/25 and 11/7/2025, for the 9 p.m. administration time, there were no

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. (continued on next page)

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F 0770 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 failed to obtain complete blood count with differential (CBC with differential - a blood test that measures red blood cells, white blood cells, and platelets used to help diagnose and monitor many conditions, such as infection, inflammation, and to evaluate the effectiveness of a treatment) blood test as ordered by the physician for one of three sampled residents (Resident 2). This deficient practice had the potential to delay necessary care and services for Resident 2.Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 10/28/2025, with diagnoses of cellulitis of lower extremity (a bacterial skin infection, typically presenting as a red, swollen, warm, tender, and painful area on the leg requiring prompt antibiotic treatment to prevent serious complications), malignant neoplasm of colon (a cancerous tumor that develops in the colon lining and can spread to other parts of the body), and heart failure (a condition where the heart can't pump enough blood to meet the body's needs, causing symptoms like fatigue, shortness of breath, and swelling). During a review of Resident 2's Care Plan, initiated on 10/29/2025, the Care Plan indicated Resident 2 was receiving antibiotic therapy for left lower leg cellulitis. The Care Plan interventions indicated to administer medications as ordered. During a review of Resident 2's Minimum Data Set, dated [DATE], the MDS indicated Resident 2 had intact cognitive functioning. The MDS indicated Resident 2 required maximal assistance from the facility staff for personal hygiene, showers, and lower body dressing. During a review of Resident 2's Order Summary Report, the report indicated the following physician's order: - 11/14/2025: Repeat CBC with differential one time only for one day. During a review of Resident 2's Progress Note, dated 11/14/2025 at 14:14pm., the Progress Note indicated facility received a call from the laboratory stating that the blood sample collected for Resident 2 was clotted and could not be used for testing. The Progress Note indicated that the physician was notified, an order to repeat blood test was placed and carried out. During an interview on 12/1/2025 at 11:34 a.m. with the Infection Preventionist (IP), the IP stated when laboratory notified the facility that the collected blood specimen was clotted, she (IP) placed a new order for the blood collection on 11/14/2025. The IP stated the following day was a Saturday (11/15/2025) and the laboratory did not notify the facility that the blood would not be collected during the weekend. The IP stated there was no record to indicate the facility followed up with the laboratory after the weekend on 11/17/2025 and 11/18/2025. The IP stated the repeat CBC with differential was not completed for Resident 2. During an interview on 12/1/2025 at 3:20 p.m. with the Director of Nursing (DON), the DON stated the facility staff should have followed up with the laboratory to make sure Resident 2's order for CBC with differential was completed even if the laboratory did not notify the facility of the delay. The DON stated the blood test results were necessary for Resident 2's physician to assess and evaluate Resident 2's infection progress. The DON stated the failure to follow up with Resident 2's physician order for CBC with differential to make sure the test was completed had the potential to delay treatment for Resident 2 and negatively affect Resident 2's well-being. During a review of the facility-provided policy and procedure (P&P) titled, Laboratory Services, last revised 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. Guidelines: 1. The facility shall provide or obtain laboratory services, to meet the needs of its residents.3. The facility strives to meet the needs of residents with regard to the quality and or/timeliness of providing laboratory services and reporting laboratory results. During a review of the facility-provided policy and procedure (P&P) titled, Infection Prevention and Control Program, last revised on 12/3/2024, the P&P indicated, To ensure the Facility establishes and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements. IV. Surveillance: The Licensed Nurse will notify the attending physician to determine the treatment plan, including, but not limited to, laboratory tests, special precautions, and other interventions.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure the medical records of one of three sampled residents (Resident 2) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to ensure Resident 2's peripheral intravenous catheter (PIV catheter- a thin, flexible plastic tube inserted into a vein to deliver fluids, medications, blood, or nutrition, using a needle for placement that is then removed, leaving just the tube) removal and placement procedures were documented. These deficient practices had the potential for inaccurate medical interventions for Resident 2. Findings: During a review of Resident '2s admission Record, the admission Record indicated the facility admitted Resident 2 on 10/28/2025, with diagnoses including cellulitis of lower extremity (a bacterial skin infection, typically presenting as a red, swollen, warm, tender, and painful area on the leg requiring prompt antibiotic treatment to prevent serious complications), malignant neoplasm of colon (a cancerous tumor that develops in the colon lining and can spread to other parts of the body), and heart failure (a condition where the heart cannot pump enough blood to meet the body's needs, causing symptoms like fatigue, shortness of breath, and swelling). During a review of Resident 2's Admit/Readmit Evaluation form, dated 10/28/2025, the form indicated the facility admitted Resident 2 with right antecubital (AC-the region at the front, or inner crook, of the elbow, forming a triangular depression known as the antecubital fossa) PIV. During a review of Resident 2's Minimum Data Set (MDS - resident assessment tool), dated 11/4/2025, the MDS indicated Resident 2 had intact cognitive functioning. The MDS indicated Resident 2 required maximal assistance from the facility staff for personal hygiene, showers, and lower body dressing. During a review of Resident 2's Order Summary Report, the report indicated the following physician's order: -10/28/2025: IV peripheral active therapy orders: Start IV, change site every 72 hours and as needed for infiltration (occurs when an IV's non-irritating fluid leaks from the vein into the surrounding skin, causing swelling, coolness, pain, or numbness, and can happen if the catheter slips or the vein is fragile) or soiling. May extend beyond 72 hours due to poor venous access. During a concurrent interview and record review on 12/1/2025 at 10:36 a.m. with Licensed Vocational Nuse (LVN) 1, Resident 2's Progress Notes dated 11/6/2025 and 11/12/2025 were reviewed. The Progress Note dated 11/6/2025 indicated Resident 2 did not have a PIV catheter. The Progress Note dated 11/12/2025 indicated Resident 2's left forearm PIV catheter was removed. LVN 1 stated there was no record to indicate when and why Resident 2's right AC PIV was removed. LVN 1 stated there was no record to indicate when Resident 2's left forearm PIV catheter was placed. During an interview on 12/1/2025 at 3:20 p.m. with the Director of Nursing (DON), the DON stated facility staff should have assessed and documented the reason Resident 2's initial PIV catheter was dislodged or removed. The DON stated the facility staff should have documented when Resident 2's new PIV catheter was placed, where it was placed to monitor for possible complications. The DON stated the failure to accurately document PIC catheter removal and placement had the potential for delay of care and monitoring of Resident 2 for potential PIV complications. During a review of the facility-provided policy and procedure (P&P) titled, Catheter Insertion and Care, last revised on 12/3/2024, the P&P indicated, The following information should be recorded in the resident's medical record: 1. The date and time of the procedure. 2. The number of venipuncture attempts (maximum of two). 4. The site of insertion (be specific to name of vein, area of arm).8. The condition of the IV site. 9. Notification of the Physician (if any complications). Reporting: Notify the Supervisor if the resident refuses the procedure or if procedure is unsuccessful. 2. Report other information in accordance with facility policy and professional standards of practice.