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	06/18/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one (1) of five (5) sampled residents' (Resident 14) drug (medication) regimen was free from the use of unnecessary (any medication in excessive dose, excessive duration, without adequate monitoring) psychotropic (any medication capable of affecting the mind, emotions, and behavior) medications in accordance with the facility policy and procedure (P&P) by failing to provide a detailed clinical rationale documented for continuing Zoloft (a psychotropic medication used to treat depression) as originally prescribed on 8/29/2024 without attempting Gradual Dose Reduction ([GDR] - stepwise tapering of a medication dose to determine if symptoms or conditions can be managed by a lower dose, or if the drug can be safely discontinued). This deficient practice had the potential to place Resident 14 at risk for significant adverse consequences (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic medications, resulting in impairment or decline in the residents' mental, physical condition, functional, and psychosocial status. Findings: During a review of Resident 14's admission Record (a document containing demographic and diagnostic information,) dated 6/16/2026, the admission Record indicated the facility originally admitted Resident 14 on 4/21/2024, and re-admitted on [DATE], with a diagnosis including depression (a condition where one has constant feelings of sadness and loss of interest). During a review of Resident 14's Order Summary Report, dated 6/16/2026, indicated Resident 14 was prescribed Zoloft 50 milligram (mg- a unit of measure of mass) one (1) tablet once a day for depression manifested by verbalization of sadness, starting 9/4/2025. During a review of Resident 14's Care Plan (a document outlining a detailed approach to care customized to an individual resident's need) initiated 9/4/2025, the Care Plan indicated Resident 14 was on antidepressant medication Zoloft for depression manifested by verbalization of sadness with a goal of decreased episodes of sign and symptoms of depression. During a review of Resident 14's Minimum Data Set (MDS-a resident assessment tool), dated 10/14/2025, indicated Resident 14 did not have symptoms of feeling down, depressed, or hopeless. The MDS indicated Resident 14 diagnosis included depression. Resident 14's MDS indicated Resident 14 received antidepressants on a routine basis. During a review of Resident 14's MDS, dated [DATE], indicated Resident 14 did not have symptoms of feeling down, depressed, or hopeless. The MDS indicated Resident 14 diagnosis included depression. Resident 14's MDS indicated Resident 14 received antidepressants on a routine basis. During a review of Resident 14's MDS, dated [DATE], indicated Resident 14 did not have symptoms of feeling down, depressed, or hopeless. The MDS indicated Resident 14 diagnosis included depression. Resident 14's MDS indicated Resident 14 was not marked for receiving antidepressants on a routine basis. During a review of Resident 14's Medication Administration Record (MAR-a record of mediations administered to residents), for June 2026, the MAR indicated Resident 14 was prescribed Zoloft 50 mg one (1) tablet once a day for depression manifested by verbalization of sadness, to give at 9 a.m. During a review of Resident 14's MARs between January to June 2026, the MARs indicated: 1.Resident 14 received Zoloft 50 mg daily at 9 a.m. between 1/1/2026 and 6/15/2026 2.Resident 14 had zero (0) documented behaviors of (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	depression manifested by verbalization of sadness between 1/1/2026 and 1/31/2026 3.Resident 14 had zero (0) documented behaviors of depression manifested by verbalization of sadness between 2/1/2026 and 2/28/2026 4.Resident 14 had one (1) documented behaviors of depression manifested by verbalization of sadness between 3/1/2026 and 3/31/2026 on 3/26/2026 5.Resident 14 had zero (0) documented behaviors of depression manifested by verbalization of sadness in between 4/1/2026 and 4/30/2026 6.Resident 14 had zero (0) documented behaviors of depression manifested by verbalization of sadness between 5/1/2026 and 5/31/2026 7.Resident 14 had zero (0) documented behaviors of depression manifested by verbalization of sadness in between 6/1/2026 and 6/15/2026. During a review of Resident 14's Psychiatric Progress Notes by MD 1, dated 4/14/2026, the Progress Note indicated per nursing staff, no recent behavior disturbances manifested by verbalization of sadness have been observed. The Progress Note indicated GDR not indicated at this time as benefits of current treatment outweigh risks of dose reduction. During an interview and concurrent record review on 6/16/2026 at 3:05 p.m., with the Director of Nursing (DON,) the DON reviewed Resident 14's MARs between January and June 2026, Care plan, psychiatric note, and MDS dated [DATE], 1/12/2026 and 4/9/2026. The DON acknowledged the documentation indicated that Resident 14 had almost no documented behaviors of depression manifested by verbalization of sadness since January 2026 on the MARs, and no documented symptoms of depression on MDSs since October 2025. The DON acknowledged the care plan goals set in September 2025 for decreased episodes of sign and symptoms of depression were met. The DON acknowledged Resident 14 continued to receive Zoloft 50 mg daily as originally prescribed since 8/29/2024. The DON stated the psychiatric note dated 4/14/2026 did not indicate a specific clinical rationale for continuing Zoloft as originally prescribed or a clinical contraindication or risk for GDR. The DON stated it was important to identify the absence of behaviors and when individual resident goals were met and consider GDR for psychotropic medications to ensure residents receive treatment optimal for their condition while maintaining their highest level of well-being. The DON stated that the facility should have attempted a GDR for Zoloft 50 mg daily or provided documentation indicating a clinical rationale for continuing Zoloft 50 mg daily or what specific contraindications prevented the GDR for Resident 14. The DON stated the facility failed to attempt a GDR in two (2) separate quarters within the first year of starting Zoloft and/or to indicate a clinical rationale for continuing Zoloft or what clinical contraindications prevented a GDR. The DON stated as a result, Resident 14 was placed at risk of continuing unnecessary psychotropic medication that could result in adverse consequences and side effects, negatively impacting Resident 14's well-being. During a phone interview on 6/18/2026 at 12:06 p.m., with the Consultant Pharmacist (CP,) the CP stated that federal regulations require that a GDR be attempted in two (2) separate quarters within the first year of starting psychotropic medications, unless there's specific clinical contraindications. The CP stated the goal for GDRs was to provide behavior management at the lowest possible dose with the least number of adverse consequences for residents. The CP stated when GDRs were not attempted due to clinical contraindications, the contraindications must be thoroughly documented in the resident's clinical record. During a review of the facility's Policy and Procedures (P&P) titled Dignity and Respect Psychoactive Medications, last reviewed 12/10/2025, the P&P indicated: must only remain on psychotropic medications when a gradual dose reduction and behavioral interventions have been attempted and/or deemed clinically contraindicated. Psychotropic drug: Any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (ii) anti-depressant Unnecessary drugs: Any drug when used: 3.without adequate indications for its use Gradual Dose Reduction (GDR): stepwise tapering of a dose to determine if symptoms, conditions or risks can be managed at a lower dose or if the dose or medication can be discontinued. 2.Residents who use psychotropic drugs shall receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. 14.The medical record must include documentation of the adequate clinical indication and necessity for prescribed psychotropic (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication. 36.During the first year.the interdisciplinary team shall attempt to perform a GDR, in two separate quarters, unless clinically contraindicated. 38.A GDR may be considered clinically contraindicated for reasons including, but not limited to, the following: The physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function of exacerbate an underlying medical or psychiatric disorder. The residents target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why resident's function, exacerbate an underlying medical or psychiatric disorder. 40.Physician documentation should contain the rationale for why GDR attempts are clinically contraindicated for the resident.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with urinary incontinence received appropriate treatment and services to prevent urinary tract infections (UTI- an infection in the bladder/urinary tract) for two of three sampled residents (Resident 183 and Resident 5) reviewed under the Urinary Catheters (indwelling catheter -a hollow tube inserted into the bladder to drain or collect urine) care area by failing to: 1. Ensure the facility's policy and procedure (P&P) was followed for Resident 183, when there was no documentation of measured indwelling catheter output on multiple shifts since resident admission on [DATE]. 2. Ensure notification for an SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition [SBAR] among the residents) for Resident 183, when the indwelling catheter was bypassing (urine leaking around the outside of an indwelling catheter instead of flowing through the tube) and the indwelling catheter could not be changed by staff. These deficient practices had the potential for residents to develop catheter associated urinary tract infections (CAUTI, an infection of the urinary tract caused by an indwelling catheter) and potentially contributed to the resident's hospitalization on 6/16/2026 for urinary retention and abdominal discomfort. 3. Ensure Resident 5 received appropriate treatment and services to prevent urinary tract infection (UTI - an infection in the bladder/urinary tract) by failing to maintain Resident 5's urinary catheter (a hallow tube inserted into the bladder to drain or collect urine) in a manner that prevents urine backflow. This deficient practice had the increased potential for Resident 5 to develop catheter associated urinary tract infection (CAUTI - UTI developed in a resident with an indwelling catheter). Cross-reference F580.Findings: 1. During a review of Resident 183's admission Record, the admission Record indicated the facility admitted the resident on 6/7/2026 with diagnoses that included encounter for surgical aftercare following surgery on the genitourinary system (organs involved in both urinary and reproductive functions), abscess (a collection of pus that has built up within the tissue of the body) of corpus cavernosum (spongy tissue) and penis, Fournier gangrene (a rapidly progressive, life-threatening infection of the genitals), and other abnormal findings in urine. During a review of Resident 183's Admit/Readmit Evaluation, dated 6/7/2026, the Admit/Readmit Evaluation indicated the resident was alert and oriented to name, place, date, and time. The Admit/Readmit Evaluation further indicated Resident 183 had an indwelling catheter. During a review of Resident 183's History and Physical (H&P), dated 6/16/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 183's Physician Orders Summary Report, the Physician Orders Summary Report indicated orders for the following: -Indwelling Catheter: French number 16 (the diameter of the catheter) to drainage bag due to diagnosis of iatrogenic bladder (bladder injury), dated 6/7/2026. -Indwelling Catheter: change catheter (if blockage / leakage / removal / dislodge) as needed, dated 6/7/2026. During a review of Resident 183's Care Plan (CP) titled, (Resident 183) has an indwelling catheter, (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	initiated 6/9/2026, the CP indicated a goal that the resident would remain free from catheter related trauma and would show no signs and symptoms of UTI with interventions that included to change the catheter for leaking and to monitor / document / report to the physician for signs and symptoms of UTI including no urine output. During a review of Resident 183's SBAR form, dated 6/16/2026 at 5:12 p.m., the SBAR form indicated the resident complained of discomfort on the pelvic area and reported that he felt his urine was going to his scrotum area, the physician was made aware with orders to transport the resident to the hospital via non-emergent transport. During an observation and interview on 6/15/2026 at 9:48 a.m., in Resident 183's room, observed Resident 183 lying in bed with an indwelling catheter. Resident 183 stated his catheter had been leaking urine for about a week and all the staff were aware, but they told him they could not do anything about it because the resident needed to see the urologist (physician that specialized in the urinary tract system) to have the catheter changed. Resident 183 stated he felt uncomfortable because he was not used to being wet. During an interview on 6/16/2026 at 2:15 p.m., in the hallway outside Resident 183's room, with Family Member (FM) 1, FM 1 stated Resident 183 had been complaining since the prior week that his catheter was leaking, and she (FM 1) told the nurse. FM 1 stated she could not remember the nurse's name, but the nurse said they could not change the catheter and the resident needed to see the urologist. FM 1 stated Resident 183's catheter was still leaking urine. During an interview on 6/16/2026 at 2:28 p.m., in the hallway, with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 183's catheter had been leaking for the past two days that she had cared for him. CNA 4 stated on 6/15/2026 day shift (a standard period of time worked between 7 a.m. to 4 p.m.), she reported to Licensed Vocational Nurse (LVN) 1 that Resident 183's catheter drainage bag had zero urine output for the entire shift and all the urine had leaked into the resident's brief. CNA 4 stated Resident 183's catheter was still leaking and his brief was wet. During an interview on 6/16/2026 at 2:36 p.m. with LVN 1, at Nursing Station 1, LVN 1 stated she had been caring for Resident 183 for the past few days and was not aware of any issues reported by the family or staff regarding Resident 183's indwelling catheter. LVN 1 stated she was not aware that Resident 183's catheter was leaking. During an interview on 6/16/2026 at 2:39 p.m. with Treatment Nurse (TN) 1, TN 1 stated Resident 183 had an indwelling catheter to keep the area at the penile abscess clean and dry. TN 1 stated the indwelling catheter had bypassing issues (urine leaking around the outside of the catheter tube instead of draining properly through it) and the resident needed to follow up with the urologist. TN 1 stated only the urologist can change the resident's catheter. During a concurrent interview and record review on 6/17/2026 at 2:19 p.m., with MDS Nurse (MDSN) 1, in the conference room, reviewed Resident 183's SBAR forms and Progress Notes for 6/2026. MDSN 1 stated bypassing indicates an indwelling catheter is not functioning properly and could indicate the tubing is blocked or not inserted correctly and needs to be changed. MDSN 1 stated a change of condition is any change from the resident's baseline. MDSN 1 stated resident changes of conditions are reported by the CNAs or LNs to the supervising nurse and to the physician to determine any necessary treatments. MDSN 1 stated if a resident's catheter was bypassing, there was no urine in the drainage bag for an entire shift, and nursing staff cannot change the catheter; it would be (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	considered an SBAR and should be reported to the physician. MDSN 1 stated between Resident 183's admission and the evening shift (3 p.m. to 11 p.m.) on 6/16/2026 there was no documented evidence that it was reported to the physician that Resident 183's catheter was bypassing and needed to be changed. During a follow up interview on 6/17/2026 at 4:06 p.m. with TN 1, in the conference room, TN 1 stated when Resident 183's indwelling catheter was bypassing and there was no urine in the drainage bag for the day shift on 6/15/2026 it was considered a change of condition, and CNA 4 should have reported to LVN 1 to evaluate the catheter. TN 1 stated on the evening shift of 6/16/2026 Resident 183's abdomen was distended and he was found to be retaining 600 milliliters (mL, a unit of liquid measurement) of urine and was sent to the hospital for further evaluation. During a concurrent interview and record review on 6/18/2026 at 1 p.m. with the Director of Nursing (DON), in the conference room, reviewed the P&P regarding SBAR and indwelling catheters. The DON stated Resident 183 was newly admitted and has urological issues that require an indwelling catheter that should only be changed by the urologist. The DON stated Resident 183 had a physician's order that indicated to change the catheter if there was leaking. The DON stated bypassing could indicate that an indwelling catheter has a blockage and urine is not flowing and needs to be changed. The DON stated when an indwelling catheter bypasses and is not changed there is the potential that the resident would develop a UTI. The DON stated when Resident 183's catheter was bypassing with no urine collection in the drainage bag for an entire shift it was considered a resident change of condition that the CNA should report to the LN by completing a Stop and Watch form. The DON stated CNA 4 did not complete a Stop and Watch form on 6/15/2026 and the LN did not address Resident 183's change in condition regarding the catheter bypassing with the need to be changed. The DON stated on 6/15/2026, the physician should have been notified of Resident 183's SBAR to determine the necessary treatment but was not. The DON stated the facility P&P was not followed for SBAR potentially contributing to indwelling catheter complications resulting in hospitalization of Resident 183 on 6/16/2026. During a review of the facility P&P titled, Bowel and Bladder Retraining, last reviewed 12/10/2025, the P&P indicated, INTENT . To ensure a resident, with or without an indwelling catheter, receives the appropriate care and services to prevent urinary tract infections to the extent possible. GUIDELINES. 1. The interdisciplinary team provide appropriate and sufficient services and assistance to:. c. Prevent urinary tract infections to the extent possible. During a review of the facility P&P titled, Notification of Changes, last reviewed 12/10/2025, the P&P indicated, DEFINITIONS. A need to alter treatment significantly: . commence a new form of treatment to deal with a problem. GUIDELINES: . 1. The facility shall immediately or as soon as practicable inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representative(s) when there is: . b. A significant change in the resident's physical, mental, or psychosocial status. c. A need to alter treatment significantly; . Licensed personnel will provide timely, accurate, and standardized communication with the physician or licensed practitioner when a resident experiences a significant change in condition using the SBAR (Situation Background Assessment Recommendation) communication tool or documented equivalent in the nursing progress notes. The form is used for a resident change in condition resulting in a need to significantly alter the resident's treatment plan. 2. During a review of Resident 183's CP titled, UTI: The resident has UTI (with catheter), initiated 6/7/2026, the CP indicated the resident had a UTI with a goal to resolve without complications by (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was no CNA documentation of urine output on multiple shifts and the LN did not monitor and document I/Os since admission. During a concurrent interview and record review on 6/18/2026 at 1 p.m. with the DON, in the conference room, reviewed the P&P regarding indwelling catheters and I/O. The DON stated the way to ensure that an indwelling catheter is functioning properly is to measure and monitor the urine output in the drainage bag. The DON stated the facility process is catheter urine is measured by the CNA, then monitored and documented in the MAR by the LN every shift. The DON stated the facility P&P was not followed when the facility process for indwelling catheter I/Os was not followed for Resident 183 potentially resulting in delay of treatment and hospitalization of the resident. During a review of the facility P&P titled, Intake and Output Monitoring, last reviewed 12/10/2025, the P&P indicated, Purpose Statement. The facility provides care and services for residents who require monitoring of their intake and or output consistent with the standard of practice. INTENT. To provide guidelines for maintaining a measurement of resident's intake and output and to assess fluid balance. GUIDELINES. 2. Fluid intake and output shall be recorded for each patient: . b. For each patient with an indwelling catheter. c. Intake and output records shall be evaluated and documented weekly by a licensed nurse. PROCEDURE. 1. Measure and record all liquids ingested . 2.Measure urine. 5. Complete the intake and output record for the appropriate parameters. 3. During a review of Resident 5's admission Record (AR), the facility admitted resident originally on 1/27/2020 and readmitted on [DATE] with diagnoses including acute respiratory failure (occurs when lungs suddenly cannot get enough oxygen into the blood), neuromuscular dysfunction of the bladder (the nerves and muscles that control the bladder are not communicating properly), and muscle weakness. During a review of Resident 5's History and Physical (H&P – a document with patient's medical history and physical examination done by a physician) dated 11/01/2025, the H&P indicated that Resident 5 did not have the capacity to make decisions. During a review of Resident 5's Minimum Data Set (MDS – a resident assessment tool), dated 3/26/2026, the MDS indicated Resident 5 was dependent (helper does all the effort) with eating, personal and toileting hygiene, shower, dressing, and transfers. During a review of Resident 5's Care Plan titled, Resident 5 has an indwelling catheter due to neurogenic bladder with a goal indicating that Resident 5 will have minimized risk for complications from indwelling catheter and interventions including anchor catheter to prevent tension, observe urine odor, color clarity and amount as needed, secure catheter to facilitate urine flow, and check tubing for kinks each shift. During a concurrent observation and interview on 6/15/2026 at 10:56 a.m. with Licensed Vocational Nurse 4 (LVN 4) inside Resident 5's room, indwelling catheter was observed in a dependent loop wherein urine was observed stagnant and partially cloudy and the lower part of the bed was elevated in an angle where the catheter tubing was positioned above resident's bladder. LVN 4 stated that the tubing seemed like coiling and should drain by gravity. LVN 4 stated indwelling catheter tubing must flow by gravity and tubing should not be coiling to prevent resident from developing urinary tract infection. During an interview on 6/17/2026 at 1:15 a.m. with the Director of Nursing (DON), the DON stated that (continued on next page)

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	555904	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indwelling catheters must be checked every time a care is rendered to the resident including the color and output. The DON stated that the catheter must be positioned below the bladder to prevent backflow of the urine which could potentially lead to an infection specifically CAUTI. During a review of the facility's Policy and Procedures titled, Indwelling Catheter Use, revised on 1/2025 indicated A resident who enters the facility with an indwelling catheter or subsequently received one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is clinically necessary. (1) The facility provides the necessary treatment and services to achieve or maintain as much normal urinary function as possible for residents identified with incontinence. (6) The facility monitors residents with catheters for changes in skin integrity, skin irritation or breakdown, and signs and symptoms of urinary tract infection. (10) Catheter tubing should be positioned lower than the resident's body to facilitate drainage.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1.Reconcile (the process of comparing transactions and activity to supporting documentation) two (2) medication emergency kits ([eKIT] - kit containing medications needed to be used during emergencies) containing ([CS] - medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as narcotics, drugs or controlled medication) for June 2026, in two (2) of two (2) inspected Medication Rooms (Medication Room Station 1 and 2). 2.Account for two (2) doses of CS for Resident 19 and 74 in one (1) of five (5) inspected medication carts (Medication Cart 2 Station 2). These deficient practices increased the opportunity for CS diversion (the transfer of a CS from a lawful to an unlawful channel of distribution or use,) and exposure of harmful medications to residents in the facility, and that Residents 19 and 74 could have accidental overdose (administration of more than the prescribed dose) to CS possibly leading to physical and psychosocial harm, hospitalization and death and the potential to result in their health and well-being to be negatively impacted. Findings: During an observation and concurrent interview on 6/15/2026 at 12:15 p.m., with Licensed Vocational Nurse (LVN) 6, in Medication Room Station 2, there was: 1. One (1) medication eKIT stored in the refrigerator and labeled 35, containing lorazepam (a CS) without an accountability log for the reconciliation of CS inventory at every shift change for June 2026.ˆ Duri ng a concurrent interview, LVN 6 stated that all CSs, including medication eKITs containing CSs should be reconciled at every shift. LVN 6 stated the eKIT labeled 35 containing CSs in Medication Room Station 2 was not reconciled at every shift in June 2026, and it was important to account for all CSs to ensure accountability and prevent CS diversion. During an observation and concurrent interview on 6/15/2026 at 12:35 p.m., with LVN 7, in Medication Room Station 1, there was: 1. One (1) medication eKIT stored in the refrigerator and labeled 69, containing lorazepam without an accountability log for the reconciliation of CS inventory at every shift change for June 2026.ˆ During a concurrent interview, LVN 7 stated that all CSs, including medication eKITs containing CSs should be reconciled at every shift. LVN 7 stated the eKIT labeled 69 containing CSs in Medication Room Station 1 was not reconciled at every shift in June 2026, and it was important to account for all CSs to ensure accountability and prevent CS diversion.ˆ During an observation on 6/15/2026 at 1:14 p.m., with LVN 3, in Medication Cart 2 Station 2, there was a discrepancy in the count between the Drug Control Receipt Record/Disposition Form accountability log and the amount of medication remaining in the medication cart or medication bubble pack (medication packaging system that contains individual doses of medication per bubble) for the following residents: 1. One (1) dose of pregabalin (a CS used for neuropathic [related to nerves] pain) 75 milligram ([mg] - a unit of measure of mass) tablet was extra in the bubble pack compared to the count indicated on the Drug Control Receipt Record/Disposition Form accountability log for Resident 19. The Drug Control Receipt Record/Disposition Form accountability log for pregabalin indicated the bubble pack should have contained a total of 11 pregabalin 75 mg tablets; however the bubble pack contained 12 pregabalin 75 mg tablets and no documentation of additional administrations after 6/15/2026 at 2:07 p.m. 2. One (1) dose of lacosamide (a CS used for seizure [bursts of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle movements, behaviors, sensations or states of awareness] pain) 100 mg tablet was missing from the bubble pack compared to the count indicated on the Drug Control Receipt Record/Disposition Form accountability log for Resident 74. The Drug Control Receipt Record/Disposition Form accountability log for lacosamide indicated the bubble pack should have contained a total of 48 lacosamide 100 mg tablets, however the bubble pack contained 47 lacosamide 100 mg tablets and no documentation of additional administrations after 6/14/2026 at 5:36 p.m. During a concurrent interview, LVN 3 stated LVN 3 was about to prepare one (1) pregabalin (continued on next page)

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	06/18/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	75 mg tablet for administration at 2 p.m. to Resident 19 and had signed the Drug Control Receipt Record/Disposition Form accountability log in advance of the preparation. LVN 3 also stated that LVN 3 administered one (1) lacosamide 100 mg tablet to Resident 74 that morning (6/15/2026) at 10:01 a.m. and forgot to sign the Drug Control Receipt Record/Disposition Form accountability log. LVN 3 stated LVN 3 failed to follow the facility's policy of signing each CS dose on the Drug Control Receipt Record/Disposition Form accountability log after preparing the doses for Resident 19 and 74. LVN 3 stated LVN 3 understood it was important to document/sign each dose once prepared to ensure accountability, prevention of CS diversion, and accidental exposures of harmful substances to residents. LVN 3 stated if documentation was not accurate then it can lead to medication error if overdosed leading to stoppage of breathing, hospitalization and possibly death for Residents 19 and 74. During an interview on 6/16/2026 at 3:05 p.m., with the Director of Nursing (DON,) the DON stated that medication eKITs containing CSs needed to be counted and reconciled at every shift change to ensure accountability and prevent CS diversion.^ The DON stated the eKITs labeled 35 and 69 containing CSs in Medication Room Station 1 and 2 were not reconciled at every shift in June 2026. The DON stated that the facility will immediately implement an accountability log for reconciliation of eKits containing CSs. During the same interview, the DON stated that LVN 3 failed to follow facility policy of documenting the preparation of CS immediately on the Drug Control Receipt Record/Disposition Form accountability log for Resident 19 and 74. The DON stated not documenting the Drug Control Receipt Record/Disposition Form timely can lead to accountability failures, CS diversion, inaccurate clinical records, and accidental use and overdose of harmful substances for residents. During a review of Resident 19's admission Record (a document containing demographic and diagnostic information,) dated 6/16/2026, the admission Record indicated the facility originally admitted Resident 19 on 5/5/2026, with diagnoses including polyneuropathy (a condition where multiple nerves are damaged). During a review of Resident 19's Medication Administration Record (MAR- record of medications administered to a resident) for June 2026, the MAR indicated Resident 19 was prescribed pregabalin 75 mg for neuropathic pain, starting 5/18/2026, to be given every eight (8) hours at 6.a.m., 2 p.m. and 10 p.m. During a review of Resident 74's admission Record dated 6/16/2026, the admission Record indicated the facility originally admitted Resident 74 on 6/5/2019, and re-admitted on [DATE], with diagnoses including seizures. During a review of Resident 74's MAR for June 2026, the MAR indicated Resident 74 was prescribed lacosamide 100 mg for seizure disorder, starting 11/18/2023, to be given twice a day at 9.a.m. and 5 p.m. During a review of the Policy and Procedures (P&P) titled Controlled Medications, last reviewed 12/10/2025, the P&P indicated:D. Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the MAR: 1) Date and time of administration. (MAR, Accountability Record). 2) Amount administered. (Accountability Record). 3) Remaining quantity. (Accountability Record). 4) Initials of the nurse administering the dose, completed after the medication is actually administered. (MAR, Accountability Record). During a review of the P&P, titled Controlled Substance Storage, last reviewed 12/10/2025, the P&P indicated: E. At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two (2) licensed nurses and is documented. During a review of the P&P, titled Safeguarding Controlled Substances, last reviewed 12/10/2025, the P&P indicated: The facility has established guidelines for safe handling receiving, storing, administering, reconciling, and safeguarding controlled substances. To minimize the time between identification and actual loss or diversion of medications or suspected controlled substance diversion involving any employee, determination of the extent of loss or diversion and to safeguard patients and their property. 13. Controlled substances will be counted at the onset and completion of each shift by two nurses and verified accurately through each nurses' signature on the reconciliation log. 1. The Licensed Nurse will enter the following information immediately upon removing dose(s) from the (continued on next page)

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	06/18/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	controlled storage on the resident's individual controlled substance accountability reconciliation log. a. Date of medication removal. b. Time of medication removal. c. Amount of medication removed.d. Amount of medication remaining. e. Signature of nurse removing the medication. 1.Each individual controlled substance must be counted when there is a change in shift nurse. 4.Narcotic e-kits should be checked & verified as present/sealed or reconciled as indicated.

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	555904	A. Building B. Wing	06/18/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors (the observed or identified preparation or 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.Not administer two (2) doses of expired insulin (a medication used to control high blood sugar levels) Novolog (a brand name insulin for Aspart that is rapid-acting) Flexpen (an injection device containing insulin) by two (2) different licensed nursing staff to Resident 123 in one (1) of five (5) inspected medication carts (Medication Cart 2 Subacute.) As a result, Resident 123 received a total of two (2) doses of expired insulin from 6/11/2026 to 6/15/2026, not in accordance with manufacturer guidelines, standards of practice and facility policy and procedures. 2.Ensureˆamiodaroneˆ(medicationˆto treat life-threatening, irregular heartbeats)ˆwas administered in accordance with the physician's order to hold (do not give) for a systolic blood pressure (SBP, measures the pressure in your arteries [pathway that carries blood away from the heart]) less thanˆ(<)ˆ110 millimeters of mercury (mmHg,ˆaˆunit of measurement) for one (1) ofˆoneˆ(1) sampled resident (Residentsˆ153) reviewed during theˆhemodialysis (HD - a treatment to cleanse the blood of wastes and extra fluidsˆartificially through a machine when the kidney(s) have failed)ˆcare area.These deficient practices had the potential to cause Resident 123 and 153 to experience adverse effects (unwanted, unintended results) and serious health complications due to improper management of blood sugar and fromˆunnecessaryˆmedicationsˆincludingˆcardiovascular issues, hypotension (abnormallyˆlowˆblood pressureˆ[BP])ˆand possible coma (a state of deep unconsciousness caused by injury or illness,) resulting in hospitalization and/or death. Findings:ˆ 1. During a review of Resident 123's admission Record (a document containing demographic and diagnostic information,) dated 6/16/2026, the admission Record indicated the facility originally admitted Resident 123 on 9/24/2021 and re-admitted on [DATE] with diagnosis including Type two Diabetes Mellitus (DM2– a condition where there is high blood sugar levels.) During a review of Resident 123's Order Summary Report (a report listing the physician order for the resident), dated 6/16/2026, the report indicated Resident 123 was prescribed insulin Aspart (generic name for Novolog) to inject per sliding scale (insulin dosing plan whereby the amount of insulin administered depends on the resident's blood sugar level,) subcutaneous ([SQ] – under the skin) every eight (8) hours for Diabetes, starting 1/24/2024. During a review of Resident 123's Medication Administration Record (MAR - a document of the medications administered to a resident that is part of the resident's permanent medical record), for June 2026, the MAR indicated Resident 123 was prescribed insulin Aspart per sliding scale SQ every eight (8) hours for Diabetes, to inject at 6 a.m., 2 p.m. and 10 p.m., and that Resident 123 received two (2) doses of expired insulin Novolog Flexpen from the following nurses on the following dates and times: -LVN 4 – 1 dose at 2 p.m. on 6/14/2026, -LVN 8 - 1 dose at 6 a.m. on 6/14/2026. During an observation on 6/15/2026 at 1:35 p.m., in the presence of Licensed Vocational Nurse (LVN) 4, in Medication Cart 2 Subacute, the following medications were found either expired and not (continued on next page)

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	06/18/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discarded, or stored contrary to their respective manufacturer's specifications and facility policies and procedures: 1.One (1) open insulin Novolog Flexpen for Resident 123 was found stored at room temperature with a handwritten label indicating that use at room temperature began on 5/13/2026, and to discard in 28 days. According to the manufacturer's product labeling, open Novolog Flexpen should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 28 days of opening the pen. During a concurrent interview, LVN 4 stated according to the handwritten date Resident 123's Novolog Flexpen was opened on 5/13/2026 and considered expired on 6/10/2026. LVN 4 stated the pen was not removed and continued to be stored and used in Medication Cart 2 Subacute for Resident 123. LVN 4 stated expired medications needed to be removed from the cart and placed in the expired medication bin to be disposed of and not accidentally used for residents. LVN 4 stated that expired insulin has lost its potency (strength) and administering expired insulin Novolog after 6/10/2026 will not be effective in controlling blood sugar levels and can harm Resident 123 by causing hyperglycemia (high blood sugar levels) and coma, leading to hospitalization and death. LVN 4 stated the pen needed to be discarded and replaced with a new one from pharmacy before it expired on 6/10/2026.^ LVN 4 stated that LVN 8 and herself administered two (2) doses of expired Novolog Flexpen to Resident 123 on 6/14/2026, and these were considered significant medication errors. During an interview, on 6/16/2026 at 3:05 p.m., with the Director of Nursing (DON,) the DON acknowledged several LVN's failed to remove the expired Novolog Flexpen from Medication Cart 2 Subacute leading to the administration of two (2) expired doses of insulin to Resident 123 resulting in significant medication error. The DON stated that expired insulins have lost potency and effectiveness and when administered expired insulin will not be effective in controlling blood sugar levels leading to hyperglycemia and adverse effects for Resident 123, potentially resulting in coma, hospitalization and/or death. During a review of the facility's Policy and Procedures (P&P,) titled Administration Procedure for All Medications, last reviewed 12/10/2025, the P&P indicated: To administer medications in a safe and effective manner. D. Check expiration date on package/container before administering any medication. When opening a multidose container, place the date on the container. During a review of the facility's P&P titled Administering Medications, last reviewed 12/10/2025, the P&P indicated: The expiration/beyond use date on the medication label must be checked prior to administering. During a review of the facility's P&P titled Labeling of Biologicals and Storage of Biologicals, last reviewed 12/10/2025, the P&P indicated: The facility, in coordination with the licensed pharmacist, provides accurate labeling to facilitate precautions and safe administration of medications, and safe and secure storage. 1.The Facility shall maintain a current medication dating reference guide based on manufacturer instructions for medications that have shortened expiration periods after opening, puncture, reconstitution, activation, or removal from original packaging. 2.See Attachment A – Novolog Flexpen – 28 days. (continued on next page)

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	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of manufacturer guideline, titled Highlights of Prescribing Information for Novolog, dated 2/2025, the guide listed the following:Once a cartridge or NovoLog FlexPen or NovoLog FlexTouch is punctured, it should be kept at temperatures below 86 degrees Fahrenheit for up to 28 days. 2.During a review ofˆResident 153's admission Record (AR), the AR indicated the facility admitted the resident onˆ5/22/2026, ˆwith diagnoses that includedˆEnd Stage Renal Disease (ESRD -irreversible kidney failure),ˆdependence on HD,ˆhypertensive heart disease (refers to heart problems that occur because of highˆBPˆthat is present over a long time),ˆatrial fibrillation (A-fib -ˆan irregular and often very rapid heart rhythm that can lead to blood clots [clumps that occur when blood hardens from a liquid to a solid] in the heart),ˆand hypotension.ˆ During a review ofˆResident 153's Minimum Data Set (MDS – resident assessment tool) datedˆ5/29/2026, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDSˆfurtherˆindicatedˆtheˆresidentˆrequiredˆsubstantial / maximalˆassistanceˆfrom staff for toileting, bathing, lower body dressing,ˆpersonal and oralˆhygiene,ˆand mobility.ˆ During a review ofˆResident 153's Physician Order Summary, the Physician Order Summaryˆindicatedˆan order forˆamiodarone HCLˆOral Tabletˆ200ˆmilligram (mg – a unit of measurement) giveˆtwoˆ(2) tabletsˆby mouthˆin the morning for A-fib. Hold ifˆSBPˆ<ˆ110 orˆheart rate (HR) <ˆ60 beats per minute. Call physicianˆif SBP <90 or HR <60. Call physician if BP medications are held for one (1) week due to low parameters,ˆdatedˆ5/22/2026.ˆ During a concurrent interview and record review on 6/16/2026 at 11:45 a.m. withˆMDS Nurseˆ(MDSN) 1,ˆin the conference room Resident 153's physician orders andˆMAR forˆ6/2026 were reviewed.ˆThe MDSNˆ1ˆstatedˆtheˆfacility process isˆto document in the MARˆimmediatelyˆafter administering medication. The MDSN 1ˆstatedˆa check mark in the MARˆindicatesˆthat a medication was administered. The MDSN 1 stated Resident 153 is administeredˆamiodarone for A-fibˆand the medication should not be given if the resident's SBP <110 or HR <60. The MDSN 1 reviewed Residentˆ153's MAR for 6/2026 and notedˆamiodarone was not administered per the physician's ordersˆwhen:ˆˆ -On 6/5/2026 at 9 a.m., amiodarone was administered with an SBP of 102.ˆ -On 6/12/2026 at 9 a.m.,ˆamiodaroneˆwas administered with an SBP of 108.ˆ ˆ The MDSN 1 stated whenˆResident 153 was administered amiodaroneˆwith a SBP <110, the resident's BP could have gone down even lowerˆcausing the resident to have cardiac issues.ˆ During anˆinterview onˆ6/17/2026ˆatˆ4:40 p.m. with RN 1, RN 1ˆreviewed Resident 153's MAR and physician orders. RN 1ˆstatedˆthe MAR documentation is completed right after medication is administered and isˆaccurate. RN 1 stated if she documented medication was administered in the MAR then the medication was administered. RN 1ˆstatedˆon 6/5/2026ˆshe cared for Resident 153 and administered his medications. RN 1ˆstatedˆshe does not rememberˆholding any of Resident 153's medicationsˆon 6/5/2026. RN 1 stated when the MARˆindicatedˆResident 153's amiodarone as administered, then she administered the medication.ˆRN 1ˆstatedˆon 6/5/2026 amiodarone was not administered to Resident 153 per the physician's orderˆbecause there was a hold parameter for SBP <110, the SBP was 102,ˆand the medication was not held.ˆ (continued on next page)

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	555904	A. Building B. Wing	06/18/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During aˆconcurrentˆinterviewˆand record reviewˆonˆ6/18/2026ˆatˆ1 p.m.,ˆwith the Director of Nursing (DON),ˆreviewed the facility policy and procedureˆ(P&P)ˆregardingˆmedication administration and manufacture guidelines for amiodarone. The DONˆstatedˆthe medication administration process is to check the physician's orders, including the hold parameters, and administer medication per the orders. The DONˆstatedˆthe MAR documentation is consideredˆaccurateˆand if medication was administered as documented then itˆhappened.ˆThe DON confirmed the amiodarone manufacture guidelinesˆindicatedˆa potentialˆcardiacˆside effectˆof the medication was hypotension that is sometimes fatal.ˆThe DONˆstatedˆResident 153 was medicallyˆcomplex,ˆandˆamiodarone was not administered per the physician's ordersˆor P&Pˆand placed the resident at risk forˆcardiovascular adverse effects including hypotension.ˆˆ During a review of the facilityˆprovided Medication Guide forˆamiodarone, last reviewedˆ10/2028, theˆMedication Guideˆindicated, At the usual maintenance dose (400 mg/day) and above,ˆ(amiodarone)ˆcauses adverse reactions in about three-fourthsˆof all patients.ˆThe following side-effect rates are based on a retrospective study of 241 patients treated for 2 to 1,515ˆdays:.ˆhypotension.ˆThe following adverse reactions have beenˆidentifiedˆduring post-approval useˆ.ˆCardiac: hypotension (sometimesˆfatal).ˆ During a review of the facility P&P titled, Administeringˆ Medication, last reviewedˆ12/10/2025,ˆtheˆP&Pˆindicated, PURPOSE STATEMENT:ˆTo provide employees with guidelines for the safe andˆtimelyˆadministration of medications per physician order.ˆINTENT: To ensure medications are prepared, administered, stored,ˆdocumentedˆandˆmonitoredˆin a safe andˆaccurateˆmanner by authorized personnelˆin accordance withˆphysician orders.ˆGUIDELINES:ˆ.ˆ3.ˆMedications must be administeredˆin accordance withˆthe orders.ˆVitalˆsigns and other clinical parameters shall be assessed and evaluatedˆin accordance withˆphysician orders and the resident's individualized clinical condition, diagnoses, goals of care, andˆthe intended therapeutic use of the medication.ˆ During a review of the facility P&P titled, Unnecessary Drugs, last reviewed 12/10/2025, the P&Pˆindicated, Each resident's drug regimen shall be free from unnecessary drugs ˆThe facility is cautious inˆdeterminingˆthe necessity of proper medicationˆselectionˆand prescribing (including dose, duration, and type of medication(s)) which may help stabilize or improve a resident's outcome, quality of life and functional capacity Any medication or combination of medications-or the use of a medication without adequate indications, in excessive dose, for an excessive duration, or without adequate monitoring-may have serious side effects, such as changes in vital signs/lab values, confusion, immobility, falls, and hip fractures, which can be especially dangerous for elderly residents, in addition to an increased risk of death ˆUnnecessary drugs include .: in excessive dose . without adequate indications for its use ˆDocumentation is necessary to clarify the rationale for each medication and the approach toˆmonitorˆthe benefits and any adverse consequences ˆ

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	06/18/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to: 1. Remove and discard from use one (1) expired insulin (medication used to regulate blood sugar levels) Lispro (rapid-acting insulin) Kwikpen (an injection device containing insulin) for Resident 44, in accordance with manufacturer's requirements and facility policy and procedures (P&P) in one (1) of five (5) inspected medication carts (Medication Cart 2 Station 1).2. Remove and discard from use one (1) expired insulin Novolog (rapid-acting insulin) Flexpen (an injection device containing insulin) for Resident 123, in accordance with manufacturer's requirements and facility P&P in one (1) of five (5) inspected medication carts (Medication Cart 2 Subacute).3. Label and store one (1) levalbuterol (a medication used to treat and prevent shortness of breath) inhalation solution foil pouch (a package made of foil protecting the inhalation solution from light and degradation) and dorzolamide with timolol (a combination medication used to decrease pressure in the eye) ophthalmic (related to the eye) solution foil pouch for Resident 57 at room temperature in accordance with the manufacturer's requirements and facility P&P in one (1) of five (5) inspected Medication Carts (Medication Cart 2 Station 1). 4. Label one (1) open epogen (medication used to treat anemia [having low red blood cells) vial with date open for Resident 80 in accordance with manufacturer's requirements and facility P&P in one (1) of two (2) inspected Medication Rooms (Medication Room Station 1). These deficient practices increased the risk that Residents 44, 57, 80 and 123 could have received medication that had become ineffective or toxic due to improper storage or labeling, possibly leading to health complications resulting in hospitalization or death. Findings: During an observation on 6/15/2026 at 12:35 p.m., inside Medication Room Station 1, in the presence of Registered Nurse (RN) 4, the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: 1. One (1) open and used multi dose (containing more than one dose) vial of epogen for Resident 80 was found stored in the refrigerator containing unused volume of medication, without a label indicating when the vial was first used/punctured. According to manufacturer's product storage and labeling, epogen multi-dose vials should be stored in the refrigerator between 36 and 46 degrees Fahrenheit and to throw away multiple-dose vials no later than 21 days from the first day vial was punctured. During a concurrent interview with RN 4, RN 4 stated the epogen vial for Resident 80 was open and used with some volume of medication remining in the vial and was not labeled with a date when the vial was opened. RN 4 stated the epogen vial for Resident 80 was considered expired since it was unknown when the vial was opened. RN 4 stated expired epogen vial has decreased potency (effectiveness) and since it was stored in the refrigerator could be used in error resulting in not treating or controlling Resident 80's anemia. RN 4 stated the epogen vial for Resident 80 needed to be removed from the refrigerator and disposed of to prevent accidental use. During an observation on 6/15/2026 at 12:50 p.m., in Medication Cart 2 Station 1, in the presence of Licensed Vocational Nurse (LVN) 9, the following medications were found either expired or stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: 1. One (1) open insulin Lispro Kwikpen for Resident 44 was found stored in the refrigerator with a label indicating that use began on 5/16/2026, and an additional label indicating to discard 28 days after opening. According to the manufacturer's product labeling, opened Lispro Kwikpen should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 28 days of opening. 2. One (1) open levalbuterol inhalation solution foil pouch for Resident 57, was found stored at room temperature and not labeled with a date indicating when the foil pouch was opened. According to the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	manufacturer's product storage and labeling, opened foil pouch of levalbuterol inhalation solutions should be stored between 68 to 77 degrees Fahrenheit and once the foil pouch is opened to be used within two (2) weeks. 3. One (1) open dorzolamide with timolol ophthalmic solution foil pouch for Resident 57, was found stored at room temperature and not labeled with a date indicating when the foil pouch was opened. According to the manufacturer's product storage and labeling, opened foil pouch of dorzolamide with timolol ophthalmic solutions should be stored between 68 to 77 degrees Fahrenheit and to throw away unused solutions 15 days after first opening the pouch. During a concurrent interview with LVN 9, LVN 9 stated the insulin Lispro Kwikpen for Resident 44 was opened on 5/16/2026 and expired on 6/13/2026 and continued to be stored in the refrigerator. LVN 9 stated expired insulin has lost its potency and administering expired insulin Lispro to Resident 44 will not be effective in keeping the blood sugar stable and can harm Resident 44 by causing high blood sugar levels leading to coma (a state of deep unconsciousness caused by severe injury or illness) and potential hospitalization. LVN 9 stated the Lispro Kwikpen needed to be removed from the refrigerator on 6/13/2026 and replaced with a new pen from pharmacy to prevent accidental use. During the same interview, LVN 9 stated the levalbuterol inhalation solution foil pouch and dorzolamide with timolol ophthalmic solution foil pouch for Resident 57 was not labeled with a date indicating when the foil pouches were opened. LVN 9 stated that per facility policy multi-dose products such as inhalation solutions should be labeled with the date when first opened to know when they expire. LVN 9 stated that expired medications have lost potency and will not be effective in treating residents' condition. LVN 9 stated according to the manufacturer guidelines, the levalbuterol inhalation solution should be used within two (2) weeks of opening the pouch and dorzolamide with timolol ophthalmic solution within 15 days. LVN 9 stated failing to record the date of first use could lead to Resident 57 receiving potentially expired and ineffective levalbuterol and dorzolamide with timolol. LVN 9 stated this could cause Resident 57 harm by not treating or preventing the shortness of breath, making breathing more difficult, keeping the pressure high in the eye, requiring immediate treatment and potential hospitalization. During an observation on 6/15/2026 at 1:35 p.m., in the presence of Licensed Vocational Nurse (LVN) 4, in Medication Cart 2 Subacute, the following medications were found either expired and not discarded, or stored contrary to their respective manufacturer's specifications and facility policies and procedures: 1. One (1) open insulin Novolog Flexpen for Resident 123 was found stored at room temperature with a handwritten label indicating that use at room temperature began on 5/13/2026, and to discard in 28 days. According to the manufacturer's product labeling, open Novolog Flexpen should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 28 days of opening the pen. During a concurrent interview, LVN 4 stated according to the handwritten date Resident 123's Novolog Flexpen was opened on 5/13/2026 and considered expired on 6/10/2026. LVN 4 stated the pen was not removed and continued to be stored and used in Medication Cart 2 Subacute for Resident 123. LVN 4 stated expired medications needed to be removed from the cart and placed in the expired medication bin to be disposed of and not accidentally used for residents. LVN 4 stated that expired insulin has lost its potency and administering expired insulin Novolog after 6/10/2026 will not be effective in controlling blood sugar levels and can harm Resident 123 by causing hyperglycemia (high blood sugar levels) and coma, leading to hospitalization and death. LVN 4 stated the pen needed to be discarded and replaced with a new one from pharmacy before it expired on 6/10/2026. During an interview, on 6/16/2026 at 3:05 p.m., with the Director of Nursing (DON,) the DON acknowledged that expired medications should be removed from medication carts and rooms to prevent accidental use and that multi-dose medications such as insulin pens and epogen vials should be labeled with a date indicating when use first began to know when they expire. The DON acknowledged that several LVN's failed to remove the expired Lispro Kwikpen from Medication Cart 2 Station 1 and Novolog Flexpen from Medication Cart 2 Subacute. The DON stated that expired insulins have lost potency and effectiveness and when administered expired insulin will not be effective in controlling blood sugar levels leading to hyperglycemia and adverse effects for (continued on next page)

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	06/18/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 44 and 123, potentially resulting in coma, hospitalization and/or death. During the same interview, the DON stated that the levalbuterol and dorzolamide with timolol foil pouches for Resident 57 were not labeled with a date when the pouch was opened to know when the expire. The DON stated that expired inhalation and ophthalmic solutions have lost effectiveness and when administered in error will not treat the shortness of breath or increased eye pressure further causing respiratory distress and stoppage of breathing and possible eye blindness from elevated pressure for Resident 57 requiring immediate treatment and hospitalization. During the same interview, the DON further stated the epogen vial for Resident 80 was not labeled with a date indicating when the vial was punctured and needed to be removed from the medication room and discarded to prevent accidental use. The DON stated that administering expired epogen in error will not be effective and can harm Resident 80 by not treating the anemia. During a review of facility's P&P titled Administration Procedure for all Medications, last reviewed on 12/10/2025, the P&P indicated: When opening a multidose container, place the date on the container. During a review of facility's P&P titled Storage of Medications, last reviewed on 12/10/2025, the P&P indicated: B. Certain medications or package types, such as IV sol^tions, multiple dose injectable vials, ophthalmics, blood sugar testing solutions and strips, once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency. G. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner.

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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 observation, interview, and record review, the facility failed to keep the call light (an alerting device for patients to call a nursing personnel to assist them when needed)ˆwithin reach of residents for two (2) of two (2) sampled residents (Residents 39, 110) reviewed under environment task.ˆˆ The deficient practiceˆhad the potential to place the residents at risk for delayed assistance, potentially affecting safety and timely care.ˆ ˆ Findings: 1. During a review of Resident 39's admission Record (AR), the AR indicated the facility admitted the resident on 2/17/2026, with diagnoses including type two (2) diabetes mellitus with hyperglycemia (a disorder characterized by difficulty in blood sugar control there is too much sugar in the blood); muscle weakness (Generalized) (weakness in many muscles throughout the body); cognitive communication deficit (a person has difficulty thinking, remembering things, understanding, or organizing information, which affects their ability to communicate effectively). During a review of Resident 39's History and Physical (H&P), dated 2/18/2026, the H&Pˆindicatedˆthe resident did not have the capacity to understand and make decisions.ˆ During a review of Resident 39's Minimum Data Set (MDS, a resident assessment tool), dated 5/19/2026, the MDS indicated Resident 39 had severe cognitive impairmentˆ(has major problems with thinking, memory, understanding, and may need significant assistance with daily activities and supervision for safety). The MDS indicated that the resident was dependent or required maximal assistanceˆon mobility and activities of daily livingˆ(ADLs,ˆactivities such as bathing, dressing and toileting a person performs daily). During a review of Resident 39's Fall Risk Evaluation (FRE), dated 5/19/2026, the FREˆindicatedˆthe resident was at high risk for falls.ˆ During a review of Resident 39's Care Plan (CP) Report, titled Risk for falls: Resident 39 is at risk for recurrent falls and spontaneous injuries r/t gait (the way a person walks)/balance problems, incontinence (a person is unable to fully control urine or bowel movement resulting in accidents) dated 2/23/2026, the CP indicated a goal to minimize the risk of injury from falls until the next review date. The CP intervention was to keep the call light within reach and encourage the resident to use it for assistance as needed. During a concurrent observation and interview on 6/15/2026, at 1:08 p.m., with Certified Nursing Assistant (CNA) 5 inside Resident 39's room, CNA 5 observed call light on the bottom part of the bed in between side rail and mattress. CNA 5 stated Resident 39 would not have been able to call; it would have been difficult for Resident 39 to get help, and resident could potentially fall trying to reach for the call light. During a concurrent interview and record review on 6/17/2026, at 10:20 a.m., with Licensed Vocational Nurseˆ(LVN) 5, Resident 39`s FRE dated 5/19/2026 and CP dated 2/23/2026 were reviewed. LVN 5 stated Resident 39 was at high risk for falls. LVN 5 stated the purpose of the call light is for residents to utilize it when they need assistance. LVN 5 stated Resident 39 would not have been able to reach the call light, and the resident could have potentially fallen. LVN 5 stated the care plan and policy titled, Resident Call System were not followed. During an interview on 6/18/2026 at 1:47p.m., with the Director of Nursing (DON), the DON stated the purpose of the call light is for the residents to call when they need assistance is a way to communicate with staff. The DON stated if the call light is not within reach, then there will be a delay in care. The DON stated that Resident 39 would not have been able to call for assistance because the call light was stuck between side rail and mattress and it could have been an emergency, by not having call light within reach would also delay assistance. The DON stated Resident 39 could potentially fall if resident was not able to call for assistance. The DON stated the policy and procedure (P&P) titled, Resident Call System was not followed. 2. During a review of Resident 110's AR, the AR indicated the facility originally admitted the resident on 1/16/2024 and readmitted on [DATE], with diagnoses including spinal stenosis, cervical region (a condition where the neck part of the spine becomes narrow and presses on the nerves); muscle weakness (Generalized) (weakness in many muscles throughout the body); history of falling. During a review of (continued on next page)

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	555904	A. Building B. Wing	06/18/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 110's H&P, dated 11/24/2025, the H&Pˆindicatedˆthe resident had the capacity to make decisions.ˆ During a review of Resident 110's MDS, dated [DATE], the MDS indicated that Resident 110 was able to make self- understood and had the ability to understand others and had intact cognitive function (normal thinking). The MDS indicated the resident required partial/moderate assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a review of Resident 110's FRE, dated 5/8/2026, the FREˆindicatedˆthe resident was at risk for falls.ˆ During a review of Resident 110's CP Report, titled Resident 110 is at risk for recurrent falls and spontaneous injuries r/t muscle weakness, deconditioning, spinal stenosis of cervical region, and history of falling, dated 11/19/2024, the CP indicated a goal to minimize the risk of injury from falls until the next review date. The CP intervention was to keep the call light within reach and encourage the resident to use it for assistance as needed. During a concurrent observation and interview on 6/15/2026, at 1:15 p.m., with CNA 5 inside Resident 110's room, CNA 5 observed the resident`s call light and bed remote control hanging down below and between left side bed rail and mattress. CNA 5 stated Resident 110 would not have been able to call for assistance and resident could have potentially fallen trying to reach for the call light. During a concurrent interview and record review on 6/17/2026, at 10:20 a.m., with LVN 5, Resident 110`s FRE dated 5/8/2026 and CP dated 11/19/2024 were reviewed. LVN 5 stated Resident 110 was at risk for falls. LVN 5 stated the purpose of the call light is for residents to utilize it when they need assistance. LVN 5 stated Resident 110 could have potentially fallen trying to reach for the call light. LVN 5 stated the CP and policy titled, Resident Call System were not followed. During an interview on 6/18/2026 at 1:47p.m., with the DON, the DON stated that Resident 110 would not have been able to call for assistance because the call light was not within reach and could have potentially fallen trying to reach for the call light. The DON stated the P&P titled, Resident Call System was not followed. During a review of the facility's P&P titled, Resident Call System, last reviewed on 12/10/2025, 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. Procedure: 5. When the resident is sitting in his/her chair or confined to his/her bed, be sure to provide resident with call light access. 8. Resident call system shall be accessible to residents while in their bed or other sleeping accommodations within the residents' room.

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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 observation, interview, and record review, the facility failed to immediately notify the primary care physician of a significant change in condition for one of one sampled resident (Resident 183) reviewed under the Urinary Catheters (indwelling catheter -a hollow tube inserted into the bladder to drain or collect urine) care area by failing to ensure notification for an SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition [SBAR] among the residents) when the indwelling catheter was bypassing (urine leaking around the outside of an indwelling catheter instead of flowing through the tube) with no urine output collected in the drainage bag for the day shift (7 a.m. to 3 p.m.) on 6/15/2026. This deficient practice had the potential for the resident to develop catheter associated urinary tract infections (CAUTI, an infection of the urinary tract caused by an indwelling catheter) and potentially contributed to the resident's hospitalization on 6/16/2026 for urinary retention (inability to completely empty your bladder) and abdominal discomfort. Cross-Reference F690. Findings: During a review of Resident 183's admission Record, the admission Record indicated the facility admitted the resident on 6/7/2026, with diagnoses including encounter for surgical aftercare following surgery on the genitourinary system (organs involved in both urinary and reproductive functions), abscess (a collection of pus that has built up within the tissue of the body) of corpus cavernosum (spongy tissue) and penis, Fournier gangrene (a rapidly progressive, life-threatening infection of the genitals), and other abnormal findings in urine. During a review of Resident 183's Admit/Readmit Evaluation, dated 6/7/2026, the Admit/Readmit Evaluation indicated the resident was alert and oriented to name, place, date, and time. The Admit/Readmit Evaluation further indicated the resident had an indwelling catheter. During a review of Resident 183's History and Physical (H&P), dated 6/16/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 183's Physician Orders Summary Report, the Physician Orders Summary Report indicated orders for the following: -Indwelling Catheter: French number 16 (the diameter of the catheter) to drainage bag due to diagnosis of iatrogenic bladder (bladder injury), dated 6/7/2026. -Indwelling Catheter: change catheter (if blockage / leakage / removal / dislodge) as needed, dated 6/7/2026. During a review of Resident 183's Care Plan (CP) titled, (Resident 183) has an indwelling catheter, initiated 6/9/2026, the CP indicated a goal that the resident would remain free from catheter related trauma and would show no signs and symptoms of UTI with interventions that included to change the catheter for leaking and to monitor / document / report to the physician for signs and symptoms of UTI including no urine output. During a review of Resident 183's SBAR form, dated 6/16/2026 at 5:12 p.m., the SBAR form indicated the resident complained of discomfort on the pelvic area and reported that he (Resident 183) felt his urine was going to his scrotum area, the physician was made aware with orders to transport the resident to the hospital via non-emergent transport. During an observation and interview on 6/15/2026 at 9:48 a.m., inside Resident 183's room, observed Resident 183 lying in bed with an indwelling catheter. Resident 183 stated his catheter had been leaking urine for about a week and all the staff were aware, but they told him they could not do anything about it because the resident needed to see the urologist (physician that specialized in the urinary tract system) to have the catheter changed. Resident 183 stated he (Resident 183) felt uncomfortable because he (Resident 183) was not used to being wet. During an interview on 6/16/2026 at 2:15 p.m., in the hallway outside Resident 183's room, with Family Member (FM) 1, FM 1 stated Resident 183 had been complaining since the prior week that his catheter was leaking, and she (FM 1) told the nurse. FM 1 stated she (FM 1) could not remember the nurse's name, but the nurse said they could not change the catheter and the resident needed to see the urologist. FM 1 stated Resident 183's catheter was still leaking urine. During an interview on 6/16/2026 at 2:28 p.m., in the hallway, with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 183's catheter had been leaking for the past two days that she (CNA (continued on next page)

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	555904	A. Building B. Wing	06/18/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) had cared for him. CNA 4 stated on 6/15/2026 day shift (a standard period of time worked between 7 a.m. to 4 p.m.), she (CNA 4) reported to Licensed Vocational Nurse (LVN) 1 that Resident 183's catheter drainage bag had zero urine output for the entire shift and all the urine had leaked into the resident's brief. CNA 4 stated Resident 183's catheter was still leaking and his brief was wet. During an interview on 6/16/2026 at 2:36 p.m. with LVN 1, at Nursing Station 1, LVN 1 stated she (LVN 1) had been caring for Resident 183 for the past few days and was not aware of any issues reported by the family or staff regarding Resident 183's indwelling catheter. LVN 1 stated she (LVN 1) was not aware that Resident 183's catheter was leaking. During an interview on 6/16/2026 at 2:39 p.m. with Treatment Nurse (TN) 1, TN 1 stated Resident 183 had an indwelling catheter to keep the area at the penile abscess clean and dry. TN 1 stated the indwelling catheter had bypassing issues and the resident needed to follow up with the urologist. TN 1 stated only the urologist can change the resident's catheter. During a concurrent interview and record review on 6/17/2026 at 2:19 p.m., with MDS Nurse (MDSN) 1, in the conference room, Resident 183's SBAR forms and Progress Notes for 6/2026 were reviewed. The MDSN 1 stated bypassing indicates an indwelling catheter is not functioning properly and could indicate the tubing is blocked or not inserted correctly and needs to be changed. The MDSN 1 stated a change of condition is any change from the resident's baseline. The MDSN 1 stated resident changes of conditions are reported by the CNAs or LNs to the supervising nurse and to the physician to determine any necessary treatments. The MDSN 1 stated if a resident's catheter was bypassing, there was no urine in the drainage bag for an entire shift, and nursing staff cannot change the catheter; it would be considered an SBAR and should be reported to the physician. The MDSN 1 stated between Resident 183's admission and the evening shift (3 p.m. to 11 p.m.) on 6/16/2026 there was no documented evidence that it was reported to the physician that Resident 183's catheter was bypassing and needed to be changed. During a follow up interview on 6/17/2026 at 4:06 p.m. with TN 1, in the conference room, TN 1 stated when Resident 183's indwelling catheter was bypassing and there was no urine in the drainage bag for the day shift on 6/15/2026 it was considered a change of condition, and CNA 4 should have reported to LVN 1 to evaluate the catheter. TN 1 stated on the evening shift of 6/16/2026 Resident 183's abdomen was distended and he was found to be retaining 600 milliliters (mL, a unit of liquid measurement) of urine and was sent to the hospital for further evaluation. During a concurrent interview and record review on 6/18/2026 at 1 p.m. with the Director of Nursing (DON), in the conference room, reviewed the P&P regarding SBAR and indwelling catheters. The DON stated Resident 183 was newly admitted and has urological issues that require an indwelling catheter that should only be changed by the urologist. The DON stated Resident 183 had a physician's order that indicated to change the catheter if there was leaking. The DON stated bypassing could indicate that an indwelling catheter has a blockage and urine is not flowing and needs to be changed. The DON stated when an indwelling catheter bypasses and is not changed there is the potential that the resident would develop a UTI. The DON stated when Resident 183's catheter was bypassing with no urine collection in the drainage bag for an entire shift it was considered a resident change of condition that the CNA should report to the LN by completing a Stop and Watch form. The DON stated CNA 4 did not complete a Stop and Watch form on 6/15/2026 and the LN did not address Resident 183's change in condition regarding the catheter bypassing with the need to be changed. The DON stated on 6/15/2026, the physician should have been notified of Resident 183's SBAR to determine the necessary treatment but was not. The DON stated the facility P&P was not followed for SBAR potentially contributing to indwelling catheter complications resulting in hospitalization of Resident 183 on 6/16/2026. During a review of the facility P&P titled, Bowel and Bladder Retraining, last reviewed 12/10/2025, the P&P indicated, INTENT . To ensure a resident, with or without an indwelling catheter, receives the appropriate care and services to prevent urinary tract infections to the extent possible. GUIDELINES. 1. The interdisciplinary team provide appropriate and sufficient services and assistance to:. c. Prevent urinary tract infections to the extent possible. During a review of the facility P&P titled, Notification of Changes, last reviewed 12/10/2025, the P&P (continued on next page)

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	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, DEFINITIONS. A need to alter treatment significantly: . commence a new form of treatment to deal with a problem. GUIDELINES: . 1. The facility shall immediately or as soon as practicable inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representative(s) when there is: . b. A significant change in the resident's physical, mental, or psychosocial status. c. A need to alter treatment significantly; . Licensed personnel will provide timely, accurate, and standardized communication with the physician or licensed practitioner when a resident experiences a significant change in condition using the SBAR (Situation Background Assessment Recommendation) communication tool or documented equivalent in the nursing progress notes. The form is used for a resident change in condition resulting in a need to significantly alter the resident's treatment plan.

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	555904	A. Building B. Wing	06/18/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an environment free from accidents and hazards for two of three sampled residents (Resident 96 and 188) reviewed for accidents by failing to: 1. Ensure Resident 96's room was free from liquid spills while the resident was left unattended by staff. 2. Ensure Resident 188 did not have a chair and trash bin placed on top of the floor mat (a thick, soft pad placed on the floor beside a resident's bed to cushion them if they fall) on the resident's left side of the bed. These deficient practices had the potential to result in resident falls resulting in injuries like fractures (broken bones) and lacerations. Findings: a. During a review of Resident 96's admission Record, the admission Record indicated the facility admitted the resident on 12/22/2025 with diagnoses that included unspecified dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), epilepsy (chronic disorder that causes recurrent seizures [abnormal electrical activity in the brain]), muscle weakness, and history of falling. During a review of Resident 96's Minimum Data Set (MDS – resident assessment tool), dated 5/27/2026, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated Resident 96 required substantial/maximal assistance from staff for toileting, bathing, and personal hygiene; and was dependent on staff for eating, oral hygiene, and mobility. During a review of Resident 96's History and Physical (H&P), dated 2/19/2026, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 96's Fall Risk Evaluation (FRE), dated 6/11/2026, the FRE indicated the resident was disoriented, had a history of one to two falls in the past three months, had balance problems while standing/walking, and was a high risk for falls. During a review of Resident 96's Post Fall Evaluation (PFE), the PFE indicated on 6/11/2026 the resident had an unwitnessed fall that resulted in redness to the face, bruising to the nose, bleeding lips and gums and with the upper three front teeth dislodged, abrasion with bleeding and swelling to the arm, immobility of the left elbow, and mild swelling to the left knee. The PFE indicated Resident 96 had seven falls in the last 180 days. During a review of Resident 96's Care Plan (CP) titled, Actual Fall: The resident had an actual fall from bed. initiated 6/11/2026, the CP indicated a goal that the resident would resume usual activities minimizing risk of injury with interventions that included to transfer the resident to the emergency room. During a review of Resident 96's Care Plan (CP) titled, Risk for Fall, (Resident 96) was a high risk for falls. initiated 2/18/2026, the CP indicated interventions that included to promote a safe environment with even floors that are free from spills. During a concurrent observation and interview on 6/15/2026 at 12:15 p.m., observed Resident 96 lying in bed, observed the resident was missing three front teeth. Resident 96 stated that he recently had a fall when he was trying to get up without calling for help. Resident 96 stated he lost his front teeth (continued on next page)

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	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and hurt his shoulder and leg. During an observation on 6/16/2026 at 1:20 p.m., observed Resident 96 sitting up at the left side of the bed and eating. Observed the resident was unattended by staff and there was a puddle of clear liquid between the foot of the bed and the wall that was visible from the hallway. During an observation on 6/16/2026 at 1:23 p.m., observed Licensed Vocational Nurse (LVN) 1 entered the resident's room, spoke with the resident, and exited the room while the puddle of liquid remained on the floor. During an observation and interview on 6/16/2026 at 1:50 p.m. with LVN 1, at Nursing Station 1, LVN 1 stated Certified Nursing Assistant (CNA) 3 was in Resident 96's room assisting the resident, observed CNA 3 exit the room and left the resident unattended and walked down the hall. Observed the puddle of clear liquid remained on the floor between the foot of the bed and wall. LVN 1 stated Resident 96 had a recent fall with injury. Upon the surveyor's request, observed LVN 1 then entered Resident 96's room and stated there was possibly water spilled on the floor between the foot of the bed and the wall. LVN 1 stated CNA 3 should have identified and cleaned the spill and did not. LVN 1 stated when she (LVN 1) was in the room earlier, LVN 1 did not see the liquid on the floor, but she should have. LVN 1 stated spills should be cleaned right away because they create a fall hazard for the resident. During an interview on 6/17/2026 at 10:41 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 96 had a recent fall with major injuries and was considered a high risk for falls. The ADON stated a wet floor would be considered a risk for the resident slipping and falling. The ADON stated all the staff are responsible to ensure that the resident's environment is clean and the floor is dry every time they enter the resident's room. The ADON stated when the staff left a spill in Resident 96's room, the resident could have potentially stood up and slipped on the spill resulting in further injuries like broken bones. During a concurrent interview and record review on 6/18/2026 at 1 p.m. with the Director of Nursing (DON), in the conference room, the DON reviewed the facility policy and procedures (P&P) regarding fall management and accident prevention. The DON stated staff should immediately clean liquid spills and not wait for housekeeping to clean them. The DON stated when staff does not clean a spill it is an environmental risk that could result in a resident falling. The DON stated when Resident 96 had a spill in his room that was not cleaned the facility P&P was not followed potentially resulting in further injuries in the resident. During a review of the facility P&P titled, Free of Accident Hazards / Supervision / Devices, last reviewed 12/10/2025, the P&P indicated, The facility provides an environment that is free from accident hazards over which the facility has control, and each resident receives adequate supervision to prevent avoidable accidents. An effective way for the facility to avoid accidents is to develop a culture of safety and commit to implementing systems that address resident risk and environmental hazards to minimize the likelihood of accidents. A facility with a commitment to safety: . acknowledges the high-risk nature of its population and setting . Demonstrates a commitment to safety at all levels of the organization. Processes in a facility's interdisciplinary systematic approach may include: . Identification of hazards, including inadequate supervision, and a resident's risks of potentially avoidable accidents in the resident environment. All staff is involved in observing and identifying potential hazards in the environment. Factors that may result in resident falls include, but (continued on next page)

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	06/18/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	are not limited to, . environmental hazards. wet floors. During a review of the facility P&P titled, Fall Management Program, last reviewed 12/10/2025, the P&P indicated, The facility strives to provide each resident with adequate supervision and assistance devices to minimize the risks associated with falls; and to provide an environment which remains as free from accident hazards as possible. Accident: Any unexpected or unintentional incident, which results or may result in injury or illness to a resident. Avoidable Accident: An accident which occurred because the facility failed to:. Identify environmental hazards. Evaluate and analyze the hazards and risks and eliminate them. b. During a review of Resident 188's AR, the AR indicated the facility initially admitted the resident on 6/4/2026, and readmitted on [DATE], with diagnoses including unspecified dementia, contusion of the head (a bruise caused by direct blow or jolt), dysphagia (difficulty swallowing), muscle weakness, alcohol dependence (a person's body and mind rely on alcohol to function), and history of falling. During a review of Resident 188's History and Physical (H&P), dated 6/9/2026 indicated that the resident had fluctuating capacity to understand and make decisions. The H&P also indicated the prior level of function as independent on ambulation, bathing, grooming, toileting and transfers and does not use any assistive devices. During a review of Resident 188's CP titled, Risk for Fall: The resident is at risk for recurrent falls related to contusion, gait/balance problems, impaired mobility, poor communication/comprehension, unaware of safety needs, history of fall . initiated on 6/08/2026, the CP indicated a goal that will minimize risk of injury from falls . with interventions that included bilateral floor mat/landing mat to minimize injury, and promote safe environment with (example: even floors free from spills and/or clutter, glare-free light; a working and reachable call light, personal items within reach). During a review of Resident 188's CP titled, Bilateral floor mat/landing mat: Resident utilizes floor mat/landing mat as a preventative measure to cushion the fall impact and decrease the likelihood of injury, the CP indicated a goal that resident will have reduced risks of injury from falls due to the placement of landing mats with interventions that indicated to regularly check the floor mats for any signs of wear or damage, ensuring they remain in good condition. During a concurrent observation and interview on 6/15/2026 at 11:06 a.m. with 1:1 sitter (S1 – a dedicated staff member often a nursing assistant, patient observer, or trained volunteer assigned to stay in the room and continuously monitor exactly one patient to ensure their physical safety and mental well-being), S1 stated that Resident 188 had bilateral floor mats and to the resident's left side of the bed the floor mat had a chair and trash bin on top of the mat. S1 stated that it is okay to have a chair and a trash bin on top of the floor mat and further stated that the objects were already on top of the floor mat at the start of her shift. During an observation and interview on 6/15/2026 at 11:22 a.m. with LVN 5, the LVN 5 stated that floor mat is used to assist when there is a fall for injury prevention. LVN 5 stated that it is not okay to place any objects on top of the floor mat. LVN 5 stated the chair and trash bin should not have been placed on the top the floor mat and further stated that instead of protecting the resident with the cushioned floor mat, any objects placed on top of the mat could cause injury to the resident. During an interview on 6/17/2026 at 2:08 p.m. with DON, the DON stated that the purpose of floor mats are used to prevent injury in case of fall. The DON stated that floor mats should be free from any (continued on next page)

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	555904	A. Building B. Wing	06/18/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	objects. The DON further stated that the resident can land on the object which can lead to injuries. During a review of the facility's P&P titled, Free of Accident Hazards/Supervision/Devices, revised on 1/2025, the P&P indicated, The facility provides and environment that is free from accidental hazards over which the facility has control, and each resident received adequate supervision and assistive devices for each resident to prevent avoidable accidents. Guidelines: (2) An effective way for the facility to avoid accidents or to develop a culture of safety and commit to implementing systems that address resident risk and environmental hazards to minimize the likelihood of accidents. A Systems Approach: (1-a) Identification of hazards, including inadequate supervision, and a resident's risks of potentially avoidable accidents in the resident environment. (5) Effective Accident Management identifies environmental hazards, the resident's risk for an avoidable accident, and evaluates the resident's need for supervision. (6) identifying and addressing risks, including the potential for accidents, includes consideration of the environment, the residents' risk factors, and the need for supervision, care, and assistive devices.

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	555904	A. Building B. Wing	06/18/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate care for one of one sample resident (Resident 75) receiving enteral feeding (is a feeding tube that provides liquid nutrition directly into the stomach) by failing to label the flushing bag (a bag filled with water that's connected to an enteral feeding pump system) with the name of the correct solution. This deficient practice had the potential for placing Resident 75 at risk for harm when using wrong type or old fluid in the enteral flush bag. Findings:^^ During a review of Resident 75's admission Record (AR), the AR indicated the facility originally admitted the resident on 1/28/2026, and readmitted on [DATE], with diagnoses including of hemiplegia (the severe or complete loss of motor function on one side of the body) and hemiparesis (weakness or partial paralysis affecting only one side of the body) following cerebral infarction (supply of blood to the brain becomes blocked, cutting off oxygen and vital nutrients) affecting left non-dominant side; muscle weakness (Generalized) (weakness in many muscles throughout the body); encounter for attention to gastrostomy (a routine medical visit for the routine care, cleaning, or changing of a feeding tube).^ During a review of Resident 75's History and Physical (H&P), dated 5/19/2026, the H&P^indicated that^the resident could make needs known but cannot make decisions.^ During a review of Resident 75's Minimum Data Set (MDS, a resident assessment tool), dated 5/19/2026, the MDS indicated Resident 75 was able to make self- understood and has the ability to understand others and had severe cognitive impairment^(has major problems with thinking, memory, understanding, and may need significant assistance with daily activities and supervision for safety). The MDS indicated that the resident was dependent to staff or required maximal assistance^on mobility and activities of daily living^(ADLs,^activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 75's Order Summary Report (OSR), dated 6/3/2026, the OSR indicated an order for enteral feed order every shift Diabetisource AC (a type of tube feeding): set pump @55 ml/hr (milliliters per hour) for 20 hrs., to provide 1100ml/1320KCAL (kilocalorie is a unit used to measure the amount of energy in food and tube feeding). Start infusion @1200 and continue for 20 hrs. or until total volume is complete. During a review of Resident 75's Order Summary Report (OSR), dated 6/3/2026, the OSR indicated an order for enteral feed order during every shift, flush feeding tube with water at 35ml/hr x20 hrs. via kangaroo pump (a tube feeding pump used to deliver liquid nutrition and water through feeding tube) to provide 700ml/day. During an observation on 6/15/2026 at 9:50 a.m. inside^Resident^75's room, the Diabetisource bag and flush^bag were hanging from the kangaroo pump pole. The flush bag had clear liquid and^had a label that^indicated^the bag was filled with^Diabetisource at 35ml/hr.^^ During^a concurrent^observation and interview on^6/15/2026, at 12:55 p.m., with Licensed^Vocational^Nurse^(LVN) 3,^inside Resident 75`s room, LVN 3 observed the flush bag that had a label with the solution name Diabetisource. LVN 3^stated^the^flush bag was^labeled incorrectly and should include the rate, time, and date, and the correct solution name in this situation water instead of Diabetisource. LVN 3 stated labeling Diabetisource on the water bag instead of water is incorrect and confusing and may lead to errors. During an^interview for on 6/18/2026 1:47 p.m. with the Director of Nursing (DON), the DON stated that prior to hanging the enteral feeding bag and flush bag, they are labeled with the name, rate, time, and solution name. The DON stated the flush bag was incorrectly labeled as^Diabetisource^instead of water, which could cause confusion with the delivery of the feeding and^can potentially lead to an error. During a review of the facility's policy and procedure (P&P) titled, Assisted Nutrition and Hydration, last reviewed on 12/10/2025, the P&P indicated to provide facility personnel with guidelines to ensure that a resident maintains acceptable parameters of nutritional status; is offered sufficient fluid intake to maintain proper hydration and health; and is offered a therapeutic diet when ordered.^

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	555904	A. Building B. Wing	06/18/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure that the respiratory care provided to residents was consistent with professional standards of practice for two (2) of three (3) sampled resident (Resident 30, 184) reviewed for respiratory care by failing to ensure Resident 30, and Resident 184's oxygen via nasal cannula (N/C a flexible plastic tube with two tips that go into the nose to give a person extra oxygen and help them breathe easier) tubing was labeled with the date it was last changed. This deficient practice had the potential to result in placing Residents 30 and 184 at risk for infection. Findings: 1. During a review of Residentˆ30's admission Record (AR), the AR indicated the facility admitted the resident onˆ5/20/2026, with diagnoses includingˆ acute respiratory failure with hypoxiaˆ(a sudden condition in which the lungs cannot get enough oxygen into the blood, causing low oxygen levels in the body);ˆtype two (2) diabetes mellitus with hyperglycemia (a disorder characterized by difficulty in blood sugar control there is too much sugar in the blood); muscle weakness (Generalized) (weakness in many muscles throughout the body).ˆ During a review of Residentˆ30's History and Physical (H&P), datedˆ5/29/2026, the H&Pˆindicatedˆthe resident hadˆtheˆcapacity to make decisionsˆfor herself.ˆˆ During a review of Residentˆ30's Minimum Data Set (MDS, a resident assessment tool), dated 5/27/2026, the MDS indicated,ˆResident 30ˆwas able to make self- understood andˆhas the ability toˆunderstand others and had intact cognitive function (normal thinking).ˆThe MDS indicated that the resident required maximalˆassistanceˆon mobility and activities of daily livingˆ(ADLs,ˆactivities such as bathing,ˆdressingˆand toileting a person performs daily).ˆˆ During a concurrent observation and interviewˆon 6/15/2026, at 12:42ˆp.m., withˆLicensed Vocational Nurseˆ(LVN)3,ˆinsideˆresident's room,ˆobservedˆResident 30'sˆNC was notˆlabeled with the dateˆit wasˆstarted orˆlast changed. LVN 3ˆstatedˆthe NC needs to be labeled with theˆdateˆitˆwas startedˆor changedˆfor infection control precautions. LVN 3 stated thatˆthe NCˆtubingˆis changedˆonce a week,ˆitˆis doneˆevery Tuesday atˆnight orˆchangedˆas needed.ˆLVN 3 stated ifˆtheˆNCˆis not labeled,ˆtheyˆwouldˆnot know when it was changedˆand resident isˆat risk forˆdevelopingˆrespiratory infection.ˆ During an interview on 6/18/2026 atˆ1:47p.m., with the Director of Nursing (DON),ˆthe DONˆstatedˆthatˆif the NC is not labeled with the dateˆit was started, staff are unable to determine when it is dueˆfor replacement. The DONˆstatedˆthis prevents staff from monitoringˆtimelyˆtubing changesˆin accordance withˆtheˆfacility'sˆinfection prevention practice and places the resident at riskˆofˆrespiratoryˆinfection.ˆ 2. During a review of Residentˆ184's AR, the AR indicated the facility admitted the resident onˆ6/8/2026, with diagnoses includingˆchronic obstructive pulmonary diseaseˆwithˆ(acute)ˆexacerbationˆ(COPD- a chronic lung disease causing difficulty in breathingˆandˆhas suddenly worsen);ˆmuscle weakness (Generalized) (weakness in many muscles throughout the body); history of falling.ˆ During a review of Residentˆ184's H&P, datedˆ6/9/2026, the H&Pˆindicatedˆthe resident hadˆtheˆcapacity toˆunderstand andˆmake decisionsˆfor herself.ˆˆ During a concurrent observation and interviewˆon 6/15/2026, at 12:50ˆp.m., withˆLVNˆ3, inside Resident 184`s roomˆobservedˆthe resident`s NC was not labeled with date it was started or changed. LVN 3ˆstatedˆthe NC needs to be labeled with the date it was started or changed for infection control precautions. LVN 3 stated that the NC tubing is changed once a week, it is done every Tuesday at night or changed as needed. LVN 3 stated if the NC is not labeled, they would not know when it was changed and resident is at risk for developing respiratory infection.ˆ During an interviewˆon 6/18/2026 atˆ1:47p.m., with the DON, the DONˆstatedˆthatˆif the NC is not labeled with the date it was started, staff are unable toˆdetermineˆwhen it is due for replacement. The DONˆstatedˆthis prevents staff from monitoringˆtimelyˆtubing changesˆin accordance withˆthe facility's infection prevention practice and places the resident at risk of respiratory infection.ˆ During a review of the facility'sˆpolicy and procedureˆ(P&P)ˆtitled,ˆ Oxygen Therapy,ˆlast reviewed onˆ12/10/2025, the P&Pˆindicatedˆtheˆpurpose of this procedure is to provide guidelines for the administration of (continued on next page)

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	06/18/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen.ˆ Guidelines:ˆ 8.ˆAll oxygen tubing, humidifiers, masks, and cannulas used to deliver oxygen are for single resident use only, will be changed weekly and when visibly soiled, and will be stored in a plastic bag at the resident'sˆbedside to protectˆthe equipment from dust or dirt when not in use.ˆ

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	06/18/2026

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents' drug regimen included adequate (acceptable) monitoring for HgA1c ([A1C] -a test that measures average blood sugar (BS) levels over a three-month period) levels for one (1) of five (5) sampled residents investigated for unnecessary medications (Resident 7) between 7/13/2025 and 6/16/2026. This deficient practice had the potential to cause Resident 7 to receive suboptimal (less than the highest standard or quality) care by not providing the appropriate care for Diabetes Mellitus two (2) (DM2- a condition characterized by high or uncontrolled levels of BS which can lead to serious damage to the heart, eyes and kidneys [pair of organs responsible for filtering waste materials out of the blood and passing them out of the body as urine, and regulating blood pressure of the body) resulting in poorly managed BS levels leading to long term health complications and in Resident 7's health and well-being to be negatively impacted.Findings:During a review of Resident 7's admission Record (a document containing demographic and diagnostic information) dated 6/16/2026, the admission Record indicated the facility originally admitted Resident 7 on 6/6/2024, and re-admitted on [DATE],5 with diagnosis including DM2. During a review of Resident 7's Minimum Data Set (MDS-a resident assessment tool), dated 3/11/2026, the MDS indicated Resident 7 had Diabetes Mellitus and was using insulin. During a review of Resident 7's Order Summary Report (a report listing the physician order for the resident,) dated 6/16/2026, the Order Summary Report indicated Resident 7 was prescribed Insulin (a medication used to treat high BS levels) Regular (short-acting insulin) to inject per sliding scale (insulin dosing plan whereby the amount of insulin administered depends on the resident's blood sugar level,) subcutaneous (SQ- under the skin) every six (6) hours for DM2, starting 7/13/2025. During a review of Resident 7's medication administration records (MAR- a document of the medications administered to a resident that is part of the resident's permanent medical record), for June 2026, the MAR indicated Resident 7 was prescribed Insulin Regular per sliding scale SQ every six (6) hours for DM2, to be given at 12 a.m., 6 a.m., 12 p.m. and 6 p.m. During a review of Resident 7's clinical record on 6/16/2026 at 12:45 p.m., the clinical record did not include laboratory (tests that analyze certain health status) tests or results for HbA1C since 7/13/2025. During an interview and record review on 6/16/2026 at 3:05 p.m., with the Director of Nursing (DON), the DON reviewed Resident 7's clinical record. The DON acknowledged Resident 7 had a diagnosis of DM2 and was prescribed insulin Regular per sliding scale, starting 7/13/2025. The DON stated that the DON needed time to review the laboratory tests and results. During a phone interview on 6/17/2026 at 2:24 p.m., with the DON, the DON stated after a thorough search of Resident 7's clinical record, the record did not contain baseline (initial) or subsequent (following) HgA1c level monitories since admission. The DON stated that monitoring HgA1c level was important to know if the insulin therapy was effective for the residents and if any changes to medications were needed based on the level. The DON stated that residents with DM2 and insulin should have baseline HgA1c levels when admitted and monitored every three (3) to six (6) months to ensure residents were on the right medications and DM2 was managed without long term uncontrolled blood sugar levels and health complications. The DON stated that the facility failed to monitor baseline and subsequent HgA1c levels for Resident 7, since 7/13/2025. During a phone interview on 6/18/2026 at 12:06 p.m., with the Consultant Pharmacist (CP), the CP stated for residents with DM2 that HgA1c levels should be monitored every three (3) months and for stable residents every six (6) to twelve months. The CP stated that BS level monitoring was not enough to determine effectiveness of medications, such as insulin. The CP stated that monitoring HgA1c levels every three (3) to six (6) months was a diagnostic tool to evaluate the effectiveness of therapy for residents to determine if changes in medication therapy were necessary. During a review of the facility's policy and procedure (P&P) titled Unnecessary Drugs, last revised on 12/10/2025, the P&P indicated that Each resident's drug regimen shall be free from unnecessary drugs. The intent of these (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requirements is to ensure each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being. Any medication or combination of medications-or the use of a medication without adequate indications, in excessive dose, for an excessive duration, or without adequate monitoring-may have serious side effects, such as changes in vital signs/lab values, confusion, immobility, falls, and hip fractures, which can be especially dangerous for elderly residents, in addition to an increased risk of death. 2. The facility does not promote the use of unnecessary drugs. 3. Unnecessary drugs include but may not be limited to medications used: c. Without adequate monitoring 16. Examples of inappropriate duration that should be cited for noncompliance may include: 1. The facility is responsible for the resident's medication management including but not limited to:d. Monitoring 2. The interdisciplinary team are responsible for documenting medication management steps including monitoring and documenting the resident's response to any treatment such as lab results.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview, and record review, the facility failed to ensure that one of two sampled residents (Resident 12) received a suitable meal when Resident 12 had a scheduled appointment at lunchtime. This failure had the potential for Resident 12 to have weight loss and dehydration due to missing a meal. Findings: During a review of Resident 12's admission Record, the admission Record indicated the facility admitted Resident 12 on 4/23/24 with diagnoses including cerebral infarction (irreversible damage to the brain due to lack of blood flow), diabetes (a condition where the body cannot effectively produce or use insulin, a hormone that manages blood sugar in the body), and muscle weakness. During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated 3/27/2026, the MDS indicated that Resident 12 does not have visual or hearing difficulties. The record indicated that Resident 12 has significant memory loss, uses a wheelchair, and has impairment (diminished or weakened) in both arms and legs. The record also indicated that Resident 12 is dependent on caregivers for all daily activities, including feeding assistance. During a review of Resident 12's care plan for Nutrition Risk, dated 4/23/24, the care plan indicated that Resident 12 should receive diet as ordered. During a review of Resident 12's SBAR (Situation Background Assessment Recommendation - a standardized communication framework that helps professionals share essential, concise information quickly and accurately): Change of Condition, dated 5/20/26, the record indicated that Resident 12 had a weight loss of sixteen pounds in six months. During a concurrent observation and interview on 6/15/2026 at 12:52 p.m. with Licensed Vocational Nurse (LVN) 2 in Resident 12's room, medical transport had arrived with a gurney and began taking vital signs on Resident 12. Resident 12's meal tray arrived at 12:55 p.m. LVN 2 stated that Resident 12 had an appointment and required medical transport. LVN 2 stated that due to the appointment, Resident 12 was unable to be fed a meal and was instead given an Ensure (supplemental drink). During an interview on 6/17/2026 at 12:52 p.m. with LVN 2, LVN 2 stated that Resident 12 is being monitored for weight loss. LVN 2 stated that the appointment should have been communicated to the kitchen to ensure that Resident 12 received a ?snack pack before appointment. During an interview on 6/17/2026 at 1:58 p.m. with the Registered Dietician (RD), the RD stated that Ensure should not replace a meal, as it is meant to supplement a meal. During an interview on 6/18/2026 at 9:57 p.m. with the Director of Dietary (DD), the DD stated that if a resident has an appointment at a mealtime, it must be communicated to the kitchen so that a sack lunch or alternative arrangement can be made prior to the appointment. The DD stated that the kitchen was not aware of Resident 12's appointment on 6/15/2026 and confirmed that a sack lunch was not prepared for Resident 12. The DD stated that Resident 12 should have received a sack lunch. During an interview on 6/18/2026 at 1:08 p.m. with the Director of Nursing (DON), the DON stated that the policy for Meals Packed to Go was not followed and that Ensure is not an appropriate replacement for a meal. The DON stated that if a resident with weight loss does not receive a therapeutic diet (a diet ordered by a physician as treatment for a condition), it could potentially lead to a failure of the interventions to combat weight loss. During a review of the facility's Policy and Procedure (P&P) titled, Therapeutic Diet, dated January 2026, the P&P indicated, The facility ensures residents receive and consume foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician. During a review of the facility's P&P titled, Meals Packed to Go, dated 2020, the P&P indicated, Residents in need of a meal while away from the facility will be provided with a packed meal to take with them. The P&P indicated, A member of the nursing staff will notify Dining Services prior to the time packed meal is needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 3 followed Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics] that uses targeted gown and glove use during high contact resident care activities) while administering medications to a resident with wounds) for one of three observed residents (Resident 93) for medication administration. This deficient practice had the potential to place Resident 93 at risk for infections, which could result in impairment or decline in the residents' health and well-being. Findings: During an observation on 6/15/2026 at 9:15 a.m., observed an EBP sign posted at the entry to Resident 93's room. At 9:35 a.m., LVN 3 was observed sanitizing her hands and entering Resident 93's room and administering 14 medications to Resident 93. LVN 3 was not observed wearing gloves and gown while administering Resident 93's medications. During an interview on 6/15/2026 at 12 p.m., with LVN 3, LVN 3 stated Resident 93 had an EBP sign at the entry to his room to reduce the transmission of infectious organisms to the resident because the resident had wounds. LVN 3 stated gloves and a gown should be worn when giving medical treatments to Resident 93. LVN 3 stated she failed to wear gloves and gown earlier that day (6/15/2026) when administering medications to Resident 93. During an interview on 6/16/2026 at 3:05 p.m., with the Director of Nursing (DON,) the DON acknowledged Resident 93 was placed on EBP due to wounds. The DON stated residents with wounds are at increased risk of infections. The DON stated wearing gloves and gown during medication administration helps prevent the transfer of infectious organisms from staff to the resident. The DON stated LVN 3 failed to follow facility's policy and procedures (P&P) for EBP and infection control by failing to wear gloves and gown while administering medications to Resident 93, placing the resident at risk of infections. During a review of Resident 93's admission Record (a document containing demographic and diagnostic information,) dated 6/16/2026, the admission Record indicated Resident 93 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including malignant (harmful, dangerous) neoplasm (abnormal, excessive growth) of skin. During a review of Resident 75's Order Summary Report, dated 6/14/2026, the report indicated Resident 93 was placed on EBP due to wounds, starting 5/21/2024. During a review of the facility P&P titled, Enhanced Barrier Precautions, last reviewed 12/10/2025, the P&P indicated: The facility has an established infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. EBP is an infection control intervention designed to reduce transmission of MDRO that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following: 3. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. 6. EBP should be used for any residents who meet the above criteria, wherever they reside in the facility. During a review of the EBP sign posted on Resident 93's doorstep, the sign indicated: Providers and staff must also wear gloves and a gown for the high contact resident care activities below: 3. Caring for devices & giving medical treatments.