| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065181 | A. Building<br>B. Wing | 12/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Valley View Villa | 815 Fremont Ave<br>Fort Morgan, CO 80701 |

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) |
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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to prevent a significant medication error for one (#1) of 10 residents reviewed for medication errors out of 10 sample residents.Specifically, the facility failed to ensure Resident #1 was not inadvertently administered another resident's opioid medication (medication used to treat moderate to severe pain).Findings include:I. Facility policy and procedure The Administration of Medications policy, reviewed 9/9/25, was received from the nursing home administrator (NHA) on 10/21/25 at 1:00 p.m. It read in pertinent part, The facility will ensure medications are administered safely and appropriately per physician orders to address residents' diagnoses and signs and symptoms. A 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. A significant medication error means one which causes the resident discomfort or jeopardizes his or her health and safety. Staff who are responsible for medication administration will adhere to the 10 Rights of Medication Administration: right drug, right resident, right dose, right route, right time and frequency, right documentation, right assessment, right to refuse, right evaluation/response, right education and information.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included peripheral vascular disease (a circulatory disorder caused by narrowed or blocked blood vessels outside the heart and brain), orthostatic hypotension (a sudden drop in blood pressure when you stand up from a sitting or lying position), non-pressure chronic ulcer of right foot (a slow healing wound caused by underlying conditions like poor circulation), gangrene (death of tissue caused by loss of blood supply infection or injury), pain in right foot and essential hypertension (high blood pressure). The 10/2/25 minimum data set (MDS) assessment identified Resident #1 was severely cognitively impaired with a brief interview for mental status (BIMS) score of three out of 15. Resident #1 was dependent upon staff to transfer from the bed to the chair.B. Record reviewThe physician's progress note, dated 8/21/25, documented Resident #1 was opioid tolerant on a relatively high-dose of fentanyl and the physician was going to start the resident conservatively on methadone (synthetic opioid medication used to treat severe, chronic pain) 2.5 milligrams (mg) twice a day and titrate up every five to seven days as needed while watching for sedation, confusion, respiratory depression and changes in heart rate.The progress note, dated 9/24/25 at 10:14 a.m., documented that during the morning medication count, it was noted that Resident #1's 9:00 p.m. methadone was not administered on 9/23/25. After investigation, it was discovered the resident was administered another resident's (Resident #11) Oxycontin (opioid pain medication) 30 mg instead. The physician was notified and a message was left for the resident's representative.The progress note, dated 9/24/25 at 10:37 a.m., revealed Resident #1's representative returned the phone call and was updated about the medication error.The progress note, dated 9/24/25 at 1:26 p.m., revealed Resident #1 had no signs or symptoms of adverse effects noted related to the administration of the Oxycontin medication.Review of Resident #1's September 2025 CPO revealed a<br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | physician's order for methadone HCL oral tablet 10 mg to be given by mouth two times a day for limb ischemia pain, ordered 9/20/25.-Review of Resident #1's September 2025 CPO did not reveal a physician's order for Oxycontin, the medication the resident was administered instead of methadone on 9/23/25.-However, review of another resident's (Resident #11) October 2025 CPO revealed a physician's order for Oxycontin 30 mg oral tablet, one tablet to be given by mouth two times a day for rheumatoid arthritis (an autoimmune disease that causes joint pain, swelling, and stiffness) pain, ordered 8/15/25. A Medication Discrepancy document, dated 9/24/25, was provided by the NHA on 10/20/25 at 6:17 p.m. The Medication Discrepancy document revealed that during the morning medication count, Resident #1's 9:00 p.m. methadone was not administered and instead, 30 mg of another resident's Oxycontin was administered. A report was made to the director of nursing (DON) and the physician. The document revealed no adverse effects to Resident #1 were noted throughout the night and the resident was easily aroused throughout the night. Vital signs were stable at the time and Resident #1 was alert and oriented to person. The document indicated education was to be done with registered nurse (RN) #3 and all nursing staff.III. Staff interviewsA certified nurse aide with medication authority (CNA-Med) who wished to remain anonymous was interviewed on 10/20/25 at 3:40 p.m. The CNA-Med said the facility was aware of a medication error that took place in September 2025 for Resident #1. The CNA-Med said they saw no adverse effects to Resident #1 after the error. The CNA-Med said after the medication error, staff were educated about completing the five rights of medication administration and were re-educated on how to use the medication narcotic book to ensure medication errors did not occur.Certified nurse aide (CNA) #4 was interviewed on 10/20/25 at 5:35 p.m. CNA #4 said she was not aware that the medication error for Resident #1 occurred on the night of 9/23/25 when she was working, but she said she heard about it a couple of days later. CNA #4 did not notice anything different about Resident #1 the night of the medication error. She said Resident #1 was not more tired or lethargic than normal. RN #2 was interviewed on 10/20/25 at 5:41 p.m. RN #2 said she was training RN #3 the night Resident #1's medication error occurred. RN #2 said she did not know if RN #3 was aware that RN #2 was supposed to be present during the medication administration process. RN #2 said she knew she was supposed to be present when RN #3 was passing medications, but she was needed elsewhere during the incident. RN #2 said Resident #1 was prescribed methadone for pain control. RN #2 said Resident #1 was accidentally given an Oxycontin pill instead of a methadone pill by RN #3. RN #2 said that RN #3 grabbed the wrong medication card (a type of pre-packaged medication used for dispensing and administering drugs to residents) and therefore grabbed the wrong resident's medication, which contained the Oxycontin instead of the methadone. RN #2 said Resident #1 did not have a physician's order for Oxycontin and the Oxycontin was another resident's medication. She said the medication error was not discovered until the next morning (9/24/25) during the shift change medication count. She said during the medication count, it was noted there was an extra methadone tablet in Resident #1's methadone medication cart and there was one less tablet of Oxycontin in Resident #11's Oxycontin medication card. RN #2 said the DON, the physician, and Resident #1's representative were notified. She said RN #3 completed an assessment and took a set of vital signs on Resident #1 after the medication error was discovered. RN #2 said the Resident #2 seemed the same that night 9/23/25) and that there were no changes in her pain or general status following the medication error. Following the incident, RN #2 said all nursing staff received education clarifying that preceptors must be physically present with nurse trainees during medication administration. RN #3 was interviewed on 10/20/25 at 6:02 p.m. RN #3 said she was new to the facility and was learning about the residents and their personalities. RN #3 said she administered medications for the whole floor on 9/23/25. She said the next morning (9/24/25) during the shift change medication count, a medication discrepancy was noted and upon review, she believed Resident #1 received another resident's Oxycontin instead of a methadone pill the previous evening. RN #3 said they did not find the Oxycontin medication that was missing from Resident #11's medication card anywhere else. She said she did not remember pulling Resident #11's<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Oxycontin medication card but that was the only rationale that could be explained because there was an Oxycontin tablet missing from Resident #11's card on the morning of 9/24/25 and there was an extra methadone tablet in Resident #1's medication card. RN #3 said at one point during her medication pass on 9/23/25, she got interrupted and came back to administer medications. RN #3 said she could not say whether or not her nurse trainer (RN #2) was with her at the exact time the medication error potentially occurred. RN #3 said she did not remember signing the controlled substance record book before she administered the medication to Resident #1. RN #3 said she was in and out of the room all night making sure Resident #1 was getting repositioned because Resident #1 was receiving end-of-life care at the time. RN #3 said nothing was abnormal for Resident #1 that night. She said Resident #1 did not have an increase in drowsiness or lethargy. RN #3 said she did not notice any new side effects at all and did not notice anything out of the ordinary for the resident. RN #3 said she called the physician and the DON after realizing she made an error. RN #3 said she completed an assessment and vital signs on Resident #1 within 15 to 20 minutes after finding out there had been a medication error. RN #3 said Resident #1's vital signs were at baseline. RN #3 said she received education on the five rights of medication administration after the error and she signed off on it. She said she was paired with a trainer for more shifts after the incident. She said she and the DON had a discussion about the incident. RN #3 said she was traumatized by the incident and she now triple checked her medications before administering them.The physician was interviewed on 10/21/25 at 9:50 a.m. The physician said he was aware that on 9/23/25 Resident #1 was given 30 mg of Oxycontin in error. The physician said Resident #1 had previous orders for Oxycontin 10 mg to be given every 12 hours, but the medication had been discontinued prior to the medication error on 9/23/25. The physician said that Resident #1 received 30 mg of Oxycontin in error but he did not think she was at much risk because she was already on narcotics so it was like substituting one medication for another. The physician said Resident #1 had active physician's orders for methadone at the time of the incident. The physician said Resident #1 was on narcotics at high doses before and tolerated them well. The physician said Resident #1 had been on high doses of fentanyl and methadone prior to the incident. The physician said he did not see a change in her level of consciousness or see her become more lethargic after being given Oxycontin 30 mg in error. The physician said he saw no lasting effects from the Oxycontin 30 mg being administered instead of the methadone. The physician said if someone who was opioid naive was given 30 mg of Oxycontin he would have been more concerned.The DON was interviewed on 10/21/25 at 11:44 a.m. The DON said she was told that during morning medication count on 9/24/25, RN #3 realized she pulled the wrong pain medicine and that she had pulled Resident #11's medicine and given it to Resident #1 by accident. The DON said 10 mg of methadone was scheduled for Resident #1 and RN #3 had administered Resident #11's Oxycontin 30 mg in place of the methadone. The DON confirmed RN #3 confused the methadone medication with the Oxycontin medication. She said Resident #1 had taken Oxycontin before but it was only 10 mg prior to the incident. The DON said the electronic medical administration record (EMAR) documented the methadone was given, but after investigation ,it appeared Resident #1 did not get the methadone and instead got 30 mg of oxycontin.The DON said she asked how the resident was and RN #3 said Resident #1 had no issues overnight. The DON said she herself did not see any change in Resident #1 after the incident. The DON said when she spoke to Resident #1, she would answer coherently and had a conversation with her. The DON said if Resident #1 was not opioid tolerant, the medication error could have caused decreased breathing, altered consciousness, confusion and drowsiness. The DON said the experienced nurse was supposed to stay with the new nurse during medication administration and also while they were learning new residents. The DON said RN #3 said her nurse preceptor (RN #2) was around but not hovering over her, or watching her at the time of the incident. The DON said the nurse preceptor (RN #2) was not watching exactly what RN #3 was doing. The DON said after the incident, she completed one-on-one education with RN #3 and stressed the importance of following the five rights of medication administration. The<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | DON said she started an action plan to work on decreasing the amount of medication errors. The DON said she did medication audits with nursing staff which involved observing staff members during medication administration. She also completed continued education with staff. |