

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555204	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER Childrens Hc Org No CA Saratoga Pediatric Subacute		STREET ADDRESS, CITY, STATE, ZIP CODE 13425 Sousa Lane Saratoga, CA 95070	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to maintain and meet current standards of nursing practice when, the medication was not administered according to the physician's order for one of two residents (Resident 1). This failure could potentially result in complications of the residents' medical conditions. Findings: Review of Resident 1's clinical record indicated she was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including spastic quadriplegic cerebral palsy (a permanent physical disability affecting both arms, legs, facial muscle, trunk and making movements is difficult). Review of Resident 1's Physician Order Summary Report dated 2/13/26 and 3/14/26 indicated Atropine Sulfate Ophthalmic Solution 1% (a medication used in the eye, medication also with off label to treat severe drooling) administer three drops sublingually (under the tongue) three times a day for excess saliva. During a concurrent interview and record review with the Administrator (ADM) on 6/24/26, at 10:05 a.m., the ADM reviewed Resident 1's clinical record and stated that on 6/21/26 p.m. shift (3 p.m. to 11 p.m.) there was an incident of medication administration error administered by Registered Nurse A (RN A). The ADM further stated that Atropine Sulfate Ophthalmic Solution 1% was administered as one drop OU (both eyes) instead of the prescribed sublingual route to Resident 1. The ADM stated Resident 1's physician order was revised after the incident. During an interview with the Medical Doctor (MD) on 6/24/26 at 10:32 a.m., the MD stated that he ordered Atropine Sulfate Ophthalmic Solution 1% give three drops sublingually three times a day for excess saliva. The MD further stated that he was aware about the medication administration error identified on 6/21/26 that the Atropine Sulfate Ophthalmic Solution 1% was given to Resident 1's both eyes instead of the sublingual route. The MD stated he was in the facility on 6/23/26 to assess Resident 1's condition and ordered to hold the medication from 6/23/26 through 6/28/26. The MD stated that Atropine Sulfate Ophthalmic Solution 1% was designed as eye drops but this medication could also be given sublingually as ordered for Resident 1. During a concurrent interview and record review with the ADM on 6/24/26, at 11:50 a.m., the ADM reviewed Resident 1's Medication Administration Record (MAR) and the ADM confirmed that the MAR indicated Atropine Sulfate Ophthalmic Solution 1% give three drops sublingually three times a day and was scheduled to be given by the licensed nurses (LNs) at (5 a.m., 1 p.m., and 9 p.m.) for excess saliva as ordered by the physician and should not have been given to Resident 1's eyes. During an interview with Registered Nurse B (RN B) on 6/26/26 at 9:43 a.m., RN B stated LNs need to follow the five basic rights in giving medications to residents such as; Right Patient, Right Medication, Right Dose, Right Route of administration and Right Time. RN B further stated that before giving the Atropine Sulfate Ophthalmic Solution 1% sublingual three drops three times a day to Resident 1, she checks the physician order, MAR and medication prescription label in the bottle and LNs will never make a mistake. During an interview with RN C on 6/26/26 at 12:37 p.m., RN C stated before giving the Atropine Sulfate Ophthalmic Solution 1% sublingual three drops three times a day to Resident 1, she checks the physician order or review and confirm medication by comparing the name of medication, dosage, route, time and Resident 1's name. RN C further stated that she was giving the medication sublingually as ordered by the physician. A review of the facility's policy and procedures (P&P) titled, Medication Administration, dated 2007, indicated, prior to (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration , review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR with the medication label.Medications are administered in accordance with written orders of the prescriber.		