STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065358	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Westminster	7751 Zenobia CT Westminster, CO 80030

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the medication error rate was less than five percent (%). Specifically, the facility's medication error rate was 13%, which was four errors out of 29 opportunities for error. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, page 606-607, retrieved on 4/16/24, 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: the right medication, the right dose, the right patient, the right route, the right time, the right documentation and the right indication. II. Observations and interviews On 4/29/25 at 9:30 a m. licensed practical nurse (LPN) #3 was administering medications to Resident #126. The physician's order read: -Vitamin A oral tablet 2400 micrograms (mcg) once a day for deficiency. LPN #3 said she was not able to locate the medication in the medication cart. She did not administer the medication. She did not notify the physician. At 9:39 a.m. LPN #3 was administering medications to Resident #34. The physician's order read: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065358	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Westminster	7751 Zenobia CT Westminster, CO 80030

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cranberry tablet 250 milligram (mg) once a day for urinary tract health. LPN #3 said she was not able to locate the medication in the medication cart. She did not administer the medication. She did not notify the physician. On 4/30/25 at 9:45 LPN #1 was administering medications to Resident #15. The physician's orders read: -Amlodipine 10 mg once a day for hypertension (high blood pressure). -Sodium bicarbonate (baking soda) 650 mg, two tables for upset stomach. LPN #1 said she was not able to locate the amlodipine in the medication cart. She did not administer the medication. LPN #1 pulled a bottle of Simethicone (over the counter medication used to treat bloating and gas) 80 mg tablets out of the medication cart and put two tablets in the medication cup to administer to the resident. When asked about the Simethicone LPN #1 said she made a mistake and she thought it was sodium bicarbonate. III. Staff interviews LPN #3 was interviewed on 4/29/25 at 11:30 a.m. She said both over the counter medications (cranberry and Vitamin A) and she checked the medication room and was not able to locate any additional supplies. LPN #1 was interviewed on 4/30/25 at 11:30 a.m. She said the amlodipine was not available and she did not know why. She said she called the physician and notified him that it was not available. The director of nursing (DON) was interviewed on 5/1/25 at 3:22 p.m. She said she relied on the unit managers, central supply person and the floor nurses to maintain communication to ensure all medications were available without interruptions. She said she was not aware of any formal system of tracking availability of over the counter medications. She said when a medication was not administered the physician should be notified.