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	03/06/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52309 Based on record review and interviews, the facility failed to develop and implement a baseline care plan which included the instructions needed to provide effective and person-centered care for two (#2 and #6) of three residents reviewed for baseline care plans out of 13 sample residents. Specifically, the facility failed to ensure pertinent medical information was included on Resident #2 and Resident #6's baseline care plans within 48 hours of admission. Findings include: I. Facility policy and procedure The Policy/Procedure-Nursing Administration, Subject: Care planning policy, revised January 2025, was received from the nursing home administrator (NHA) on 3/6/25 at 1:56 p.m. It read in pertinent part, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive, person-centered care plan for each resident. A care plan is initiated within 48 hours of admission per assessment findings. The care plan is developed by the IDT which includes, but is not limited to the following professionals: nursing, therapy (as indicated), social services, activities, and dietary. II. Resident #6 A. Resident status Resident #6, age 78, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included end stage renal disease, dependence on renal dialysis (medical procedure that filters waste out of the blood) and a pressure ulcer (skin damage when prolonged pressure disrupts the flow to the tissues) to the coccyx. The 1/6/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. B. Record review (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #6's admission orders, dated 12/24/24, revealed the resident was receiving renal dialysis for end stage renal disease, she had a stage 3 pressure ulcer on her coccyx and a wound to her right hand. She was maximum assistance of two staff members for transfers using a Hoyer lift, she was dependent on staff for toileting and hygiene care, she had bladder incontinence and required set up assistance for her meals. -Review of the baseline care plan, dated 12/27/24, revealed the care plan did not include information regarding the resident's dialysis three times a week, wound care to the right hand, interventions for activities of daily living (ADLs), including the use of a total lift for transfers, dependence on staff for toileting and hygiene and set up meal assistance and the need for incontinence care. III. Resident #2 A. Resident status Resident #2, age 74, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included cognitive communication deficit, type 2 diabetes mellitus without complications, hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease or unspecified chronic kidney disease and dependence on renal dialysis. The 2/18/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of eight out of 15. The MDS assessment revealed that the resident was dependent on dialysis. B. Record review -Review of Resident #4's baseline care plan, dated 1/10/25, revealed the care plan did not include information regarding interventions for the resident's chronic kidney disease and the resident's insulin use. On 2/7/25 Resident #2 was admitted to the hospital and returned to the facility on [DATE] with physician's orders for dialysis three times per week and dialysis weights could be used for facility weight monitoring. Review of Resident #2's 2/11/25 baseline care plan revealed the facility documented the resident's chronic kidney disease and insulin use on the care plan. -However, the baseline care plan did not include information related to the resident's dialysis care. IV. Staff interview (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 3/6/25 at 3:45 p.m. The DON said the admitting nurse was responsible for initiating the baseline care plan for each resident and the care plans were then audited by another nurse or the DON for accuracy. She said staff should personalize the residents' baseline care plans for such things as wounds, infections, fall risks or ADL needs. The DON said the nurses did not pull the baseline care plan to get information on a new resident because they went directly to the admitting orders for any needed information. The DON said when Resident #2 was initially admitted to the facility, he had a dialysis port (a medical device used to provide access to a patient's bloodstream for hemodialysis treatment) and a new fistula (a surgical procedure that creates a connection between an artery and a vein) but was not yet receiving dialysis. The DON said the facility was not required to include the dialysis port on the initial baseline care plan. 52288

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52094 Based on observations, record review and interviews the facility failed to ensure two (#7 and #4) of four residents reviewed for accidents out of 13 sample residents received adequate supervision to prevent accidents. Resident #7, who had diagnoses of unspecified dementia, a history of falling and muscle wasting, was admitted to the facility on [DATE]. Between 6/14/24 and 7/21/24, the resident experienced six falls. The facility failed to put effective fall interventions into place after each fall. On 8/7/24, Resident #7 experienced a seventh fall and sustained a laceration on her forehead which resulted in the resident being transferred to the hospital for sutures to the laceration. Upon the resident's return from the hospital, a fall mat and instructions to keep the resident's bed in the low position were added to the resident's care plan as fall interventions. However, between 8/7/24 and 2/19/25, Resident #7 experienced eight more falls. The facility again failed to put effective fall interventions into place following each of the resident's falls. On 2/22/25 Resident #7 experienced another fall (fall #16) and sustained a laceration to her left eyebrow and a hematoma (an injury that causes blood to collect and pool under the skin) to her left cheek. The resident was again transported to the hospital for evaluation and treatment of the injuries. Upon the resident's return to the facility, Resident #7 was moved to a room closer to the nurses station in order to more closely monitor her, however, the resident sustained another fall on 3/1/25. Due to the facility's failures to determine the root cause of the resident's continued falls and put effective, person-centered interventions into place, Resident #7 experienced 17 falls between 6/14/24 and 3/1/25, two of which required transportation to the hospital for treatment of injuries. Additionally, the facility failed to ensure Resident #4 had effective person-centered interventions put into place after each of her 12 falls between 11/8/24 and 2/17/25 to prevent further falls. Findings include: I. Facility policy and procedure The Falls Monitoring and Management policy, revised January 2025, was provided by the nursing home administrator (NHA) on 3/6/25 at 5:06 p.m. It revealed in pertinent part, The licensed nurse is responsible for assessing and evaluating the resident's fall risk on admission, quarterly, and with a significant change in condition. The nurse will document fall risk on the Fall Risk Assessment form and implement a plan of care for high fall risk residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	For an individual who has fallen, the following interventions should include, but are not limited to, obtain vital signs, assess for head injury/change in level of consciousness, assess for change in normal range of motion/weight bearing, initiate neurological assessment on residents that have hit their head or un-witnessed fall (even if resident states they did not hit their head, because they may have hit their head and may not have a recollection that they hit their head), assess for pain, precipitating factors, details on how fall occurred, provide first aid (including intervention for pain if pain is identified), notify MD (physician) for further orders, notify responsible party, document details under Risk Management in electronic medical record (EMR), document neurological assessments on Neurological Assessment form, complete initial neurological assessment, update plan of care to minimize risks for injury due to falls. Examples of interventions to minimize risks for injury due to falls include, but are not limited to; vitamin D, fall mats, raised edge mattresses, night lights, non-skid socks, hip protectors, toileting schedule, therapy evaluation, restorative program evaluation, monitor/document daily for 72 hours, notify physician if signs/symptoms of complications and update plan of care. The IDT (interdisciplinary team) will meet in the morning to discuss the following: predisposing factors, injuries and interventions. The IDT will place a fall IDT note in the computer with verification of interventions or new interventions. Recommended in the morning meeting would be the director of nursing (DON)/ designee, activities, social services and therapy. II. Resident #7 A. Resident status Resident #7, age greater than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (stroke) affecting right dominant side, unspecified dementia, history of falling, history of transient ischemic attack (a temporary interruption of blood flow to the brain that causes sudden neurological symptoms that typically resolve within 24 hours, also known as a mini-stroke) and muscle wasting. The 2/19/25 minimum data set (MDS) assessment revealed the resident was not able to complete the brief interview for mental status (BIMS) assessment.The Care Area Assessment revealed she had dementia and delirium. She scored zero on all memory questions. She used a wheelchair, she required maximum assistance with showers, supervision with toileting and moderate assistance with transferring. The MDS assessment indicated the resident had a fall since admission. B. Observations On 3/5/25 at 11:40 a.m. Resident #7 was sitting alone in the common area. On 3/6/25 at approximately 9:00 a.m., the resident was sitting in the hallway. She had bruises to her left cheek and she had a visible laceration under her left eyebrow. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/6/25 at 6:45 p.m. Resident #7 was sitting in the dining room in her wheelchair. She was supervised by a staff member. She had a bruise on her left cheek and was wearing a band-aid on her cheek. She did not pay attention or react to her surroundings and did not interact with her peers or caretaker during meal time. Her gaze remained on the table and on her meal in front of her. C. Record review The 1/30/23 admission fall risk assessment identified Resident #7 as a high risk for falls. It instructed staff to lower her bed and to encourage her to be in common areas for increased supervision. Furthermore, it recommended an anti-rollback or anti-tipper device evaluation for her wheelchair. The 2/22/25 and the 3/5/25 fall risk assessments documented that Resident #7 fell more than three times in the last three months. Review of Resident #7's at risk for falls care plan, initiated 3/22/24 and revised 3/6/25, revealed the resident was at risk for falls related to CVA (stroke), weakness, and paired mobility. The goal was to prevent any fall related injuries by providing physical therapy and providing physical assistance with mobility. The interventions added to the at risk for falls care plan on 3/22/24 included anticipating and meeting the residents needs, placing the resident's call light within reach, avoiding rearranging furniture, frequent room checks, clearing pathways and lowering the bed. The interventions added to the at risk for falls care plan on 7/24/24 included offering/assisting with toileting the resident before meals and at bedtime. The interventions added to the at risk for falls care plan on 8/8/24 included placing the resident's bed in the lowest position when she was in bed. The interventions added to the at risk for falls care plan on 3/6/25 care plan included frequent rounding and anticipating the resident's needs and encouraging the resident to be in common areas to increase supervision. -The facility failed to implement new fall interventions following Resident #7's falls on 6/14/24, two falls on 6/23/24, 11/2/24, 12/19/24, three falls on 12/23/24, 12/27/24 and 2/19/25 (see fall incidents below). The actual fall care plan, initiated 12/20/24 and revised on 3/1/25, documented the resident had had an actual fall. The goal was for the resident to resume usual activities without further incident through the review date. -The facility failed to initiate an actual fall care plan until 12/20/24, after the resident had already sustained 10 falls between 6/14/24 and 12/19/24, one of which required transportation to the hospital for sutures to a laceration on her forehead (see fall incidents below). Interventions added to the actual fall care plan on 12/20/24 included directing staff to keep the bed in the lowest position and continuing interventions on the at risk for falls care plan. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interventions added to the actual fall care plan on 3/1/25 included evaluating her wheelchair for proper fitting and frequent room checks. Review of Resident #7's Kardex (a quick care plan summary reference tool to assist staff in providing efficient and consistent care of residents) on 3/6/25 revealed the resident was to have her bed in the lowest position when in bed, and staff was to conduct frequent rounding, anticipate the resident's needs and encourage the resident to be in common areas for increased supervision. Therapy was to evaluate the resident for the use of anti-rollback or anti-tipper devices to her wheelchair, if appropriate. -However, according to the DON, anti-tipper devices were placed on the resident's wheelchair, but were removed because they did not work for the resident (see DON interview below). Review of Resident #7's electronic medical record (EMR) revealed the resident had 17 falls from 6/14/24 through 3/1/25. Review of Resident #7's falls between 6/14/24 and 3/1/25 revealed the following: 1. Fall incident on 6/14/24 at 6:45 p.m. - unwitnessed The 6/14/24 progress note documented that a certified nurse aide (CNA) found Resident #7 sleeping in her chair. CNA helped her to get into bed by request. Shortly after, a CNA found Resident #7 lying on the floor mat in her room. The CNA notified the nurse. Resident #7 sustained a bruise on her left elbow but her skin remained intact. The 6/17/24 IDT review note documented that an up/down therapy assessment was scheduled as an intervention. The note documented risk factors were poor safety awareness, poor cognition, and incontinence. -However, Resident #7's fall occurred shortly after she had been put to bed by a CNA after being up in her chair. -The facility failed to identify the root cause of the fall. 2. Fall incident on 6/22/24, time not documented - unwitnessed The 6/22/24 fall investigation documented a CNA found Resident #7 lying on the floor in front of her wheelchair in the activity room. Three staff assisted Resident #7 back to her wheelchair using a gait belt. A registered nurse (RN) assessed the resident for injury and pain. She complained about high hip pain but no injury was found. The 6/24/24 IDT review documented that an x-ray was ordered. CNAs and nurses were educated on the risk of leaving residents unattended. The note documented risk factors were lack of coordination, cognitive deficits, hypertension and muscle weakness. -However, there were no additional fall interventions added to the fall care plan following the 6/22/24 fall (see care plan above). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Additionally, Resident #7 was observed alone in the common area on 3/5/25 (see observations above). -The facility failed to identify the root cause of the fall. 3. Fall incident on 6/23/24 at 2:40 a.m. - unwitnessed The 6/23/24 progress note documented that a nurse and a CNA found Resident #7 lying on the living room floor. It documented the resident attempted to walk on her own instead of using her wheelchair. The 6/24/24 IDT review note documented that the physician ordered laboratory bloodwork (labs) and a urinary analysis due to the resident's increased confusion and multiple falls. The physician's goal was to rule out a urinary tract infection (UTI) as she had a history of UTIs. 4. Fall incident on 6/23/24, time not documented - unwitnessed The 6/23/24 progress note documented that a CNA found Resident #7 sitting on the floor in front of her wheelchair in the common area. -However, according to the 6/24/24 IDT note for the resident's 6/22/24 fall, staff was educated on the risks of leaving the resident unattended (see above). -Additionally, Resident #7 was observed alone in the common area on 3/5/25 (see observations above). The 6/25/24 IDT review note documented that Resident #7 continued therapy for safety awareness. The note documented risk factors were lack of coordination, cognitive deficits, hypertension and muscle weakness. -The facility failed to identify the root cause of the fall. 5. Fall incident on 7/6/24 at 5:11 p.m. - unwitnessed The 7/6/24 fall investigation documented that Resident #7 was found sitting on the floor in the television (TV) area. She had a bruise on the back of her head. The 7/8/24 IDT review note documented that the resident needed to be reevaluated for safety awareness. Her wheelchair needed to be assessed for anti-roll back or anti-tipped back. The note documented risk factors were lack of coordination, cognitive deficits, hypertension and muscle weakness. -The facility failed to identify the root cause of the fall. 6. Fall incident on 7/21/24 at 4:15 p.m. - unwitnessed The 7/21/24 fall investigation documented that a nurse found Resident #7 sitting on the floor in her room in front of her wheelchair. (continued on next page)

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	065405	A. Building B. Wing	03/06/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 7/22/24 IDT review note documented that Resident #7's social worker was going to set up a care conference with the family to discuss relocating the resident to a locked unit. The note documented risk factors were lack of coordination, cognitive deficits, hypertension and muscle weakness. -However, there was no follow up note to indicate whether the care conference occurred or not. 7. Fall incident on 8/7/24 at 12:16 p.m. - unwitnessed The 8/7/24 fall investigation documented that a CNA found Resident #7 on the floor in front of her bed. She suffered a laceration on her forehead and was transported to the hospital. The 8/7/24 progress note documented Resident #7 hit her forehead and suffered bruises to her left and right elbow. She received two sutures at the hospital which would be removed in five days. She had no new behaviors or pain and her vital signs were within normal limits. The 8/8/24 IDT review note documented that Resident #7`s room was assessed for safety. Staff removed her nightstand for safety. Additional interventions added were the placement of a fall mat and ensuring the resident's bed was in the low position. The note documented risk factors were lack of coordination, cognitive deficits, hypertension and muscle weakness. -However, the facility failed to update the at risk for falls care plan with the fall mat intervention following the resident's 8/7/24 fall. -The facility failed to identify the root cause of the fall. 8. Fall incident on 9/10/24 at 6:02 p.m. - unwitnessed The 9/10/24 fall progress note documented a nurse found Resident #7 lying on the floor in front of a couch. The 9/11/24 IDT review note documented that the anti-roll back device was in place, however, it was not functional. The facility requested therapy to assess for proper functioning of the anti-roll back device. There was no mention of the fall location. -The note did not document what other safety interventions would be put into place if the anti-roll back devices were not functioning properly. -The facility failed to identify the root cause of the fall. 9. Fall incident on 11/2/24 at 6:36 p.m. - witnessed The 11/2/24 fall investigation documented that staff reported Resident #7 fell to the floor in her bathroom while wiping herself after a bowel movement. She hit her head on the wall. The 11/4/24 IDT note documented staff were educated on fall prevention and would encourage Resident #7 to use the grab bars during toileting. The IDT team note documented she had a risk factor of lack of coordination, cognitive deficits and dementia. (continued on next page)

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	065405	A. Building B. Wing	03/06/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The facility failed to update the at risk for falls care plan with a new fall intervention following the resident's 11/2/24 fall (see care plan above). 10. Fall incident on 12/19/24 at 5:48 p.m. - unwitnessed The 12/19/24 fall risk assessment revealed Resident #7 was a high risk for falls. The 12/19/24 fall investigation documented staff found Resident #7 lying on the East hallway floor. Her wheelchair was tipped over backwards. The resident had a bump to the back of her head with redness. The resident was assisted back to the wheel chair. The fall investigation documented the predisposing psychological factors were confusion, incontinence and impaired memory. The 12/19/24 IDT review note documented lab work was ordered. -The note did not document that additional fall interventions were put into place. -The facility failed to update the at risk for falls care plan with a new fall intervention following the resident's 12/19/24 fall (see care plan above). -The facility failed to identify the root cause of the fall. The 12/20/24 nursing note documented the swelling to the back of Resident #7's head was decreasing. The resident had four large bruises to her right lower arm and a urine culture was pending results. 11. Fall incident on 12/23/24 at 7:00 a.m. - unwitnessed The 12/23/24 fall investigation documented that staff found Resident #7 in another resident`s room. She was laying on her back close to the bed. Her wheelchair was near her. The resident had no injuries. The investigation revealed she was assisted back to her wheel chair and range of motion was completed. The resident had no injury. The fall investigation documented the predisposing physiological factor was confusion. The 12/24/24 IDT review note documented the physician needed to review the resident's medications. -The note did not document that additional fall interventions were put into place. -The facility failed to update the at risk for falls care plan with a new fall intervention following the resident's 12/23/24 at 7:00 a.m. fall (see care plan above). -The facility failed to identify the root cause of the fall. 12. Fall incident on 12/23/24 at 1:15 p.m. - unwitnessed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 12/23/24 fall investigation documented another resident reported to the nurse that Resident #7 was on the floor. Resident #7 was sitting on the floor by the common area next to her wheelchair. She wore non-skid socks and shoes. The floor was dry and uncluttered. She hit her head. The fall investigation documented the predisposing physiological factors were a current UTI and impaired memory. The 12/24/24 IDT review note documented the physician ordered labs which came back positive for a UTI. The resident was currently on antibiotics due to confusion and falls. -The note did not document that additional fall interventions were put into place. -The facility failed to update the at risk for falls care plan with a new fall intervention following the resident's 12/23/24 at 1:15 p.m. fall (see care plan above). -The facility failed to identify the root cause of the fall. 13. Fall incident on 12/23/24 at 3:15 p.m. - unwitnessed The 12/23/24 fall investigation documented staff found Resident #7 on the floor in the dining room. She was laying on her back under a table. The resident was assessed and she denied pain. The fall investigation documented the predisposing physiological factors were confusion and impaired memory. The 12/24/24 IDT note documented that the physician reviewed the Resident #7's medications and implemented medication changes. -The note did not document what the medication changes were or that additional fall interventions were implemented. -The facility failed to update the at risk for falls care plan with a new fall intervention following the resident's 12/23/24 fall at 3:15 p.m. fall (see care plan above). -The facility failed to identify the root cause of the fall. 14. Fall incident on 12/27/24 at 4:27 a.m - witnessed The 12/27/24 fall investigation documented that staff witnessed Resident #7 yelling and propelling her wheelchair. She attempted to transfer from her wheelchair to a sofa. She started to slide then sat on the floor. The fall investigation documented the predisposing physiological factors were confusion, weakness, gait imbalance and impaired memory. The 12/27/24 IDT review note documented the physician needed to complete a medication evaluation. (continued on next page)

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	065405	A. Building B. Wing	03/06/2025

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

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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 0689 Level of Harm - Actual harm Residents Affected - Few	-However, physician evaluation of the resident's medications was documented as an intervention for the resident's falls on 12/23/24 and the medication review was documented as having been completed in the 12/24/24 IDT review notes (see above). -The facility failed to update the at risk for falls care plan with a new fall intervention following the resident's 12/27/24 fall (see care plan above). 15. Fall incident on 2/19/25 at 7:44 a.m. - unwitnessed. The 2/19/25 fall investigation documented Resident #7 was found on the floor by her bed. She tried to ambulate without assistance. She wore non-skid socks. The resident's call light was within reach, however, she did not use her call light. The fall investigation documented the predisposing physiological factors were confusion, incontinence and impaired memory. She ambulated without assistance. The 2/19/25 IDT review note documented interventions were for frequent room checks and to meet the resident's needs. -However, the note did not specify what needs the resident needed met or how staff was to ensure those needs were met. -The facility failed to update the at risk for falls care plan with a new fall intervention following the resident's 2/19/25 fall (see care plan above). -The facility failed to identify the root cause of the fall. 16. Fall incident on 2/22/25 at 1:45 a.m. - unwitnessed The 2/22/25 fall investigation documented that staff heard Resident #7 calling for help. Staff found the resident lying on the floor on her left side. Her face was covered in blood. Her head was close to the drawer. She told staff she wanted to go to the bathroom when she fell . She sustained a cut to the left eyebrow measuring 2.5 centimeters (cm) in length by 0.5 cm wide and she had a hematoma to her left cheek. The resident said her head hurt. Pressure was applied to the cut on her left eyebrow to control bleeding. The 2/22/25 hospital records revealed the resident had a hematoma over her left cheek, but no facial fractures. The 2/24/25 IDT review note documented Resident #7 was transported to the hospital for treatment. She was moved closer to the nurses station after her return to the facility. -However, the facility failed to move Resident #7 closer to the nurses station as a fall intervention until after the resident had sustained 16 falls, two with injuries that required transportation to the hospital for treatment. -The facility failed to identify the root cause of the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	17. Fall incident on 3/1/25 at 6:30 p.m. - unwitnessed The 3/1/25 fall investigation documented that Resident #7 slid from her wheelchair to the floor in the dining area. The resident did not have any injuries. The RN completed a total head to toe assessment and found no apparent injury. She was assisted back to the wheelchair. The fall investigation documented the predisposing psychological factors were incontinence and impaired memory. The 3/4/25 IDT review note documented the resident needed to be re-evaluated for proper wheelchair cushion fitting and staff were to notify hospice if wheelchair replacement was needed. The 3/6/25 progress note (added during the survey) documented that occupational therapy (OT) the resident's wheelchair fit and cushion that morning (3/6/25) to reduce risk of falls. Resident #7 reported the wheelchair was comfortable and the wheelchair cushion was in good shape. Dycem (a non-slip material used to provide stability and improve gripability) was added under the cushion to reduce the risk of the wheelchair cushion slipping and the OT recommended continued use of the cushion and wheelchair. -However, the assessment of the resident's wheelchair and cushion did not occur until 3/6/25, five days after the resident's 3/1/25 fall. -The facility failed to identify the root cause of the fall. D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 3/6/25 at 10:15 a.m. LPN #1 said Resident #7 had a fall on 2/22/25 which resulted in a transport to the hospital. LPN #1 said the resident received steri-strips to her left eye brow for the laceration. She said the resident frequently fell . She said that she got up by herself and then fell . She said the resident was recently moved to a room closer to the nurses station. She said that helped, however, she said the resident still had falls. She said Resident #7 had dementia and would continue to get up by herself. She said she had a urinary tract infection which had increased her fall risk. However, she said the resident had no infection currently. She said staff were encouraged to keep the resident in the common areas so she could be supervised. The DON was interviewed on 3/6/25 at 4:40 p.m. The DON said Resident #7 had sustained numerous falls and was at a high risk for falls. She said after each fall, the IDT discussed the falls and the reason for each fall and tried to prevent further falls with interventions. She said sometimes the interventions were effective and other times they were not effective. She said Resident #7 had close monitoring. The DON said the resident started on hospice services on 2/19/25. The DON said Resident #7's wheelchair was assessed for anti-tip bars, however, she said the bars were removed because they did not work for the resident. She said the wheelchair was not the cause of the frequent falls. She said she would review the Kardex and would remove the anti-tip device. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON reviewed Resident #7's EMR and said she could not locate documentation that the resident's medications were reviewed by the physician, as was documented as the intervention after the resident's 12/27/24 fall. The DON said Resident #7 was working with restorative nursing on range of motion. She said the staff kept the resident busy with activities. The DON said the facility had tried different interventions to prevent Resident #7's falls, such as medication review, activities, close monitoring and removing furniture from the resident's room. However, she said the facility had not been able to identify reasons for the resident's frequent falls. She said she was not able to answer how the facility monitored and assessed fall prevention effectiveness. -However, review of the fall investigations did not indicate the facility attempted to identify the root cause of Resident #7's falls after each fall. The DON said she encouraged Resident #7's family to visit more frequently. 52309 III. Resident #4 A. Resident status Resident #4, age less than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included left sided hemiplegia (paralysis affecting only one side of your body), muscle weakness, cognitive communication deficit, abnormalities of gait and mobility, and history of falling. The 2/11/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 11 out of 15. Resident #4 was substantial/maximal assistance to sit to stand and partial/moderate assistance with chair/bed-to-chair transfer. B. Observations During a continuous observation on 3/5/25, beginning at 11:30 a.m. and ending at 12:10 p.m., the following was observed: At 11:35 a.m. Resident #4 self transferred to her wheelchair from her bed and self propelled the wheelchair to the dining room. The resident had an ankle motion walking boot on her left foot. At 11:50 a.m. Resident #4 self propelled her wheelchair to her room and self transferred to her bed. At 12:00 p.m. Resident #4 self transferred to her wheelchair from her bed and self propelled the wheelchair to the dining room. C. Resident interview (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #4 was interviewed on 3/5/25 at 3:35 p.m. Resident #4 said she fell a lot at home and broke her foot. She said she had fallen at the facility. She said was supposed to call for help when getting up but had to wait too long for staff to respond so she got up on her own. D. Record review The admission fall risk assessment, dated 11/4/24, revealed Resident #4 had a history of falls, required assistive devices, was regularly incontinent and was identified as a high risk for falls. Review of Resident #4's activities of daily living (ADL) self care performance deficit care plan, initiated 11/5/24, indicated Resident #4 required partial assistance with chair/bed to chair and toilet transfers. Review of the risk for falls care plan, initiated 11/7/24 and revised 2/11/25, revealed Resident #4 was at risk for falls due to recent surgery (left ankle) and had gait/balance problems. Pertinent interventions included ensuring the resident's call light was within reach and her bed was in the lowest position. Review of the actual fall care plan, initiated 11/18/24 and revised 12/17/24 revealed Resident #4 had an actual fall. Pertinent interventions included frequent room checks, medical provider to evaluate and order laboratory (lab) work and offering to transfer the resident to her wheelchair when awake. The Kardex Report, dated 3/6/25, indicated Resident #4 was a high fall risk and required frequent rounding, staff were to anticipate her needs, encouraging the resident to be in common areas for increased supervision as appropriate and to monitor for falls. Review of Resident #4's EMR revealed the resident had 12 falls from 11/15/24 through 2/17/25. Review of Resident #4's falls between 11/18/24 and 2/17/25 revealed the following: 1. Fall incident on 11/15/24 - unwitnessed The 11/15/24 fall risk evaluation identified the resident was a high risk for falls. The 11/15/24 fall investigation documented Resident #4 was found on the floor in her room next to the bed. The wheelchair was not locked and the resident had one non-skid sock on her right foot. Staff were unable to put a non-skid sock over the splint on her left foot. The resident had no injuries, but had a small red mark on her back. Resident #4 complained of pain to her left lower extremity (LLE). The resident said she was trying to get back into bed. The resident was educated on call light use and keeping weight off of her LLE. Resident #4 voiced understanding and apologized for trying to walk. The fall investigation documented the predisposing physiological factors were confusion and gait imbalance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The interdisciplinary team (IDT) review of the fall, dated 11/18/24, revealed the interventions put into place were to remind the resident to use the call system when she needed assistance with transfers and the resident continued on therapy services addressing overall safety awareness for decreased risks for falls. 2. Fall incident 11/26/24 - unwitnessed The 11/26/24 fall risk evaluation identified the resident was a medium risk for falls. The 11/26/24 fall investigation documented the resident was lying on the floor. Resident #4 said she was trying to go to bed. The resident was assessed and assisted to bed with the assistance of two staff members. The fall investigation documented the predisposing physiological factors were confusion, incontinence and gait imbalance. The IDT review of the fall, dated 11/27/24, revealed the interventions put into place were to check labs for ammonia level (a nitrogen-containing waste product produced by the body's metabolism) and the resident continued on therapy services to address overall safety awareness for decreased risk for falls. 3. Fall incident on 11/27/24 - un[TRUNCATED]

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52288 Based on record review and interviews, the facility failed to ensure one (#5) of four residents had an effective pain management regimen in a manner consistent with professional standards of practice out of 13 sample residents. Resident #5 was admitted to the facility on [DATE] with a diagnosis of low back pain and dementia. The resident was on a scheduled pain regimen, which consisted of Tylenol 1000 milligrams (mg) three times a day and Aspercreme 1% (topical pain medication) to be applied to the resident's right shoulder twice a day. On 1/23/25 at 3:40 a.m. the resident began complaining of excruciating pain to her shoulder, back of both thighs, both knees, calves and hips. The facility failed to address Resident #5's reports of excruciating pain for three and a half hours until the nurse obtained a physician's order to administer Valium (muscle relaxer medication). Findings include: I. Facility policy and procedure The Pain Management policy, revised January 2025, was received from the nursing home administrator (NHA) on 3/6/25 at 1:56 p.m. The policy read in pertinent part, Resident pain is assessed and managed by an interdisciplinary team who work together to achieve the highest practicable outcome. The facility assists each resident with pain to maintain or achieve the highest practicable level of well-being and functioning by: screening to determine if the resident has been or is experiencing pain; comprehensive evaluation of the pain, licensed nurse will completed the LN-pain (licensed nurse pain) evaluation or PAINAD (pain assessment in advanced dementia) and use of pharmacological and/or non-pharmacologic interventions to manage the pain and/or try to prevent the pain consistent with the resident's goals. For the resident who is unable to communicate verbally or understand abstract concepts use PAINAD. II. Resident #5 A. Resident status Resident #5, age 67, was admitted on [DATE] and discharged on [DATE] to the hospital. According to the February 2025 computerized physician orders (CPO), diagnoses included low back pain, post-traumatic stress disorder, unspecified, dementia with other behavioral disturbance, anxiety disorder, unspecified, and unsteadiness on feet. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The 12/18/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of two out of 15. The resident required assistance from one staff member with showering, toileting, transferring and personal hygiene. The assessment revealed the resident was on a scheduled pain management regimen, which included both medication and non-medication interventions for pain. B. Record review The pain care plan, initiated 5/29/24, identified the resident was at risk for both chronic and acute pain related to depression and disease progression. Pertinent interventions included administering pain medications as ordered, completing a pain scale every shift, repositioning the resident for comfort, providing non pharmacological interventions, anticipating the resident's need for pain relief and responding immediately to any complaint of pain. -The care plan failed to reveal the resident's pain goals, acceptable levels of pain or what type of pain assessment should be used to evaluate pain. The 12/20/24 quarterly pain management review documented the resident could not be interviewed and the PAINAD assessment was to be completed. -However, the January 2025 CPO revealed the physician's order indicated to use a numerical pain scale. Review of the January 2025 CPO revealed the following physician's orders related to pain management: Monitor pain every shift, using a 0 to 10 scale; 0 was no pain, 1 to 3 was mild pain, 4 to 5 was moderate pain, 6 to 9 was severe pain and 10 was excruciating pain. Tylenol extra strength 500 mg, give 1000 mg three times a day for chronic pain, ordered 10/8/24. Aspercreme arthritis pain external gel 1%, apply to the right shoulder topically two times a day for pain, ordered 6/9/24. Aspercreme Lidocaine external cream 4%, apply to affected area topically two times a day for pain, ordered 1/23/25. -The physician's order did not specify where the affected area was. Ibuprofen oral tablet, give 400 mg by mouth one time for pain, ordered 1/24/25. Valium oral tablet 5 mg, give 5 mg by mouth STAT (immediately) for hallucinations/anxiety, ordered 1/23/25. Review of the January 2025 medication administration record (MAR), from 1/22/25 to 1/24/25 revealed the following: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Tylenol 100 mg was administered on 1/23/25 at 7:14 a.m. and 12:06 p.m. Aspercreme arthritis pain external gel 1% was administered on 1/22/25 at 11:34 a.m. and 8:05 p.m. to both shoulders, on 1/23/25 at 7:08 a.m. and 11:05 a.m. to her shoulders and on 1/24/25 at 9:09 a.m. to her right front shoulder. Aspercreme Lidocaine external cream 4% was administered on 1/23/25 at 9:08 a.m. and 4:46 p.m. and on 1/24/25 at 9:09 a.m. Ibuprofen 400 mg was administered on 1/24/25 at 7:50 a.m. Valium 5 mg was administered on 1/23/25 at 7:51 a.m. -The ibuprofen and Valium were not administered until three and a half hours after the resident was screaming out in excruciating pain (see progress notes below). The 1/23/25 nursing note revealed Resident #5 was heard screaming at 3:40 a.m. The resident was sitting on the toilet. She complained of pain to her shoulder, backs of both thighs, both knees, calves and hips. The physician was contacted. The physician instructed to apply Aspercreme (topical pain medication) to the affected areas. -Review of the January 2025 medication administration record (MAR) revealed the resident was administered Aspercreme 1% at 7:08 a.m., (three and a half hours after the resident was screaming in pain), which was applied to the resident's shoulders. Review of the MAR did not document the facility administered Aspercreme to the resident's thighs, knees, calves and hips (see MAR above). The 1/23/25 nursing note, documented at 7:14 a.m., revealed Resident #5 continued to display signs of pain and was administered 1000 mg of Tylenol. The 1/23/25 nursing note, documented at 7:36 a.m., revealed the nurse practitioner (NP) was contacted because the resident was shaking, was having hallucinations and crying that she hurt so bad but was unable to tell staff where she hurt. The NP gave a verbal order for Valium 5 mg one dose, nitrofurantoin (antibiotic) 50 mg daily prophylaxis (preventative) for chronic urinary tract infection (UTI) and ordered a CBC (complete blood count, blood test) and a CMP (comprehensive metabolic panel, blood test) STAT. The 1/23/25 NP note, documented at 11:36 a.m., documented that Resident #5 was lying in bed shivering and stating that she was in pain. The note documented the resident was unable to point out where the pain was. The note documented the resident went to an urology appointment on 1/22/25 and received a physician's order to start on antibiotics prophylactically, which she had not started yet. The resident had a temperature between 99.4 and100 degrees Fahrenheit. The note documented the resident had Tylenol 1000 mg scheduled three times a day. The resident denied congestion and a sore throat. The 1/23/25 nursing note, documented at 7:51 a.m., revealed Valium 5 mg was administered to the resident. -Review of the resident's electronic medical record (EMR) did not reveal documentation indicating the facility addressed the resident's pain for three and a half hours. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The 1/24/25 physician note, documented at 6:43 a.m., revealed the resident was lying in bed, alert, appeared weak, but had no acute distress. She had some pain when her right leg was moved, but appeared comfortable when at rest and not being disturbed. She was unable to recall any specific injury and staff had no reports of an accident. The right thigh was swollen and tender. An x-ray was ordered. The physician prescribed ibuprofen 400 mg to be given one time. The note was updated to indicate the imaging confirmed a femur fracture and the resident was transferred urgently to the hospital. The 1/24/25 nursing progress note, documented at 7:09 a.m., revealed the resident was having excruciating pain to her right leg. Staff received a verbal physician's order for ibuprofen 400 mg one time, Eliquis 10 mg (blood thinning medication used to prevent blood clots) twice a day for seven days and an ultrasound for her upper right leg. C. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 3/6/25 at 11:13 a.m. LPN #1 said on the morning of 1/23/25, she checked on Resident #5 and noted the resident had a low-grade fever. She said the resident was lying on her back and was moaning in pain. She said registered nurse (RN) #1 assessed the resident and informed her that the resident's leg and her upper leg appeared swollen and questioned whether it could be a blood clot. LPN #1 said she then contacted the physician and obtained orders for an x-ray and an ultrasound. LPN #1 said the resident was found to have a fracture after the x-ray was completed. LPN #1 said prior to 1/23/25, Resident #5 did not complain of pain. She said the staff were supposed to use the PAINAD scale for pain assessment, since the resident was cognitively impaired. LPN #1 said on 1/23/25 the resident was voicing that she was in pain, so the 10 out of 10 pain scale was utilized. LPN #1 said the resident was typically very quiet and her pain medication regimen was effective. LPN #1 said prior to this incident, Resident #5 never complained of pain. The director of nursing (DON) was interviewed on 3/6/25 at 3:42 p.m. The DON said on 1/22/25 Resident #5 was at her normal baseline. The DON said Resident #5 went to an urology appointment on 1/22/25. She said the resident came back to the facility with a physician's order for a prophylactic antibiotic for UTIs. The DON said that in the early morning of 1/23/25, the resident walked herself to the bathroom. She said the CNAs heard Resident #5 screaming and rushed to her room to assess the situation. The DON said the resident was complaining of pain in her thighs, knees, calves and shoulders. The DON said the resident was assisted back to bed. The DON said Resident #5 was complaining of pain in the morning and the CNA did not want to get her up because she was saying she was hurting. The DON said she reviewed Resident #5's medical record and said the resident was on scheduled Tylenol three times a day. She said she also had Aspercreme 1% gel for her shoulder pain. The DON confirmed the Tylenol was given as scheduled on 1/23/25 at 7:14 a.m. The DON said that follow up after administering pain medication should typically occur within one to two hours, depending on the individual, as some residents had higher pain tolerance. She said since Resident #5 was crying out in excruciating pain, follow up should have occurred every 30 minutes to monitor her condition and ensure pain relief was achieved. -However, review of Resident #5's EMR did not reveal the facility regularly monitored Resident #5 after she reported pain (see record review above).