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	03/25/2026

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

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 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. Based on interview and record review, the facility failed to follow professional standards of nursing practice for one of three sampled residents (Resident 1 and Resident 2) by failing to:1. Ensure Licensed Vocational Nurse (LVN) 1 created Resident 1's Change of Condition (COC) Evaluation form. Resident 1 was reported wandering in another resident's room on 3/13/2026. Resident 1's Attending physician (MD) 1 and Family Member (FM) 1 were not notified. 2. Ensure licensed nurses appropriately assessed and monitored Resident 1's medical status following the resident's COC on 3/13/2026 related to the resident's new wandering behavior. These deficient practices had the potential to result in the failure to identify continued or worsening clinical deterioration, thereby placing Resident 1 at risk for adverse health outcomes and compromised safety. During a review of Resident 1's undated admission Record, the admission Record indicated on the facility admitted the resident 12/22/2025 and readmitted the resident on 2/27/2026 with diagnoses including type 2 diabetes mellitus (a disease that occurs when the blood sugar level is too high), chronic obstructive pulmonary disease (COPD - a progressive, long-term disease that makes it hard to breathe due to damaged, inflamed, and narrowed airways), and cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). During a review of Resident 1's Wandering/Elopement Risk Evaluation, dated 2/18/2026, the Wandering/Elopement Risk Evaluation indicated the resident was not at risk for wandering and elopement. 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 2/19/2026, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 2/25/2026, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was intact. During an interview on 3/25/2026 at 1:39 p.m. with Resident 2, who was cognitively intact, Resident 2 stated Resident 1 went inside her room three times on 3/13/2026. Resident 2 stated Resident 3, who was also cognitively intact, reported the incidents to a licensed nurse. Resident 2 stated Resident 1 continued going in her room on 3/14/2026 and 3/15/2026. During an interview on 3/25/2026 at 3:45 p.m. with LVN 1, LVN 1 stated Resident 3 reported to her that Resident 1 was inside Resident 2 and 3's room. LVN 1 stated Resident 1's wandering behavior was new to the resident. LVN 1 stated that she reported the incident to the licensed nurse in charge of Resident 1 at the 11 p.m. to 7 a.m. shift. During an interview on 3/25/2026 at 1:01 p.m. and a concurrent record review of Resident 1's medical records, reviewed with LVN 3, LVN 3 stated Resident 1's wandering behavior was a change in the resident's condition. LVN 3 stated there was no documented COC for Resident 1 on 3/13/2026. LVN 3 further stated there was no documented evidence that MD 1 and FM 1 were notified about Resident 1's wandering behavior on 3/13/2026. LVN 3 stated Resident 1 should be monitored every shift for 72 hours. RN 1 stated Resident 1's Progress Notes indicated there was no documented evidence that the resident was monitored on the following shifts:a. On 3/14/2026 (7 a.m. to 3 p.m. shift and 3 p.m. to 11 p.m. shift),b. On 3/15/2026 (7 a.m. to 3 p.m. shift, 3 p.m. to 11 p.m. shift, and 11 p.m. to 7 a.m. shift), andc. On 3/16/2026 (7 a.m. to 3 p.m. shift). LVN 3 stated that care not documented was considered (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: 555904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not provided. LVN 3 further stated that failure to document Resident 1's change of condition and the monitoring provided for the resident's wandering behavior could put Resident 1 and other residents' safety at risk. During an interview on 3/25/2026 at 2:05 p.m. with the Director of Nursing (DON), the DON stated Resident 1's wandering behavior was new to the resident and should be documented as a change of condition. The DON stated Resident 1 should be monitored every shift for at least 72 hours following COC. The DON stated there was no confirmed documented evidence of monitoring on the identified shifts. The DON stated failure to monitor Resident 1 every shift after a COC could result in missed signs of aggression, altercation with other residents, and compromised resident safety. The DON acknowledged and stated the facility failed to identify, document, and monitor Resident 1's change of condition. During a review of the facility's policy and procedure (PnP) titled, Notification of Changes, last reviewed on 12/10/2025, the PnP indicated the facility shall immediately. consult with the resident's physician and notify.the resident representative(s) when there is. a significant change in the resident's physical, mental, or psychosocial status. The PnP indicated the SBAR (Situation-Background-Assessment-Recommendation) charting form is designed to make the charting process more efficient and serves as the actual documentation of a resident change in condition. The PnP indicated the licensed nurse acting within his/her scope of practice will collect patient data and complete the Situation, Background, Appearance, and Request sections that are applicable. During a review of the facility's PnP titled, Documentation Policy, last reviewed on 12/10/2025, the PnP indicated it is the policy of this facility to document relevant findings in the clinical record. The PNP indicated 72-hour charting shall be initiated at the following times. a significant change in physical, mental, or psychosocial status of the resident (progression, regression, new problems).