STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065354	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colorow Health Care LLC	885 S Hwy 50 Business Loop Olathe, CO 81425

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** 48412 Based on record review and interviews, the facility failed to ensure one (#1) of three free of significant medications errors out of three sample residents out of four sample residents. Specifically, the facility failed to ensure Resident #1 was not administered another resident's medications, which caused her to be sent to the hospital. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2022), E.[NAME], St. Louis Missouri, pp. 606-607. Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. II. Resident #1 (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	A. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure with hypoxia, chronic diastolic (congestive) heart failure and cognitive communication deficit. The 2/14/25 minimum data set (MDS) assessment revealed Resident #1 was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. Resident #1 required partial assistance with self-care, functional cognition, upper body dressing and was independent with mobility. B. Resident #1's representative interview Resident #1's representative was interviewed on 3/26/25 at 9:20 a.m. The representative said she received a call from a nurse apologizing for giving Resident #1 the wrong medication. She was informed the resident was being sent to the emergency room to be monitored for adverse reactions. The representative said she was frustrated the medication error occurred. C. Record review On 2/19/25, a progress note documented that a nurse gave Resident #1 200 milligrams (mg) of pregabalin (nerve pain medicine) and 25 mg of metoprolol (blood pressure medication) in error. The resident experienced nausea and was sent to the hospital to be monitored. On 2/20/25, emergency room notes documented Resident #1 experienced cardiac dysrhythmia (irregular heartbeat), hypotension (low blood pressure) and bradycardia (low heart rate). III. Staff interviews The nursing home administrator (NHA) was interviewed on 3/26/25 at 10:45 p.m. The NHA said the nurse that administered the wrong medication to Resident #1 on 2/19/25 resigned after the incident. Registered nurse (RN) #1 was interviewed on 3/26/25 at 11:30 a.m. RN #1 said she was new to the facility but in order to prevent a medication error she asked residents for their date of birth to confirm it was the right person. RN #1 said if the resident was unable to provide their date of birth she asked other staff to confirm she had the right medications for the right person. The NHA was interviewed again on 3/26/25 at 12:00 p.m. The NHA said she did not get to complete an interview with the nurse who accidentally gave Resident #1 the wrong medications. The NHA said the nurse managers completed medication pass observations with all the nurses to ensure education was up to date and no further medication errors would occur after the medication error occurred on 2/19/25.