

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

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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 07/08/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide the necessary care and services to attain or maintain the highest practicable physical well-being for one of three sampled residents (Resident 3). The facility failed to: Reassess the need for the continuation of the wound care for Resident 3 who had an actively draining and worsening surgical wound/incision on the right side of head status post right side craniotomy (a surgical procedure where a surgeon temporarily removes a section of bone from the right side of the skull [the protective bone shell that forms the shape of the head] to access the brain). This deficient practice has the potential for delayed wound healing and an increased risk for surgical wound/incision infection. On 6/20/2026, Resident 3 observed with myiasis (a parasitic infection caused by fly larvae [maggots] infesting live human or animal tissue) infestation on his (Resident 3) surgical wound on his right side of the head and his (Resident 3) ear requiring a transfer to General Acute Care Hospital (GACH) 1 on 6/20/2026. Findings: During a review of Resident 3's undated admission Record (AR), the AR indicated the facility admitted Resident 3 on 5/15/2026 with diagnoses that included hemiplegia (a severe or complete loss of motor function [the body's ability to control voluntary muscle movement to perform physical tasks] or paralysis [the complete or partial loss of voluntary muscle function in one or more muscles in the body] one side of the body) and hemiparesis (a mild to moderate weakness affecting one side of your body), following cerebral infarction (a brain tissue death caused by a lack of blood flow to a specific region of the brain) affecting left non-dominant side, acute respiratory failure (when lungs cannot get enough oxygen into the blood, or they cannot remove enough waste gas out) with hypoxia (a medical condition when body's tissues and organs do not get enough oxygen to function properly), encounter for attention to tracheostomy (a surgically created opening made directly into the front of the neck and into the windpipe), and dependence on respiratory ventilator (a person cannot breathe adequately on their own and relies on a mechanical breathing machine to stay alive). During a review of Resident 3's Admit/Readmit (Admission/Readmission) Evaluation (ARE), dated 5/15/2026 at 12:18 p.m., the ARE indicated Resident 3 was admitted with an admitting diagnoses of right side craniotomy, acute encephalopathy (a sudden, widespread brain dysfunction), and right Middle Cerebral Artery (MCA, one of the three major arteries supplying blood to the brain) stroke (a stroke [a blood supply to the part of the brain is suddenly interrupted or reduced] that happens when the MCA on the right side of the brain becomes blocked by a blood clot or bursts). The ARE's Skin Integrity indicated Resident 3 had craniotomy on the right side of the head. During a review of Resident 3's History of Present Illness and Physical Exam (H&P - a medical report that summarizes a resident's complete medical past and current physical health), dated 5/17/2026, the H&P indicated Resident 3 did not have the capacity to make decisions for himself. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 5/25/2026, the MDS indicated Resident 3 was rarely/never able to (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understand others and was rarely/never able to make self-understood. The MDS indicated Resident 3's cognitive skills for daily decision making were severely impaired (a person completely or near completely lost the ability to make safe, logical, and correct decisions for their own day-to-day survival). The MDS indicated Resident was dependent (helper does all the effort) with oral hygiene, showering, upper and lower body dressing, and personal hygiene. During a review of Resident 3's undated Order Summary Report (OSR, a vital medical document that lists every active treatment, medication, and care instruction by a physician for a resident), the OSR indicated the following physician orders: Right side of head craniotomy, cleanse with Normal Saline (NS - a simple, sterile mixture of water and salt), pat dry (to dry a surface by gently pressing a clean cloth against it, without rubbing or wiping), apply betadine (an antiseptic [germ-killing] medicine called povidone-iodine, a liquid used to kill germs) and leave open to air as needed for skin maintenance for 14 days. The OSR indicated an order start date of 5/16/2026 and order end date of 5/30/2026. Right side of head craniotomy, cleanse with NS, pat dry, apply betadine, and leave open to air every day shift for skin maintenance for 14 days. The OSR indicated an order start date of 5/17/2026 and order end date of 5/31/2026. Cadexomer Iodine External Gell (a topical [applied directly on the surface of the body] antimicrobial medication used primarily in professional wound care to treat chronic, highly draining [wet] wounds) 0/9 percent (% a ratio by the hundreds), apply to surgical head wound topically every day shift for wound for 14 days. The OSR indicated an order start date of 6/4/2026 and order end date of 6/19/2026. Cadexomer Iodine External Gell 0/9 %, apply to surgical head wound topically one time a day for wound management for 14 days. The OSR indicated an order start date of 6/2/2026 and order end date of 6/16/2026. Povidone-iodine solution (a highly effective, broad-spectrum [a treatment or chemical that is highly effective against a wide variety of germs] antiseptic chemical compound (a chemical substance applied directly to the wound to kill or stop the growth of microorganisms [germs], used to kill a wide array of bacteria, viruses, fungi, and parasites) 10 %, apply to the right side of head surgical incision topically every day shift for wound management for 14 days, with NS, pat dry, apply and cover with dry dressing. The OSR indicated an order start date of 6/3/2026 and order end date of 6/17/2026. During a review of Resident 3's Treatment Administration Record (TAR, a formal document used to track non-medication clinical treatments provided to a resident) from 5/1/2026 to 5/31/2026, the TAR indicated: Right side of head craniotomy, cleanse with NS, pat dry, apply betadine and leave open to air as needed for skin maintenance for 14 days. The TAR indicated the treatment was not administered in May 2026. Right side of head craniotomy, cleanse with NS, pat dry, apply betadine and leave open to air every day shift for skin maintenance for 14 days. The TAR indicated the treatment was started on 5/17/2026 and the last treatment was done on 5/27/2026. During a review of Resident 3's Medication Administration Audit Report for the schedule dates from 6/1/2026 to 6/30/2026, the Medication Administration Audit Report indicated: Povidone-Iodine Solution 10%, apply to right side of head surgical incision topically every day shift for wound management for 14 days. Cleanse with NS, pat dry, and cover with dry dressing. Medication Administration Audit Report indicated the treatment was started on 6/3/2026 and the last treatment was administered on 6/16/2026 at 12:52 p.m. Medication Administration Audit Report did not indicate if the treatment was administered on 6/17/2026. Cadexomer Iodine External Gel 0.9%, apply to surgical head wound topically every day shift for wound management for 14 days. Medication Administration Audit Report indicated the treatment was started on 6/5/2026 and the last treatment was administered on 6/18/2026 at 10:21 a.m. Medication Administration Audit Report did not indicate if the treatment was administered on 6/19/2026. Cadexomer Iodine External Gel 0.9%, apply to surgical head wound topically one time a day for wound management for 14 days. Medication (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administration Audit Report indicated the treatment was started on 6/2/2026 and the last treatment was administered on 6/4/2026 at 9 a.m. During a review of Resident 3's Wound Weekly Monitoring Assessment - Non-Pressure, dated 5/16/2026, the Wound Weekly Monitoring Assessment - Non-Pressure indicated Resident 3 was admitted with right side of head craniotomy, with 100 % dry scab (a hard, protective crust that forms over a wound) and no drainage (a fluid that leaks out of wound or surgical incision). During a review of Resident 3's Situational Background Assessment and Request (SBAR - a tool used to clearly share important information with others): Change of Condition (COC - a noticeable shift in a resident's baseline health status), dated 5/28/2026 at 12:33 a.m. the SBAR:COC indicated swelling to the right side of head and leaking of clear fluid from craniectomy (a surgical procedure where a surgeon removes a section of the skull bone [bone flap] and does not immediately replace it) incision. The SBAR:COC indicated Resident 3 had clear liquid pooling in his right ear and a trail of clear liquid running from the edge of the craniectomy incision. The SBAR:COC indicated that upon assessment right side of Resident 3's head was swollen. The SBAR:COC indicated 911 (the universal emergency telephone number) was called on 5/28/2026 at 12:34 a.m. and Resident 3 left the facility at 12:50 a.m. During a review of Resident 3's undated OSR, the OSR indicated a physician order send Resident 3 to emergency room (ER - a hospital department equipped and staffed to treat people with sudden, severe illnesses or injuries) via 911 for further evaluation of swelling to right side of head and leaking of clear liquid from craniectomy incision one time only for one day. The OSR indicated order date of 5/28/2026. During a review of Resident 3's General Acute Care Hospital (GACH) 1 Discharge summary, dated [DATE] at 3:45 p.m., the GACH 1 Discharge Summary indicated Resident 3 developed increasing drainage and wound dehiscence (to burst, split, or pop open along a natural line or seam) from the craniotomy site with associated purulent (a thick, cloudy, and milky fluid that oozes from a wound, usually signaling that the body is actively fighting an infection) drainage from the ear, prompting transfer back to the hospital for neurosurgical evaluation. The Discharge Summary indicated neurosurgery evaluated Resident 3 and determined no indication for operative interventions. The Discharge Summary indicated the drainage from the inferior porthole (a wound or a packet of skin breakdown located on the lower part of the resident's body) of the craniectomy incision was felt to represent a cerebrospinal fluid (a clear, colorless, and watery liquid that continuously circulates through and around the brain and spinal cord [connects brain to the rest of the body]) leak rather than a drainable infection, a suture (a [NAME] used by doctors to hold the skin together after surgery) was placed with successful cessation (stopped) of drainage. During a review of Resident 3's Wound Weekly Monitoring Assessment - Non-Pressure, dated 6/2/2026, the Wound Weekly Monitoring Assessment Non-Pressure indicated a right side of head surgical incision measuring 12 centimeters (cm - a unit of measurement), scattered scabs along surgical site, site above the ear is leaking fluid clear and white, surrounding tissue is blanchable (a red area of the skin that turns white or pale when pressed with a finger, then turns red again when released) redness. During a review of Resident 3's Wound Weekly Monitoring Assessment - Non-Pressure, dated 6/16/2026, the Wound Weekly Monitoring Assessment - Non-Pressure indicated right side of head surgical site with drainage noted seeping from the wound site, moderate (more than 25% and less than 75%) serous (clear, watery) drainage with surrounding tissue blanchable redness. During a review of Resident 3's SBAR:COC, dated 6/19/2026 at 12:49 a.m., the SBAR:COC indicated Resident 3 was noted with purulent drainage from right side of craniectomy incision. Resident 3 noted with purulent (pus or fluid that contains pus) drainage leaking from his (Resident 3) right side craniectomy incision in two different areas, one anterior (toward the front) to his ear and one superior (above or higher) to his ear. The SBAR:COC indicated area superior to ear is still swollen and some redness noted around (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incision. The SBAR:COC indicated Resident 3 pushed nurse's (RN 2's) arm away while attempting to clean the drainage that had pooled in his (Resident 3) ear. Resident 3 repeatedly puts his right hand on the area of his head where the bone flap was removed on the right side. During a review of Resident 3's Wound Weekly Monitoring Assessment - Non-Pressure, dated 6/20/2026, the Wound Weekly Monitoring Assessment - Non-Pressure indicated right side of head surgical site measuring 30 cm in length and 0.1 cm in width, surgical site has 0.3 cm length dehiscence (a clinical measurement indicating how long the open, separated section of a surgical incision is) with purulent drainage seeping from the wound site, no redness, mild swelling, and maggots coming out of ear canal. Additional information indicated the surgical site was cleaned with NS, and pat dry, ear canal was cleaned with four-by-four sterile gauze and NS. During a review of Resident 3's SBAR:COC, dated 6/20/2026 at 9:24 a.m., the SBAR:COC indicated worsening right ear infection with increased purulent drainage and small maggots crawling from right ear and right craniectomy site. The SBAR:COC indicated upon rounding with Nurse Practitioner (NP - a registered nurse with extra education, like a master's or doctorate degree), (unspecified), noted Resident 3 with worsening right ear infection, increased purulent drainage, and small maggots crawling out from right ear canal and right craniectomy site. NP (unspecified) and Medical Doctor (MD)1 ordered to transfer Resident 3 via non emergent transportation to General Acute Care Hospital (GACH) 1. During a review of Resident 2's undated admission Record (AR), the AR indicated the facility admitted Resident 2 on 6/21/2026 with diagnoses that included muscle weakness and depressive episodes (a specific period of time during which a person experiences a persistent, overwhelming feeling of sadness or a complete loss of interest in activities they normally enjoy). During a review of Resident 2's History of Present Examination (H&P), dated 6/24/2026, the H&P indicated Resident 2 had the capacity to make to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had intact cognition. During an interview on 7/7/2026 at 1 p.m. with Resident 2 in the resident's room, Resident 2 stated facility had flies but not all the time, only when they open the window. Resident 2 stated even the nurses (unable to recall the names) have seen the flies. Resident 2 stated that there was a time when a nurse (Resident 2 was not able to recall nurses' name and the time) came in and told Resident 2 to cover up because there was a fly on his open wound in his (Resident 2) left knee. Resident 2 stated the nurses try to get rid of them. During a concurrent interview and record review on 7/7/2026 at 1:56 p.m. of Resident 3's June 2026 TAR with Treatment Nurse (TN) 1, TN 1 stated that she worked with Resident 3 on 6/19/2026. TN1 reviewed Resident 3's June 2026 TAR and stated that for the povidone-iodine she (TN 1) did not sign off that the treatment was done. TN 1 stated since it was not signed off, she (TN 1) cannot say Resident 3 received the treatment on 6/19/26. TN 1 stated if residents are not given wound treatment can be a potential for infection. During a concurrent interview and record review on 7/7/2026 at 2:23 p.m. of Resident 3's June 2026 TAR with TN 2, TN 2 stated she (TN 2) worked on 6/20/2026. TN 2 stated Resident 3 had a surgical site on his right side of scalp; craniotomy closed with sutures. TN 2 stated craniotomy surgical site was initially dry without swelling then it got softer, it was boggy (a wound or the skin around it that feels abnormally soft, spongy, or mushy to the touch), it started to drain and it felt like there was drainage under the skin. TN 2 stated on 6/20/2026, Resident 3 was laying on his back, had a chuck pad (disposable, waterproof, absorbent pad) behind his (Resident 3) head and she (TN 2) noticed small maggots, the maggots were crawling out of Resident 3's ear canal, mostly ear, and surrounding cheek and going back of the ear. TN 2 stated there were a handful of maggots. TN 2 stated she tried to clean and noticed in the ear canal the maggots were pocketed in Resident 3's ear. TN 2 stated she noted a small amount of drainage from the surgical site draining into Resident 3's ear. (continued on next page)		

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