| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065345 | A. Building<br>B. Wing | 02/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Suites at Someren Glen Care Center, The | 5000 E Arapahoe Rd<br>Centennial, CO 80122 |

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<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 ensure the residents were kept free from significant medication errors for one (#1) out of six residents out of six sample residents.Specifically, the facility failed to administer Resident #1's blood pressure medication per physician's orders. Findings include:Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 2/3/26 and 2/4/26, resulting in the deficiency being cited as past noncompliance with a correction date of 12/20/25.I. Facility plan The nursing home administrator (NHA) and the regional corporate nurse provided the facility's medication administration parameter plan dated 12/16/25, on 2/3/26. The plan documented the following:On 12/16/25 a record review for Resident #1 who lived on the memory care unit, was performed by the regional clinical nurse which revealed the medication midodrine was not administered according to the parameters set by the facility physician 49 times. On 12/16/25 the former director of nursing (DON) provided a verbal education to the nursing staff on the memory care unit on following physician's orders for blood pressure parameters. The regional corporate nurse said no one else on the memory care unit received midodrine. On 12/17/25 a medication review was completed for all residents in the facility on midodrine, and all nurses who had provided the medication outside of parameters were identified for upcoming one to one education.On 12/19/25 a plan of action was discussed with the interdisciplinary team (IDT) and its implementation began the following day on 12/20/25.On 12/20/25 all residents who had orders for midodrine were identified and reviewed to ensure compliance. An audit began to review residents with cardiac medications to determine if the parameters were followed as ordered. Four instances were revealed as non-compliant. Corrective measures were put in place for the four instances as well as education for any staff who did not comply with the physician's orders for Resident #1.12/23/25 the audit that was completed on 12/17/25 was reviewed and revealed 12 facility nurse employees did not provide Resident #1's midodrine medication in accordance with the parameters set by physicians. There were also three nursing agency employees identified who provided Resident #1 with midodrine outside of the physician set parameters. The facility management provided disciplinary action to the 12 nurses who did not follow the physician's orders. The nursing staff agency was notified that three of their nurses did not comply with physician's orders for medication parameters. On 1/5/26 the physician's provider team reviewed all midodrine orders to determine any changes that might be needed to blood pressure parameters for administration.From 12/20/25 through 1/5/26 a follow-up audit was conducted to determine if the education for the 12 nurses who had disciplinary action for not following the blood pressure parameters for Midodrine was being followed. On 1/6/26 it was revealed one nurse after the parameter education and disciplinary action provided a resident with a medication not according to the blood pressure parameters. The nurse was immediately released from their position at the facility.On 1/7/26 all nursing staff had voicemail reminders to take a training course about the administration of medications according to parameters set<br><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 | by the physicians on the facility's computer based education program. All nurses complied with the required education by 1/14/26.On 1/12/26 the facility's all staff training included medication parameters in its training.The facility will review the incident, corrective action, and monitoring in the monthly quality assurance and performance improvement (QAPI) meeting. The first post-incident QAPI meeting will be held in February 2026.II. Facility policy and procedureThe Medication Administration Guidelines policy and procedure, dated 2007, was provided by the NHA on 2/3/26 at 12:08 p.m. via email. It revealed in pertinent part, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record (MAR). Compare the medication and dosage schedule on the resident's MAR with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule. Apply a direction change sticker to (the) label if directions have changed from the current label. Medications are administered in accordance with written orders of the prescriber. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse contacts the prescriber for clarification. This interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate. Obtain and record any vital signs as necessary prior to medication administration.III. Resident #1A. Resident statusResident #1, age over 70, was admitted to the facility on [DATE], and readmitted on [DATE]. He was discharged from the facility on 12/6/25. According to the December 2025 computerized physician orders (CPO), the diagnoses included orthostatic hypotension (low blood pressure), unspecified dementia with unspecified behavioral disturbances, chronic kidney disease, hypomagnesemia (low levels of magnesium), and osteoarthritis (a degenerative joint disease).The 11/17/25 minimum data set (MDS) assessment revealed the resident had short and long term memory problems, severe impairment with cognitive daily decision making skills, and delusions. He did not reject care from staff. He ambulated with a front wheel walker. B. Record reviewReview of the resident's August 2025 physician's orders revealed the following physician's order:Midodrine 10 mg (milligrams) by mouth two times per day for orthostatic hypotension. Hold the administration of the medication if the systolic blood pressure was greater than 100 millimeters of mercury (mmHG), ordered on 8/12/25.After the resident returned on 9/10/25 from a hospital stay, the physician's order was updated to the following:Midodrine 10 mg (milligrams) by mouth three times per day (an increase of one dose per day) for orthostatic hypotension. Hold the administration of the medication if the systolic blood pressure was greater than 100 mmHg, ordered 9/10/25.Review of the resident's medication administration record from 8/12/25 to 9/10/25 revealed the resident was administered Midronen 49 times when the resident's blood pressure was documented outside the parameters from the physician's orders. IV. Staff interviewsThe regional corporate nurse was interviewed on 2/3/26 3:30 p.m. The regional corporate nurse said on 12/16/25 the she completed an audit of Resident #1's EMR, which revealed Resident #1 had systolic blood pressure parameters for midodrine. She said the medication was to be held when Resident #1's systolic blood pressure was over 100 mmHg. The RCN said it was discovered that the nursing staff had not held the medication 49 times when his systolic blood pressure was over 100 mmHg. The regional corporate nurse said the<br><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 | situation needed to be self-reported to the state agency. The RCN said immediate education began when the situation was found on 12/16/25 to the nursing staff who worked on the memory care unit where the resident lived. The RCN said by 12/20/25 medications were reviewed for everyone on the same medication as Resident #1, as well as other medications which required blood pressure parameters to administer. The RCN said education was provided to all of the nursing staff, and was ongoing to ensure professional standards of practice continued. The RCN said on 12/16/25 no other residents on the memory care unit were on midodrine. The facility's medical director was interviewed on 2/3/26 at 3:20 p.m. via the telephone. The medical director said his company took over the building in responsibility at the end of October 2025. The medical director said the facility had a systemic problem with following physician's orders for medication parameters but the facility staff had worked on fixing the situation in different ways. The medical director said he expected the nursing staff to follow physician's orders for the residents. The medical director said when a resident on midodrine had a systolic blood pressure of over 130 mmHg, it was not good and the medication may need to be adjusted. The medical director said Resident #1 went to the hospital in December 2025 because of pneumonia and acute kidney problems. The medical director said not following the medications systolic blood pressure parameters would not be the reason for Resident #1's hospitalization. LPN #1 was interviewed on 2/4/26 at 11:20 a.m. LPN #1 said the assistant director of nursing (ADON) called her about a required training about medication parameters. LPN #1 said the training was somewhere between mid to late December 2025. LPN #1 said she had to read a packet with information about a medication called midodrine. LPN #1 said the information was how each resident on that medication needed to have their blood pressure parameters checked because each person had different parameters with that medication.Registered nurse (RN) #2 was interviewed on 2/4/26 at 12:35 p.m. RN #2 said the former DON gave nurses individual training about medication parameters somewhere around mid December 2025. RN #2 said the nurses were also required to do training on the company's computer education system on the same subject. RN #2 said medications may need parameters with blood pressure and nurses need to follow the physician's orders or a resident could be at risk. RN #2 said if a nurse needed guidance with a resident and their parameters, the medical provider should be called. The NHA was interviewed on 2/4/26 at 2:00 p.m. The NHA said the facility had a systemic problem with nurses following physician's orders about medication administration and adherence to a physician's orders for blood pressure parameters. The NHA provided all of the documented training that had been provided to the nursing staff about the subject since the matter was discovered. The NHA said the nurses would continue to be audited and monitored to make sure all facility nurses continued to follow the professional standard of practice for medication administration The NHA said the subject would be reviewed for at least three months in the monthly QAPI meeting until substantial compliance was met. |