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	06/25/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#4) of four residents were free from significant medication errors out of five sample residents. Specifically, the facility failed to ensure Resident #4 did not receive another resident's medications. Findings include: I. Professional reference According to Clinical Nursing Skills & Techniques by [NAME], [NAME] & [NAME], 8th Edition (2021), page 480-489, Safe medication administration: To prevent medication errors follow the six rights of medication administration consistently every time you administer medications. Many medication errors are linked in some way to an inconsistency in adhering to the six rights: -The right medication; -The right dose; --The right patient; -The right route; -The right time; and, -The right documentation. Read the label on the medication container and compare it with the MAR (medication administration record) at least three times before removing the container from the supply drawer, when placing the medication in an administration cup/syringe, and just before administering the medication to the patient. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Medication errors often harm patients because of inappropriate medication use. Errors include inaccurate prescribing; administering the wrong medication, by the wrong route, and in the wrong time interval; and administering extra doses or failing to administer a medication. II. Resident #4 A. Resident Status Resident #4, age greater than 65, was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus with hyperglycemia, unspecified atrial fibrillation, acute diastolic (congestive) heart failure, chronic kidney disease, stage 3, essential (primary) hypertension, gout, dysthymic disorder, insomnia and muscle weakness. According to the 3/13/25 minimum data set (MDS) assessment, the resident had moderately impaired cognition with a brief interview for mental status (BIMS) score of 12 out of 15. She was dependent on a wheelchair for mobility. She needed supervision with activities of daily living (ADLs). The MDS assessment indicated the resident was receiving hypoglycemic (lowering blood sugar) medication and an anti-hypertensive (lowering high blood pressure) medication. B. Resident interview Resident #4 was interviewed on 6/25/25 at 3:00 p.m. Resident #4 said she remembered receiving another resident's medications. She said the facility told her that she was given the wrong medications accidentally. She said she felt dizzy and she had a stomachache all night. She said she was not able to eat for 24 hours. C. Record review The 5/15/25 progress note, documented at 12:59 p.m., revealed that licensed practical nurse (LPN) #1, who was an agency staff nurse, administered the incorrect medications to Resident #4. The note indicated LPN #1 notified the physician, the director of nursing (DON) and the resident's representative. The note revealed that Resident #4's vital signs were taken and found to be within normal range for the resident. The progress note revealed that Resident #4 was free of discomfort and adverse reaction. Review of the facility investigation for the medication error revealed Resident #4 was administered Lisinopril 40 milligrams (mg), duloxetine 60 mg and bupropion 300 mg ER (extended release). -Review of Resident #4`s May 2025 CPO revealed she did not have physician's orders for Lisinopril (treats high blood pressure), duloxetine (antidepressant medication) or bupropion (antidepressant medication). III. Staff interviews (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 6/25/25 at 12:17 p.m. The DON said Resident #4 was administered another resident's medications on 5/15/25. The DON said the medications the resident accidentally received included Lisinopril 40 milligrams (mg), Duloxetine 60 mg and Wellbutrin 300 mg ER (extended release). She said the LPN who administered the wrong medications to the resident was an agency nurse. The DON said her first day of work in the facility was 5/14/25. She said the medication error with Resident #4 occurred the next day, on 5/15/25, and she was not yet familiar with the staff or the residents. She said the corporate clinical resource nurse provided medication administration education to all nurses in the facility after the medication error. She said the agency LPN (LPN #1) did not return to the facility.