STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065405	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parker Post Acute	9398 Crown Crest Blvd Parker, CO 80138

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536 Based on record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one (#2) of three residents reviewed out of eight sample residents. Specifically, the facility failed to ensure transportation services were provided for Resident #2 which resulted in the resident missing an appointment with her oncologist and several chemotherapy infusion appointments. Findings include: I. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the October 2024 computerized physician orders (CPO), diagnoses included malignant bladder cancer with bilateral nephrostomy (kidney) tubes. The 7/22/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. Resident #2 required set up assistance with eating, oral hygiene, dressing, and showers. She required supervision for toileting, and transfers, and was independent with bed mobility. II. Facility policy and procedure The Arranging Transportation policy, revised May 2020, was provided by the nursing home administrator (NHA) on 10/21/24 at 3:56 p.m. It read in pertinent part, It is the policy of this facility for the facility staff to assist in arranging for transportation when such assistance is requested or needed. The cost of transportation will be covered, as dictated by insurance coverage. II. Resident interview (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 was interviewed on 10/21/24 at 11:55 a.m. Resident #2 said she had missed appointments for oncology and chemotherapy infusions since being at the facility. She said there was a problem with transportation but she wanted to continue with her cancer care and be able to attend her future appointments. III. Resident care manager interview Resident #2's third-party care manager (CM), was interviewed by telephone on 10/22/24 at 10:21 a.m. The CM said Resident #2 had missed an oncologist office visit on 9/17/24 and had missed chemotherapy infusion appointments on 9/5/24, 9/19/24 and 9/26/24. The CM said on 8/16/24 she spoke with scheduler (SCH) #1 on the telephone about Resident #2's cancer care appointments. She said SCH #1 told her she had confirmed transportation for the resident's 8/15/24 to 9/26/24 appointments. However, the CM said Resident #2 did not attend those appointments on 9/5/24, 9/17/24, 9/19/24 and 9/26/24 because transportation had not been arranged by the facility. The CM said she contacted the facility on 10/15/24 to confirm Resident #2 attended her appointment on 10/14/24 and to ensure transportation for 10/17/24 had been arranged. The CM said on 10/17/24 the facility confirmed by email message Resident #2 attended her appointment on 10/14/24 and transportation was arranged for the 10/17/24 appointment. The CM said Resident #2 missed the appointments on 10/14/24 and 10/17/24. -However, there was no documentation in Resident #2's electronic medical record (EMR) to indicate the resident had actually attended the appointment on 10/14/24, despite the email message from the facility indicating she had. IV. Record review -A review of Resident #2's electronic medical record (EMR) revealed there were no physician orders documented oncologist or chemotherapy infusion appointments. -Further review of Resident #2's EMR revealed there were no progress notes documented regarding the resident's missed appointments or that the resident's primary care physician was informed when Resident #2 missed her cancer care appointments. V. Staff interviews Registered nurse (RN) #1 was interviewed on 10/21/24 at 12:20 p.m. RN #1 said the facility had a process for residents to attend appointments. She said when the nurse was notified of an appointment, the nurse entered a physician's order into the resident's EMR so the date and time of the appointment populated on the resident's treatment administration record (TAR) where it was visible to the nurses. RN #1 said the scheduler made transportation arrangements and added the appointments to an electronic calendar that was accessible to the nursing staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #2 was interviewed on 10/21/24 at 12:07 p.m. RN #2 said she provided care to Resident #2 but she was unaware Resident #2 had missed several cancer care appointments. She said it was important for the provider to be notified about missed appointments to allow the provider to evaluate and intervene if needed. RN #2 said when the nurse confirmed an appointment for a resident, the nurse completed a transportation request for the appointment and forwarded the form to the scheduler to make the transportation arrangements. SCH #2 was interviewed on 10/21/24 at 12:40 p.m. SCH #2 said when she received a transportation request form from a nurse, it was her responsibility to arrange transportation for the appointment. She said after the transportation was arranged, she entered the appointment and transportation information on an electronic calendar that was accessible to the nursing staff. She said if the nursing staff did not notify her of residents' appointments, there would be no transportation arranged for the appointments. -SCH #2 was unable to locate transportation request forms or billing invoices for Resident #2's cancer care appointments on 9/5/24, 9/17/24, 9/19/24, 9/26/24, 10/14/24 and 10/17/24. SCH #1 was interviewed on 10/22/24 at 9:40 a.m. SCH #1 said she worked as an interim transportation scheduler during August 2024 throughOctober 2024. She said she recalled speaking with Resident #2's third-party CM about her cancer care appointments for 8/29/24 through 9/26/24. -SCH #1 said she scheduled transportation for Resident #2 for those dates during that time period, however, she was unable to provide copies of the scheduling calendar, transportation request forms, or billing invoices for transportation on the dates of missed appointments. The NHA was interviewed on 10/22/24 at 12:07 p.m. The NHA said it was the policy of the facility to arrange transportation for residents' appointments when needed. The NHA said he was unaware Resident #2 had missed her cancer care appointments. The NHA said during July 2024 through October 2024 the facility had a change of scheduling staff and a new scheduler was hired on 10/7/24. The NHA said the new scheduler used the transportation request form to confirm residents' needs and to communicate transportation with nursing staff. VI. Facility follow-up On 10/22/24 at 3:55 p.m., the NHA provided copies of the transportation request forms for Resident #2's future cancer care appointments scheduled on 10/25/24, 10/31/24, 11/7/24, 11/21/24, and 11/27/24. The NHA said he had educated all nursing staff and schedulers to use the transportation request forms for every request received in any manner (email, telephone, paperwork, or in person).