STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056407	A. BUILDING _____ B. WING _____	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL SAINTS HEALTHCARE SUBACUTE	11810 SATICOY STREET NORTH HOLLYWOOD, CA 91605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §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 needs that are identified in the comprehensive assessment. The comprehensive care plan must 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 under §483.10, including the right to refuse	F 656	Resident (1) returned from an acute care hospital stay on 3-22-2021 for a matter unrelated to Clonidine medication. Resident (1) did not require hospitalization from the Clonidine medication administration on 3/22/2021 through 3/26/2021. Resident (1) was subsequently admitted to the acute care hospital on 4/13/2021 for a separate clinical matter. The care plan for Resident (1) was updated on 4/1/2022 to include specific instructions on not preparing the Clonidine medication and who will double check the medication and how the double check will be completed by the licensed primary nurse with the unit charge nurse. The Clonidine dose is prepared by the pharmacy in prefilled syringes per the physicians order. All other residents care plans were reviewed for individual centered care. 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 orders for Clonidine or other blood pressure medications were noted as correct.	4/9/2022

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

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F 656	Continued From page 1 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care to prevent further medication error from Clonidine (a medication used to treat hypertension [or high blood pressure, a condition in which the force of the blood against the artery walls is too high]) for one of two sampled residents (Resident 1) who had a previous history of being administered clonidine in error by the facility from 3/22/2021 to 3/26/2021. As a result, on 2/6/2022 during the 5 p.m. medication pass, Licensed Vocational Nurse 1 (LVN 1) attempted to administer Resident 1 in high amount which was noticed by Family Member 1 (FM 1) and prevented LVN 1 from	F 656	A series of in-service training was completed by the Director of Staff Development concluding on April 9, 2022. The in-service with lesson plan titled POC-Medication Pass, Signing the MAR, Med. Verification & 2nd Signatures was given to pediatric licensed nurses and pediatric charge nurses on the two step verification of correct labeling, and correct dosing and two step verification of Clonidine and other blood pressure medications. At the time of medication administration the two step verification requirement is completed by the licensed nurse and the charge nurse for Resident 1. The eight rights of medication administration were reviewed and reinforced to prevent medication errors. (Right Resident, Right medication, Right time, Right dose, Right route, Right Documentation, Right Reason, Right Response). At the conclusion of the medication pass the licensed nurse signs the medication administration record. A quality assurance monitor was initiated to ensure that residents are free of medication errors and a second quality assurance monitor was initiated to ensure individual center care plans are maintained. These quality assurance monitors will be completed by the Director of Nurse's and the Pediatric Nurse Manager each week for 90 days to ensure that this corrective action is achieved. A "Resident Medication Error" tool and a "Individual Centered Care Plan Tool" will be used by the Pediatric Manager and Director of Nurses to collect data. The data will be entered into the Quality Assurance Monitors by the Pediatric Manager and Director of Nurses. The Quality Assurance Monitor will be evaluated for effectiveness during quarterly QAPI meetings for 90 days.	4/9/2022

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F 656	Continued From page 2	F 656		

overdosing Resident 1.

Findings:

A review of Resident 1's Admission Record (Face Sheet) indicated the facility admitted the resident, a 10 year-old male, on 1/25/2017 and last re-admitted the resident on 5/4/2021 with diagnoses including chronic respiratory failure with hypoxia (the inability to effectively exchange carbon dioxide and oxygen, resulting in chronically low oxygen levels), gastrostomy tube (GT, a surgically inserted tubing into the stomach through the abdominal wall for the purpose of administering medications and food) and hypertension.

A review of Resident 1's Care Plan titled, "Potential for Possible Drug Reactions Related to History of Clonidine Drug Overdose," dated upon re-admission on 5/4/2021, indicated Resident 1 would receive the right dose of medications at all times. The interventions included giving Clonidine and to double check the dosage before giving the medication but did not indicate who would "double check" and how the double check would be done. The care plan did not include specific instructions of preparing the medication. The conversion of the order dose into milliliters (ml) and what syringe size to use to draw the liquid medication to measure the does accurately and safely.

A review of the Physician's Order for Resident 1, dated 7/13/2021, indicated Clonidine 0.1 milligrams per milliliter (mg/ml) liquid suspension, administer the resident 0.03 mg (30 micrograms [mcg] through the GT every eight hours.

A review of Resident 1's Minimum Data Set

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F 656	Continued From page 3	F 656		

(MDS, a standardized assessment and care-screening tool), dated 12/28/2021, indicated Resident 1 was severely impaired in cognition (unable to comprehend, communicate needs, make decisions, and remember). Resident 1 was dependent on staff for all activities of daily living (ADLs, such as bed mobility, transfer, dressing, eating and toilet use).

On 2/11/2022 at 9:51 a.m., during an interview, Register Nurse (RN 1) Pediatric Unit Manager stated Resident 1's Clonidine had to be co-signed in the Medication Administration Record (MAR) by the licensed nurse administering the medication and the RN in charge to verify the correct Clonidine dosage. The MAR indicated Clonidine scheduled administration times were at 1 a.m. 9 a.m. and 5 p.m. RN 1 stated on 2/6/2022 (Sunday) at 5 p.m., she was not at work and FM 1 called her concerned about LVN 1 almost giving Resident 1 an abnormally high dose of Clonidine. RN 1 stated she then, called RN 2, who acknowledged co-signing the MAR without verifying the correct dose.

On 2/11/2022 at 11:02 a.m., during an interview, LVN 1 stated on 2/6/2022, around 5 p.m., she drew up Resident 1's Clonidine 3.1 ml in a 5 ml. syringe for the 5 p.m. medication administration. LVN 1 stated she took the syringe and showed it to RN 2 who co-signed the medication. RN 2 stated "glanced" at the medication without checking how much medication was drawn up. LVN 1 stated she did not bring the medication bottle to RN 2 to show her the medication bottle. LVN 1 stated she should have brought the bottle so RN 2 could observe the medication label which had the medication name and concentration needed to calculate the amount to

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F 656	Continued From page 4 obtain. On 2/11/2022 at 12:50 p.m., during an interview, RN 2 confirmed that on 2/6/2022, at around 5 p.m., LVN 1 showed her the syringe and asked to co-sign the MAR, which she did. RN 2 stated she looked at the syringe but did not check how much was in the syringe. RN 2 stated FM 1 came to the nurses' station upset because LVN 1 had drawn up too much Clonidine. On 2/11/2022, at 3:30 p.m., during an interview, Physician 1 stated the facility reported on 2/6/2022 Resident 1 nearly received ten times the ordered dose of clonidine. MD 1 and MD 2 stated receiving an overdose of that amount could result in a drop in blood pressure and could be fatal. A review of the facility's policy and procedures titled, "Checking Parameters before Administering Medications for Specific Residents, effective 3/30/2021, indicated the goal was to administer medications is a safe manner taking into consideration certain types of medications including Clonidine. The second licensed nurse must verify the dosage prior to its administration, and initial the resident's MAR. A review of the facility's policy and procedures, titled, "MAR Documentation," effective 1/1/2022, indicated the purpose of the for medications that require a second signature, licensed nurses must ask a charge nurse to double check the correct dose of medication for accuracy. The policy indicated charge nurses must document on the MAR their check for any medication they verify.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		

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F 658	Continued From page 5 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure its staff provided services that met professional standards of quality for two of two sampled residents (Residents 1 and 2) by: 1. Licensed Vocational Nurse 1 (LVN 1) documenting in the Medication Administrator Record (MAR) the administration of medications prior to administering the medications to Residents 1 and 2 instead of after their administration. 2. Registered Nurse 2 (RN 2) documenting in Resident 1's MAR verifying the correct dosage of Clonidine (a medication used to treat hypertension [or high blood pressure, a condition in which the force of the blood against the artery walls is too high] by decreasing the heart rate and relaxing the blood vessels so that blood can flow more easily through the body) LVN 1 prepared on 2/6/2022, without actually verifying it was correct. LVN 1 had prepared a wrong dose. 3. RN 3 not documenting the administration of Clonidine to Resident 1 in the MAR on 2/6/2022 at 5 p.m. because LVN 1 had already documenting its administration and RN 3 did not correct the MAR documentation. 4. RN 4 not documenting in the MAR verifying the	F 658	LVN (1) was in serviced and retrained on the facility policy of Medication Administration Documentation which includes initialing of medications given on April 8, 2022. Resident (1) and resident (2) were not affected by the medication administration recordation in the (MAR) by LVN (1). RN (2) resigned on 3/10/2022. RN (3)'s last day worked was March 27, 2022. When RN (3) returns, an in service on the procedure on how to address changes to the medication administration record to correct erroneous entries will be completed. RN (4) last day worked was 3/14/2022, and is on a leave of absence, should RN (4) return, an in service on the two step procedure on how to counter sign and correct a previous entry made in the medication administration record in error by another licensed nurse will be completed. All residents requiring a two-step drug dose verification by licensed nurses was confirmed by audit and in service on April 4, 2022 by the licensed pharmacy nurse consultant and the director of nurses. All other residents MAR records were checked and no other residents were affected by the isolated medication administration recordation.	4/9/2022

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F 658	Continued From page 6 correct dose of Clonidine RN 3 prepared on 2/6/2022 for Resident 1, because RN 2 had already signed for it. These deficient practices had the potential to result in the residents to receive medications in error and /or not receiving the ordered medications which could result in health complications including death. Findings: 1a. On 2/11/2022 at 9:15 am., during a medication pass observation, LVN 1 prepared six medications scheduled for 9 a.m. to administer Resident 2 through the gastrostomy tube (GT, a surgically inserted tubing into the stomach through the abdominal wall for the purpose of administering medications and food). After LVN 1 prepared the six medications (Lactobacillus, Claritin, Famotidine, Omega 3, Atenolol, and Rifaximin) she documented in the MAR, by entering her name initials, as administered. When asked LVN 1 the reason she signed the MAR as medications being given when they were not administered, LVN 1 stated she always did that but provided no explanation. A review of Resident 2's Admission Record (Face Sheet) indicated the facility admitted the resident, a 17-year-old male, on 5/31/2018 and re-admitted him on 10/13/2021 with diagnoses including congenital malformation syndrome (birth defects, occur because of an improper development before birth) and GT. A review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 1/25/2022, indicated	F 658	A series of in-service training spanning various dates were completed by the Director of Staff Development concluding on April 9, 2022. The in-service with lesson plan titled POC-Medication Pass, Signing the MAR, Med. Verification, & 2nd Signatures verification, was given to pediatric licensed nurses and pediatric charge nurses on the two step verification of correct labeling, and correct dosing of Clonidine and other blood pressure medications. The Charge Nurses completed a preliminary audit of all blood pressure medications that are delivered from the pharmacy for correct labeling, and correct dosing. The new or refilled medication label is verified for accuracy by comparing the label and dosage against the physician's orders in the medical record, and the Medication Administration Record. A second verification is completed by the primary nurse prior to the Clonidine administration. The primary nurse will continue to verify that the medication labels and dosages are accurate by comparing the label and dosage against the physician's orders and Medication Administration Record. The 8 rights of medication administration were reviewed and reinforced to prevent medication errors. (Right Resident, Right medication, Right time, Right dose, Right route, Right Documentation, Right Reason, Right Response). At the conclusion of the medication administration the licensed nurse signs the medication administration record.	4/9/2022

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F 658	Continued From page 7 Resident 2 was severely impaired in cognition (unable to comprehend, communicate needs, make decisions, and remember). Resident 2 was dependent on staff for all activities of daily living (ADLs, such as bed mobility, transfer, dressing, eating and toilet use). A review of the Physician's Orders for Resident 2 scheduled for 9 a.m. indicated: a. Lactobacillus 4 tablets via GT twice a day for gastrointestinal integrity (helps with digestion), dated 10/13/2021. b. Claritin 10 milligrams (mg) via GT every day for allergic rhinitis (nose inflammation due to an allergen), dated 5/13/2021. c. Famotidine 20 mg via GT for gastroesophageal reflux disease (GERD, acid reflux), dated 10/13/2021. d. Omega 1000 mg via GT twice a day for mild hypercholesterolemia (high cholesterol), dated 10/13/2021. e. Atenolol 2mg per milliliters (ml) give 20 mg via GT every day, hold for SBP f. Rifaximin 550 mg tablet via GT three times a day for small intestine to prevent bacterial overgrowth, dated 10/13/2021. On 2/11/2022 at 2:20 p.m., during an interview with RN 1 (the Pediatric Unit Manager) and a concurrent reviewed the facility's policy on Medication Administration Techniques, RN 1 stated it was the practice for licensed nurses to sign a resident's MAR after giving medications, not before as indicated in the policy. 1b. A review of Resident 1's Admission Record indicated the facility admitted the resident, a 10 year-old male, on 1/25/2017 and last re-admitted him on 5/4/2021 with diagnoses including chronic	F 658	A quality assurance monitor was initiated to ensure that residents are free of medication errors. The quality assurance monitor will be completed by the Director of Nurse's and the Pediatric Nurse Manager each week for 90 days to ensure that this corrective action is achieved. A "Resident Medication Error" tool will be used by the Pediatric Manager and Director of Nurses to collect data. The data will be entered into the Quality Assurance Monitor by the Pediatric Manager and Director of Nurses. The Quality Assurance Monitor will be evaluated for effectiveness during quarterly QAPI meetings for 90 days.	4/9/2022

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F 658	Continued From page 8	F 658		

respiratory failure with hypoxia (the inability to effectively exchange carbon dioxide and oxygen, resulting in chronically low oxygen levels) dependent on a ventilator (a breathing machine use for a person unable to breathe on his/her own), GT, and hypertension (or high blood pressure, a condition in which the force of the blood against the artery walls is too high).

A review of Resident 1's Care Plan titled, "Potential for Possible Drug Reactions Related to History of Clonidine Drug Overdose," dated upon re-admission on 5/4/2021, indicated Resident 1 would receive the right dose of medications at all times. The interventions included giving Clonidine and to double check the dosage before giving the medication.

A review of the Physician's Order for Resident 1, dated 7/13/2021, indicated Clonidine 0.1 mg/ml liquid suspension, administer the resident 0.03 mg (equivalent to 30 micrograms [mcg]) through the GT every eight hours.

2. On 2/11/2022 at 9:51 a.m., during an interview, RN 1 stated Resident 1's Clonidine had to be co-signed in the MAR by the licensed nurse administering the medication and by the RN in charge of the unit (Charge Nurse) verifying the correct Clonidine dose. RN 1 stated on 2/6/2022 (Sunday) at 5 p.m., she was not at work and FM 1 called her concerned about LVN 1 almost giving Resident 1 an abnormally high dose of Clonidine. RN 1 stated she then, called RN 2, who acknowledged co-signing the MAR without verifying the correct dose. RN 1 stated RN 3 was assigned to give the Clonidine scheduled at 5 p.m. due to FM 1's complaint.

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F 658	Continued From page 9 3. On 2/16/2022 at 12:52 p.m., during a telephone interview, RN 3 stated on 2/6/2022 giving Resident 1 Clonidine at 5:30 pm but did not sign the MAR because LVN 1 had already signed for it. 4. During a phone interview with RN 4 on 2/16/2022 at 1:08 pm., he stated he was the charge nurse who checked the clonidine dose prepared by RN 3 on 2/6/2022 at 5 pm. RN 4 was unable to verify that he had initialed Resident 1's February 2022 MAR or had documented in Resident 1's Nursing Flowsheet. A review of the facility's policy and procedures titled, "Checking Parameters before Administering Medications for Specific Residents, effective 3/30/2021, indicated the goal was to administer medications is a safe manner taking into consideration certain types of medications including Clonidine. The second licensed nurse must verify the dosage prior to its administration, and initial the resident's MAR. A review of the facility's policy and procedures, titled, "MAR Documentation," effective 1/1/2022, indicated the purpose of the for medications that require a second signature, licensed nurses must ask a charge nurse to double check the correct dose of medication for accuracy. The policy indicated charge nurses must document on the MAR their check for any medication they verify.	F 658		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755	LVN (1) was in serviced and retrained on the facility policy of Medication Administration Documentation which includes the documentation of medications on the medication administration record after the medications are administered by the licensed nurse on April 8, 2022. Resident (1) and resident (2) were not affected by LVN (1)'s having signed the medication administration record (MAR) prior to administering the medications.	4/9/2022

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F 755	Continued From page 10 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to assure accurate administration of medications for two of two sampled residents (Residents 1 and 2) by: 1. Licensed Vocational Nurse 1 (LVN 1) documenting in the Medication Administration Record (MAR) the administration of medications	F 755	RN (2) resigned on 3/10/2022. RN (3)'s last day worked was March 27, 2022. When RN (3) returns, an in service on the procedure on how to address changes to the medication administration record to correct erroneous entries will be completed. RN (4) last day worked was 3/14/2022, and is on a leave of absence, should RN (4) return, an in service on the two step procedure on how to counter sign and correct a previous entry made in the medication administration record in error by another licensed nurse will be completed. All pediatric residents requiring a two-step drug dose verification and the sequence of signing the medication administration record by licensed nurses was confirmed by audit and in service on April 6, 2022.	4/9/2022

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F 755	Continued From page 11 prior to administering the medications to Residents 1 and 2. 2. Registered Nurse 2 (RN 2) documenting in Resident 1's MAR verifying the correct dosage of Clonidine (a medication used to treat hypertension [or high blood pressure, a condition in which the force of the blood against the artery walls is too high] by decreasing the heart rate and relaxing the blood vessels so that blood can flow more easily through the body) LVN 1 prepared on 2/6/2022, without actualy verifying the dose. LVN 1 had prepared a wrong dose. 3. RN 3 not documenting the administration of Clonidine to Resident 1 in the MAR on 2/6/2022 at 5 p.m. because LVN 1 had already documented its administration and RN 3 did not correct the MAR documentation. 4. RN 4 not documenting in the MAR verifying the correct dose of Clonidine RN 3 prepared on 2/6/2022 for Resident 1 because RN 2 had already signed for it. These deficient practices had the potential to result in the residents to receive medications in error and /or not receiving the ordered medications which could result in health complications including death. Findings: 1a. On 2/11/2022 at 9:15 am., during a medication pass observation, LVN 1 prepared six medications scheduled for 9 a.m. to administer Resident 2 through the gastrostomy tube (GT, a surgically inserted tubing into the stomach through the abdominal wall for the purpose of	F 755	A series of in-service training was completed by the Director of Staff Development concluding on April 9, 2022. The in-service with lesson plan titled POC-Medication Pass, Signing the MAR, Med. Verification & 2nd Signatures was given to pediatric licensed nurses and pediatric charge nurses on the two step verification of correct labeling, and correct dosing of Clonidine and other blood pressure medications. The Charge Nurses completed a preliminary audit of all blood pressure medications that are delivered from the pharmacy for correct labeling, and correct dosing. The new or refilled medication label is verified for accuracy by comparing the label and dosage against the physician's orders in the medical record, and the Medication Administration Record. A second verification will be completed by the primary nurse. The primary nurse will also verify that the medication label and dosage is accurate by comparing the label and dosage against the physician's orders and Medication Administration Record. The eight rights of medication administration were reviewed and reinforced to prevent medication errors. (Right Resident, Right medication, Right time, Right dose, Right route, Right Documentation, Right Reason, Right Response). At the conclusion of the medication pass the licensed nurse signs the medication administration record.	4/9/2022

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F 755	Continued From page 12 administering medications and food). After LVN 1 prepared the six medications (Lactobacillus, Claritin, Famotidine, Omega 3, Atenolol, and Rifaximin) she documented in the MAR, by entering her name initials, as administered. When asked LVN 1 the reason she signed the MAR as medications being given when they were not administered, LVN 1 stated she always did that. A review of Resident 2's Admission Record (Face Sheet) indicated the facility admitted the resident, a 17-year-old male, on 5/31/2018 and re-admitted him on 10/13/2021 with diagnoses including congenital malformation syndrome (birth defects, occur because of an improper development before birth) and GT. A review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 1/25/2022, indicated Resident 2 was severely impaired in cognition (unable to comprehend, communicate needs, make decisions, and remember). Resident 2 was dependent on staff for all activities of daily living (ADLs, such as bed mobility, transfer, dressing, eating and toilet use). A review of the Physician's Orders for Resident 2 scheduled for 9 a.m. indicated: a. Lactobacillus 4 tablets via GT twice a day for gastrointestinal integrity (helps with digestion), dated 10/13/2021. b. Claritin 10 milligrams (mg) via GT every day for allergic rhinitis (nose inflammation due to an allergen), dated 5/13/2021. c. Famotidine 20 mg via GT for gastroesophageal reflux disease (GERD, acid reflux), dated 10/13/2021. d. Omega 1000 mg via GT twice a day for mild	F 755	A quality assurance monitor was initiated to ensure that residents are free of medication errors. The quality assurance monitor will be completed by the Director of Nurse's and the Pediatric Nurse Manager each week for 90 days to ensure that this corrective action is achieved. A "Resident Medication Error" tool will be used by the Pediatric Manager and Director of Nurses to collect data. The data will be entered into the Quality Assurance Monitor by the Pediatric Manager and Director of Nurses. The Quality Assurance Monitor will be evaluated for effectiveness during quarterly QAPI meetings for 90 days.	4/9/2022

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hypercholesterolemia (high cholesterol), dated 10/13/2021.
e. Atenolol 2mg per milliliters (ml) give 20 mg via GT every day, hold for SBP
f. Rifaximin 550 mg tablet via GT three times a day for small intestine to prevent bacterial overgrowth, dated 10/13/2021.

On 2/11/2022 at 2:20 p.m., during an interview with RN 1 (the Pediatric Unit Manager) and a concurrent reviewed the facility's policy on Medication Administration Techniques, RN 1 stated it was the practice for licensed nurses to sign a resident's MAR after giving medications, not before as indicated in the policy.

1b. A review of Resident 1's Admission Record indicated the facility admitted the resident, a 10 year-old male, on 1/25/2017 and last re-admitted him on 5/4/2021 with diagnoses including chronic respiratory failure with hypoxia (the inability to effectively exchange carbon dioxide and oxygen, resulting in chronically low oxygen levels) dependent on a ventilator (a breathing machine use for a person unable to breathe on his/her own), GT, and hypertension (or high blood pressure, a condition in which the force of the blood against the artery walls is too high).

A review of Resident 1's Care Plan titled, "Potential for Possible Drug Reactions Related to History of Clonidine Drug Overdose," dated upon re-admission on 5/4/2021, indicated Resident 1 would receive the right dose of medications at all times. The interventions included giving Clonidine and to double check the dosage before giving the medication.

A review of the Physician's Order for Resident 1,

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F 755	Continued From page 14	F 755		

dated 7/13/2021, indicated Clonidine 0.1 mg/ml liquid suspension, administer the resident 0.03 mg (equivalent to 30 micrograms [mcg]) through the GT every eight hours.

2. On 2/11/2022 at 9:51 a.m., during an interview, RN 1 stated Resident 1's Clonidine had to be co-signed in the MAR by the licensed nurse administering the medication and by the RN in charge of the unit (Charge Nurse) verifying the correct Clonidine dose. RN 1 stated on 2/6/2022 (Sunday) at 5 p.m., she was not at work and FM 1 called her concerned about LVN 1 almost giving Resident 1 an abnormally high dose of Clonidine. RN 1 stated she then, called RN 2, who acknowledged co-signing the MAR without verifying the correct dose. RN 1 stated RN 3 was assigned to give the Clonidine scheduled at 5 p.m. due to FM 1's complaint.

3. On 2/16/2022 at 12:52 p.m., during a telephone interview, RN 3 stated on 2/6/2022 giving Resident 1 Clonidine at 5:30 pm but did not sign the MAR because LVN 1 had already signed for it.

4. During a phone interview with RN 4 on 2/16/2022 at 1:08 pm., he stated he was the charge nurse who checked the clonidine dose prepared by RN 3 on 2/6/2022 at 5 pm. RN 4 was unable to verify that he had initialed Resident 1's February 2022 MAR or had documented in Resident 1's Nursing Flowsheet.

A review of the facility's policy and procedures titled, "Checking Parameters before Administering Medications for Specific Residents, effective 3/30/2021, indicated the goal was to administer medications is a safe manner taking into

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F 755	Continued From page 15 consideration certain types of medications including Clonidine. The second licensed nurse must verify the dosage prior to its administration, and initial the resident's MAR. A review of the facility's policy and procedures, titled, "MAR Documentation," effective 1/1/2022, indicated the purpose of the for medications that require a second signature, licensed nurses must ask a charge nurse to double check the correct dose of medication for accuracy. The policy indicated charge nurses must document on the MAR their check for any medication they verify.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) was free from any significant medication error when, on 2/6/2022 during the 5 p.m. medication pass, Licensed Vocational Nurse 1 (LVN 1) attempted to administer Resident 1 Clonidine (a medication used to treat hypertension [or high blood pressure, a condition in which the force of the blood against the artery walls is too high] by decreasing the heart rate and relaxing the blood vessels so that blood can flow more easily through the body) in high amount but Family Member 1 (FM 1) noticed and prevented LVN 1 from giving Resident 1 an overdose of Clonidine. Resident 1 had received Clonidine in error from 3/22/2021 to 3/26/2021, overdosing (an excessive and dangerous dose of a drug) him	F 760	On February 6, 2022, a Clonidine medication draw preparation error was noted immediately by LVN 1 for resident 1. The preparation error was reported to the charge nurse RN 2. RN 2 called and notified physician MD 2. The physician MD 2 instructed the Registered Nurse RN 2 to ensure that the correct dose of Clonidine will be administered. The proper dose was subsequently administered and no adverse reaction occurred for resident 1. 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 medications were audited for correct labeling, dosing, and blood pressure parameters. All medication administration orders for Clonidine or other blood pressure medications were noted as correct.	4/9/2022

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F 760	Continued From page 16 requiring hospitalization. This deficient practice placed Resident 1 at risk of repeated overdose which could have resulted in severe complications and death. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the facility admitted the resident, a 10 year-old male, on 1/25/2017 and last re-admitted the resident on 5/4/2021 with diagnoses including chronic respiratory failure with hypoxia (the inability to effectively exchange carbon dioxide and oxygen, resulting in chronically low oxygen levels) dependent on a ventilator (a breathing machine use for a person unable to breathe on his/her own), gastrostomy tube (GT, a surgically inserted tubing into the stomach through the abdominal wall for the purpose of administering medications and food) and hypertension. A review of Resident 1's Care Plan titled, "Potential for Possible Drug Reactions Related to History of Clonidine Drug Overdose," dated upon re-admission on 5/4/2021, indicated Resident 1 would receive the right dose of medications at all times. The interventions included giving Clonidine and to double check the dosage before giving the medication. A review of the Physician's Order for Resident 1, dated 7/13/2021, indicated Clonidine 0.1 milligrams per milliliter (mg/ml) liquid suspension, administer the resident 0.03 mg (30 micrograms [mcg]) through the GT every eight hours. A review of Resident 1's Minimum Data Set	F 760	A series of in-service training was completed by the Director of Staff Development concluding on April 9, 2022. The in-service with lesson plan titled POC-Medication Pass, Signing the MAR, Med. Verification & 2nd Signatures was given to pediatric licensed nurses and pediatric charge nurses on the two step verification of correct labeling, and correct dosing of Clonidine and other blood pressure medications. The Charge Nurses completed a preliminary audit of all blood pressure medications that are delivered from the pharmacy for correct labeling, and correct dosing. The new or refilled medication label is verified for accuracy by comparing the label and dosage against the physician's orders in the medical record, and the Medication Administration Record. A second verification will be completed by the primary nurse. The primary nurse will also verify that the medication label and dosage is accurate by comparing the label and dosage against the physician's orders and Medication Administration Record. At the time of medication administration the two step verification requirement is completed by the licensed nurse and the charge nurse. The eight rights of medication administration were reviewed and reinforced to prevent medication errors (Right Resident, Right medication, Right time, Right dose, Right route, Right Documentation, Right Reason, Right Response). At the conclusion of the medication pass the licensed nurse signs the medication administration record.	4/9/2022

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F 760	Continued From page 17 (MDS, a standardized assessment and care-screening tool), dated 12/28/2021, indicated Resident 1 was severely impaired in cognition (unable to comprehend, communicate needs, make decisions, and remember). Resident 1 was dependent on staff for all activities of daily living (ADLs, such as bed mobility, transfer, dressing, eating and toilet use). On 2/11/2022 at 9:51 a.m., during an interview, Registered Nurse (RN 1) Pediatric Unit Manager stated Resident 1's Clonidine had to be co-signed in the Medication Administration Record (MAR) by the licensed nurse administering the medication and by the RN in charge of the unit (Charge Nurse) verifying the correct Clonidine dose. RN 1 stated on 2/6/2022 (Sunday) at 5 p.m., she was not at work and FM 1 called her concerned about LVN 1 almost giving Resident 1 an abnormally high dose of Clonidine. RN 1 stated she then called RN 2, who acknowledged co-signing the MAR without verifying the correct dose. RN 1 had filled out a written Statement form because of FM 1's complaint. On 2/11/2022 at 11:02 a.m., during an interview, LVN 1 stated on 2/6/2022, around 5 p.m., she drew up Resident 1's Clonidine 3.1 ml in a five-ml syringe for Resident 1's 5 p.m. medication administration. LVN 1 stated she took the syringe and showed it to RN 2 who co-signed the medication. LVN 1 stated she did not bring the medication bottle to RN 2 to show her the medication bottle to observe the medication label which indicates the medication name and concentration needed in order to calculate how much medication should be obtained. LVN 1 stated after RN 2 co-signed the medication on the MAR, she took the medication to Resident 1's	F 760	A quality assurance monitor was initiated to ensure that residents are free of medication errors. The quality assurance monitor will be completed by the Director of Nurse's and the Pediatric Nurse Manager each week for 90 days to ensure that this corrective action is achieved. A "Resident Medication Error" tool will be used by the Pediatric Manager and Director of Nurses to collect data. The data will be entered into the Quality Assurance Monitor by the Pediatric Manager and Director of Nurses. The Quality Assurance Monitor will be evaluated for effectiveness during quarterly QAPI meetings for 90 days.	4/9/2022

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bedside to give but then she realized the Clonidine amount was 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 noticing the wrong amount of Clonidine.

On 2/11/2022 at 12:50 p.m., during an interview, RN 2 confirmed that on 2/6/2022, at around 5 p.m., LVN 1 showed her the syringe and asked to co-sign the MAR, which she did. RN 2 stated she looked at the syringe but did not check how much was in the syringe. RN 2 stated FM 1 came to the nurses' station upset because LVN 1 had drawn up too much Clonidine. RN 2 stated she called Physician 2, on call for Resident 1's attending physician, Physician 2, to report the incident but did not document in Resident 1's clinical record.

On 2/11/2022, at 3:30 p.m., during an interview, Physician 1 stated the facility reported on 2/6/2022 Resident 1 nearly received ten times the ordered dose of clonidine. MD 1 and MD 2 stated receiving an overdose of that amount could result in a drop in blood pressure and could be fatal.

A review of the facility's policy and procedures titled, "Checking Parameters before Administering Medications for Specific Residents, effective 3/30/2021, indicated the goal was to administer medications is a safe manner taking into consideration certain types of medications including Clonidine. The second licensed nurse must verify the dosage prior to its administration, and initial the resident's MAR.

A review of the facility's policy and procedures, titled, "MAR Documentation," effective 1/1/2022, indicated the purpose of the for medications that

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F 760	Continued From page 19 require a second signature, licensed nurses must ask a charge nurse to double check the correct dose of medication for accuracy. The policy indicated charge nurses must document on the MAR their check for any medication they verify.	F 760		