STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065212	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westlake Health and Rehabilitation Center	1637 29th Ave Pl Greeley, CO 80634

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure one (#12) out of four sample residents were free from significant medication errors. Resident #12, who was admitted to the facility on [DATE], had a mechanical heart valve and was at a high risk for deep vein thrombosis (DVT). The resident had a physician's order to receive warfarin (a bloodthinning medication) to assist with preventing blood clots. Additionally, the resident had a physician's order to periodically monitor the resident's PT/INR (prothrombin time test/international normalized ratio - a blood test that measures how long it takes the blood to clot). The resident's physician adjusted the resident's warfarin dose based upon the results of the PT/INR blood test. According to the pharmacist ([NAME]), Resident #12's therapeutic level of warfarin (PT/INR goal range) was 2.5 seconds to 3.5 seconds (see [NAME] interview below). On 2/17/25 a physician's order was obtained to hold Resident #12's warfarin medication on 2/18/25 and 2/19/25 due to a PT/INR level of 4.84 seconds, which meant the resident's blood clotting time was too high. The facility was to recheck the PT/INR and give a one-time dose of warfarin 4 milligrams (mg) on 2/20/25. The resident's PT/INR was rechecked on 2/20/25 and was 3.12 seconds. The facility's nurse received a verbal physician's order to restart Resident #12's warfarin at 3.5 mg and recheck the PT/INR the following Wednesday (2/26/25). However, the facility failed to ensure the 2/21/25 physician's order for warfarin was transcribed into the electronic medication record (EMR) and onto Resident #12's February 2025 medication administration record (MAR), which resulted in a failure to provide anticoagulant medication for seven days and led to a significant reduction in Resident #12's PT/INR level to 0.97 seconds (indicating the resident's blood clotting time was too low, potentially increasing the risk for the resident to develop blood clots). The facility's failure to administer Resident #12's anticoagulant therapy for seven days led to a non-therapeutic PT/INR level and placed Resident #12 at greater risk for a blood clot. Resident #12 developed a blood clot in his right leg and later required an above the knee (AKA) amputation. The facility's failure to ensure staff accurately transcribed Resident #12's physician's order for warfarin resulted in a situation of serious harm. Findings include: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065212	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westlake Health and Rehabilitation Center	1637 29th Ave Pl Greeley, CO 80634

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 4/2/25 to 4/7/25, resulting in the deficiency being cited as past noncompliance with a correction date of 3/21/25. I. Situation of serious harm The facility failed to ensure Resident #12's 2/21/25 physician's order for warfarin was transcribed into the resident's EMR and onto the resident's February 2025 MAR, which resulted in a failure to provide anticoagulant medication for seven days and led to a significant reduction in Resident #12's PT/INR level. The facility's failure to administer Resident #12's anticoagulant therapy for seven days led to a non-therapeutic PT/INR level and placed Resident #12 at greater risk for a blood clot. Resident #12 developed a blood clot in his right leg and later required an above the knee (AKA) amputation. The failure to ensure staff accurately transcribed Resident #12's physician's order for warfarin resulted in a situation of serious harm. II. Facility's plan of correction The corrective action plan implemented by the facility in response to Resident #12's serious medication error on 2/21/25 was provided by nursing home administrator (NHA) #1 on 4/4/25 at 10:33 a.m. The stated purpose of the plan was to address the significant medication error and prevent any additional residents from suffering an adverse outcome. The plan revealed the following: Identification of others - the facility took the following actions to prevent an adverse outcome from reoccurring. All applicable facility policies and procedures were reviewed/revised by the director of nursing (DON) or designee (completion date 3/21/25). Systemic changes - the DON or designee re-educated licensed nurses on facility policies regarding medication transcription as well as transcribing physician's orders and notifying the physician. All nurses were educated prior to working their next shift. The DON completed corrective action and one-to-one education with a licensed nurse who was identified as being deficient in their practice resulting in this citation. A complete medication review will be completed on all residents who are prescribed warfarin. Monitoring - the DON or designee will complete weekly chart audits on all residents receiving warfarin medication to ensure the orders were transcribed properly, the medication was given as ordered/parameters followed, the physician was notified when there was a medication transcription error and the physician contact is properly documented. The audits will continue until compliance can be maintained three days (audits) per week for three consecutive months. The administrator implemented a QAPI/PIP (quality assurance and performance improvement/performance improvement project) as a means to gather and process information from the audits. Findings will be reported at the monthly quality assurance meeting for a minimum of three months. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065212	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westlake Health and Rehabilitation Center	1637 29th Ave Pl Greeley, CO 80634

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Date of compliance: 3/21/25. III. Facility policy and procedure The Anticoagulant Therapy policy, revised October 2024, was provided by NHA #1 on 4/7/25 at 4:42 p.m. It read in pertinent part, The anticoagulant medication administration record (MAR) is completed for residents receiving oral warfarin (brand name replaced) therapy. Complete the MAR, including the usual resident identifying information and the order date, warfarin dosage and dates for INR laboratory (lab) testing due in the boxes as indicated. As medications ordered are changed or laboratory results become available, the MAR is updated to include the new information. For any anticoagulant use, the facility will monitor for signs and symptoms of bleeding as needed. The warfarin log is completed for each resident receiving warfarin therapy. The log is completed with the usual resident identifying information, as well as the resident's initial INR range or goal according to the physician. Subsequently, resident INR laboratory results, medication dosage orders and dosage changes are recorded by the nurse in charge. Log follow up is assigned to one nurse for periodic auditing to ensure appropriate completion of the log. Prior to administering warfarin, please reference the warfarin tracking form. IV. Facility investigation of transcription omission and education provided in response to Resident #12's serious medication error on 2/21/25 NHA #1 provided a timeline of the investigation, the facility's findings and the education plan on 4/4/25 at 10:33 a.m. The information provided revealed the following: The investigation revealed a transcription error was noted on 2/21/25 and was the reason Resident #12 missed his warfarin from 2/21/25 to 2/27/25. The nurse received an order on 2/21/25 for 3.5 mg warfarin daily and to recheck INR on 2/26/25. She completed the warfarin log with the information about the new warfarin dosage, but did not transcribe the order into Resident #12's EMR. On 2/27/25 another nurse noted there was no current order for warfarin for Resident #12. The nurse who discovered the error obtained a physician's order for an INR. When the results came back, a different nurse (the night shift nurse) contacted the on-call provider and obtained a one-time physician's order for warfarin 4 mg with orders to follow up with the resident's usual physician for additional doses. No further misses for warfarin were found. A performance improvement plan was initiated by the facility on 3/13/25 and staff education was provided. The staff education document, which contained 16 licensed nursing staff signatures, revealed the following in pertinent part, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065212	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westlake Health and Rehabilitation Center	1637 29th Ave Pl Greeley, CO 80634

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	A detailed progress note should be placed in the residents' charts summarizing the lab results, physician notified, and any new orders given or orders to continue the same dose and next INR draw. Nurses are responsible for updating the order in the EMR and verifying its accuracy. In the warfarin (log) book, the date, current warfarin orders and INR results and next INR draw should be recorded, as well as what the medication dosage was changed to or if the same dose is to be continued. Please note any misstep in this process could result in life threatening harm to the resident. V. Resident #12 A. Resident status Resident #12 Resident #12, age [AGE], was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included right leg above the knee amputation, respiratory failure, aortic (heart) valve disorder, cerebral infarction (stroke), thoracic aneurysm (weakened area in body's main artery in the chest) and epilepsy. The 3/12/25 minimum data sets (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview of mental status (BIMS) score of 11 out of 15. He required set up assistance with eating, and was dependent on staff for toileting, showering, dressing, repositioning and transferring. B. Resident observation and resident representative interview Resident #12's representative was interviewed on 4/7/25 at 12:55 p.m. The representative said as Resident #12 was being transferred to the hospital on 3/12/25, she overheard a facility nurse tell another nurse that the resident was accidentally taken off Coumadin (warfarin) for a period of time. The representative said she wanted to learn more about this when Resident #12 was readmitted to the facility, however, the facility refused to discuss what had happened during the care conference meeting after the resident's readmission. The representative said the facility representative at the care conference told her they would schedule another time to discuss the resident's missed warfarin doses, yet this had not happened. The representative said Resident #12's INR level was supposed to be maintained between 2.5 seconds to 3. 5 seconds and the facility had not done a good job maintaining the resident's INR at the desired level. The representative said the hospital physician told her it was difficult to determine if the missed warfarin doses could have contributed to Resident #12's leg being required to be amputated, as his leg had circulatory issues for years. During the resident representative's interview, Resident #12 was observed to repeatedly say they cut off my leg several times. C. Record review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065212	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westlake Health and Rehabilitation Center	1637 29th Ave Pl Greeley, CO 80634

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #12's anticoagulant therapy care plan, revised 3/28/25, documented the resident received an anticoagulant due to atrial fibrillation (an irregular heart beat that causes poor blood flow). The interventions included obtaining labs as ordered, monitoring and reporting signs/symptoms of thromboembolism (when a blood clot breaks off and travels through the bloodstream), monitoring, documenting and reporting to the physician as needed signs of anticoagulant therapy complications, resident teaching, reviewing medication list for interactions and ultrasounds as ordered per physician. An additional anticoagulant therapy care plan was initiated on 3/11/25, documented Resident #12 was at risk for deep vein thrombosis (DVT, a blood clot in a deep vein) related to the resident's history of DVTs, a mechanical heart valve, immobility and chronic anticoagulant therapy. The interventions included administering medications as ordered, monitoring and documenting side effects and effectiveness, inspecting legs and feet for skin color/temperature, monitoring laboratory values to monitor and document effects of anticoagulant therapy, reporting lab values outside desired range, monitoring, reporting, and documenting to the physician as needed any signs and symptoms of complications and repositioning and ambulating the resident as frequently as possible, at a minimum of every two hours. The anticoagulant therapy flowsheet for Resident #12 was provided by NHA #1 on 4/4/25 at 10:33 a.m. It documented the diagnoses requiring Resident #12's anticoagulant therapy included atrial fibrillation, mechanical heart valve and recurrent DVT. The documented goal for the INR level was 2.5 to 3.5. The flowsheet had labeled columns to enter the date, the INR level, the current warfarin dose and any new physician's orders. Resident #12's flowsheet documented the following: On 2/18/25, the INR result was 4.84, the current dose documented was 4 mg warfarin, and there was additional written documentation to hold the warfarin for two days and recheck 2/20/25, per physician assistant (PA). On 2/20/25, the INR result was 3.12, the current dose was documented that warfarin was on hold. -However, the February 2025 MAR revealed warfarin 4 mg was administered to Resident #12 on 2/20/25. On 2/21/25, the INR result was again documented as 3.12, the current dose documented warfarin 3.5 mg daily and there was additional documentation to recheck the resident's INR on 2/26/25. -However, the EMR revealed no daily physician's order for warfarin 3.5 mg to begin on 2/21/25 and review of Resident #12's February 2025 MAR revealed there were no documented doses of warfarin administered to the resident between 2/21/25 and 2/27/25 (a period of seven days). On 2/27/25, the INR result was 0.97, and there was no documentation for a current warfarin dose, however, there was additional documentation for a stat (immediate) INR. -However, review of the lab results revealed Resident #12's INR was 0.97 on 2/26/25 and the INR was actually 0.92 on 2/27/25. The INR flow sheet did not have an INR entry documented on 2/26/25. The INR flowsheet further revealed there was no documentation for a current dose of warfarin from 2/27/25 until 3/4/25. -However, review of the EMR revealed a physician's orders for warfarin beginning on 2/28/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065212	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westlake Health and Rehabilitation Center	1637 29th Ave Pl Greeley, CO 80634

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #12's February 2025 and March 2025 MAR revealed the resident received all doses of warfarin from 2/28/25 to 3/4/25. A physician progress note, dated 3/7/25, documented there was difficulty maintaining Resident #12's INRs over 2.5. Resident #12 had been on 3 mg of warfarin daily for several weeks, but the resident's INR had dropped from 1.9 to 1.2. The resident's dose was increased to 4 mg daily. -The physician's progress note did not reveal whether the physician was aware of Resident #12's missed doses of warfarin from 2/21/25 to 2/27/25. A nurse progress note, dated 3/12/25 at 4:50 p.m., documented Resident #12's pedal (foot) pulse had diminished to the right lower extremity with spreading reddened petechiae (tiny round brown-purple spots due to bleeding under the skin) and possible hematoma (a collection of blood outside of a vessel) to the anterior ankle that had worsened per spouse and report received from the DON. The hospital was notified and informed of pending results of an arterial doppler ultrasound (a non-invasive imaging test that uses sound waves to evaluate the blood flow in the arteries of your arms and legs) performed on 3/12/25 and the nurse practitioner (NP) gave an order for Resident #12 to be transferred to the hospital to rule out a possible arterial occlusion. A nurse progress note, dated 3/12/25 at 8:25 p.m., documented the facility was alerted to critical imaging results of the arterial doppler which was performed on 3/12/25 at the facility, prior to Resident #12's hospitalization. The hospital was contacted and alerted to the critical results and the information was faxed to the emergency department. Resident #12's hospitalization record was provided by NHA #1 on 4/4/25 at 10:33 a.m. The hospital records revealed the documented admission diagnosis for Resident #12 on 3/13/25 was atherosclerosis (build up caused narrowing and reduced blood flow) of the native artery of the right lower extremity with rest pain (pain when resting). Resident #12 underwent a right above the knee amputation during his hospitalization on 3/18/25. A physician's progress note, dated 4/3/25 at 12:37 p.m., documented Resident #12 was extensively discussed at QAPI on 3/18/25. The resident's diagnosis was ASVD (atherosclerotic vascular disease) of the right leg arteries with rest pain (pain when resting) which suggested chronic ischemia/arterial insufficiency. -However, the physician's progress note was not written until 4/3/25, during the survey (over two weeks after the 3/18/25 QAPI meeting). A review of anticoagulant medication administration for Resident #12 from 3/21/25 to 4/3/25 revealed the resident had received all of his warfarin doses as ordered and the facility was monitoring for other residents receiving warfarin, per the facility's corrective action plan. VI. Staff interviews (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065212	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westlake Health and Rehabilitation Center	1637 29th Ave Pl Greeley, CO 80634

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The medical director (MD) was interviewed on 4/3/25 at 4:35 p.m. The MD said Resident #12's ultrasound result, prior to his hospitalization on 3/12/25, revealed an occlusion (blockage) of the right popliteal artery (blood vessel located behind the knee). The MD said he was aware of Resident #12's missed warfarin doses. He said the occlusion was probably chronic (longstanding) and he wrote a statement on 4/3/25 (during the survey) regarding this opinion. He said the only way to know with certainty the cause of the occlusion would be to review the information in the pathology report of Resident #12's above the knee amputated (AKA) leg, which would have shown if the condition were chronic or not. The MD said he was unable to obtain Resident #12's pathology report at the time of interview. The physician (PHY) was interviewed on 4/3/25 at 4:50 p.m. The PHY said though his name was entered by the nursing staff on the physician orders, the physician's orders placed on 2/27/25 were likely provided by an on-call provider. The PHY said the facility had a history of serious issues with warfarin management. The PHY said he did not think physician's orders were being entered properly by nursing staff all of the time. The PHY said there was a situation for another resident in which an INR was reported and the physician communicated the orders, however the orders were not implemented for a few days. The PHY said he had conveyed the importance of the process for warfarin orders with the facility. The PHY said the facility had provided education to staff since Resident #12's incident and he was also taking an active role to ensure the process was being followed. The clinical resource person (CRP) was interviewed on 4/3/25 at 4:58 p.m. The CRP said Resident #12 had missed warfarin administration doses for five consecutive days. The CRP then reviewed documentation in Resident #12's EMR (during the interview) and said she did not find any warfarin doses given from 2/21/25 to 2/27/25, for seven days. Registered nurse (RN) #1 was interviewed on 4/3/25 at 6:38 p.m. RN #1 said she reported Resident #12's INR result from 2/20/25. RN #1 said she received verbal orders from the physician. She said Resident #12 received a one-time dose of warfarin 4 mg on 2/20/25 and then was supposed to receive daily warfarin 3.5 mg to begin on 2/21/25 with a recheck of his INR level on 2/26/25. RN #1 said she entered the information on Resident #12's INR flow sheet and thought she had entered the physician's order for daily warfarin into the EMR, however, she said when the DON later asked her about Resident #12's missed warfarin doses, she was not able to find any physician's order in the EMR for the daily warfarin doses which were to begin on 2/21/25. RN #1 said it was important to monitor INR levels for residents on anticoagulants to maintain a therapeutic level of the medication. RN #1 said she was reeducated about transcription of medication orders, including the importance of documenting physician's orders into the EMR. RN #2 was interviewed on 4/3/25 at 9:40 p.m. RN #2 said if he received physician's orders for warfarin, he would place the order in the resident's EMR immediately and would expect the dose of the medication to be adjusted as needed, based upon the resident's INR levels. RN #3 was interviewed on 4/3/25 at 9:44 p.m. RN #3 said if she received physician's orders for medications, she would enter the orders in the resident's EMR at the time the order was received. Licensed practical nurse (LPN) #3 was interviewed on 4/7/25 at 9:35 a.m. LPN #3 said the facility provided nursing staff education a few weeks ago to ensure no missed doses of warfarin for the residents. LPN #3 said the education included the correct process for taking and entering physician's orders. LPN #3 said residents who missed doses of anticoagulant medications could develop blood clots and this could be life threatening. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065212	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westlake Health and Rehabilitation Center	1637 29th Ave Pl Greeley, CO 80634

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	RN #1 was interviewed again on 4/7/25 at 9:50 a.m. RN #1 said if residents did not receive their anticoagulant medication as ordered, they could develop a blood clot, pulmonary embolism (a blot clot in the lungs) or a stroke. LPN #2 was interviewed on 4/7/25 at 10:10 a.m. LPN #2 said the physicians wanted Resident #12's INR level to be between 2.5 to 3.5. LPN #2 said she reviewed Resident #12's EMR for lab results and orders on 2/27/25 and she noticed his INR was very low (0.97). LPN #2 said Resident #12's EMR also had no physician's orders for warfarin since 2/20/25. LPN #2 said Resident #12's anticoagulant therapy flow sheet revealed he was supposed to receive warfarin 3.5 mg daily beginning on 2/21/25. LPN #2 said the process for anticoagulant therapy included receipt of INR result, reporting of the result to the physician, information entered on the anticoagulant flow sheet with the INR result and new physician's orders, physician's orders entered in the EMR and a progress note entered about the process that was followed. LPN #2 said she contacted the DON and the physician when she realized Resident #12 had not received the warfarin as ordered. LPN #2 said Resident #12 was at risk of getting blood clots. She said residents could get blood clots if warfarin was not given as ordered. LPN #2 said the facility provided education to nursing staff after this incident, which included reporting of INR results, receipt of physician's orders, using the INR flow sheet and the importance of entering physician's orders for warfarin in the EMR. LPN #1 was interviewed on 4/7/25 at 10:34 a.m. LPN #1, who was also a unit manager, said she assisted the staff development coordinator with education the education that was provided to staff after Resident #12 was transferred to the hospital on 3/12/25. She said staff education included the importance of calling physicians with lab results, obtaining physician's orders, entering pertinent information on the INR flow sheet and entering the new physician's orders in the EMR. LPN #1 said she knew Resident #12 had missed doses of warfarin, but she did not know details or the extent of the missed doses until 3/10/25 when LPN #2 asked her to look at Resident #12's right lower leg, which had new redness. She said there were petechiae of Resident #12's right ankle measuring approximately three centimeters (cm) by six cm. LPN #1 said there was another area on top of the right foot with a hematoma which had the same measurement. LPN #1 said she received physician's orders for an ultrasound of Resident #12's right leg and she placed the orders in the EMR. DON #1 was interviewed on 4/7/25 at 10:59 a.m. DON #1 said LPN #2 reported Resident #12's missed doses of warfarin to her early in the morning of 2/27/25. She said they identified this as a medication error, notified the physician and received an order for an INR. She said the provider did not want to place an order at the time, as the facility expected providers to visit Resident #12 that day. She said a physician did not see Resident #12 that day and there was a delayed receipt of warfarin orders for Resident #12. -Resident #12 did not receive a new physician's order for warfarin until 2/27/25 at 10:25 p.m. and the warfarin dose was not administered until 2/28/25 at 12:10 a.m. DON #1 said she reported Resident #12's missed doses of warfarin to NHA #1 and suspended RN #1 on 2/27/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065212	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westlake Health and Rehabilitation Center	1637 29th Ave Pl Greeley, CO 80634

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	DON #1 was interviewed again on 4/7/25 at 12:15 p.m. DON #1 said she did not know why there was not a physician's order for resumption of Resident #12's warfarin or why the medication was not given until 16 hours after LPN #2 discovered the missed doses. DON #1 said staff should have recognized prior to 2/27/25 that Resident #12 had not received warfarin doses. DON #1 said nurse staff education did not begin until 3/13/25, the day after Resident #12 was sent to the hospital with a blood clot. She said staff education (in addition to education for RN #1) should have begun when the medication error was initially discovered on 2/27/25, as staff did not recognize the missed warfarin doses for seven days. The pharmacist ([NAME]) was interviewed on 4/7/25 at 2:10 p.m. The [NAME] said Resident #12's INR should be between 2.5 to 3.5 for his condition. The [NAME] said the missed warfarin doses contributed to his decreased INR, which increased the chance of clotting, and any clots could increase the risk for amputation. The [NAME] said the anticoagulant policy would show the strategy to increase the INR to a therapeutic level. The [NAME] said if doses were missed, he would give a warfarin dose immediately and possibly a bolus dose (a one-time larger dose). The [NAME] said after missed doses of warfarin, the goal was to return the resident to a therapeutic INR range as quickly as possible. The [NAME] said in Resident #12's case, he would have suggested a bolus dose, possibly 10 mg. The [NAME] said this type of bolus dose was not used for Resident #12. The [NAME] said Resident #12's INR was currently back within a therapeutic range.