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	05/21/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide emergency basic life support and cardiopulmonary resuscitation (CPR) when needed for one (#1) of three residents reviewed for advance directives out of seven sample residents.Resident #1 was admitted to the facility on [DATE] with a history of acute and chronic respiratory failure and aspiration pneumonia.On [DATE], the power of attorney for Resident #1 completed and signed a Colorado Medical Orders for Scope of Treatment (MOST). The MOST form documented Resident #1 desired to receive CPR with full treatment in the event it was required. On [DATE], a physician's order was entered into Resident #1's electronic medical record (EMR) that identified Resident #1 was a full code and should receive CPR. Additionally, the profile screen in Resident #1's EMR record revealed Resident #1 had an advance directive for full code/CPR. On [DATE] at 2:30 a.m. registered nurse (RN) #1 heard a scream from Resident #1's room. When RN #1 entered the room, he heard and observed Resident #1 and his spouse discussing the continued use of an arm sling. While in the room, Resident #1 complained of shortness of breath. RN #1 assessed Resident #1 and initiated a nebulizer breathing treatment. RN #1 remained with Resident #1 during the breathing treatment and, after the treatment, determined Resident #1 had oxygen saturation (measure of oxygen in the blood) readings over 90% and the resident was stable. On [DATE] at 2:57 a.m. RN #1 returned to Resident #1 and found Resident #1 was unresponsive in his bed. RN #1 exited the room and instructed certified nurse aide (CNA) #1 to call 911 and to call the nurse from another floor to respond for assistance. RN #1 retrieved a portable oxygen cylinder and returned to Resident #1 and began CPR. RN #1 provided CPR for approximately three minutes. RN #1 stopped CPR, exited the room and went to the nurses' desk to verify the code status on Resident #1's MOST form.At 3:02 a.m. RN #2 and CNA #2 arrived at Resident #1's room with the emergency response (crash) cart. At the same time, a law enforcement officer arrived at Resident #1's room carrying an automatic external defibrillator. RN #1 entered Resident #1's room after the law enforcement officer and informed the officer and other staff members present that Resident #1's had a MOST form that identified that Resident #1 had a do-not-resuscitate advance directive, and CPR was not resumed. Resident #1 was pronounced deceased at 3:07 a.m.-However, Resident #1's code status indicated the resident wanted CPR.Specifically, the facility failed to:-Provide CPR for Resident #1 until relieved by emergency medical services personnel; and,-Ensure staff received education and training to accurately verify advance directives during an emergency.Findings include:I. Findings of Immediate Jeopardy A. Situation of immediate jeopardyThe facility failed to provide CPR for Resident #1 until relieved by emergency medical services personnel. Additionally, the facility failed to ensure staff had education and training to accurately verify advance directives during an emergency.B. Facility notice of immediate jeopardyOn [DATE] at 2:25 p.m., the nursing home administrator (NHA) was notified of the immediate jeopardy situation created by the facility's failure to ensure Resident #1 received basic life support and CPR according to his advance directives.C. Facility plan to remove immediate jeopardyOn [DATE] at 6:21 p.m. the NHA provided a plan to remove the immediate jeopardy situation. The plan read: 1. Immediate action On [DATE] the facility completed an investigation (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	regarding the initiation of basic life support and CPR for Resident #1. The root cause analysis of the CPR event revealed areas of concern related to staff education and emergency response for Resident #1.2. Identification of others An audit was completed on [DATE] by the director of nursing (DON) and/or a designee. The audit included a review of direct care staff for current competencies for CPR, code status verification, accurate MOST form review, and communication of correct code status to emergency medical services personnel.Additionally, on [DATE], audits were completed to ensure all residents had current MOST forms with code status documentation, physician orders in the EMR, CPR, and code status competency.3. Systemic changesBeginning [DATE], all newly hired and agency staff would receive education before providing direct care regarding code status verification, initiation of CPR, emergency response expectations, and CPR protocols to transfer care or discontinue CPR. The DON educated all nursing staff on following the physician's orders for emergency resuscitation, and if they had questions or concerns about any order, they must notify the provider and document the reasons for the concern. 4. MonitoringOn [DATE], the facility would conduct weekly audits of 10 residents to verify code status accuracy, MOST form accuracy, accessibility to direct care staff, and to ensure code status was correctly documented consistently across documentation systems. The audit results would be reviewed weekly by the interdisciplinary team (IDT) for effectiveness. D. Removal of immediate jeopardyBased on the facility's plan above, the immediate jeopardy was removed on [DATE] at 6:21 p.m. However, deficient practice remained at a G level, actual harm that was isolated.II. Facility policy and procedureThe CPR policy, revised [DATE], was provided by the NHA on [DATE] at 11:10 a.m. The policy read in pertinent part,It is the policy of this facility to provide basic life support, including CPR, to any resident requiring such care before the arrival of emergency medical personnel.The facility will have staff certified in CPR available 24 hours a day to provide basic life support and CPR before the arrival of emergency medical services personnel.If a resident experiences a cardiac or respiratory arrest and the resident does not show clinical signs of irreversible death, the facility staff must provide basic life support, including CPR, before the arrival of emergency medical services for all residents who have requested CPR in their advance directives or as designated in related physician orders.III. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE] and passed away on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included right arm fracture, acute and chronic respiratory failure, aspiration pneumonia, dysphagia (difficulty swallowing), atrial fibrillation (abnormal heart rate) and pulmonary high blood pressure.The [DATE] minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. C. Record review1. Care planThe oxygen therapy care plan, initiated [DATE], revealed Resident #1 required oxygen therapy due to ineffective respiratory function. Pertinent interventions included giving medications as ordered, monitoring and documenting side effects and effectiveness of oxygen therapy, monitoring for symptoms of respiratory distress and reporting the symptoms to the physician as needed and administering oxygen as ordered.2. Progress notes and assessmentsThe [DATE] nurse progress note, documented at 7:52 a.m., revealed that at 2:30 a.m. RN #1 heard a scream from Resident #1's room. When RN #1 arrived, Resident #1 said he was uncomfortable and wanted his right arm sling removed. The progress note revealed Resident #1 then complained of feeling short of breath. RN #1 administered a nebulizer treatment that was ineffective, and Resident #1's oxygen saturations remained below 90%. The resident declined being transferred to the emergency department. The progress note revealed that after the nebulizer treatment, RN #1 applied oxygen at a flow rate of 5 liters per minute (LPM) via a non-rebreather mask. RN #1 documented the oxygen saturation was 93% to 94% and noted Resident #1 was stable. The progress note revealed that after 20 to 25 minutes, RN #1 returned to Resident #1 and found Resident #1 not breathing and with no pulse. The progress note revealed Resident #1 was confirmed to have an advance directive with full code status and full treatment. Paramedics arrived and confirmed Resident #1 was not breathing and had no pulse.-Review of the EMR did not reveal any further documentation (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	regarding the CPR event on [DATE].Review of the [DATE] CPO revealed a physician's order that identified Resident #1 was a full code and should receive CPR, ordered on [DATE]. Additionally, the profile screen in Resident #1's EMR record revealed Resident #1 had an advance directive for full code/CPR. D. Video surveillance review and timelineThe [DATE] facility's video surveillance review was received from the NHA on [DATE] at p.m. The surveillance review revealed the following timeline of events:-At 2:57 a.m. RN #1 entered Resident #1's room.-At 2:58 a.m. RN #1 exited the room, retrieved a portable oxygen cylinder, and returned to Resident #1's room. CNA #1 used the telephone and called 911 and the upstairs floor staff. -At 3:01 a.m. emergency medical services (EMS) arrived at the entrance to the facility.-At 3:02 a.m. RN #1 exited Resident #1's room, and RN #2 and CNA #2 entered Resident #1's room with the crash cart.-At 3:03 a.m. EMS entered Resident #1's room.The [DATE] facility's event timeline was received from the NHA on [DATE] at 2:31 p.m.The timeline revealed that on [DATE] at 2:30 a.m., Resident #1 yelled out and RN #1 responded. Resident #1 complained of discomfort from the right arm sling, and then shortness of breath. RN #1 administered a nebulizer treatment that was ineffective, and Resident #1's oxygen saturations remained below 90%. Resident #1 declined being transferred to the emergency department.The timeline documented that after the nebulizer treatment, RN #1 applied oxygen at a flow rate of 5 LPM via a non-rebreather mask. RN #1 documented the oxygen saturation was 93% to 94% and noted Resident #1 was stable.Twenty to 25 later, RN #1 returned to Resident #1's room to reassess Resident #1 and found Resident #1 not breathing and without a pulse. RN #1 initiated CPR and directed CNA #1 to notify EMS and retrieve the crash cart.-EMS arrived and confirmed Resident #1 had no pulse and no respiration, and death procedures were initiated. IV. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on [DATE] at 8:24 a.m. LPN #1 said she had worked in the facility for over 18 months and was involved in admitting residents. LPN #1 said the admission packet included paperwork with a blank MOST form that was completed with the resident and/or responsible party. LPN #1 said that after the MOST form was completed, the admitting nurse entered the resident's desired advance directives into the EMR. LPN #1 said the MOST form was then placed in a binder at the nurses' station for the provider to review and sign. LPN #1 said the MOST form was used to clearly identify if a resident wanted to be a full code or do not resuscitate, and what level of care was desired, such as full treatment or comfort care. LPN #1 said she was not aware of any CPR outcomes in the previous week where code status was mistaken and led to staff withholding CPR. LPN #1 said education about CPR and emergency response had been provided in approximately [DATE], and was from computer-based education. LPN #1 said that if she found an unresponsive resident, she was able to verify code status using her shift report sheet, using the EMR, or referencing the MOST form binder at the nurses' desk. LPN #1 said in nursing school, she was taught that once CPR was initiated, CPR was not stopped until emergency services personnel arrived or if the rescuer was physically unable to continue CPR. CNA #3 was interviewed on [DATE] at 8:41 a.m. CNA #3 said she had worked at the facility for over three years and had a current CPR certification. CNA #3 said she maintained a current CPR certification, but was unsure if she was required to have the certification for her position. CNA #3 said she was aware of the resident's code status by referring to her report sheet. CNA #3 said she was unsure who verified each code status and who updated the report sheet. CNA #3 said that if she were unsure of a resident's code status, she would verify with the nurse. CNA #3 said that if she found a resident unresponsive, she would call out for help from coworkers and initiate CPR. CNA #3 said she had not had recent education or training on verification of advance directives or CPR protocol regarding the initiation and stopping of CPR. The DON was interviewed on [DATE] at 9:50 a.m. The DON said she reviewed the [DATE] CPR event in the morning of [DATE]. The DON said she spoke to RN #1 on [DATE] (the day after Resident #1 passed away). The DON said after RN #1 determined Resident #1 was unresponsive, he left the room to ask CNA #1 to call 911. The DON said RN #1 grabbed an additional oxygen cylinder and returned to Resident #1 and initiated CPR. The DON said RN #1 was rushing from the heat of the moment, and while providing CPR, RN #1 thought that he had tried (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to wake up the sleeping spouse to talk about CPR. The DON said RN #1 was unable to wake the spouse and left the room to verify advance directives and code status on the MOST form. The DON said RN #1 should not have stopped CPR until he was relieved, but had just wanted to make sure he was doing what Resident #1 desired. The DON said on [DATE], during the quality assurance meeting, the committee discussed reviewing the process for direct care staff to quickly and accurately identify advance directive/code status for residents so that future CPR events would not be delayed. RN #1 was interviewed by telephone on [DATE] at 4:49 p.m. RN #1 said he was assigned to care for Resident #1 on [DATE]. RN #1 said that at 2:30 a.m., he heard a scream from Resident #1's room, and when he entered the room, he observed Resident #1 and his spouse arguing about whether or not to remove his arm sling. RN #1 said Resident #1 then complained of shortness of breath. RN #1 said he completed an assessment and offered to transfer Resident #1 to the emergency department, but Resident #1 declined. RN #1 said he offered and administered a nebulizer treatment with a medication used to open up respiratory airways. RN #1 said the nebulizer treatment was ineffective, and Resident #1's oxygen saturations remained below 90%. RN #1 said he then placed a non-rebreather mask on Resident #1 with an oxygen flow rate of 5 LPM and that was effective to raise the oxygen saturation to 90% to 93%. RN #1 said Resident #1 was then stable, and he left the room to care for other residents assigned to him. RN #1 said he returned to reassess Resident #1 at 2:57 a.m. and found Resident #1 was not breathing and did not have a pulse. RN #1 said he went quickly to call out for CNA #1 to call 911, and he obtained another oxygen cylinder and returned to initiate CPR for Resident #1. RN #1 said that he thought Resident #1 was not revivable but that he should initiate CPR anyway. RN #1 said he provided CPR for a few minutes and then left the room to verify the advance directive/code status for Resident #1. RN #1 said that as he left the room, RN #2 and CNA #2, who was working upstairs, were heading to Resident #1's room with the crash cart. RN #1 said he went to the nurses' station and used the MOST form binder to locate Resident #1's MOST form. RN #1 said that he noted on the MOST form that it indicated an advance directive was do not resuscitate and returned to Resident #1's room to update caregivers. RN #1 said when he entered the room, RN #2, law enforcement, and paramedics were present. RN #1 said that he informed EMS providers that Resident #1 had a do-not-resuscitate advance directive. RN #1 said that it was then discovered he had referenced a MOST form from another resident. RN #1 said that when the error was discovered, the spouse declined further CPR. RN #1 said the event happened in a very quick sequence, and he thought to himself that while doing CPR, he should confirm code status and needed to leave the room to confirm advance directives. RN #2 was interviewed on [DATE] at 5:29 p.m. RN #2 said he and CNA #2 responded to the CPR event on [DATE] from an upstairs floor. RN #2 said they arrived at Resident #1's room with the crash cart at the same time the law enforcement officer arrived with an automatic external defibrillator. RN #2 said RN #1 informed EMS personnel that Resident #1 had a do-not-resuscitate order, and when it was discovered the incorrect information was provided, EMS and the spouse determined Resident #1 had expired, and CPR was not resumed. The NHA was interviewed on [DATE] at 2:53 p.m. The NHA said that on [DATE] (during the survey), the facility completed an ad-hoc (impromptu) quality improvement meeting and initiated a plan of correction for CPR/code response. The NHA said on [DATE], he initiated policy education with direct care staff regarding CPR initiation, the continuation of CPR until relieved, and correctly verifying code status.