STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065100	A. Building B. Wing	06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Canyon Respiratory and Rehabilitation Center	2515 Pitman Pl Pueblo, CO 81004

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39261 Based on record review and interviews, the facility failed to ensure the residents were kept free from significant medication errors for one (#1) of three out of seven sample residents. Specifically, the facility failed to ensure a registered nurse (RN) #1 correctly transcribed the physician order for Resident #1. Resident #1 was administered 175 mg (milligrams) of clozapine (antipsychotic) when the physician order was for 75 mg. The assistant director of nursing (ADON) administered the 175 mg of clozapine to Resident #1 on 5/18/22, and several hours after the administration of the medication the resident became unresponsive while away from the facility and was transported to a local hospital. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 6/27/22 to 6/28/22, resulting in the deficiency being cited as past noncompliance with a correction date of 6/23/22. I. Professional reference [NAME] Nursing Drug Handbook 2020, Kizior, R. J. and [NAME], K.J., St. Louis Missouri 2020, revealed the following pharmaceutical information: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-page (pp). 276-278 read in part: Clozapine (Clonaril, Fazaclo, Versacloz). Clinical classification-antipsychotic. Uses: Management of severely ill schizophrenic patients who fail to respond to other antipsychotic therapy. Treatment of recurrent suicidal behavior in schizophrenia or schizoaffective disorder. Off label treatments, schizoaffective disorder, bipolar disorder obsessive-compulsive disorder and agitation to Alzheimer's dementia. Black box alert significant risk of life-threatening agranulocytosis (decline in white blood cells), increased risk of potentially fatal cardiovascular events, particular myocarditis, in elderly patients with dementia related psychosis. May cause severe orthostatic hypotension, bradycardia, syncope, cardiac arrest and dose dependent seizures. Precautions/caution in patients with: history of seizures, cardiovascular disease, respiratory or renal impairments; and patients at risk of aspiration pneumonia, urinary retention, bowel obstruction, visual disturbances and diabetes. Avoid using it for patients with dementia. Side effects: Frequent drowsiness, salivation, tachycardia, dizziness and constipation. Occasional: hypotension headache, tremors, syncope, diaphoresis, dry mouth nausea, visual disturbances, nightmares, restlessness, agitation, hypertension and abdominal distress. Monitor blood pressure, pulse, white blood cell count and supervise for suicidal risk during early therapy. II. Facility policy and procedure The Medication Errors policy and procedure, revised November 2017, was provided by the director of nursing (DON) on 6/28/22 at 4:30 p.m. It read in pertinent part: Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services. III. Resident #1 A. Resident status Resident #1, age under 65, was admitted to the facility on [DATE]. According to the May 2022 computerized physician orders (CPO), the diagnoses included schizophrenia, dementia without behavioral disturbance, anxiety, and major depressive disorder. The 5/18/22 minimum data set (MDS) assessment revealed the resident had short term memory problems, and her cognitive skills for daily decision making were severely impaired. She required extensive assistance of one staff member with mobility and activities of daily living (ADLs). She did not have any behaviors or rejections of care. B. Record review A review of the resident's May 2022 physician orders revealed the following orders: -Clozapine tablet 75 mg (miligram) by mouth one time a day for schizophrenia for seven days, ordered 5/17/22 with a start date of 5/18/22. -Clozapine tablet 100 mg by mouth one time a day for schizophrenia until 5/25/22, ordered 5/17/22 with a start date of 5/18/22. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A review of the resident's nursing progress notes revealed the following progress notes: 5/18/22: Received call from (name of outside provider) stating that (the) resident was transported from (name of outside provider) to (local hospital) as resident had gone unresponsive while at (name of outside provider). (Outside provider) notified family of resident. Prior to leaving to (name of outside provider), resident was alert and at baseline walking around. Resident ate breakfast and was sitting in living room prior to leaving. 5/19/22: Transcription error reviewed by IDT (interdisciplinary team) and recommendation made for education with the Nurse that entered (the) order incorrectly. No abuse/neglect suspected. A review of the hospital records from 5/18/22 revealed the following ICU (intensive care unit) progress note: This is a (age) woman with a history of schizophrenia and depression who presents from her (name of facility) after being found unresponsive. Unable to obtain any history from the patient as she is unresponsive. Per report from someone at the facility, the patient likely received double her dose of clozapine. Patient has cognitive impairment at baseline and does have a history of catatonia (abnormality of movement and behavior arising from a disturbed mental state) but she normally is awake and answers questions. On arrival to the ER (emergency room) the patient was hypotensive (low blood pressure) and hypoxemic (low oxygen levels). VBG (venous blood gas) revealed severe respiratory acidosis (failure of ventilation and accumulation of carbon dioxide) with pH 7.09. She was put on a BiPAP (bilevel positive airway pressure). The patient has paperwork indicating comfort measures only. Her medical decision-maker is present at bedside when I evaluated the patient in the ER, she said that she decided to change goals of care to selective treatment today. Patient was admitted to the ICU in shock on pressors (medicines to tighten blood vessels and raise blood pressure). C. Facility investigation On 5/18/22 the facility began an investigation of the incident immediately upon learning of the medication error. The investigation revealed RN #1 had made a transcription error for the resident's clozapine. The investigation revealed the order was for the resident to receive 75 milligrams (mg) of clozapine for seven days, and then increase the dose to clozapine 100 mg indefinitely. The order as written read: 4/27/22 recommending starting clozapine 25 mg (miligram), titrating 25 mg weekly to a goal of 100 mg daily. The facility investigation determined RN #1 had entered the order so that both doses (75 mg and 100 mg) started on the same day, therefore the resident was given 175 mg of clozapine on 5/18/22 instead of the physician ordered 75 mg. IV. Facility actions (continued on next page)

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