POC Accepted 04/10/2002 Surveyor ID# PRINTED: 04/13/2022 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  ALL SAINTS HEALTHCARE SUBACUTE  (X41)D SUMMARY STATEMENT OF DEFICIENCIES (PACE DEFICIENCY) MIST BE PRECEDED BY FULL (REQUIATORY OR LSC IDENTIFYING INFORMATION)  FOUR INITIAL COMMENTS  The following represents the findings of the Department of Public Health during an Abbreviated Survey.  Complaint Number: CA00772472  Representing the Department of Public Health: HFEN ID: 34659  The inspection was limited to the specific complaint investigated and does not represent the findings on a full inspection of the facility.  Four deficiencies were issued for Complaint Number CA00772472  F 656 SS=D  CFR(s): 483.21(b)(T) The facility must develop and implement a comprehensive Care Plans \$483.21(b)(1) The facility must develop and implement a comprehensive consistent with the resident rights set forth at \$483.10(c)(2) and \$483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	STATEMENT OF DI AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION (X	(3) DATE SURVEY COMPLETED	
ALL SAINTS HEALTHCARE SUBACUTE  (X4) ID PROFITE PARTY OF DEFICIENCIES (EACH CORRECTION WIST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  F 000 INITIAL COMMENTS  The following represents the findings of the Department of Public Health during an Abbreviated Survey.  Complaint Number: CA00772472  Representing the Department of Public Health: HFEN ID: 34659  The inspection was limited to the specific complaint investigated and does not represent the findings on a full inspection of the facility.  Four deficiencies were issued for Complaint Number CA00772472  F 656 Develop/Implement Comprehensive Care Plan S 483.21(b)(1)  \$483.21(b)(1) The facility must develop and implement a comprehensive Person-centered care plan for each resident, consistent with the resident rights set forth at \$483.10(c)(2) and \$483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial			056407	B. WING		C <b>03/29/2022</b>	
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	§4 im ca res §4 ob	183.21(b)(1) The fact plement a comprehate plan for each resistent rights set for 183.10(c)(3), that incipectives and timefra	cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's		not preparing the Clonidine medication as who will double check the medication and the double check will be completed by the licensed primary nurse with the unit chanurse. The Clonidine dose is prepared by pharmacy in prefilled syringes per the	and d how ne arge	
assessment. The comprehensive care plan must	ne as	eeds that are identif ssessment. The con	ied in the comprehensive nprehensive care plan must			Lewed	
describe the following -  (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights  An audit was completed on all residents who are prescribed Clonidine or other blood pressure medications by the Director of Nurses the Pediatric Manager and the Pharmacy Consultant on April 4 and 5, 2022. The residents with Clonidine and blood pressure medication orders were audited for correct labeling, dosing, and blood pressure parameters. All medication administration	(i) or ph rec (ii) un pro	The services that a maintain the residence mysical, mental, and quired under §483 Any services that a moder §483.24, §483. ovided due to the residence.	are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights		are prescribed Clonidine or other blood pressure medications by the Director of Nurses the Pediatric Manager and the Pha Consultant on April 4 and 5, 2022. The residents with Clonidine and blood press medication orders were audited for correlabeling, dosing, and blood pressure	armacy sure ect	
under §483.10, including the right to refuse orders for Clonidine or other blood pressure medications were noted as correct.  ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DA					medications were noted as correct.	(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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVAND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVAND PLAN OF CORRECTION (X3) DATE SURVAND PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) DATE SURVAND PLAN OF CORRECTION (X6)							
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		056407	B. WING			03/:	29/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				1	1810 SATICOY STREET		
ALL SAIN	TS HEALTHCARE SUB	ACUTE		N	IORTH HOLLYWOOD, CA 91605		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(IE	DATE
F 656	Continued From pag	ne 1	F	656	A series of in-service training was co by the Director of Staff Development	mpleted	
. 000			' '	000	concluding on April 9, 2022. The in-se	rvice	
	treatment under §48				with lesson plan titled POC-Medication		
		services or specialized			Signing the MAR, Med. Verification & 2		
		es the nursing facility will			Signatures was given to pediatric lice		
	provide as a result o				nurses and pediatric charge nurses on step verification of correct labeling,		
		f a facility disagrees with the			correct dosing and two step verificati		
	•	ARR, it must indicate its			Clonidine and other blood pressure	.011 01	
		lent's medical record.			medications. At the time of medication	1	
	\ <i>\</i>	ith the resident and the			administration the two step verificati	.on	
	resident's representative(s)- (A) The resident's goals for admission and				requirement is completed by the licens		
					nurse and the charge nurse for Resider		4/9/2022
	desired outcomes.				The eight rights of medication adminis		1/ 5/ 2022
		reference and potential for			were reviewed and reinforced to prever medication errors. (Right Resident, Ri		
	_	cilities must document			medication, Right time, Right dose, Ri		
		t's desire to return to the			route, Right Documentation, Right Reas		
	community was asse	essed and any referrals to			Right Response). At the conclusion of		
	local contact agencie	es and/or other appropriate			medication pass the licensed nurse sig	ns the	
	entities, for this purp	oose.			medication administration record.		
	(C) Discharge plans	in the comprehensive care					
	plan, as appropriate	, in accordance with the			A quality assurance monitor was initia		
	requirements set for	th in paragraph (c) of this			ensure that residents are free of medi		
	section.				errors and a second quality assurance was initiated to ensure individual cer		
	This REQUIREMEN	T is not met as evidenced			care plans are maintained. These quali		
	by:				assurance monitors will be completed by	- 1	
	Based on interview	and record review, the facility			Director of Nurse's and the Pediatric	Nurse	
	failed to develop and	d implement a comprehensive			Manager each week for 90 days to ensur	e that	
	person-centered car	e to prevent further			this corrective action is achieved. A		
	medication error from	n Clonidine (a medication			"Resident Medication Error" tool and a		
	used to treat hyperte	ension [or high blood			"Individual Centered Care Plan Tool" w		
	pressure, a condition	n in which the force of the			used by the Pediatric Manager and Direction Nurses to collect data. The data will		
	blood against the ar	tery walls is too high]) for one			entered into the Quality Assurance Mor		
	_	dents (Resident 1) who had a			by the Pediatric Manager and Director		
		eing administered clonidine in			Nurses. The Quality Assurance Monitor		
		rom 3/22/2021 to 3/26/2021.			evaluated for effectiveness during qua QAPI meetings for 90 days.	ırterly	
	As a result, on 2/6/2	022 during the 5 p.m.			will meetings for 70 days.		
		censed Vocational Nurse 1					
	-	administer Resident 1 in					
	, ,	was noticed by Family					
	•	nd prevented LVN 1 from					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	, ,	ATE SURVEY DMPLETED
		056407	B. WING			C <b>03/29/2022</b>
	ROVIDER OR SUPPLIER	ACUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 11810 SATICOY STREET NORTH HOLLYWOOD, CA 91605		'	00/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	Sheet) indicated the a 10 year-old male, re-admitted the residuagnoses including with hypoxia (the inacarbon dioxide and chronically low oxyg (GT, a surgically insthrough the abdominadministering medically hypertension.  A review of Residen "Potential for Possib History of Clonidine re-admission on 5/4 would receive the rightness. The intervent and to double check medication but did recheck" and how the The care plan did not of preparing the method of the control of the Physical Carlon (Control of the Physical of the control of the Physical Opening of the Physical of the Physical of the Physical Opening of the Physical Open	t 1.  t 1's Admission Record (Face facility admitted the resident, on 1/25/2017 and last dent on 5/4/2021 with chronic respiratory failure ability to effectively exchange	F 6	56		
	administer the resid [mcg] through the G	ter (mg/ml) liquid suspension, ent 0.03 mg (30 micrograms T every eight hours. t 1's Minimum Data Set				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		056407	B. WING		03/29/2022
ALL SAINTS HEALTHCARE SUBACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE 11810 SATICOY STREET NORTH HOLLYWOOD, CA 91605	1 00/25/2022		
PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 656	(MDS, a standardiz care-screening tool Resident 1 was sev (unable to compreh make decisions, an dependent on staff (ADLs, such as bed eating and toilet use On 2/11/2022 at 9:5 Register Nurse (RN stated Resident 1's in the Medication Act the licensed nurse and the RN in charge Clonidine dosage. It is considered to the licensed nurse and the RN in charge Clonidine dosage. It is considered to scheduled administ a.m. and 5 p.m., 1 called her concern Resident 1 an abnor RN 1 stated she the acknowledged co-sverifying the correct On 2/11/2022 at 11: LVN 1 stated she to RN 2 who co-significant syringe for the 5 p.r. LVN 1 stated she to RN 2 who co-significant at checking how much LVN 1 stated she did bottle to RN 2 to she LVN 1 stated she she so RN 2 could obserwhich had the media.	ed assessment and ), dated 12/28/2021, indicated erely impaired in cognition end, communicate needs, d remember). Resident 1 was for all activities of daily living I mobility, transfer, dressing, e).  61 a.m., during an interview, 11) Pediatric Unit Manager Clonidine had to be co-signed dministration Record (MAR) by administering the medication ge to verify the correct The MAR indicated Clonidine ration times were at 1 a.m. 9 N 1 stated on 2/6/2022 she was not at work and FM med about LVN 1 almost giving rmally high dose of Clonidine. en, called RN 2, who igning the MAR without it dose.  102 a.m., during an interview, 15/2022, around 5 p.m., she 1s Clonidine 3.1 ml in a 5 ml. m. medication administration. 100 the syringe and showed it med the medication. RN 2 the medication without medication was drawn up. d not bring the medication ow her the medication bottle. 10 and 12/2021 10 and 13/2022 11 and 12/2022 12 and 13/2022 13 and 14/2022 14 and 15/2022 15/2022 16 and 16/2022 16 and 16/2022 16 and 16/2022 17 and 16/2022 17 and 16/2022 18 and 18/2022 18 and 1	F 65	6	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		056407	B. WING			C	
	ROVIDER OR SUPPLIER  TS HEALTHCARE SUBA		B. Wille	STREET ADDRESS, CITY, STATE, ZI 11810 SATICOY STREET NORTH HOLLYWOOD, CA 91		03/29/2022	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	obtain.  On 2/11/2022 at 12:50 RN 2 confirmed that op.m., LVN 1 showed in co-sign the MAR, while looked at the syringe was in the syringe. RI nurses' station upset up too much Cloniding.  On 2/11/2022, at 3:30 Physician 1 stated the 2/6/2022 Resident 1 rordered dose of clonic receiving an overdose in a drop in blood president and in the dications for Special 3/30/2021, indicated the medications is a safe consideration certain including Clonidine. The must verify the dosag and initial the resident A review of the facility titled, "MAR Documer indicated the purpose require a second sign ask a charge nurse to dose of medication for indicated charge nurse MAR their check for a second sign ask a charge nurse to dose of medication for indicated charge nurse MAR their check for a second sign ask a charge nurse to dose of medication for indicated charge nurse MAR their check for a second sign ask a charge nurse to dose of medication for indicated charge nurse MAR their check for a second sign ask a charge nurse to dose of medication for indicated charge nurse MAR their check for a second sign ask a charge nurse to dose of medication for indicated charge nurse MAR their check for a second sign and the second sign ask a charge nurse to dose of medication for indicated charge nurse to the second sign ask a charge	O p.m., during an interview, on 2/6/2022, at around 5 her the syringe and asked to ch she did. RN 2 stated she but did not check how much N 2 stated FM 1 came to the because LVN 1 had drawn e.  I p.m., during an interview, of facility reported on hearly received ten times the dine. MD 1 and MD 2 stated e of that amount could result assure and could be fatal.  I's policy and procedures meters before Administering fic Residents, effective he goal was to administer manner taking into types of medications The second licensed nurse e prior to its administration, the second licensed nurse is policy and procedures, of the for medications that ature, licensed nurses must adouble check the correct raccuracy. The policy es must document on the my medication they verify.		556			
F 658 SS=E		eet Professional Standards i)	F	658			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		056407	B. WING				29/ <b>2022</b>
	ROVIDER OR SUPPLIER	CUTE		11810 SATICOY S	S, CITY, STATE, ZIP CODE STREET WOOD, CA 91605	1 00/	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	§483.21(b)(3) Compr The services provide as outlined by the co must- (i) Meet professional This REQUIREMENT by: Based on observation review, the facility fail provided services that of quality for two of two (Residents 1 and 2) the 1. Licensed Vocation documenting in the Maccord (MAR) the accord (MAR) the according residents 1 and 2 instantial administration.  2. Registered Nurse Resident 1's MAR vecal Clonidine (a medication of the control of the cont	rehensive Care Plans d or arranged by the facility, imprehensive care plan, standards of quality. T is not met as evidenced on, interview, and record led to ensure its staff at met professional standards to sampled residents oy: all Nurse 1 (LVN 1) Medication Administrator Iministration of medications the medications to stead of after their  2 (RN 2) documenting in rifying the correct dosage of on used to treat blood pressure, a condition the blood against the artery decreasing the heart rate and ssels so that blood can flow the body) LVN 1 prepared on ually verifying it was correct. a wrong dose.  atting the administration of t 1 in the MAR on 2/6/2022 IN 1 had already inistration and RN 3 did not	F 63	LVN (1) was facility polyocumentation medications (1) and resimedication and (MAR) by LVN RN (2) resignation and the licensed the director and no other medication and the licensed the director and no other medication and the licensed the director and no other medication and the licensed the director and no other medications are supplied to the licensed the director and no other medications are supplied to the licensed the director and no other medications are supplied to the licensed the director and no other medications are supplied to the licensed the director and no other medications are supplied to the licensed the director and no other medications are supplied to the licensed the director and no other medications are supplied to the licensed the director and no other medications are supplied to the licensed to the	gned on 3/10/2022.  st day worked was March 27, returns, an in service on how to address changes to administration record to contries will be completed.  day worked was 3/14/2022, of absence, should RN (4) record to enter sign and correct a previous ter sign and correct a previous the medication administrator by another licensed nupleted.  ts requiring a two-step drum by licensed nurses was codd in service on April 4, 20 depharmacy nurse consultant of nurses.  esidents MAR records were corresidents were affected by dication administration	tration of desident do by the in the in the in the in the other contract and is return, re on rious ration arse and dose on firmed 022 by and thecked	4/9/2022

PRINTED: 04/13/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		056407	B. WING		1	C <b>29/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	23/2022
				11810 SATICOY STREET		
ALL SAIN	TS HEALTHCARE SUBA	CUTE		NORTH HOLLYWOOD, CA 91605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	correct dose of Clonic 2/6/2022 for Resident already signed for it.  These deficient practive result in the residents error and /or not recemedications which cocomplications including.  Findings:  1a. On 2/11/2022 at 9 medication pass obsemedication pass obsemedications schedule Resident 2 through the surgically inserted tube through the abdominated administering medications prepared the six med Claritin, Famotidine, Output Resident 2 through the six med Claritin, Famotidine, Output Resident Six medications being give administered, LVN 1 to but provided no explain the six medications being give administered, LVN 1 to but provided no explain the six medications designed in the six medications and six medications are six medications a	dine RN 3 prepared on a 1, because RN 2 had a ces had the potential to to receive medications in a civing the ordered and result in healthing death.  2:15 am., during a contract of the prepared six and for 9 a.m. to administer the gastrostomy tube (GT, a contract of the purpose of the total wall for the purpose of the total wall for the purpose of the total cations (Lactobacillus, Domega 3, Atenolol, and the tented in the MAR, by the total size of the total wall for the purpose of the total wall wall wall wall wall wall wall w	F 658	A series of in-service training spann various dates were completed by the D of Staff Development concluding on Ap 2022. The in-service with lesson plan POC-Medication Pass, Signing the MAR, Verification, & 2nd Signatures verificates given to pediatric licensed nurse pediatric charge nurses on the two states verification of correct labeling, and dosing of Clonidine and other blood pedications. The Charge Nurses comple preliminary audit of all blood pressumedications that are delivered from the pharmacy for correct labeling, and condosing. The new or refilled medication is verified for accuracy by comparing label and dosage against the physicial orders in the medical record, and the Medication Administration Record. A verification is completed by the prime nurse prior to the Clonidine administ. The primary nurse will continue to verthat the medication labels and dosage accurate by comparing the label and dagainst the physician's orders and Meadministration Record. The 8 rights of medication administration were review reinforced to prevent medication error (Right Resident, Right medication, Right Resident, Right Reason, Right Re At the conclusion of the medication administration record.	irector ril 9, titled Med. cation, s and ep correct ressure ted a re the rrect n label the n's second ary ration. rify s are posage dication f ed and rs. ght	4/9/2022
	(MDS, a standardized					

Facility ID: CA920000001

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION  G		PLETED
		056407	B. WING			C / <b>29/2022</b>
	ROVIDER OR SUPPLIER	ACUTE		STREET ADDRESS, CITY, STATE, ZIP COD 11810 SATICOY STREET NORTH HOLLYWOOD, CA 91605		2312022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
F 658	Resident 2 was seve (unable to comprehe make decisions, and dependent on staff f (ADLs, such as bed eating and toilet use.  A review of the Physischeduled for 9 a.m. a. Lactobacillus 4 ta gastrointestinal integdated 10/13/2021. b. Claritin 10 milligra allergic rhinitis (nose allergen), dated 5/13c. Famotidine 20 mg reflux disease (GER 10/13/2021. d. Omega 1000 mg hypercholesterolemi 10/13/2021. e. Atenolol 2mg per GT every day, hold if f. Rifaximin 550 mg day for small intestir overgrowth, dated 1  On 2/11/2022 at 2:20 with RN 1 (the Pedia concurrent reviewed Medication Administ stated it was the pra sign a resident's MA not before as indicated 1b. A review of Resi indicated the facility year-old male, on 1/2	erely impaired in cognition and, communicate needs, defended, defende	F 6:	A quality assurance monitor we ensure that residents are freerrors. The quality assurance completed by the Director of Pediatric Nurse Manager each to ensure that this corrective achieved. A "Resident Medicat will be used by the Pediatric Director of Nurses to collect will be entered into the Qual Monitor by the Pediatric Mana of Nurses. The Quality Assurabe evaluated for effectiveness quarterly QAPI meetings for 9	ee of medication e monitor will be Nurse's and the week for 90 days e action is cion Error" tool Manager and data. The data dity Assurance ager and Director unce Monitor will as during	4/9/2022

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	' '	OMPLETED
		056407	B. WING			C 03/29/2022
	ROVIDER OR SUPPLIER	ACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE 11810 SATICOY STREET NORTH HOLLYWOOD, CA 91605		03/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 658	effectively exchange resulting in chronical dependent on a venuse for a person unal own), GT, and hype pressure, a conditional blood against the array A review of Residen "Potential for Possib History of Clonidine re-admission on 5/4, would receive the right times. The intervent and to double check medication.  A review of the Physical dated 7/13/2021, incliquid suspension, amg (equivalent to 30 the GT every eight had administering the machange of the unit (Ocorrect Clonidine do (Sunday) at 5 p.m., 1 called her concern Resident 1 an abnor RN 1 stated she the acknowledged co-signed the correct verifying ve	th hypoxia (the inability to carbon dioxide and oxygen, lly low oxygen levels) tilator (a breathing machine able to breathe on his/her rtension (or high blood in in which the force of the tery walls is too high).  It 's Care Plan titled, lle Drug Reactions Related to Drug Overdose," dated upon (2021, indicated Resident 1 ght dose of medications at all ions included giving Clonidine the dosage before giving the dicated Clonidine 0.1 mg/ml dminister the resident 0.03 micrograms [mcg]) through dours.  It's Clonidine had to be R by the licensed nurse edication and by the RN in charge Nurse) verifying the se. RN 1 stated on 2/6/2022 she was not at work and FM led about LVN 1 almost giving mally high dose of Clonidine. In, called RN 2, who gning the MAR without dose. RN 1 stated RN 3 was Clonidine scheduled at 5	F 6	58		

	DEFICIENCIES CORRECTION	A. BUILDING COMPLETED		(X3) DATE SURVEY COMPLETED	
		056407	B. WING		C <b>03/29/2022</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  11810 SATICOY STREET  NORTH HOLLYWOOD, CA 91605	03/29/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5475
	3. On 2/16/2022 at 12 telephone interview, Figiving Resident 1 Closign the MAR because for it.  4. During a phone interview, It is a proposed by RN 3 on unable to verify that he resident 1's Nursing.  A review of the facility titled, "Checking Para Medications for Special/3/30/2021, indicated the medications is a safe consideration certain including Clonidine." must verify the dosage and initial the resident A review of the facility titled, "MAR Documer indicated the purposed require a second sign ask a charge nurse to dose of medication for indicated charge nurse MAR their check for a second sign ask a their check for a second sign and indicated charge nurse to dose of medication for indicated charge nurse to make the purposed require a second sign ask a charge nurse to dose of medication for indicated charge nurse to make the purposed require a second sign ask a charge nurse to dose of medication for indicated charge nurse to make the purposed require a second sign ask a charge nurse to dose of medication for indicated charge nurse to make the purposed require a second sign ask a charge nurse to dose of medication for indicated charge nurse to the purposed require a second sign ask a charge nurse to dose of medication for indicated charge nurse to the purposed require a second sign ask a charge nurse to the purposed require a second sign ask a charge nurse to the purposed require a second sign ask a charge nurse to the purposed require a second sign ask a charge nurse to the purposed require a second sign ask a charge nurse to the purposed require a second sign ask a charge nurse to the purposed require a second sign ask a charge nurse to the purposed require a second sign ask a charge nurse to the purposed require a second sign ask a charge nurse to the purposed require a second sign ask a charge nurse to the purposed require a second sign ask a charge nurse to the purposed require a second sign ask a charge nurse to the purposed require a second sign ask a charge nurse to the purposed require a second sign	2:52 p.m., during a RN 3 stated on 2/6/2022 nidine at 5:30 pm but did not the LVN 1 had already signed  erview with RN 4 on the stated he was the the ecked the clonidine dose 2/6/2022 at 5 pm. RN 4 was the had initialed Resident 1's to had documented in Flowsheet.  The spolicy and procedures the goal was to administer the goal was to administe	F 65	LVN (1) was in serviced and retrained facility policy of Medication Administ Documentation which includes the	the censed nd
	The facility must prov	ide routine and emergency to its residents, or obtain		having signed the medication administr record (MAR) prior to administering th medications.	ation

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION		PLETED
		056407	B. WING		1	C <b>29/2022</b>
	ROVIDER OR SUPPLIER	CUTE		STREET ADDRESS, CITY, STATE, ZIP CODE 11810 SATICOY STREET NORTH HOLLYWOOD, CA 91605	1 00	20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	Communication page		F 75	5		
	personnel to adminis permits, but only und a licensed nurse.  §483.45(a) Procedum pharmaceutical service that assure the accurdispensing, and administration of meet to \$483.45(b) Service Comust employ or obtain pharmacist whoselesses of the provision the facility.  §483.45(b)(1) Provide aspects of the provision the facility.  §483.45(b)(2) Establicate facility and disposition sufficient detail to enarconciliation; and \$483.45(b)(3) Determined and permits REQUIREMENT by:  Based on observation review, the facility fair pharmaceutical service administration of meets ampled residents (Reconstruction).	lity may permit unlicensed ter drugs if State law er the general supervision of es. A facility must provide ces (including procedures ate acquiring, receiving, inistering of all drugs and he needs of each resident.  Consultation. The facility in the services of a licensed es consultation on all on of pharmacy services in shes a system of records of n of all controlled drugs in able an accurate enter that drug records are in count of all controlled drugs riodically reconciled.  The is not met as evidenced enter the interview, and record led to provide ces to assure accurate dications for two of two desidents 1 and 2) by:  all Nurse 1 (LVN 1)		RN (2) resigned on 3/10/2022.  RN (3)'s last day worked was March 2' When RN (3) returns, an in service of procedure on how to address changes medication administration record to erroneous entries will be completed.  RN (4) last day worked was 3/14/2022 on a leave of absence, should RN (4) an in service on the two step proceds how to counter sign and correct a prentry made in the medication administracord in error by another licensed will be completed.  All pediatric residents requiring a drug dose verification and the sequence signing the medication administration by licensed nurses was confirmed by in service on April 6, 2022.	and is return, are on evious cration nurse	4/9/2022
	documenting in the M	al Nurse 1 (LVN 1) ledication Administration Iministration of medications				

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI COMPLET						
			A. BOILDI	NG _	<del></del>		;
		056407	B. WING			1	29/2022
	ROVIDER OR SUPPLIER  TS HEALTHCARE SUB	ACUTE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 1810 SATICOY STREET IORTH HOLLYWOOD, CA 91605		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	prior to administerin Residents 1 and 2.  2. Registered Nurse Resident 1's MAR v Clonidine (a medical hypertension [or high in which the force of walls is too high] by relaxing the blood v more easily through 2/6/2022, without act 1 had prepared a with 3. RN 3 not docume Clonidine to Resider at 5 p.m. because L documented its admicorrect the MAR documented its admicorrect dose of Cloric 2/6/2022 for Reside already signed for it These deficient praces and for not recomedications which complications include Findings:  1a. On 2/11/2022 at medication pass observed in the resident 2 through surgically inserted to	g the medications to  2 (RN 2) documenting in erifying the correct dosage of tion used to treat h blood pressure, a condition the blood against the artery decreasing the heart rate and essels so that blood can flow the body) LVN 1 prepared on stualy verifying the dose. LVN rong dose.  Inting the administration of the 1 in the MAR on 2/6/2022 VN 1 had already hinistration and RN 3 did not cumentation.  Inting in the MAR verifying the hiddine RN 3 prepared on the total to the country of the country	F	755	A series of in-service training was comby the Director of Staff Development concluding on April 9, 2022. The in-servith lesson plan titled POC-Medication Signing the MAR, Med. Verification & 2: Signatures was given to pediatric licer nurses and pediatric charge nurses on step verification of correct labeling, correct dosing of Clonidine and other pressure medications. The Charge Nurses completed a preliminary audit of all bipressure medications that are delivered the pharmacy for correct labeling, and dosing. The new or refilled medication is verified for accuracy by comparing label and dosage against the physician orders in the medical record, and the Medication Administration Record. A serverification will be completed by the purse. The primary nurse will also verthe medication label and dosage against physician's orders and Medication Administration Record. The eight right medication administration were reviewed reinforced to prevent medication, Right Resident, Right medication, Right Resident, Right medication, Right Reason, Right Response). At the conclusion of the medication administration record.	rvice Pass, and ased the two and blood s lood d from correct label the 's cond primary ify that urate by the s of d and s. ant time, tation, licensed	4/9/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		056407	B. WING			C 29/2022	
	NAME OF PROVIDER OR SUPPLIER  ALL SAINTS HEALTHCARE SUBACUTE			STREET ADDRESS, CITY, STATE, ZIP CODE  11810 SATICOY STREET  NORTH HOLLYWOOD, CA 91605		20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 755	administering medical prepared the six medical claritin, Famotidine, Rifaximin) she documentering her name in asked LVN 1 the real medications being gradministered, LVN 1  A review of Resident Sheet) indicated the a 17-year-old male, whim on 10/13/2021 we congenital malformatoccur because of an before birth) and GT  A review of Resident (MDS, a standardized care-screening tool), Resident 2 was sever (unable to comprehen make decisions, and dependent on staff for (ADLs, such as bed eating and toilet use A review of the Physischeduled for 9 a.m. a. Lactobacillus 4 tall gastrointestinal integrated 10/13/2021. b. Claritin 10 milligra allergic rhinitis (nose allergen), dated 5/13 c. Famotidine 20 mg	ations and food). After LVN 1 dications (Lactobacillus, Omega 3, Atenolol, and mented in the MAR, by iditials, as administered. When son she signed the MAR as iven when they were not stated she always did that.  It 2's Admission Record (Face facility admitted the resident, on 5/31/2018 and re-admitted with diagnoses including tion syndrome (birth defects, improper development  It 2's Minimum Data Set and assessment and and adated 1/25/2022, indicated arely impaired in cognition and, communicate needs, are rall activities of daily living mobility, transfer, dressing, beliefs via GT twice a day for arity (helps with digestion), area inflammation due to an	F 75	A quality assurance monitor wa ensure that residents are free errors. The quality assurance completed by the Director of N Pediatric Nurse Manager each w to ensure that this corrective achieved. A "Resident Medicatiwill be used by the Pediatric Director of Nurses to collect will be entered into the Qualimonitor by the Pediatric Managof Nurses. The Quality Assurance be evaluated for effectiveness quarterly QAPI meetings for 90 grants of the policy of the pediatric Managof Nurses. The Quality Assurance evaluated for effectiveness quarterly QAPI meetings for 90 grants of the policy of the pediatric Managof Nurses. The Quality Assurance evaluated for effectiveness quarterly QAPI meetings for 90 grants of the pediatric Managof Nurses.	e of medication monitor will be Jurse's and the week for 90 days action is on Error" tool Manager and data. The data ty Assurance ger and Director ace Monitor will	4/9/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		056407	B. WING			C <b>03/29/2022</b>	
	ALL SAINTS HEALTHCARE SUBACUTE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  (FACH DEFICIENCY MUST BE DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE  11810 SATICOY STREET  NORTH HOLLYWOOD, CA 91605		03/23/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 755	Continued From pag	ge 13 ia (high cholesterol), dated	F 75	55			
	10/13/2021. e. Atenolol 2mg per GT every day, hold f. Rifaximin 550 mg	milliliters (ml) give 20 mg via for SBP tablet via GT three times a ne to prevent bacterial					
	with RN 1 (the Pedia concurrent reviewed Medication Administ stated it was the pra	0 p.m., during an interview atric Unit Manager) and a d the facility's policy on tration Techniques, RN 1 actice for licensed nurses to AR after giving medications, ted in the policy.					
	indicated the facility year-old male, on 1/him on 5/4/2021 with respiratory failure weffectively exchange resulting in chronical dependent on a venuse for a person una own), GT, and hype pressure, a conditio	ident 1's Admission Record admitted the resident, a 10 '25/2017 and last re-admitted th diagnoses including chronic ith hypoxia (the inability to e carbon dioxide and oxygen, illy low oxygen levels) itilator (a breathing machine able to breathe on his/her rtension (or high blood in in which the force of the tery walls is too high).					
	"Potential for Possib History of Clonidine re-admission on 5/4 would receive the rig times. The intervent	at 1's Care Plan titled, ble Drug Reactions Related to Drug Overdose," dated upon /2021, indicated Resident 1 ght dose of medications at all ions included giving Clonidine at the dosage before giving the					
	A review of the Phys	sician's Order for Resident 1,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	COMPLETED
		056407	B. WING		C 03/29/2022
NAME OF PROVIDER OR SUPPLIER  ALL SAINTS HEALTHCARE SUBACUTE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE  11810 SATICOY STREET  NORTH HOLLYWOOD, CA 91605	1 33/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 755	liquid suspension, a mg (equivalent to 30 the GT every eight l	dicated Clonidine 0.1 mg/ml administer the resident 0.03 0 micrograms [mcg]) through hours.	F 75	5	
	RN 1 stated Reside co-signed in the MA administering the m charge of the unit (Correct Clonidine do (Sunday) at 5 p.m., 1 called her concern Resident 1 an abno RN 1 stated she the acknowledged co-siverifying the correct	9:51 a.m., during an interview, not 1's Clonidine had to be a R by the licensed nurse dedication and by the RN in Charge Nurse) verifying the ose. RN 1 stated on 2/6/2022 she was not at work and FM ned about LVN 1 almost giving armally high dose of Clonidine. en, called RN 2, who igning the MAR without a dose. RN 1 stated RN 3 was be Clonidine scheduled at 5 complaint.			
	telephone interview giving Resident 1 C	12:52 p.m., during a , RN 3 stated on 2/6/2022 lonidine at 5:30 pm but did not use LVN 1 had already signed			
	2/16/2022 at 1:08 p charge nurse who c prepared by RN 3 o unable to verify that	nterview with RN 4 on m., he stated he was the shecked the clonidine dose on 2/6/2022 at 5 pm. RN 4 was the had initialed Resident 1's R or had documented in g Flowsheet.			
	titled, "Checking Pa Medications for Spe 3/30/2021, indicated	ity's policy and procedures rameters before Administering ecific Residents, effective d the goal was to administer fe manner taking into			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		E CONSTRUCTION	COMPLETED	
		056407	B. WING		C 03/29/2022	
	LL SAINTS HEALTHCARE SUBACUTE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  (FACH DEFICIENCY MUST BE DESCRIBED BY FULL)			STREET ADDRESS, CITY, STATE, ZIP CODE  11810 SATICOY STREET  NORTH HOLLYWOOD, CA 91605		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 760 SS=D	including Clonidine. must verify the dosa, and initial the reside.  A review of the facilit titled, "MAR Docume indicated the purpos require a second sig ask a charge nurse t dose of medication frindicated charge nur MAR their check for Residents are Free CCFR(s): 483.45(f)(2)  The facility must ens §483.45(f)(2) Residemedication errors. This REQUIREMEN by: Based on interview failed to ensure one (Resident 1) was fremedication error who p.m. medication past 1 (LVN 1) attempted Clonidine (a medicathypertension [or high in which the force of walls is too high] by relaxing the blood vemore easily through Family Member 1 (FLVN 1 from giving Reclonidine. Resident	types of medications The second licensed nurse ge prior to its administration, nt's MAR.  y's policy and procedures, entation," effective 1/1/2022, e of the for medications that nature, licensed nurses must to double check the correct for accuracy. The policy ses must document on the any medication they verify. of Significant Med Errors  ure that its- nts are free of any significant T is not met as evidenced and record review, the facility of two sampled residents er from any significant en, on 2/6/2022 during the 5 s, Licensed Vocational Nurse to administer Resident 1	F 760		diately ion e RN 2. 2. The red dose he ered  ts who od of  2022. d ressure tion	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					l l	С
		056407	B. WING		03/	29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ALL CAIN	TO LIEAL THOADE OUD	ACUTE		11810 SATICOY STREET		
ALL SAINTS HEALTHCARE SUBACUTE			NORTH HOLLYWOOD, CA 91605			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 760	' '		F 76	0		
	requiring hospitaliza	ition.				
		ce placed Resident 1 at risk of which could have resulted in s and death.		A series of in-service training by the Director of Staff Develop concluding on April 9, 2022. The with lesson plan titled POC-Medi Signing the MAR, Med. Verificati Signatures was given to pediatri nurses and pediatric charge nurs	oment e in-service ication Pass, ion & 2nd ic licensed	4/9/2022
	Sheet) indicated the a 10 year-old male, re-admitted the resi diagnoses including with hypoxia (the incarbon dioxide and chronically low oxygventilator (a breathin unable to breathe outbe (GT, a surgical stomach through the purpose of administrand hypertension.  A review of Resider "Potential for Possit History of Clonidine re-admission on 5/4 would receive the ritimes. The interventiand to double check medication.  A review of the Physical	gen levels) dependent on a ang machine use for a person in his/her own), gastrostomy by inserted tubing into the elabdominal wall for the ering medications and food)  at 1's Care Plan titled, ble Drug Reactions Related to Drug Overdose," dated upon 1/2021, indicated Resident 1 ght dose of medications at all ions included giving Clonidine at the dosage before giving the 1/2021, indicated Resident 1, dicated Clonidine 0.1 ter (mg/ml) liquid suspension, ent 0.03 mg (30 micrograms		step verification of correct lab correct dosing of Clonidine and pressure medications. The Charge completed a preliminary audit of pressure medications that are defined the pharmacy for correct labeling correct dosing. The new or refile medication label is verified for comparing the label and dosage aphysician's orders in the medication Medication Administration Resecond verification will be comparing that the medication label is accurate by comparing the label against the physician's orders and Administration Record. At the timedication administration the two verification requirement is complicensed nurse and the charge nueight rights of medication administration administration record to medication, Right time, Right do route, Right Documentation, Right Response). At the conclusion medication administration record	other blood e Nurses f all blood elivered from ng, and lled r accuracy by against the al record, and ecord. A pleted by the e will also l and dosage and Medication ime of wo step pleted by the urse. The nistration prevent nt, Right ose, Right nt Reason, ion of the rrse signs the	
	dated 7/13/2021, in milligrams per millili administer the resid [mcg]) through the 0	dicated Clonidine 0.1 ter (mg/ml) liquid suspension, ent 0.03 mg (30 micrograms GT every eight hours.				
	A review of Resider	t 1's Minimum Data Set				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		056407	B. WING			C / <b>29/2022</b>	
NAME OF PROVIDER OR SUPPLIER  ALL SAINTS HEALTHCARE SUBACUTE		STREET ADDRESS, CITY, STATE, ZIP CODE  11810 SATICOY STREET  NORTH HOLLYWOOD, CA 91605					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	Resident 1 was sever (unable to compreher make decisions, and dependent on staff for (ADLs, such as bed reating and toilet use)  On 2/11/2022 at 9:51 Registered Nurse (Ristated Resident 1's Coin the Medication Adrithe licensed nurse and by the RN in chand by the RN in chand by the RN in chand stated on 2/6/2022 (Sonot at work and FM 1 LVN 1 almost giving Fight dose of Clonidin called RN 2, who ack MAR without verifying filled out a written Staff 1's complaint.  On 2/11/2022 at 11:00 LVN 1 stated on 2/6/2 drew up Resident 1's syringe for Resident administration. LVN 1 and showed it to RN imedication bottle to remedication bottle to concentration needed	d assessment and dated 12/28/2021, indicated rely impaired in cognition and, communicate needs, remember). Resident 1 was a rall activities of daily living mobility, transfer, dressing,  a.m., during an interview, N 1) Pediatric Unit Manager clonidine had to be co-signed ministration Record (MAR) by diministering the medication arge of the unit (Charge correct Clonidine dose. RN 1 canday) at 5 p.m., she was called her concerned about Resident 1 an abnormally e. RN 1 stated she then mowledged co-signing the grade the correct dose. RN 1 had attement form because of FM  2 a.m., during an interview, 2022, around 5 p.m., she Clonidine 3.1 ml in a five-ml 1's 5 p.m. medication stated she took the syringe 2 who co-signed the atted she did not bring the RN 2 to show her the observe the medication label	F 76	A quality assurance monitor wa initiated to ensure that resid free of medication errors. The assurance monitor will be comp the Director of Nurse's and th Pediatric Nurse Manager each w 90 days to ensure that this co action is achieved. A "Residen Medication Error" tool will be the Pediatric Manager and Dire Nurses to collect data. The dabe entered into the Quality As Monitor by the Pediatric Manag Director of Nurses. The Qualit Assurance Monitor will be eval effectiveness during quarterly meetings for 90 days.	ents are quality leted by e eek for rrective t used by ctor of ta will surance er and y uated for	4/9/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		056407	B. WING				C
		056407	B. WING			03/	29/2022
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ALL SAIN	TS HEALTHCARE SUBA	CUTE			11810 SATICOY STREET		
7122 071111				NORTH HOLLYWOOD, CA 91605			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	DAIL
	1		+		+		
F 760	Continued From page	e 18	F	760	0		
	bedside to give but th	en she realized the					
	Clonidine amount was	s too much and she should					
	have instead used a	one-ml syringe not a five-ml					
	syringe and get only (	0.3 ml LVN 1 did not mention					
	FM 1 was the one no	ticing the wrong amount of					
	Clonidine.						
		0 p.m., during an interview,					
		on 2/6/2022, at around 5					
	•	ner the syringe and asked to					
		ch she did. RN 2 stated she					
		but did not check how much					
	, ,	N 2 stated FM 1 came to the					
	-	because LVN 1 had drawn					
	-	e. RN 2 stated she called					
		or Resident 1's attending					
		2, to report the incident but					
	did not document in F	Resident 1's clinical record.					
	O= 0/44/0000 =+ 0.00	) duning an interview					
		) p.m., during an interview,					
	Physician 1 stated the						
		nearly received ten times the dine. MD 1 and MD 2 stated					
		e of that amount could result ssure and could be fatal.					
	iii a diop iii biood pre	ssure and could be latal.					
	A review of the facility	's policy and procedures					
	_	meters before Administering					
		ific Residents, effective					
	-	the goal was to administer					
	medications is a safe	<del>-</del>					
	consideration certain						
		The second licensed nurse					
		e prior to its administration,					
	and initial the residen						
	A review of the facility	's policy and procedures,					
		ntation," effective 1/1/2022,					
		of the for medications that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION  NG	(X	(X3) DATE SURVEY COMPLETED	
		056407	B. WING _			C <b>03/29/2022</b>	
NAME OF PROVIDER OR SUPPLIER  ALL SAINTS HEALTHCARE SUBACUTE			STREET ADDRESS, CITY, STATE, ZIP CODE  11810 SATICOY STREET  NORTH HOLLYWOOD, CA 91605				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 760	require a second sigr ask a charge nurse to dose of medication for indicated charge nurse	e 19 nature, licensed nurses must of double check the correct or accuracy. The policy ses must document on the any medication they verify.	F 7	760			