

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 06/10/2026
NAME OF PROVIDER OR SUPPLIER The Ellison John Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 43830 10th Street West Lancaster, CA 93534	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, facility failed to ensure an accurate assessment was conducted for one of three sampled residents (Resident 1) when Resident 1 did not have an accurate assessment of the skin conditions that was conducted on 5/25/2026. This deficient practice has the potential to result in Resident 1's delay in necessary care and treatment. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 5/15/2026 with diagnoses including hemiplegia (paralysis of one entire side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and muscle weakness. During a review of Resident 1's Admit/Readmit Evaluation, dated 5/15/2026, the Admit/Readmit Evaluation did not indicate that Resident 1 had a deep tissue injury (DTI - a non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue caused by prolonged pressure or friction where the true depth and severity of the wound cannot be seen). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/25/2026, the MDS indicated Resident 1's cognitive skills (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) for daily decision making was severely impaired. The MDS indicated Resident 1 was dependent on facility staff on rolling to the left and right sides. The MDS indicated sitting to lying and lying to sitting actions were not attempted due to medical conditions or safety concerns. The Skin Conditions section of the MDS indicated Resident 1 had one unstageable DTI that was present on admission. During a concurrent interview and record review on 6/9/2026 at 2:37 p.m. with MDS Nurse (MDSN) 1, Resident 1's Change of Condition form, dated 5/25/2026, was reviewed. MDSN 1 stated Resident 1's DTI developed at the facility. MDSN 1 stated Resident 1's MDS assessment on skin condition was inaccurate. MDSN 1 stated that failure to accurately document Resident 1's skin condition in the MDS could negatively affect the resident's plan of care. During an interview on 6/9/2026 at 3:57 p.m. with the Director of Nursing (DON), the DON stated Resident 1's MDS was one of the tools used to the Resident 1's care plan. The DON stated failure to accurately assess and document Resident 1's skin condition in the MDS could result in an inaccurate resident care plan. The DON acknowledged and stated the facility failed to accurately document Resident 1's skin conditions on the MDS assessment following the resident's admission. During a review of the facility's policy and procedure (PnP) titled, Accuracy of Assessments, last reviewed on 12/10/2025, the PnP indicated the MDS assessment must accurately reflect the residents' status. The PnP indicated the assessment must represent an accurate picture of the resident's status during the observation period of the MDS. The PnP further indicated the initial comprehensive assessment provides starting point data for ongoing assessment of resident progress.		

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow professional standards of nursing practice for three of three sampled residents (Resident 5, Resident 6, and Resident 7) by failing to: 1. Ensure licensed nurses appropriately assessed and monitored Resident 5's medical status following the resident's Change of Condition (COC - any sudden or major shift in a person's physical, mental, or behavioral health compared to their normal baseline) on 6/7/2026 related to the alleged physical aggression with Resident 6.2. Ensure licensed nurses appropriately assessed and monitored Resident 6's medical status following the resident's Change of Condition (COC) on 6/7/2026 related to the alleged physical aggression with Resident 5.3. Ensure licensed nurses appropriately assessed Resident 7's mental status (the brain's ability to clearly think) following the resident's admission on [DATE]. These deficient practices had the potential to result in the failure to identify continued or worsening clinical deterioration thereby placing Resident 5, 6, and 7 at risk for adverse health outcomes and compromised safety. Findings: 1. During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 5/19/2026 with diagnoses including metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), muscle weakness, and depression (serious mood disorder characterized by persistent, intense, and long-lasting feeling of sadness or a loss of interest in activities). During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 5/26/2026, the MDS indicated Resident 5's cognitive skills (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) for daily decision making was severely impaired. During a review of Resident 5's COC form, dated 6/7/2026, the COC form indicated on 6/7/2026 at 11:13 a.m., Resident 5 was heard yelling in the station A hallway. The COC form indicated that Resident 5 allegedly reported getting hit on the arm by Resident 6. During a concurrent interview and record review on 6/10/2026 at 4:30 p.m. with the Assistant Director of Nursing (ADON), Resident 5's Progress Notes, dated 6/7/2026 to 6/10/2026 were reviewed. The ADON stated residents should be monitored every shift for 72 hours after a change of condition. The ADON stated Resident 5's Progress Notes indicated there was no documented evidence that the resident was monitored on the following shifts: a. On 6/7/2026 (11 p.m. to 7 a.m. shift), b. On 6/8/2026 (3 p.m. to 11 p.m. shift and 11 p.m. to 7 a.m. shift), and c. On 6/9/2026 (11 p.m. to 7 a.m. shift). The ADON stated care not documented was considered not provided. The ADON stated that failure to document Resident 5's medical status monitoring following a change of condition could put Resident 5's safety at risk. 2. During a review of Resident 6's admission Record, the admission Record indicated the facility admitted the resident on 1/6/2022 with diagnoses including cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), hemiplegia (inability to move one side of the body), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) for daily decision making was intact. During a review of Resident 6's COC form, dated 6/7/2026, the COC form indicated on 6/7/2026 at 11:13 a.m., Resident 6 was heard yelling in the station A hallway. The COC form indicated that Resident 6 allegedly hit Resident 5 on the right arm. During a concurrent interview and record review on 6/10/2026 at 4:30 p.m. with the ADON, Resident 6's Progress Notes, dated 6/7/2026 to 6/10/2026 were reviewed. The ADON stated residents should be monitored every shift for 72 hours after a change of condition. The ADON stated Resident 6's Progress Notes indicated there was no documented evidence that the resident was monitored on 6/8/2026 (3 p.m. to 11 p.m. shift). The ADON stated care not documented was considered not provided. The ADON stated that failure to document Resident 6's medical status monitoring following a change of condition could put Resident 6's safety at risk. During an interview on (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/10/2026 at 5:33 p.m. with the Director of Nursing (DON), the DON stated Resident 5 and Resident 6 should be monitored every shift for 72 hours after a change of condition. The DON stated there was no confirmed documented evidence of monitoring on the identified shifts for Resident 5 and 6. The DON stated failure to monitor Resident 5 and 6 every shift after a COC could result in the resident's missed signs of aggression, altercation with other residents, and compromised resident safety. The DON stated that care not documented was considered not provided. The DON acknowledged and stated the facility failed to monitor and document Resident 5 following a change of condition. During a review of the facility's policy and procedures (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).3. During a review of Resident 7's admission Record, the admission Record indicated the facility admitted the resident on 6/4/2026 with diagnoses including urinary tract infection (an infection caused by bacteria entering the urinary system), sepsis (the body's life-threatening reaction to an infection), and muscle weakness. During a review of Resident 7's General Acute Care Hospital (GACH) 1 Discharge summary, dated [DATE], GACH 1 Discharge Summary indicated Resident 7 had diagnoses that included dementia (a decline in brain function including memory, language, reasoning, and behavior severe enough to interfere with daily life), cognitive impairment, and altered mental status. During a review of Resident 7's Progress Notes, dated 6/4/2026, the Progress Notes indicated the resident alert and oriented times one (a medical phrase used to describe a person's mental status indicating the person only know their own identity and recognize themselves). During a concurrent interview and record review on 6/10/2026 at 4:02 p.m. with Registered Nurse (RN) 1, Resident 7's Admit/Readmit Evaluation, dated 6/4/2026, was reviewed. RN 1 stated Resident 1 was only responsive to his name. RN 1 stated Resident 7's Admit/Readmit Evaluation indicated the resident was alert, oriented to person, place, time, situation, and was verbally appropriate. RN 1 stated Resident 7's documented assessment on the Admit/Readmit Evaluation was not accurate. RN 1 stated inaccurate assessments could result in miscommunication amongst the healthcare team. RN 1 further stated inaccurate assessments could negatively affect Resident 7's safety. RN 1 acknowledged and stated the facility failed to accurately assess and document Resident 7's mental status on admission. During an interview on 6/10/2026 at 5:33 p.m. with the DON, the DON stated Resident 7's documented admission assessment was inaccurate. The DON stated inaccurate assessment could result in inappropriate and incomplete plan of care for Resident 7. The DON acknowledged and stated the facility failed to ensure accurate resident assessment was performed on admission and documented in the resident's medical records. During a review of the PnP titled, Accuracy of Assessments, last reviewed on 12/10/2026, the PnP indicated the intent to ensure each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline. 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).		

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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 5) was maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to ensure licensed nurses documented Resident 5's assessment timely. This deficient practice resulted in inaccurate information on Resident 5's medical records and had the potential for delayed and inaccurate medical interventions. Findings: During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 5/19/2026 with diagnoses including metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), muscle weakness, and depression (a common, serious mood disorder characterized by persistent, intense, and long-lasting feeling of sadness or a loss of interest in activities). During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 5/26/2026, the MDS indicated Resident 5's cognitive skills (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) for daily decision making was severely impaired. During a review of Resident 5's Change of Condition (COC - any sudden or major shift in a person's physical, mental, or behavioral health compared to their normal baseline) form, dated 6/7/2026, the COC form indicated on 6/7/2026 at 11:13 a.m., Resident 5 was heard yelling in station A hallway. The COC form indicated that Resident 5 allegedly reported getting hit on the arm by Resident 6. During a concurrent interview and record review on 6/10/2026 at 4:30 p.m. with the Assistant Director of Nursing (ADON), Resident 5's Progress Notes, dated 6/7/2026 to 6/10/2026, were reviewed. The ADON stated should be monitored every shift for 72 hours after a change of condition. The ADON stated Resident 5's Progress Notes indicated he (ADON) assessed Resident 5 on 6/8/2026 at 6:33 a.m. and documented the assessment on 6/10/2026 at 3:34 p.m., two days, nine hours, and one minute after. The ADON stated on 6/9/2026 at 6:39 a.m., he assessed Resident 5 and documented the assessment on 6/10/2026 at 3:37 p.m., 32 hours and 58 minutes after. The ADON stated his documented assessment of Resident 5 was not documented timely and did not indicate that the documentation was a late entry. During an interview on 6/10/2026 at 5:33 p.m. with the Director of Nursing (DON), the DON stated the assessment on Resident 5 was not documented timely and did not indicate that the documentation was a late entry. The DON acknowledged and stated the facility failed to timely document the assessment on Resident 5 and failed to indicate the documentation as a late entry. During a review of the facility's policy and procedures (PnP) titled, Documentation Policy, last reviewed on 12/10/2025, the PnP indicated late entries in the clinical record are dated for the day of entry. These entries are to be made to the record in a timely manner. Late entries are to include the date and time the late entry was made and the date for the late entry. Example: 05/05/02 1400 entry for 05/03/02 1000.		