| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065256 | A. Building<br>B. Wing | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Highline Post Acute | 6060 E Iliff Ave<br>Denver, CO 80222 |

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 - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<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 - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents were free from any significant medication errors, affecting one (#1) of three residents out of 10 sample residents.Specifically, the facility failed to provide Resident #1 with the physician-prescribed medication for human immune deficiency virus (HIV) disease.Resident #1 was admitted to the facility on [DATE] with a physician's order to receive the HIV medication Biktarvy. Biktarvy consists of three components, bictegravir, emtricitabine & tenofovir alafenamide (tenofovir). On [DATE], the nurse who admitted Resident #1 transcribed the Biktarvy order as tenofovir alafenamide only. The nurse did not recall why the order was changed, and there was no evidence that the pharmacist or the medical director reviewed the order before it was changed.Resident #1 continued on tenofovir only from [DATE] until [DATE] when the prescription read to discontinue. On [DATE], neither the facility nursing staff, the facility pharmacist who performed a monthly medication review prior to the medication being discontinued, nor the medical director reordered the medication for Resident #1. Antiretroviral (ART) therapy for HIV is a lifelong medication. From [DATE] until [DATE], Resident #1 did not receive any HIV medications.On [DATE], Resident #1 went to a local hospital to undergo his approximately every six to nine month viral load blood test. (Viral load blood test for HIV is used to determine how well the ART is working) The viral load blood work documented Resident #1 had a viral load of 65,900. According to the hospital gerontologist, had Resident #1 received his HIV medications as ordered, his viral load numbers would be approximately zero, an undetectable level that meant the virus was suppressed, preventing disease progression and transmission.Also on [DATE], when Resident #1 went to the hospital for his bloodwork, his medication orders sent from the facility did not include Biktarvy as prescribed in February 2025. The hospital physician wrote a medication order for Biktarvy on [DATE], and on [DATE], Resident #1 began taking Biktarvy, the medication he should have been on since [DATE] for his HIV.The facility's failure to administer Biktarvy as ordered created the likelihood for serious resident harm. According to the hospital gerontologist, tenofovir was not sufficient to treat HIV on its own. Serious harm was also likely due to the resident's exposure since February 2025 to an incomplete medication regimen, which can create an even greater drug resistance to Biktarvy for HIV (meaning Resident #1 may develop a resistance to the HIV drug Biktarvy due to it not being administered since February 2025).Findings include:I. Findings of immediate jeopardyA. Failure to administer medications as orderedThe facility failed to accurately transcribe the physician's order for a compound anti-viral medication for HIV, which led to Resident #1 not receiving the correct combination medication from [DATE] until [DATE]. When the incorrect medication order expired on [DATE], the medical director and the facility pharmacist were not consulted, and the medication was not renewed. The resident did not receive any anti-viral medications in the compound for HIV from [DATE] to [DATE].B. Facility notice of immediate jeopardyOn [DATE] at 2:50 p.m., the nursing home administrator (NHA), the director of nursing (DON), and clinical resource #1 were notified of the facility's failure to prevent a significant medication error by not ensuring Resident #1 received his HIV medication as prescribed. The medication error created a situation of immediate jeopardy for serious harm. C. Facility plan to remove immediate jeopardyOn [DATE], the NHA, DON, and clinical resource #1 presented the following plan to address the immediate jeopardy situation. It read in pertinent part, Immediate Action Done: On [DATE], Resident #1's medication list was printed and reviewed with the facility physician for accuracy. On [DATE], the hospital's infectious disease office (for Resident #1) was contacted regarding follow-up appointment recommendations for lab monitoring. Beginning [DATE], the DON or designee will prioritize reviewing current residents who are receiving clinically significant medications such as insulin, anticoagulants, cancer agents, antivirals, and medications for multiple sclerosis or Parkinson's. This review will focus on order accuracy. Once those residents are completed, the DON/designee will review all remaining residents. This plan will be completed by [DATE]. On [DATE], the DON or designee reviewed all resident orders with a discontinuation date using the order listing report to ensure accuracy. This was completed on [DATE]. Plan: (Facility name) Medication policy was reviewed on [DATE] by the NHA, the DON, and the medical director. Beginning [DATE], new admission orders will be reviewed against the discharge orders to ensure transcription accuracy. Any discrepancies identified will be clarified with the attending physician. This process will be ongoing. Beginning [DATE], the primary physician will review new admission orders in conjunction with the history and physicals to ensure accuracy. This will be an ongoing process. Beginning [DATE], consultant |