STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave 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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were free from significant medication errors for one (#1) of three residents reviewed for medications errors out of four sample residents. Specifically the facility failed to:-Ensure Resident #1 was administered Midodrine (for low blood pressure) per physician's orders and parameters;-Ensure Resident #1 had a blood pressure taken prior to administration of a hypotension medication; and,-Identify and document medication errors.Findings include: I. Facility policy and procedureThe Medication Administration policy, revised April 2019, was provided by the nursing home administrator (NHA) on 10/8/25 at 11:40 a.m. It read in pertinent part, Medications are administered in a safe and timely manner, as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medication errors are documented, reported and reviewed by the quality assurance performance improvement (QAPI) committee to inform process changes and or the need for additional staff training.The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.Vital signs and allergies are checked prior to administration of the medication.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE] and discharged [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included unspecified cirrhosis of the liver, muscle weakness, acute respiratory failure with hypoxia (low oxygen) and chronic hepatic (liver) failure.The 8/11/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. He used a wheelchair and required maximal assistance with lower body dressing, putting on/off footwear, rolling left to right and sitting to lying. His overall goal was to discharge into the community.B. Record reviewReview of Resident #1's August 2025 CPO revealed the following physician's order related to hypotension (low blood pressure). Midodrine HCl (for hypotension) 5 mg (milligrams) by mouth three times a day for hypotension. Do not give if the blood pressure (BP) was above 100/60 millimeters of mercury (mmHg), ordered 8/7/25. -The physician's order required a blood pressure to be taken prior to administering the medication. A review of the August 2025 medication administration records (MAR) revealed Resident #1 was administered Midodrine 29 times during the month. Resident #1's blood pressure was not taken prior to the administration of the medication on the following days:-8/9/25 for the morning and evening dose; and,-8/10/25 for the morning dose.The Midodrine was administered 21 times when Resident #1's BP was not within the correct physician ordered parameters to give the medication or the medication was not administered when it should have been administered per the parameters. The administration discrepancies were as follows: On 8/10/25 at 12:00 p. m. Resident #1's BP was 112/62 mmHg The medication was administered but should have been held per the physician ordered parameters. On 8/11/25 at 12:00 p.m. Resident #1's BP was 106/94 mmHg. The medication was administered but should have been held per the physician ordered parameters. On 8/11/25 Resident #1's evening BP was 98/54 mmHg. The medication should have been administered per the physician ordered parameters but it was not administered. On 8/13/25 at 7:00 a.m. Resident #1's BP was 165/77 mmHg. The medication was administered but should have been held per the physician ordered parameters. On 8/13/25 at 12:00 p.m. Resident #1's BP was 111/60 mmHg. The medication was administered but should have been held per the physician ordered parameters. On 8/13/25 Resident #1's evening BP was 102/66 mmHg. The medication was administered but should have been held per the physician ordered parameters.On 8/14/25 at 7:00 a.m. Resident #1's BP was 127/66 mmHg. The medication was administered but should have been held per the physician ordered parameters. On 8/14/25 at 12:00 p. m. Resident #1's BP was 113/69 mmHg. The medication was administered but should have been held per the physician ordered parameters. On 8/14/25 Resident #1's evening BP was 110/72 mmHg. The medication was administered but should have been held per the physician ordered parameters.On 8/15/25 at 7:00 a.m. Resident #1's BP was 107/66 mmHg. The medication was administered but should have been held per the physician ordered parameters. On 8/15/25 at 12:00 p.m. Resident #1's BP was 115/80. The medication was administered but should have been held per the physician ordered parameters. On 8/15/25 Resident #1's evening BP was 153/80 mmHg. The medication was administered but should have been held per the physician ordered parameters.On 8/16/25 at 7:00 a.m. Resident #1's BP was 107/76 mmHg. The medication was administered but should have been held per the physician ordered parameters. On 8/16/25 at 12:00 p