STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555904	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE ELLISON JOHN TRANSITIONAL CARE CENTER	**43830 10TH STREET WEST LANCASTER, CA 93534**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 interview and record review, the facility failed to administer [MEDICATION NAME] (a medication used to treat wound infection) as ordered by the physician for one of three sampled residents (Resident 1). This deficient practice placed Resident 1 at risk for prolonged infection such [MEDICAL CONDITION] (a life-threatening illness caused by the body's response to an infection) and hospitalization . Findings: A review of the Admission Record indicated the facility admitted Resident 1 on 12/11/19 with [DIAGNOSES REDACTED]. A review of Resident 1's Comprehensive Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 12/18/19 indicated Resident 1 is alert and requires extensive assistance from staff with bed mobility, dressing and toilet use. A review of Resident 1's Order Summary Report dated 12/11/19 indicated to administer [MEDICATION NAME] Capsule 300 milligrams (mg - a unit of measure) one capsule by mouth every 12 hours for wound infection. A review of Resident 1's Medication Administration Record [REDACTED]. On 2/24/20 at 12:40 p.m., during an interview and concurrent review of Resident 1's clinical record, the Director of Nursing (DON) confirmed Resident 1 did not receive five doses of [MEDICATION NAME] (12/16/19 at 9:00 a.m., 12/26/19 at 9:00 p.m., 12/27/19 at 9:00 a.m., 12/27/19 at 9:00 p.m. and 12/28/19 at 9:00 a.m.). The DON stated the licensed nurses should have anticipated and ensured medications were refilled and delivered timely. The DON stated the pharmacy should have been informed when there were only about five [MEDICATION NAME] left and the physician should have been notified Resident 1 did not receive [MEDICATION NAME] as ordered. A review of the facility's policy and procedure titled, Medication - Administration, with a revision date of 7/1/16, indicated medications will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.