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 _____	**09/08/2020**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to implement infection control practices for two of three sampled employees, Cook 1 and the Dietary Service Supervisor (DSS) by failing to wear mask while in the facility. This deficient practice had the potential for the spread of infection. Findings: On 7/20/2020, at 3:46 p.m., during a Dietary Services observation, Cook 1 was not wearing a mask. At time of the observation, during an interview, Cook 1 stated the mask was in his pocket because while he was cooking, there was no need to wear a mask. When asked if he was cooking, Cook 1 stated he was not. On 7/20/2020, at 3:51 p.m., during an observation and concurrent interview, DSS was not wearing a mask. DSS continued to state he should be wearing a mask at all the times but since there were not many people in the kitchen, it was okay not to have a mask on. On 7/20/2020, at 4 p.m., during an interview, the Infection Preventionist (IP) Nurse stated all staff should be wearing face masks including office staff and kitchen staff. The facility's policy and procedure titled Infection Prevention Control for COVID-19 or Persons Under Investigation (PUI), date revised June 9, 2020, indicated all facility personnel should wear a surgical mask while they are in the facility.

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