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 03/20/2026
NAME OF PROVIDER OR SUPPLIER The Ellison John Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the call light device (also known as a call bell or nurse call button, is a device typically found near a patient's bed or within reach. consists of a button that, when pressed, sends a signal to the nursing station or a centralized system, alerting healthcare providers that assistance is required in the room) was answered timely for two of three sampled residents (Residents 1, and 3).This failure had the potential to result in a delay in care and not receiving assistance timely.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 that included other sequelae of nontraumatic intracerebral hemorrhage (long-term, lasting complications or physical/cognitive deficits remaining after the initial brain bleed has stabilized), diabetes mellitus, (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and generalized weakness.During a review of Resident 1'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 11/6/2025, the H&P indicated Resident 1 was alert and orientated to person, place and time.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 11/11/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required maximum assistance from staff for all Activity of Daily Living (ADL). The MDS indicated Resident 1 was frequently incontinent (unable to control) of bowel and bladder. During an interview on 3/17/2026, at 9:39 a.m., with Family Member 1 (FM 1), FM 1 stated on 11/15/2025, Resident 1 had an episode of vomiting. Resident 1 pressed the call light multiple times to request assistance, but no one had responded after 30 to 60 minutes.b. During a review of Resident 3?s admission Record, the admission Record indicated the facility admitted Resident 3 on 2/27/2026, with diagnoses that included right femur (thigh bone) neck fracture (break in the bone), generalized muscle weakness and dysphagia (difficulty swallowing).During a review of Resident 3's history and physical dated 3/1/2026, the H&P indicated Resident 3 had the capacity to understand and make decisions.During a review of Resident 3's MDS, dated [DATE], the MDS indicated cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 3 required maximum assistance from staff for toileting and showering. The MDS indicated Resident 3 was frequently incontinent with bowel and bladder function.During an interview on 3/20/2026, at 8:57 a.m., with Resident 3, Resident 3 stated on the evening shift, the staff sometimes take a while to respond to the call light for incontinent care. Resident 3 stated if no one answers the call light he (Resident 3) calls FM 3 to ask for assistance.During an interview on 3/20/2026, at 1 p.m., with FM 3, FM 3 stated it is mostly on the evening shift that Resident 3 calls her (FM 3) when no one answers when he (Resident 3) presses the call light to be changed. FM 3 stated she (FM 3) then calls the facility to ask someone to change Resident 3's incontinent brief. FM 3 stated she (FM 3) does not want Resident 3 to develop skin breakdown.During an interview on 3/20/2026 at 1:56 p.m., with the DON, the DON stated delay in responding to a call light can delay providing a residents needs. The DON stated delay in responding to Resident 1 and Resident 3's call light can possibly cause skin breakdown such as pressure ulcers (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

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	03/20/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(PU- (localized damage to the skin and/or underlying tissue usually over a bony prominence).During a review of facility's policy and procedure (P&P), titled, Resident Call System, dated 1/2025. The P&P indicated, The facility is adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from the residents' bedside, floor, or toileting facilities.

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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 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. Based on interview and record review, the facility failed to notify one of three sampled residents (Resident 1) Family Member 1 (FM 1), who had Power of Attorney (POA-is a legal document that authorizes a chosen person to act on behalf of another person regarding financial, legal, or medical affairs. It is used to ensure decisions can be made if the principal is unable to do so due to illness, incapacity, or absence) of Resident 1's Coronavirus (COVID-19, highly contagious respiratory disease is thought to spread from person to person through droplets released when an infected person coughs, sneezes or talks. It may also spread by touching the surface with the virus on it and then touching one's mouth, nose, or eyes) result.This failure violated Resident 1's and FM 1's right to be informed and had the potential to increase Resident 1's and FM 1's level of anxiety (an intense, persistent, and often overwhelming feeling of worry, dread, or unease).Findings:During a review of Resident 1?s admission record, the admission record indicated the facility admitted Resident 1 on 11/4/2025, with diagnoses that included other sequelae of nontraumatic intracerebral hemorrhage (long-term, lasting complications or physical/cognitive deficits remaining after the initial brain bleed has stabilized), diabetes mellitus, (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and generalized weakness. The admission Record indicated Family Member 1 (FM 1) and FM 2 were Resident 1's POA.During a review of Resident 1'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 11/6/2025, the H&P indicated Resident 1 had glaucoma (an eye condition that damages the optic nerve. This damage can lead to vision loss or blindness) with poor vision. The H&P indicated Resident 1 was alert and oriented to person, place and time.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 11/11/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS further indicated Resident 1 required maximum assistance from staff for all ADL.During a review of Resident 1's Change of Condition (COC- a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated 11/15/2025, the COC indicated on 11/15/2025, at 11:35 a.m., Licensed Vocational Nurse 2 (LVN 2) reported to Registered Nurse 1 (RN 1) that Resident 1 had vomited. The COC indicated RN 1 notified FM 1 and FM 1 requested for Resident 1 to be tested for COVID-19.During an interview on 3/17/2026, at 9:39 a.m., with FM 1, FM 1 stated on 11/15/2025, she (FM 1) had requested to test Resident 1 for COVID-19. FM 1 stated she (FM 1) was not informed of the test result.During a concurrent interview and record review on 3/20/2026, at 10:51 a.m. with LVN 1, Resident 1's COC, dated 11/15/2025, and Progress Notes, dated 11/15/2025, were reviewed. The COC indicated FM 1 requested Resident 1 be tested for COVID-19. LVN 1 stated Resident 1's COVID-19 test result indicated Resident 1 did not have COVID-19. LVN 1 stated there was no documentation that FM 1 was notified of the COVID-19 test result. LVN 1 stated it is important to notify FM 1 of the COVID-19 test result since FM 1 had requested the test.During an interview on 3/20/2026, at 11:49 a.m., with RN 1, RN 1 stated she (RN 1) tested Resident 1 for COVID-19 on 11/15/2025 and the test was negative for COVID-19. RN 1 stated there was no documentary evidence in Resident 1's medical record that FM 1 was informed of the COVID-19 test result. RN 1 stated she (RN 1) should have documented, because if it's not documented it did not happen. RN 1 stated Resident 1's medical record was incomplete.During an interview on 3/20/2026, at 1:56 p.m., with the Director of Nursing (DON), the DON stated RN 1 should have documented in Resident 1's medical record that she (RN 1) had notified FM 1 of the COVID-19 test result. The DON stated it is important to document accurate and complete medical records. The DON stated it is Resident 1 and FM 1's rights to be informed.During a review of facility's policy and procedure (P&P), titled, Notification of Changes, dated 1/2026, the policy and procedure indicated, The Situation Background Assessment (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Recommendation (SBAR) charting form remains in the medical record and serves as a data gathering tool and documentation of communication with the physician and resident representative, as applicable, regarding resident status. Use the Progress Note section for other information necessary that is NOT already included on the form.

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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 - Some	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 interview and record review, the facility failed to develop and implement a person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one of three sampled residents (Resident 1) by failing to:1. Develop a care plan to address Resident 1's need for maximum assistance from staff for eating as indicated in Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 11/11/1025. 2. Implement the care plan regarding Resident 1's risk of constipation (when your bowel movements become less frequent and stools become difficult to pass).3. Develop a care plan to address Resident 1's refusal of insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) glargine (medication that is a long-acting type of insulin that works slowly, over about 24 hours). These failures had the potential to result in a delay in the delivery of necessary care and services and had the potential to result in weight loss, constipation and hyperglycemia (elevated blood sugar).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 that included other sequelae of nontraumatic intracerebral hemorrhage (long-term, lasting complications or physical/cognitive deficits remaining after the initial brain bleed has stabilized), diabetes mellitus, (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and generalized weakness. The admission record indicated Family Member 1 (FM 1) and FM 2 were Resident 1's power of attorney (POA- is a legal document that authorizes a chosen person to act on behalf of another person regarding financial, legal, or medical affairs. It is used to ensure decisions can be made if the principal is unable to do so due to illness, incapacity, or absence).During a review of Resident 1's Order Summary Report, dated 11/4/2025, the Order Summary Report indicated Resident 1 was on a Controlled Carbohydrate Diet (diet regulates the timing and amount of carbohydrate intake throughout the day to prevent blood sugar spikes), with no added salt, regular texture with thin liquids consistency.During a review of Resident 1'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 11/6/2025, the H&P indicated Resident 1 had glaucoma (an eye condition that damages the optic nerve. This damage can lead to vision loss or blindness) with poor vision. The H&P indicated Resident 1 was alert and oriented to person, place and time.During a review of Resident 1's Care Plan, dated 11/10/2025, the Care Plan for activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) indicated Resident 1 required assistance with eating. The Care Plan indicated no intervention of what kind of assistance would be provided to Resident 1.During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required maximum assistance from staff for all ADL's. The MDS indicated Resident 1 was frequently incontinent (unable to control) of bowel and bladder functions.During an interview on 3/17/2026, at 9:39 a.m., with FM 1, FM 1 stated Resident 1 was visually impaired (having restricted vision, or no usable vision; partially or completely blind), and the facility would deliver her (Resident 1) food tray, inform her (Resident 1) of what was on the tray and leave her (Resident 1) to eat on her (Resident 1) own. FM 1 stated the food that she (Resident 1) was informed to be on the tray were not on her (Resident 1) the tray.During a concurrent interview and record review on 3/20/2026, at 10:51 a.m. with Licensed Vocational Nurse 1 (LVN 1), Resident 1's admission record, and MDS, dated [DATE], were reviewed. LVN 1 stated Resident 1 had a diagnosis of glaucoma and the MDS indicated Resident 1 required maximum assistance with eating.During an interview on 3/20/2026, at 1:03 p.m., with the MDS Nurse (MDSN), Resident 1's MDS, dated [DATE], and Care Plan for Glaucoma, dated 11/4/2025 and the Care Plan on the ADL, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 11/10/2025, were reviewed. The Care Plan titled glaucoma due to impaired visual functioning indicated an intervention to encourage independence with ADLs, and assist as needed. The MDSN stated Resident 1 had impaired vision and required maximum assistance from staff for eating. The MDSN stated the Care Plan for ADL's indicated no intervention of what kind of assistance would be provided to Resident 1 while eating. The MDSN stated the Care Plan should have indicated that Resident 1 required maximum assistance with eating from staff. The MDSN stated the interventions included in Resident 1's Care Plan are important to plan the type of care that will be provided to Resident 1.During an interview on 3/202/2026, at 1:56 p.m., with the Director of Nursing (DON), the DON stated the care plan for glaucoma and ADL's should have indicated an intervention that Resident 1 required maximum assistance for eating from staff. The DON stated the care plan for Resident 1 should be individualized to provide specific care and assistance to Resident 1 to prevent potential weight loss.b. During a review of Resident 1's Order Summary Report, dated 11/4/2025, the following orders indicated to administer the following medications as ordered;1. Bisacodyl (medication used to treat constipation) rectal suppository (a medication designed to be inserted into the anus) 10 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), insert one suppository rectally every 12 hours as needed for constipation.2. Milk of magnesia (MOM- medication that relieves constipation in 30 minutes to 6 hours and treats heartburn [a painful burning sensation in the chest or throat caused by stomach acid flowing back into the esophagus]/indigestion [discomfort after eating]) suspension (a liquid mixture where solid drug particles are dispersed throughout a liquid but not dissolved in it) 400 mg/5 milliliter (ml-unit of measurement), give 30 ml by mouth every 24 hours as needed for constipation if no bowel movement in three days.During a review of Resident 1's Point of Care (POC)-Response History for Bowel Movements, dated 11/4/2025, to 11/17/2025, the POC-Response History for Bowel Movements indicated Resident 1 did not have bowel movements on 11/7/2025, 11/8/2025, 11/9/2025, 11/11/2025 and 11/15/2025.During a review of Resident 1's Care Plan, dated 11/4/2025, the Care Plan titled "at risk for constipation" indicated an intervention to administer medications as ordered, monitor for the effectiveness/side effects (unwanted symptoms caused by medical treatment) and notify the physician as needed.During a review of Resident 1's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 11/2025, the MAR indicated the nurses did not administer bisacodyl and MOM to Resident 1 on 11/7/2025, 11/8/2025, 11/9/2025, 11/11/2025 and 11/15/2025.During a concurrent interview and record review on 3/20/2026, at 10:51 a.m. with LVN 1, Resident 1's Care Plan for constipation, dated 11/4/2025, POC-Response History for Bowel Movements, dated 11/4/2025 to 11/17/2025, and MAR, dated 11/2025, were reviewed. LVN 1 stated Resident 1 did not have bowel movements on 11/7/2025, 11/8/2025, 11/9/2025, 11/11/2025 and 11/15/2025. LVN 1 stated the nurses did not administer bisacodyl to Resident 1 on 11/7/2025, 11/8/2025, 11/9/2025, 11/11/2025 and 11/15/2025. LVN 1 stated the nurses did not administer MOM to Resident 1 on 11/9/2025 (third day of having no bowel movement). LVN 1 stated the nurses should have administered the bisacodyl as ordered by the physician and as indicated in Resident 1's Care Plan to prevent constipation. LVN 1 stated the nurses should have administered the MOM on 11/9/2025, as ordered by the physician and as indicated in Resident 1's Care Plan to prevent constipation and impaction. LVN 1 stated Resident 1's care plan was not followed. LVN 1 stated the Care Plan is developed and implemented to ensure each residents' problems have interventions. LVN 1 stated if care plan was not implemented Resident 1 could have pain, nausea and vomiting from constipation.During a concurrent interview and record review on 3/20/2026, at 1:03 p.m., with the MDSN, Resident 1's Care Plan, dated 11/4/2025, was reviewed. The MDSN stated Resident 1's Care Plan for at risk for constipation indicated an intervention to administer medication as ordered.During an interview on 3/20/2026, at 1:56 p.m., with the DON, the DON stated the nurses should have followed the care plan to prevent constipation by administering the medication ordered by the physician. The DON stated if medication was not administered and the care plan not followed, Resident 1 could have developed further constipation (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that could potentially cause abdominal discomfort and abdominal pain.c. During a review of Resident 1's Order Summary Report, dated 11/4/2025, the Order Summary Report indicated, an order for insulin glargine subcutaneous (under the skin) solution 100 units per ml, inject 20 units subcutaneously one time a day for DM, rotate injection sites, hold (temporarily stop) for blood sugar less than 100 mg per deciliter (dl-unit of measurement).During a review of Resident 1's MAR, dated 11/2025, the MAR indicated on 11/15/2025, and 11/16/2025, Resident 1 refused glargine.During a concurrent interview, and record review on 3/20/2026, at 10:51 a.m. with LVN 1, Resident 1's, Order Summary Report, dated 11/4/2025, and MAR, dated 11/2025, were reviewed. LVN 1 stated the MAR dated 11/15/2025, and 11/16/2025, indicated at 9 a.m., Resident 1 refused glargine. LVN 1 stated a care plan should be developed regarding Resident 1's refusal of glargine.During a concurrent interview, and record review on 3/20/2026, at 1:03 p.m., with the MDSN, Resident 1's Care Plans were reviewed. The MDSN stated there was no care plan developed for Resident 1's refusal of insulin glargine.During an interview on 3/20/2026, at 1:56 p.m., with the DON, the DON stated there was no care plan developed for Resident 1's refusal of insulin glargine. The DON stated Resident 1's refusal of insulin should have been care planned to prevent further risk for hyperglycemia.During a review of facility's policy and procedure (P&P) titled, Develop-Implement Comprehensive Care Plans, dated 1/2026, was reviewed. The P&P indicated, The facility develops a person-centered comprehensive care plan that is 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.1. The comprehensive care plan describes: a. The services that are to be furnished are to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. b. Any services that are not provided due to the resident's exercise of right to refuse treatment.2. Care plans must be person-centered and reflect the residents' goals for admission and desired outcomes, interventions that reflect the resident's cultural preferences, values, and practices.5. Facility staff shall work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices, and goals during their stay at the facility.6. The facility establishes, documents, and implements the care and services provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life.Refusal of Treatment1. A resident may choose to refuse services or treatments that staff believe may be indicated to assist the resident in reaching his or her highest practicable level of well-being or to keep the resident safe.2. When a resident's choice to decline care or treatment poses a risk to the resident's health or safety, the comprehensive care plan must. a. Identify the care or service being declined. b. The risk the decline poses to the resident. c. Efforts by the interdisciplinary team (IDT- a coordinated group of experts from several different fields who work together) to educate the resident and the representative, as appropriate; and d. Attempts to find alternative means to address the identified risk.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of three sampled residents (Residents 1) by failing to: 1. Follow the physician's order to administer bisacodyl (medication used to treat constipation [when bowel movements become difficult, infrequent or painful, often resulting in hard, dry stool]) and milk of magnesia (MOM-medication that relieves constipation in 30 minutes to six hours) when Resident 1 had no bowel movements on 11/7/2025, 11/8/2025, 11/9/2025, 11/11/2025, and 11/15/2025.2. Ensure bisacodyl administration to Resident 1 on 11/10/2025, indicated the dosage, time of administration and who administered the medication.3. Follow the physician orders to administer glargine insulin (a long-acting insulin used to lower blood sugar for 24 hours) on 1/16/2025.4. Ensure administration of metoprolol (medication used to treat high blood pressure [HTN], metformin (medication used to treat high blood sugar), and enoxaparin sodium (medication used to prevent blood clot) as per its policy for medication administration.These failures had the potential to result in medication errors and could cause Resident 1 to have constipation, HTN, hyperglycemia (elevated blood sugar) and had the potential to result in blood clots (clump of blood cells and proteins that forms when blood changes from liquid to solid).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 that included other sequelae of nontraumatic intracerebral hemorrhage (long-term, lasting complications or physical/cognitive deficits remaining after the initial brain bleed has stabilized), diabetes mellitus, (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and generalized weakness.During a review of Resident 1's Order Summary Report, dated 11/4/2025, the Order Summary Report indicated the following orders:1. Bisacodyl rectal suppository (a medication designed to be inserted into the anus) 10 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), insert one suppository rectally every 12 hours as needed for constipation.2. MOM suspension (a liquid mixture where solid drug particles are dispersed throughout a liquid but not dissolved in it) 400 mg/5 milliliter (ml-unit of measurement), give 30 ml by mouth every 24 hours as needed for constipation if no bowel movement in three days.During a review of Resident 1'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 11/6/2025, the H&P indicated Resident 1 was alert and orientated to person, place and time.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 11/11/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required maximum assistance from staff for all ADL's. The MDS indicated Resident 1 was frequently incontinent (unable to control) of bowel and bladder functions.During a review of Resident 1's Point of Care (POC)-Response History for Bowel Movements, dated 11/4/2025, to 11/17/2025, the POC-Response History for Bowel Movements indicated Resident 1 did not have bowel movements on 11/7/2025, 11/8/2025, 11/9/2025, 11/11/2025 and 11/15/2025.During a review of Resident 1's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 11/2025, the MAR indicated the nurses did not administer bisacodyl and MOM to Resident 1 on 11/7/2025, 11/8/2025, 11/9/2025, 11/11/2025, and 11/15/2025.During a concurrent interview, and record review on 3/20/2026, at 10:51 a.m. with Licensed Vocational Nurse 1 (LVN 1), Resident 1's POC-Response History for Bowel Movements, dated 11/4/2025, to 11/17/2025, and MAR, dated 11/2025, were reviewed. LVN 1 stated Resident 1 did not have bowel movements on 11/7/2025, 11/8/2025, 11/9/2025, 11/11/2025, and 11/15/2025. LVN 1 stated the nurses did not administer bisacodyl to Resident 1 on 11/7/2025, 11/8/2025, 11/9/2025, 11/11/2025, and 11/15/2025. LVN 1 (continued on next page)

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 03/20/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the nurses did not administer MOM to Resident 1 on 11/9/2025, (third day of not having a bowel movement). LVN 1 stated the nurses should have administered the bisacodyl as ordered by the physician. LVN 1 stated the nurses should have administered the MOM on 11/9/2025, as ordered by the physician to prevent constipation and impaction (a severe form of constipation where dry, hard stool becomes stuck in the rectum or colon, often requiring medical intervention). LVN 1 stated Resident 1's physician order was not followed.During an interview on 3/20/2026, at 1:56 p.m. with the Director of Nursing (DON), the DON stated nurses should have offered and administered bisacodyl and MOM as per the physician order, when Resident 1 had no bowel movement in a day. The DON stated if Resident 1 refused the medications, nurses should have documented. The DON stated Resident 1 could developed constipation, discomfort and pain from not receiving the bisacodyl and MOM.During a review of facility's policy and procedure (P&P), titled, Administering Medications, dated 3/2023, last reviewed on 12/10/2025, the P&P indicated, To provide employees with guidelines for the safe and timely administration of medications per physician order. 3. Medications must be administered in accordance with the orders.During a review of facility's P&P, titled, Preparation and General Guidelines-Medication Administration, dated 10/2012, last reviewed on 12/10/2025, the P&P indicated, Medications are administered in accordance with written orders of the prescriber.b. During a review of Resident 1's Change of Condition (COC), dated 11/10/2025, timed at 12 noon, the COC indicated bisacodyl was administered to Resident 1's frontal private area. During a review of Resident 1's MAR, dated 11/2025, the MAR indicated Licensed Vocational Nurse 4 (LVN 4) administered bisacodyl on 11/13/2025, at 6:31 a.m. the MAR did not indicate administration of bisacodyl on 11/10/2025.During a concurrent interview and record review on 3/20/2026, at 1:56 p.m., with the DON, Resident 1's COC, dated 11/10/2025, was reviewed. The DON stated on 11/10/2025, LVN 5 administered the bisacodyl to Resident 1 but did not document administration in Resident 1's MAR. The DON stated the Assistant Director of Nursing (ADON), documented the administration because LVN 5 did not document. The DON stated LVN 5 should have documented bisacodyl administration because she (LVN 5) administered the medication. The DON stated if medication was given and not documented, it could possibly cause medication error.During a review of facility's P&P, titled, Preparation and General Guidelines-Medication Administration, dated 10/2012, and last reviewed on 12/10/2025, the P&P indicated, Administration: . The person who prepares the dose of administration is the person who administers the dose.Documentation:1. The individual who administers the medication dose records the administration on the residents MAR directly after the medication is given. At the end of the medication pass, the person administering the medication reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off duty without first recording the administration of any medications.5. When as needed (PRN) medications are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration (if other than oral), and, if applicable, the injection (use of a syringe and needle to push fluids or drugs into the body) site. b. Complaints or symptoms for which the medication was given. c. Results achieved from giving the dose and the time results were noted. d. Signature or initials of person recording administration and signature or initials of person recording effects, if different from the person administering the medication.c. During a review of Resident 1's Order Summary Report, dated 11/4/2025, the Order Summary Report indicated insulin glargine subcutaneous (under the skin) solution 100 unit/ml, inject 20 units subcutaneously one time a day for DM, rotate injection sites. Hold (temporarily stop) blood sugar less than 100 mg/ deciliter (dl-unit of measurement).During a review of Resident 1's MAR, dated 11/2025, the MAR indicated glargine was not administered on the following dates:1. On 11/12/2025, Resident 1's blood sugar was 105 mg/dl.2. on 11/16/2025, Resident 1's blood sugar was 145 mg/dl.During a concurrent interview, and record review on 3/20/2026, at 10:51 a.m., with LVN 1, Resident 1's Order Summary Report, dated 11/4/2025, and the MAR, dated 11/2025, were reviewed. LVN 1 stated on 11/12/2025, Resident 1's blood sugar was 105 mg/dl and glargine should have been (continued on next page)

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 03/20/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered. LVN 1 stated on 11/16/2025, Resident 1's blood sugar was 145 mg/dl and glargine should have been administered. LVN 1 stated if Resident 1 had refused the glargine, nurses should have documented in Resident 1's Progress Notes the reason why it was refused. LVN 1 stated Resident 1's blood sugar can increase because glargine was not administered.During an interview on 3/20/2026, at 1:56 p.m., with the DON, the DON stated nurses should have administered glargine to Resident 1 on 11/12/2025, and 11/16/2025, as per the physician's order. The DON stated Resident 1's blood sugar had the tendency to increase because insulin was not administered. The DON stated Resident 1 could have uncontrolled elevated blood sugar.During a review of facility's P&P, titled, Insulin Administration, dated 2/2024, and last reviewed on 12/10/2025, the P&P indicated, To provide licensed staff with guidelines for the safe administration of insulin. 3. The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order.Procedure.2. Monitor blood glucose per physician order.8. Check the order for the amount of insulin to be administered.Documentation.l. The resident's blood glucose result, as ordered.2. The site of the injection site.3. The amount of sliding scale insulin as indicated; and4. Any indication the resident did not tolerate the procedure well.d. During a review of Resident 1's Order Summary Report, dated 11/4/2025, the Order Summary Report indicated the following orders: 1. Enoxaparin sodium injection solution 300 mg/3 ml, inject 0.3 ml subcutaneously every 12 hours for deep vein thrombosis (DVT-a serious blood clot that forms in a vein deep inside the body, usually in the leg or calf) prophylaxis (action taken to prevent disease). 2. Metformin hydrochloride oral tablet 1000 mg, give one tablet by mouth two times a day for DM with meals.3. Metoprolol tartrate oral tablet 25 mg, give one tablet by mouth two times a day for HTN, give with meals.During a review of Resident 1's MAR, dated 11/2025, the MAR indicated the following:1. Enoxaparin sodium was scheduled at 9 a.m., and 9 p.m.2. Metformin hydrochloride was scheduled at 9 a.m., and 5 p.m.3. Metoprolol tartrate was scheduled at 9 a.m., and 5 p.m.During a review of Resident 1's Medication Admin Audit Report, dated 11/12/2025, the Medication Admin Audit Report indicated the following:1. Enoxaparin sodium was scheduled at 9 a.m., LVN 2 administered at 11:05 a.m.2. Metformin hydrochloride scheduled at 9 a.m., LVN 2 administered at 11:04 a.m.3. Metoprolol tartrate scheduled at 9 a.m., LVN 2 administered at 11:05 a.m.During a review of Resident 1's Medication Admin Audit Report, dated 11/14/2025, the Medication Admin Audit Report indicated the following:1. Enoxaparin sodium was scheduled at 9 a.m., LVN 2 administered at 10:57 a.m.2. Metformin hydrochloride was scheduled at 9 a.m., LVN 2 administered at 10:59 a.m.3. Metoprolol tartrate was scheduled at 9 a.m., LVN 2 administered at 11:04 a.m.During a concurrent interview, and record review on 3/20/2026, at 10:51 a.m., with LVN 1, Resident 1's Physician Orders, dated 11/4/2025, Medication Admin Audit Report, dated 11/12/2025, and 11/14/2025, were reviewed. LVN 1 stated medications should be administered one hour before and one hour after the scheduled time. LVN 1 stated if enoxaparin is given late and too close to the next scheduled time of administration it could potentially cause bleeding. LVN 1 stated giving metformin late can increase Resident 1's blood sugar. LVN 1 stated giving metoprolol later than the scheduled time can increase Resident 1's blood pressure.During an interview on 3/20/2026, at 1:56 p.m., with the DON, the DON stated the nurses should administer the medication within one hour before and one hour after scheduled time. The DON stated giving enoxaparin late can possibly cause a blood clot. The DON stated giving metformin late can increase Resident 1's blood sugar. The DON stated giving metoprolol late can cause Resident 1's blood pressure to increase.During a review of facility's P&P, titled, Preparation and General Guidelines-Medication Administration, dated 10/2012, and last reviewed on 12/10/2025, the P&P indicated, 5. Medications are administered without unnecessary interruptions. 11) Medications are administered within 60 minutes of scheduled time, except before, with or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility.

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 03/20/2026
NAME OF PROVIDER OR SUPPLIER The Ellison John Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 maintain accurate and complete medical record for one of three sampled residents (Resident 1) by failing to complete Resident 1's Change in Condition (COC a-document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated 11/10/2025.This failure had the potential to cause confusion in care and causing the medical record to contain inaccurate documentation.Findings:During a review of Resident 1?s admission record, the admission record indicated the facility admitted Resident 1 on 11/4/2025, with diagnoses that included other sequelae of nontraumatic intracerebral hemorrhage (long-term, lasting complications or physical/cognitive deficits remaining after the initial brain bleed has stabilized), diabetes mellitus, (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and generalized weakness.During a review of Resident 1'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 11/6/2025, the H&P indicated Resident 1 was alert and orientated to person, place and time.During a review of Resident 1's Change of Condition (COC- a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated 11/10/2025, the COC indicated on 11/10/2025, at 12 noon, bisacodyl (medication used to treat constipation) suppository (a medication designed to be inserted into the anus) was inserted in Resident 1's frontal private area. The COC indicated the date of the last bowel movement was blank.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 11/11/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required maximum assistance from staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During an interview on 3/17/2026, at 9:39 a.m., with Family Member 1 (FM 1), FM 1 stated on 11/10/2025, a suppository was inserted in the wrong area.During a concurrent interview, and record review on 3/20/2026, at 9:54 a.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 1's COC, dated 11/10/2025, was reviewed. LVN 1 stated Resident 1's COC did not indicate the date of the last bowel movement to justify the reason for the insertion of bisacodyl. LVN 1 stated it is important to have an accurate medical record to make sure appropriate treatment is provided.During an interview on 3/20/2026, at 1:56 p.m. with the Director of Nursing (DON), the DON stated LVN 3 should have filled out Resident 1's COC to ensure a complete and accurate medical record to prevent confusion in care.During a review of facility's policy and procedure (P&P), titled, Documentation Policy, dated 3/2023, and last reviewed on 12/10/2025, the P&P indicated, It is the policy of this facility to document relevant findings in the clinical record.Situation Background Assessment Recommendation (SBAR) Charting FormThe SBAR Charting Form is designed to make the charting process more efficient. This is the actual entry of a resident change in condition and becomes part of the communication record regarding resident status and notifications.This form is to be used for a resident change in condition, deviation or variance from procedure, deviation or variance from policy, or any accident or incident involving the resident.To use the form, complete the checklist Before Calling the Medical Doctor/Nurse Practitioner/Physician AssistantComplete the Situation, Background, Appearance and Request sections completely. If information is not applicable then chart NA or N/A.