STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065318	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irondale Post Acute	7150 Poplar St Commerce City, CO 80022

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (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 0693 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 with a feeding tube received appropriate treatment and services for one (#2) of four residents reviewed out of seven sample residents.Specifically, the facility failed to ensure Resident #2 received his tube feeding administration as ordered by the physician. Findings include:I. Resident #2A. Resident status Resident #2, age [AGE], was admitted on [DATE] and discharged on 11/1/25 to the emergency department via ambulance. According to the November 2025 computerized physician orders (CPO), diagnoses included pneumonia, muscle weakness, acute respiratory failure, dysphagia oropharyngeal phase (difficulty swallowing), protein calorie malnutrition and cerebral infarction (a blood clot in artery in the brain that cuts off oxygen and nutrients to the brain). The 10/29/25 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for a mental status (BIMS) score of 13 out of 15. He required partial to moderate assistance with toileting transfers and chair to bed transfers. The resident required supervision or touching assistance with oral hygiene and personal hygiene. The MDS assessment indicated the resident had a feeding tube upon admission and was receiving 51% or more of his calories through a feeding tube and 501 cubic centimeters (CC) a day of fluid through a feeding tube.B. Record reviewThe enteral feeding care plan, initiated 10/24/25, documented Resident #2 required tube feedings related to difficulty with swallowing. Interventions included elevating the head of the bed at least 30 to 45 degrees at all times during feeding, providing the resident tube feeding and water flushes per physician's orders, obtaining and monitoring lab/diagnostic work as ordered and report results to doctor and follow up as indicated , providing care to feeding tube site as ordered and monitor for signs and symptoms of infection, registered dietitian (RD) to evaluate quarterly and as needed, monitoring caloric intake and estimating needs, making recommendations for changes to tube feeding as needed and use enhanced barrier precautions.The nutrition care plan, initiated on 10/24/25 and revised on 10/29/25, documented Resident #2 had nutritional problem or potential nutritional problem related to his nothing by mouth (NPO) status, currently on tube feedings, pneumonia, aneurysm and acute respiratory failure. Resident #2 had a mini nutritional assessment (MNA) score of five indicating a malnourished status . Pertinent included administering medications as ordered, providing the tube feed as ordered: give 1430 ml enterally every 24 hours for continuous tube feeding.The hospital Discharge summary, dated [DATE], documented the following enteral feed physician's order for Resident #2: Enteral feed via nasogastric (NG) tube. Nutren 1.5 (enteral feed formula) with a continuous rate of 65 milliliters (ml) per hour (1430 ml total per day) with 30 ml free water bolus for tube patency every four hours. -However, review of the November 2025 CPO revealed the enteral feed orders were not entered into Resident #2's CPO until 10/28/25, five days after the resident was admitted to the facility. Review of the November 2025 CPO revealed the following physician's order for Resident #2:Nutren 1.5 oral liquid. Give 1430 ml enterally every 24 hours via feeding tube, ordered on 10/28/25 at 1:00 p.m.-Review of Resident #2's EMR did not reveal documentation indicating Resident #2 receive his enteral feed physician's orders as indicated on the hospital discharge paperwork from 10//23/25 until 10/28/25.C. Staff interviewsThe registered dietitian (RD), the assistant director of nursing (ADON) and the regional clinical resource were interviewed together on 12/8/25 at 1:58 p. m.The RD said when Resident #2 admitted from the hospital, the physician's ordered indicated Resident #2 was NPO with supplemental feeding via tube feed. The RD said the specific diet orders were to give Nutren 1.5 continuous, with a total volume of 1430 ml over 24 hours. The RD said the diet orders should have been transcribed into the medication administration record (MAR). The RD said the admitting nursing staff must have missed these orders upon admission. The regional clinical resource said ideally, the diet ordered was verified with the facility's physician and entered into the resident's CPO. The regional clinical resource said it was the admitting nurses responsibility to verify the hospital discharge orders with the facility physician upon admission. The regional clinical resource said this was important to ensure all of the physician's orders were entered because the facility needed to ensure Resident #2 did not miss any of his nutritional requirements. The regional clinical resource said the potential negative outcomes of a resident not receiving his nutritional requirements could result in a medical decline. The ADON said she provided education to the admitting nurse and all of the nurses in the facility regarding the process of verifying discharge orders and inputting them to the resident's EMR upon admission. The ADON said she provided this training on 10/28/25 after she noticed the missing orders in Resident #2' EMR. The RD said this was important to ensure Resident #2