STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065405	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Parker Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** Based on observations, record review and interviews, the facility failed to provide an effective pain management regimen in a manner consistent with professional standards of practice, resident-centered care plans, and resident preferences for one (#64) of three residents out of 62 sample residents. Resident #64, was admitted on [DATE] with a diagnosis including sepsis, acute respiratory failure, congestive heart failure, pneumonia and pressure-induced deep tissue damage of the left ankle. Resident #64 said he experienced pain when the staff were repositioning him. Observations revealed while the staff were repositioning Resident #64, he cried out in pain and asked the staff to stop. The staff continued care despite the resident crying out in pain and did not stop to reassess the resident to ensure he did not suffer from additional pain. Specifically, the facility failed to stop providing care and reassess Resident #64 when he cried out in acute pain. Findings include: I. Facility policy and procedureThe Pain Management policy, revised January 2026, was provided by the nursing home administrator (NHA) on 3/12/26 at 8:39 p.m. It read in pertinent part, The facility will assess each resident for pain to maintain or achieve the highest predictable level of well-being and functioning by screening to determine if the resident has been or is experiencing pain. Provide a comprehensive evaluation of pain by licensed nursing staff and using pharmacological and non-pharmacological interventions to manage the pain and try to prevent the pain, while staying consistent with the residence goals. Residents will be assessed for pain on admission, and if pain is indicated throughout the nursing home admission assessment using verbal and non- verbal assessment. The facility will continue to monitor and assess a resident's pain on a regular basis.II. Resident #64 A. Resident statusResident #64, age greater than 65, was admitted on [DATE], sent to the hospital via 911 emergency transport for shortness of breath on 2/3/26, readmitted from the hospital for pneumonia on 2/22/26 and discharged to home with family on hospice on 3/11/26. According to the March 2026 computerized physician orders (CPO), diagnoses included sepsis, acute respiratory failure, congestive heart failure, pneumonia and pressure-induced deep tissue damage of the left ankle. The 3/1/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of eight out of 15. He required partial to moderate assistance with rolling from his back to his left and right side. The resident required substantial to maximal assistance with toileting hygiene and bathing and showers. The assessment revealed Resident #64 did not have a pain management regimen. He took pain medication as needed and received non-medication interventions for pain. The assessment said he had no pain in the past five days of the look back assessment period. B. Resident interview Resident #64 was interviewed on 3/11/26 at 1:30 p.m Resident #64 said he had pain when the nursing staff repositioned him. He said he was always in pain when he moved or repositioned in bed and he was always tired. He said he did not have pain when he was lying still. He said he did not currently have pain because he was not moving. He said when the nursing staff repositioned him, his pain increased to 8 out of 10 all over his body. He said did not know if he received medication for his pain. He said the nursing staff never asked him if he had pain. He said he would like pain medication before the nursing staff repositioned him. He said he often needed help from nursing staff for changing positions because he was unable to (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 0697 Level of Harm - Actual harm Residents Affected - Few	reposition in bed independently. C. ObservationsOn 3/11/26 at 1:38 p.m., certified nurse aid (CNA) #5 and registered nurse (RN) #5 repositioned and provided incontinent care to Resident #64. The resident had contractors in the bilateral lower extremities and bilateral upper extremities. The resident said to the nursing staff oh that hurts and that hurts repeatedly as the staff repositioned the resident. The staff assisted Resident #64 with rolling from his left side to his right side. CNA #5 said to Resident #64 I know it hurts but we are trying to be fast ok. Resident #64 was moaning loudly. Resident #64 said please help me to the nursing staff very loudly. CNA #5 said to the resident I know, I know. Resident #64 said to CNA #5 You don't know how bad it hurts. CNA #5 and RN #5 continued with resident care. RN #5 said to Resident #64 said to the resident I will see if you have any pain medication when we are done. RN # 5 return with Tylenol 650 mg and administered to the resident. -The staff did not assess the residents pain level and location. The facility nursing staff continued with care, despite the resident reporting pain. D. Record review Review of Resident #64's comprehensive care plan did not reveal documentation regarding interventions to include non-pharmacological interventions, monitoring for pain medication effectiveness, and monitoring for side effects of opioid (a class of natural, man-made, or semi-synthetic chemical compounds that interact with opioid receptors on nerve cells in the body and brain to reduce the intensity of pain signals) use. Resident #64's March 2026 CPO revealed the following physician's orders: Oxycodone 5 milligram (mg). Give one tablet by mouth four times a day for pain, ordered 3/5/26.Acetaminophen. Take 325 mg two tablets by mouth every six hours as needed for pain, ordered 2/22/26.Review of the March 2026 medication administration record (MAR) revealed Resident #64 was administered the oxycodone at 12:00 p.m. -However, Resident #64 cried out in acute pain during care and the staff did not stop care to reassess the resident to alter the care being provided to ensure the resident no longer experienced acute pain (see observations above). D. Staff interviews RN #5 was interviewed on 3/11/26 at 4:00 p.m. RN #5 said her responsibilities at the facility included medication administration, assessment of the resident's skin, assessment and monitoring a resident's pain and comfort level and documenting any change of condition in the resident chart. She said Resident #64 was always in pain when he needed to be repositioned. She said she should have stopped providing care when the resident started moaning and telling the staff that he was in pain. She said she would always treat a resident pain level prior to providing care. She said she continued providing care to the resident because she wanted to complete care first. She said Resident #64 had scheduled pain medication in the morning. She said she did not assess the resident pain level when she gave him his scheduled pain medication. She said she only assessed the resident's pain level and location if she was giving a PRN (as needed) pain medication. She said she would then document the pain assessment in the resident's medical record, and do a pain reassessment 30 minutes after the PRN medication was administered. She said if a resident was taking pain medication she monitored for side effects such as drowsiness, change and level of consciousness, breathing difficulties and vital sign changes. CNA #5 was interviewed on 3/11/26 at 4:20 p.m. CNA #5 said she provided care for the residents including assisting with, providing showers, repositioning and toileting hygiene. She said Resident #64 was always in pain whenever he was touched or repositioned. She said she tried to complete the repositioning for Resident #64 quickly and provided verbal reassurance to him when he started to complain of pain. She said she would not stop providing care assistance to the resident if he complained of pain. She said when Resident #64 complained of pain, she would complete the care being provided first, and then report the pain to the nurse when she was finished providing care. CNA #7 was interviewed on 3/12/26 at 9:57 a.m. She said she was familiar with Resident #64. She said the resident would require staff assistance with bed mobility. She said the resident would require repositioning every two hours because he had wounds on his feet. She said the resident required two staff to be repositioned. She said the resident would moan in pain when being repositioned. She said when the resident would moan during repositioning, she would tell the nurse the resident was in pain after the repositioning was finished. She said she wanted to complete the care first before notifying (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	the nurse of the reported pain symptoms. The nursing home administrator (NHA), the director of nursing (DON) and the clinical nurse resource were interviewed together on 3/12/26 at 4:28 p.m. The DON said Resident #64 was readmitted to the facility for sepsis after he acquired pneumonia. The DON said he was in a lot of pain most of the time since being readmitted to the facility. She said the resident recently had a referral to hospice because he was not doing so well. She said the resident had a medication order for stronger pain medication. She said the nursing staff would assess Resident #64 for pain using a verbal one to 10 pain scale in addition to non verbal pain indicators. The DON said a brief pain assessment was completed every shift as a part of the daily nursing documentation. The DON said the CNA's are expected to report any symptoms of pain to the nursing staff immediately. The DON said the nursing staff chart by exemption means a separate detailed pain assessment is not required. The DON said the nurses relied on the residents to report any current pain to the nurses. The clinical consultant said sometimes the family members of Resident #64 would decline repositioning of the resident because of the discomfort and pain it caused the resident. The clinical consultant said the nursing staff were trained upon hire of pain reporting and assessments. He said the CNAs should be reporting any symptom of pain to the nurses, so that a determination of the cause of pain can be established.The NHA said it was important to assess a resident when there were pain indicators to rule out things like broken bones because of the resident's terminal diagnosis. The NHA said he would start reeducation of the nursing staff immediately. The NHA said the reeducation was needed to ensure the staff are following the training they received when they were hired for pain assessments. The NHA said a complaint of pain should be treated as a new symptom every time.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to ensure infection prevention and control programs were maintained and followed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on three out of three floors. Specifically, the facility failed to: -Ensure staff followed appropriate hand hygiene while performing wound care and don correct PPE (gown) while perform transfers for Resident #6; and,-Ensure staff wore the appropriate personal protective equipment (PPE) when providing care to residents who were on enhanced barrier precautions (EBP); -Ensure staff wore the appropriate PPE when providing care to residents who were on contact precautions;-Ensure contaminated laundry was handled appropriately; and,-Ensure oxygen tubing was handled in a sanitary manner.Findings include: I. EBP failures A. Professional reference According to the Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), retrieved on 3/19/26 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, It read in pertinent part, Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing. B. Observations On 3/10/26 at 8:22 a.m. registered nurse (RN) #1 was administering intravenous (IV) medication to Resident #135's chest port. -RN #1 failed to don (put on) a gown. The sign on the resident's door indicated gloves and a gown must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care. On 3/10/26 at 9:40 a.m. Resident #6 was being assisted with a transfer from his bed to his electric (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wheelchair via mechanical lift by two unidentified certified nurse aides (CNAs). The two unidentified CNAs were wearing gloves. -The CNAs failed to wear a gown. On 3/11/26 at 1:38 p.m. CNA #5 and RN #5 were repositioning Resident #64. There was a sign on Resident #64's door that indicated the resident was on EBP. The sign on the resident's door indicated gloves and a gown must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care. Resident #64 was on EBP due to his wound on his left lateral ankle. C. Staff interviews RN #1 was interviewed on 3/10/26 at 8:30 a.m. She said Resident #135 did not have any current precautionary measures in place for giving medication through his intravenous line. -However, Resident #135 was on EBP. RN #5 was interviewed on 3/11/26 at 4:00 p.m. She said if a resident were on contact precautions or EBP, she would wear a gown and gloves when entering the resident's room. She said the facility staff would look for signage on a resident's door to let them know if a resident was on precautions. She said this was important because we want to prevent infection to residents who were at a higher risk for infection due to skin injury. She said she did not see the sign on Resident # 64's door indicating that he was on EBP. She said if she would have seen the sign on Resident number 64's door, she would have worn a gown and gloves when repositioning and providing pier care for the resident. CNA #5 was interviewed on 3/11/26 at 4:20 p.m. CNA #5 said if a resident was on precautions, she would wear gloves with a gown. CNA #5 said she did not know the difference between contact precautions and EBP. She said she received training on precautions every year on the facility on-line learning platform. She said no one told her Resident #64 was on EBP. She said normally the nurses would tell her if a resident was on precautions, in which she would wear a glove and gown when providing care. She said the glove and gowns were important to prevent the resident from getting an infection. II. Hand hygiene failures A. Professional reference According to The Centers for Disease Control and Prevention's (CDC) Hand Hygiene for Healthcare Workers (2/27/24), retrieved on 3/21/26 from https://www/cdc.gov/cleanhands/hcp/clinical-safety/index.html, Hand hygiene protects both healthcare personnel and patients. Cleaning your hands reduces the potential spread of germs, including those resistant to antibiotics. Clean your hands immediately before touching a patient and after touching a patient or the patient's surroundings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Facility policy and procedure The Infection Control policy, undated, was received from the nursing home administrator (NHA) on 3/9/26 at 1:20 p.m. The policy read in pertinent part, The objective of the infection prevention and control program was to establish written standards, policies and procedures for a system in preventing, identifying, reporting, investigating and controlling infections following accepted national standards for all residents. Prevention of the spread of infections are accomplished by use of standard precautions and or other transmission based precautions, handwashing, appropriate treatment and follow-up, and employee work restriction for illness. Hand hygiene procedures will be followed by staff involved in direct resident contact. C. Observations On 3/10/26 at 9:57 a.m. licensed practical nurse (LPN) #1 was performing wound care for Resident #6. The resident had a wound on his left heel. LPN #1 removed the old wound dressing from the left heel on Resident #6. LPN #1 changed her gloves without performing hand hygiene. LPN #1 donned new gloves, touched her clipboard located outside the resident's room, and went back into the residents room to apply the new wound dressing. Upon prompting LPN #1 removed her gloves, performed hand hygiene and donned a new pair of gloves. LPN #1 proceeded to reach into her pocket of her scrubs to grab an ink pen to write her initials and date on the new clean wound dressing. LPN #1 proceeded to apply the new clean wound dressing on to the resident's left heel. -LPN #1 failed to change your gloves or perform hand hygiene after reaching into her scrub pants pocket for the ink pen. D. Staff interviews LPN #1 was interviewed on 3/10/26 at 10:10 a.m. LPN #1 said she did not realize she contaminated her gloves when going to check the wound order on her clipboard outside of the resident's room. LPN #1 said she assumed her gloves were still clean as she reached in her pocket to retrieve the ink pen. LPN #1 said it was important to perform hand hygiene and change gloves in between possible contamination to prevent the spread of bacteria causing infection. The director of nursing (DON) and the infection preventionist (IP) were interviewed together on 3/12/26 at 1:47 p.m. The IP said if a resident was on EBP, the nursing staff did not need to wear a gown if they were assisting the resident with bed to chair transfers or linen change. The IP said gloves and gowns were only needed during wound care activities. -However, a gown and glove should be worn when completing wound care (see professional reference above). The DON said nursing staff were expected to wear a gown and gloves while performing any high-contact direct resident care activity. The DON said high-contact resident care activity would include wound care, administering intravenous medications, assisting with resident transfers, linen change, or peri care. The DON said any resident that had a wound, in-dwelling device such as a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	percutaneous endoscopic gastrostomy (PEG) tube, an IV, wound vacuum, foley catheter would be required to be on EBP. The DON said EBP was utilized to prevent residents from acquiring an infection because they were at higher risk. The DON said EBP precautions would be added to the residents chart as a physician's order and in the care plan for the nurses to reference. The DON said EBP would also be indicated on the resident's Kardex (staff directive tool) for the CNA's to reference. III. Contact precaution failures A. Facility policy and procedure The Infection Prevention and Control Program, revised April 2024, was provided by the NHA on 3/9/26 at approximately 1:45 p.m. It read that when a resident was on contract precautions a gown, gloves and mask must be worn. B. Observations On 3/10/26 at approximately 9:15 a.m. Resident #94`s room had a sign that indicated the resident was on contact precautions.  On 3/10/26 at 9:22 a.m. the scheduler entered Resident #94`s without putting on PPE. On 3/10/26 at 9:22 a.m. an unidentified CNA entered Resident #94`s room without donning PPE.  On 3/11/26 at 9:57 a.m. the speech therapist was sitting on Resident #94`s footboard. The speech therapist was not wearing PPE. An unidentified CNA was observed on 3/12/26 at 8:06 a.m. entred Resident #94`s room with her breakfast tray. She had gloves on when she walked down the hallway.  -The unidentified CNA failed to don a gown.  On 3/12/26 at 8:10 a.m. an unidentified CNA entered Resident #94`s room. She wore gloves when she walked down the hallway with the breakfast tray in hand. She placed the breakfast tray by Resident #94`s roommate and left. -She did not wear a gown or mask. C. Staff interviews LPN #2 was interviewed on 3/10/26 at 9:22 a.m. LPN #2 said she did not have to wear PPE if she did not provide direct care to Resident #94. CNA #3 was interviewed on 3/12/26 at 8:12 a.m. CNA #3 said Resident #94 was not on precautions according to her list CNA #3 said the nurse would inform her at the beginning of her shift if there were any residents on isolation precautions. She said there were also signs on the residents' doors to indicate if they were on isolation precautions. She said she would don into PPE before entering the room if a resident was on contact precautions. She said PPE was mandatory whether staff provided direct or indirect care. She said the PPE must be discarded inside the room before exiting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN #3 was interviewed on 3/12/26 at 8:30 a.m. RN #3 said Resident #94 was on contact precautions because she had shingles. RN #3 said staff must don PPE before entering a room when a resident was being monitored for shingles. She said PPE must be worn whether the staff were providing direct or indirect care. RN #3 said Resident #94 was not cleared of shingles. The assistant director of nursing (ADON) was interviewed on 3/12/26 at 8:48 a.m. She said Resident #94 was on the highest level of precaution due to shingles. She said if staff provided direct or indirect care for Resident #94 they needed to wear a mask and a gown. She said Resident #94 was highly infectious. She said the room itself must be taken as infectious. IV. Laundry room failures A. Professional reference The CDC, Environment Cleaning Procedures, (revised 1/28/24) was retrieved on 3/15/26 from https://www.cdc.gov/infection-control/hcp/environmental-control/laundry-bedding.html/. It read in pertinent part, Laundry workers should wear appropriate personal protective equipment (gloves and protective garments) while sorting soiled fabrics and textiles. B. Facility policy and procedure The Infection Prevention and Control Program policy, revised April 2024, was received from the NHA on 3/9/26 at 1:45 p.m. It read in pertinent part, Anyone who handles soiled laundry must wear protective gloves and other appropriate protective equipment (gowns if soiling of clothing is likely). B. Observations and interview An observation was conducted on 3/11/26 at 4:35 p.m. of the facility laundry room. Housekeeper (HK) #1 provided a tour of the laundry room including the soiled area (where all items needing to be laundered were handled) and the clean area (all laundered items needing folding). HK #1 said the soiled laundry was sent down a laundry chute and landed into a rolling container. HK #1 said the soiled laundry was sorted into the appropriate cart and rolled to the washing machines. HK #1 said PPE was only worn when sorting sugar bags or biohazard bags. HK #1 said when the laundry was done being washed, it was placed into appropriate rolling carts and rolled to the dryer. HK #1 said when the drying was complete, the clean laundry was brought to the clean area where it was folded or hung and then distributed back to the facility. HK #1 said all of the facility staff had access to the laundry chute and would bag the soiled laundry accordingly. She said clear bags were used for non contaminated items including bed sheets, linens, and towels. She said these bags were sorted and washed accordingly. HK #1 said gloves were used for the sorting process. She said the sugar bags (bags that disintegrate in the wash) and yellow bio hazard bags were carried down and laundered separately. HK #1 said full PPE was used for this process which included gloves, mask, and a gown. HK #1 said when sorting the laundry the staff checked for items including hearing aids as sometimes they were thrown in with the residents' bedding. She said sometimes the staff found contaminated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	laundry had come down in the clear bag. HK #1 said she would get frustrated because staff had access to a hopper unit (rinsing station) and sometimes bedsheets would come down with fecal matter or be drenched in urine. When this happened, the laundry staff would have to rinse off the debris before laundering it. HK #1 said she was caught off guard when contaminated laundry came down and she was not wearing PPE. HK #1 further said the process of the clean area where she and another staff member would fold and put away the laundry into carts for distribution back to the facility. She said this included towels, washcloths, linens, pillows and personal clothing. HK #1 said this was a shared responsibility between her and her co-worker (HK #2). HK #1 said when a resident was placed on transmission based precautions, their laundry was generally placed in a sugar bag or the bio hazard bag. She said she was not aware of any other indication of contaminated laundry. HK #1 said she had confidence in the floor staff that laundry would be bagged accordingly. HK #1 said there were times when personal items or contaminated items came down the chute. HK #1 said she informed her manager when that happened. D. Staff interviews The housekeeping supervisor (HKS) and the NHA were interviewed on 3/11/26 at 4:59 p.m. The HKS said the process that HK #1 described was the correct process. She said she was not aware staff needed to don PPE when sorting through the laundry that was not in a biohazard bag. She said she understood the importance of preventing the spread of pathogens in the laundry room and would educate staff about donning the appropriate PPE moving forward. The DON and the IP were interviewed on 3/12/26 at 2:45 p.m. The IP said she was not aware the laundry staff were not donning the appropriate PPE. The IP said it was important to wear a gown when sorting clothes as a measure to ensure infection control was being practiced and no cross contamination was occurring. The IP said she would talk to management to determine which areas in the facility needed re education on infection control. The IP said training would be provided to the laundry department. The DON agreed additional immediate training was needed. V. Failed to replace a contaminated nasal cannula A. Observations On 3/12/26 at 9:52 a.m. in the second floor dining area the activities assistant (AA) was untangling a resident's nasal cannula from underneath the resident's wheelchair. The resident was assisted away from the dining area and was positioned in front of the nurses' station. The AA was weaving the cannula around the wheel and frame of the wheelchair. The cannula was on the floor several times during the untangling process. The AA untangled the cannula and tried to place the cannula back on the resident. The AA placed the cannula around both of the residents ears but then hesitated to place the nasal prongs of the cannula into the residents nose. She tried two times and then put the cannula on the resident's blanket. The AA then walked to the nurses' station and spoke with CNA #2. The AA then walked back to the dining room to assist another resident leaving the dining room. At 9:54 a.m. CNA #2 walked over and greeted the resident with the cannula. She quickly placed the cannula back on the resident and was observed checking both sides of the cannula around the ears and the nose of the resident for placement. CNA #2 then went back to the nurses' station. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065405	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Parker Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 9398 Crown Crest Blvd Parker, CO 80138	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Staff interviews CNA #2 was interviewed on 3/12/26 at 9:55 a.m. CNA #2 said the AA asked her for assistance as she was not sure how to place a cannula on someone. CNA #2 said she quickly finished up her note and then came over to the resident to assist. CNA #2 said she was not aware the cannula had been on the floor. CNA #2 said staff would replace the cannula if it touched a contaminated surface. CNA #2 said this practice was to maintain good infection control. The AA was interviewed on 3/12/26 10:12 a.m. The AA said she tried her best to assist the resident, but did not know how. The AA went to the first person at the nurses' station for assistance. The AA did not know the process for replacing or cleaning cannulas and said that was another reason why she asked for assistance. The AA said she did not receive infection control or infection prevention training regarding cannulas. The AA said she did not recall if she told the CNA the cannula was on the floor. The IP and the DON were interviewed together on 3/12/26 at 2:45 p.m. The IP and the DON said it was best practice to replace a contaminated cannula to prevent cross contamination which was crucial for infection control and also to prevent respiratory concerns for the residents'. The IP said she would talk to management to determine which areas in the facility needed re education on infection control. The IP said training would be provided to the staff. The DON said additional immediate training was needed.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to honor residents' choices for two (#58 and #42) of three residents out of 62 sample residents.Specifically, the facility failed to:-Facilitate and honor a wheelchair preference for Resident #58; and,-Ensure Resident #42's call light was within reach.Findings include:I. Facility policy and procedureThe Resident Rights policy and procedure, revised February 2026, was received from the nursing home administrator (NHA) on 3/12/26 at 9:03 p.m. It read in pertinent part, It is the policy of the facility that all resident rights be followed according to state and federal guidelines as well as other regulatory agencies. The resident has the right to be treated with consideration, respect, and full recognition of his or her dignity and individuality. The right to self-determination through support of choice.II. Resident #58A. Resident statusResident #58, age greater than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, muscle weakness, depression, chronic pain syndrome, and muscle contracture.The 12/30/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was dependent on staff assistance with toileting, bathing, personal hygiene, transfers, and moderate assistance with dressing. She used a wheelchair for mobility.The MDS assessment indicated the resident did not have behaviors or rejection of care during the review period.B. Resident interviewResident #58 was interviewed on 3/10/26 at 4:15 p.m. Resident #58 said she had a power wheelchair that had been taken away from her by the facility due to an incident that happened a couple of years ago. Resident #58 said she ran into a wall with her power wheelchair and fractured her foot. Resident #58 said that, due to that incident, she was provided with a manual wheelchair and had not been permitted to use her electric power wheelchair since then. Resident #58 said she informed the facility during her care conference in December 2025 of her interest in resuming use of her electric power wheelchair. She said she had not received any update concerning her request. Resident #58 said she felt no one cared about her feelings, and that was very upsetting.C. Record reviewThe mobility care plan, revised 5/3/24, revealed Resident #58 had limited physical mobility related to contracture of the right hand. Interventions included providing supportive care and mobility assistance as needed. The quarterly interdisciplinary team (IDT) conference summary, dated 2/17/25, revealed Resident #58 inquired again about the use of her electric wheelchair. The care conference summary documented that the director of rehabilitation (DOR) and the resident's sister reminded Resident #58 of past conversations regarding poor safety choices while using the electric wheelchair and the injury that resulted from that incident.-However, review of the electronic medical record (EMR) did not reveal the facility re-assessed the resident to determine if it was safe to use the power wheelchair after the request was made.The social services summary note, dated 12/23/25, did not document the resident's request to use her electric wheelchair (see resident interview above).A review of psychiatric evaluation note, dated 2/9/26, documented Resident #58 was using a manual wheelchair but requesting access to her electric wheelchair for improved mobility and independence. The note documented the request was relayed to the social services department. -However, the facility did not make any attempts to assess Resident #58's safety when using her power wheelchair as requested.III. Resident #42A. Resident statusResident #42, age greater than 65, was admitted on [DATE]. According to the March 2026 CPO, diagnoses included chronic kidney disease, dementia, pain in the right shoulder, muscle weakness, overactive bladder, and unspecified hearing loss.The 1/13/26 MDS assessment revealed Resident #42 was cognitively impaired with a BIMS score of eight out of 15. She required partial/moderate assistance with toileting, showers, and transfers, and did not reject care.B. ObservationsOn 3/9/26 at 4:03 p.m. Resident #42 was observed lying in bed in her room (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with her call light device on the floor under her bed out of the resident's reach.On 3/10/26 at 2:28 p.m. Resident #42 was lying in bed in her room. The resident's call light device was on the floor under her bed, out of the resident's reach. A certified nursing assistant (CNA) #8 walked into Resident #42's room, briefly checked on the resident and walked out without ensuring the resident's call light was within her reach.On 3/11/26 at 11:00 a.m. Resident #42 was observed lying in her bed in her room. Resident #42's call light device was on the floor under her bed in the same position that it was the last two days during the observations.At 11:03 a.m. Resident #42 yelled out several times for help. CNA #3 arrived and walked into the resident's room. The CNA assisted Resident #42 in opening a bottle of Coke. CNA #3 noticed the call light on the floor out of the resident's reach and placed it within reach.C. Resident interviewResident #42 was interviewed on 3/11/26 at 11:03 a.m. Resident #42 said she stayed in her room most of the day, except for a few preferred activities. She said she did not know where her call light was and usually yelled out for help. The resident said she preferred not to yell when she needed help.D. Record reviewThe fall care plan, initiated 4/17/24 and revised 9/11/24, revealed Resident #42 was at risk for falls related to dementia and decreased mobility. Interventions included ensuring the call light was within reach, encouraging the resident to use it for assistance as needed, and ensuring needed items were within the resident's reach.-However, the resident's call light was not consistently in place (see observations above).IV. Staff interviewsCNA #3 was interviewed on 3/11/26 at 11:15 a.m. CNA #3 said Resident #42 had a hearing deficit making it difficult to communicate with her. CNA #3 said Resident #42 was yelling for assistance to open a bottle of Coke. CNA #3 said the resident's call light was under her bed. CNA #3 said the resident was at risk for falls and required assistance with her daily care.The social services director (SSD) and social services assistant (SSA) were interviewed on 3/12/26 at 9:56 a.m. The SSA said the resident resides on her floor and was familiar with her care. The SSA said she was not aware of Resident #58's desire to use her electric wheelchair. The SSA said the resident had always used a manual wheelchair since she became the SSA.The SSD said Resident #58 was cognitively intact and was her own power of attorney (POA).The SSD said she was present at the last care conference on 12/23/25 for Resident #58 and recalled that the resident expressed a desire to use her electric wheelchair for better mobility and independence. The SSD said the DOR had a conversation with the resident's sister and the resident regarding the use of the electric wheelchair. The SSD said she had not followed up with DOR and the resident sister concerning Resident #42's request.The DOR was interviewed on 3/12/26 at 10:10 a.m. The DOR said she was present at the last care conference held on 12/23/25 for Resident #58. The DOR said she remembered the resident's desire to use her electric wheelchair; however was waiting for the resident's sister to purchase a smaller electric wheelchair. She said Resident #58's current electric wheelchair was stored in the facility's basement. The DOR said she did not complete a safety assessment when the resident expressed a desire to use her electric wheelchair. The DOR said she had no documentation of any safety concerns discussions held with Resident #42's sister.The assistant director of nursing (ADON) was interviewed on 3/12/26 at 3:50 p.m. The ADON said Resident #42 had hearing loss and required staff to speak louder in order for her to understand conversations. She said the resident was a fall risk and required staff to ensure her call light was within her reach at all times. The ADON said she did not know why Resident #42's call light was out of her reach for three consecutive days. The ADON said she would immediately provide education to all nursing staff to ensure that residents' call lights were within reach, so residents would not have to yell for assistance.

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	03/12/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to investigate and report an alleged violation of potential abuse to the State Survey and Certification Agency in accordance with state law for two (#56 and #102) of five residents reviewed for abuse out of 62 sample residents.Specifically, the facility failed to timely report an incident of potential sexual abuse involving Resident #56 and Resident #102 to the State Agency.Findings include:I. Facility policy and procedureThe Reporting Alleged Violations of Abuse, Neglect, Exploitation, or Mistreatment policy, revised October 2022, was provided by the nursing home administrator (NHA) on 3/12/26 at 8:39ˆp.m. It read in pertinent part, It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment. Residents must not be subjected to abuse by anyone, including, but not limited to: facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, resident representatives, families, friends, or other individuals. response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will ensure that all alleged violations are reported immediately but not later than two hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury, and not later than twenty-four hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury. The facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported to the administrator of the facility, the state survey agency, and adult protective services, and will conduct a prompt, thorough, and complete investigation in response to reportable allegations of abuse, neglect, mistreatment, exploitation, or misappropriation of resident property.II. Resident #56A. Resident statusResident #56, age [AGE], was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included dementia with other behavioral disturbance and cognitive communication deficit.The 12/22/25 minimum data set (MDS) assessment documented the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. She required one person's assistance as needed for transfers, bathing, and toileting.B. Resident #56's representatives interviewResident #56's representative was interviewed on 3/11/26 at 2:48 p.m. The representative said he was aware of Resident #56's close relationship with Resident #102. The representative said he was not aware of the incident on 11/18/25. He said nobody reported it to him. C. Record reviewThe behavioral care plan, revised on 3/24/25, documented Resident #56 had potential for behavior problems related to her dementia. Interventions included anticipating and meeting needs, approaching the resident in a calm manner, assisting to develop more appropriate methods of coping and interacting, encouraging to express feelings appropriately, providing opportunity for positive interaction, stopping and talking with her as passing by, explaining all procedures before starting and allowing her to adjust to changes, reasonably discussing behavior, explaining to her why the behavior was inappropriate or unacceptable, praising any indication of progress or improvement in behavior, and providing a program of activities of interest to the resident.The 11/18/25 nursing progress note documented in Resident #56 electronic medical record (EMR) revealed Resident #56 was found naked in Resident #102's bedroom, right after dinner. A staff member spoke to her, she got dressed and came out of the room. Resident #56 spent the rest of the evening watching television in the living room. The director of nursing (DON) was aware of the incident.III. Resident #102A. Resident statusResident #102, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the March 2026 CPO, diagnoses included Parkinson's disease with dyskinesia (involuntary, erratic muscle movements), auditory hallucinations and visual hallucinations. The 12/26/25 MDS assessment documented the resident had moderate cognitive impairment with a BIMS score of 10 out of 15. He required one to two staff members assistance for (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfers, bathing, and personal hygiene. B. Record reviewThe behavioral care plan, revised on 12/18/25, documented Resident #102 had the potential for behavior problems that included yelling at staff members and attempting to enter others' rooms related to wanting to spend time with another female resident. Interventions included anticipating and meeting needs, approaching in a calm manner, assisting to develop more appropriate methods of coping and interacting, encouraging to express feelings appropriately, documenting behaviors and resident response to interventions, discussing behaviors, explaining why behavior was inappropriate or unacceptable and praising any indication of progress in behavior.-The facility was unable to provide documentation that the incident of potential sexual abuse was reported to the State Agency.VI. Staff interviewsCertified nurse aide (CNA) #6 was interviewed on 3/11/26 at 4:27 p.m. CNA #6 said Resident #56 and Resident #102 were boyfriend and girlfriend. She said she heard from other staff members that they had the right to have relationships. CNA #6 said she was aware of the incident on 11/18/25 and that it was reported to the nursing department. CNA #6 said she was not sure if it happened only once.Licensed practical nurse (LPN) #3 was interviewed on 3/11/26 at 4:55 p.m. LPN #3 said she was aware of a romantic relationship between Resident #56 and Resident #102. LPN #3 said she was not aware of the incident on 11/18/25.The NHA, the DON, the clinical consultant, the social services director (SSD) and the social services consultant were interviewed together on 3/12/26 at 5:23 p.m. The NHA said the facility staff were aware of the relationship between Resident #56 and Resident #102. He said Resident #56 and Resident #102 had been involved in a relationship for a while now and said they were in love. He said the relationship was complicated as Resident #102 was still married and his wife visited the facility. He said Resident #56 had cognitive impairment and was diagnosed with dementia. The NHA said Resident #102 also had cognitive impairment, but not as much. The NHA said Resident #102 was diagnosed with Parkinson's disease. The NHA said he was not aware of the incident in November 2025 when Resident #56 was found naked in Resident #102's room (see progress notes above).The DON said the incident was reported to her by the nurse. She said it was her understanding Resident #56 went into Resident #102's room and was taking off her clothes when the nursing staff walked by. She said she did not think Resident #56 was fully naked. The DON said the facility did not have documentation of an investigation following the incident to determine what happened. She said the facility did not have documentation of an evaluation of consent for either Resident #56 or Resident #102. The DON said she did not think Resident #56 could consent to a sexual relationship with Resident #102 due to her cognitive status.Cross-reference F744 failure to effectively identify person-centered approaches for dementia care.The SSD said she was aware of the incident between Resident #56 and Resident #102. She said she spoke to both residents and said Resident #56 was in the process of undressing but not completely undressed. She said Resident #102 had his clothes on.The SSD said she spoke with Resident #56's representative regarding the incident.-However, according to an interview conducted with Resident #56's representative, he said he was never made aware of the incident in November 2025 when Resident #56 was found naked in Resident #102's room (see resident representative interview above).The SSD said she did not document the conversation with either resident or with Resident #56's representative. She said prior to the incident in November 2025, both residents were friends and would sit together and talk. She said they were together constantly and it was not long after the relationship started that it had escalated into holding hands and then with the encounter in November 2025. The SSD said the facility did not document the relationship between Resident #56 and Resident #102 in either resident's EMR. She confirmed the facility did not include the relationship in either resident's comprehensive care plan.The SSD said she felt Resident #102 was able to consent, however the concern would be if Resident #56 could consent. The SSD said there was no written documentation that consent had been evaluated for either resident.The NHA said the facility did not report the incident in November 2025 between Resident #56 and Resident #102 to the State Agency. The clinical consultant said this incident did not represent abuse since the residents were in a relationship. The clinical consultant confirmed the federal (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regulation read to report an allegation of potential abuse, not actual. He said the determination of abuse should be through the investigation into the incident. The NHA said the facility did not conduct a formal investigation into the incident between Resident #56 and Resident #102. The NHA, the DON and the SSD confirmed each resident had the right to change their consent even though they were in a relationship.

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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure proper treatment and assistive devices to maintain hearing abilities for one (#36) of three residents reviewed for hearing problems of 62 sample residents. Specifically, the facility failed to ensure Resident #36`s pocket audio device was regularly charged for the resident`s use. Findings include:I. Facility policy and procedureThe Hearing and Vision Services policy, revised 2026, was provided by the nursing home administrator (NHA) on 3/12/26 at 8:39 p.m. It revealed in pertinent part, It is the policy of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated. The facility will utilize the comprehensive assessment process for identifying and assessing a resident`s vision and hearing abilities in order to provide person-centered care. This process includes: ongoing monitoring of sensory problems. Employees should refer any identified need for hearing or vision services/appliances to the social worker/social service designee. Employees will assist the resident with the use of any devices or adaptive equipment needed to maintain vision or hearing.II. Resident #36A. Resident statusResident #36, age [AGE], was admitted to the facility on [DATE] and readmitted on [DATE]. According to the March 2026 computerized physician orders (CPO) diagnoses included chronic obstructive pulmonary disease with exacerbation, type 1 diabetes mellitus without complications, bipolar disorder, personal history of transient ischemic attack and cerebral infarction without residual deficit, and cognitive communication deficit.The 1/7/26 minimum data set (MDS) assessment document the resident had no cognitive impairment as evidenced by a brief interview for mental status (BIMS) with a score of 14 out of 15. According to the MDS assessment she required moderate assistance with toileting and showering and supervision with dressing. The resident had impaired communication due to impaired hearing according to the care plan. B. Resident observations and interviewOn 3/10/26 Resident #36 was seated in her wheelchair, facing away from the door. She did not wear a hearing aid nor did she have the pocket audio device with her. She did not respond to initial greetings. Resident #36 said she said she could not hear.On 3/10/26 at approximately 2:30 p.m. licensed practical nurse (LPN) #2 entered Resident #36`s room. Resident #36 was facing away from the door. She was not wearing her hearing aide nor did she have the pocket audio device with her. After LPN #2 called Resident #36`s name several times without response, LPN #2 stepped in front of Resident #36. Resident #36 lifted her head and looked up. LPN #2 asked the resident about the pocket audio device whereabouts several times before Resident #36 finally replied the question. Resident #36 said she was not sure. LPN #2 pointed at Resident #36`s bedside table drawer. The pocket audio device and the hearing aid were in the drawer.Resident #36 was interviewed on 3/10/26 at approximately 2:30 p.m. Resident #36 said the hearing aid stopped working months ago. She said the pocket audio device did not work appropriately because it only held one hour charge and the staff often forgot to charge it. Resident #36 was interviewed again 3/11/26 at 10:06 a.m. Resident #36 said she felt helpless for not hearing and being cut off from the world without hearing. She said she was not able to hear the staff at all. She said her pocket audio device was given by her power of attorney after being left without a working hearing aid for several weeks. She said she kept forgetting to charge the pocket hearing aid and the certified nurse aides (CNA) did not stay on top of the charging either. She said she asked the staff to keep it charged. She said she stopped using the pocket hearing device because every time she tried it was not charged. Resident #36 was interviewed again on 3/11/26 at 2:30 p.m. She said there was no point in having the pocket audio device on her neck during the day because it only held charge for an hour. She said she only used the audio device for appointments. C. Record reviewThe communication care plan, initiated on 6/26/24, revealed the resident had impaired communication due to impaired hearing. The care plan documented Resident #36 was hard of hearing and declined the use of hearing aids. The care plan documented she used a pocket talker for most communications and was able to adjust the volume to (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her preference. Interventions included offering audiology visits as needed, talking to the resident face-to-face per her preference, using the pocket talker and using cue cards to communicate with the resident. The 2/17/23 ancillary services note documented Resident #36 had bilateral hearing loss ranging from moderately-severe to profound. Rechargeable devices were recommended to alleviate the need for frequent battery changes in her hearing aid. -Review of Resident #36's electronic medical record (EMR) did not reveal any documentation regarding the resident's hearing impairments, broken hearing aids or the charging issues with the pocket talker. D. Staff interviewsCNA #1 was interviewed on 3/11/26 at 12:40 p.m. CNA #1 said Resident # 36 was not able to hear without the pocket audio device. CNA #1 said the staff had to talk loud and get very close to Resident #36 to make sure Resident #36 could hear them if she did not have the device. She said Resident #36 did not wear the device most times. CNA #1 said she was not sure why Resident #36 did not wear the device more often. LPN #2 was interviewed on 3/11/26 at 1:18 p.m. She said Resident #36 could not hear without the pocket audio device. She said it depended on Resident #36`s mood whether she wore the device or not. She said Resident #36 wore the device on most days. She said the device did not hold charge, but Resident #36 did not allow staff to charge it for her. The social services director (SSD) was interviewed on 3/11/26 at 1:31 p.m. She said the pocket audio device had been the most effective communication method with Resident #36. She said she did not know about the pocket audio device charging problems. She said these problems should be tracked in nursing reports or in the grievance form. She said Resident #36 had not been seen by the audiologist in 2025. The SSD said the resident was scheduled to see the audiologist on 3/26/26.

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	03/12/2026

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 - Minimal harm or potential for 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** Based on record review, observations and interviews, the facility failed to ensure an environment free of accident hazards for one (#46) of two of five residents reviewed for accident hazards out of sample residents reviewed for accident hazards.Specifically the facility failed to ensure fall interventions were implemented for Resident #46 as written in the care plan. Findings include:I. Resident #46A. Resident statusResident #46, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included history of falling, unspecified abnormalities of gait and mobility, and palliative care.The 3/2/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. The MDS assessment identified the resident required substantial and maximal assistance with functional abilities. B. Record reviewResident #46's care plan, initiated 5/27/25, revealed Resident #46 was at risk for falls due to deconditioning. Pertinent interventions included keeping the call light within reach, keeping the bed in the lowest position and keeping needed items within reach. The progress note, dated 6/3/25, revealed Resident #46 had a fall while the hospice certified nurses aid (CNA) was assisting him with a shower. The CNA was unable to catch his fall and he hit the back of his head in the shower. Additional interventions were implemented on 6/5/26 including neurological checks, range of motion checks and vital signs. C. ObservationsOn 3/9/26 at 11:56 a.m. Resident #46 was in his room resting in his bed. The bed was approximately three feet in the air.On 3/9/26 at 2:26 p.m. Resident #46 was in his room resting in his bed. The bed was approximately three feet in the air.On 3/10/26 at 8:20 a.m. Resident #46 was in his room resting in his bed. The bed was approximately three feet in the air.On 3/10/26 at 11:03 a.m. Resident #46 was in his room resting in his bed. The bed was approximately three feet in the air.On 3/10/26 at 3:34 p.m. Resident #46 was in his room resting in his bed. The bed was approximately three feet in the air.On 3/11/26 at 8:07 a.m. Resident #46 was in his room resting in his bed. The bed was approximately three feet in the air.On 3/11/26 at 10:12 a.m. Resident #46 was in his room resting in his bed. The bed was approximately three feet in the air.On 3/12/26 at 11:35 a.m. Resident #46 was in his room resting in his bed. The bed was approximately three feet in the air.On 3/12/26 at 11:50 a.m. registered nurse (RN) #6 lowered Resident #46's bed to the lowest position.D. Staff interviewsRN #6 was interviewed on 3/11/26 at 11:50 a.m. RN #6 said fall interventions the facility implemented included keeping the bed in the lowest position, frequent checking and sometimes fall mats. RN #6 said Resident #46 was at risk for falls and had fall interventions. During the interview, RN #6 observed resident #46s bed in the highest position and immediately went into the residents room and to lower the bed. RN #6 said the CNA did not leave the bed in the lowest position as Resident #46 care plan reads (see above)The director of nursing (DON) and the assistant director of nursing (ADON) were interviewed on 3/12/26 at 4:00 p.m. The ADON said residents with fall interventions had specific interventions in their care plans. The ADON said Resident #46 was a fall risk and had specific interventions implemented. The ADON said she was not aware Resident #46 had his bed the highest position (see observations above). The DON said specific floor training would be provided as a reminder to staff of which residents were at risk for falls.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide necessary respiratory care and services consistent with professional standards of practice and the comprehensive person-centered care plan for one (#21) of one resident reviewed for respiratory care out of 62 sample residents.Specifically, the facility failed to ensure that Resident #21 received oxygen therapy in accordance with their physician's orders. Findings include:I. Facility policy and procedureThe Oxygen Administration, Storage, and Handling policy, revised January 2026, was provided by the nursing home administrator (NHA) on 3/12/26 at 9:03 p.m. It read in pertinent part, It is the policy of this facility to promote resident safety with oxygen administration.Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain medical gases shall be trained on the risks associated with their handling and use.II. Resident #21A. Resident statusResident #21, age greater than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), moderate, persistent asthma, chronic respiratory failure with hypoxia, major depressive disorder, and obstructive sleep apnea.The 3/10/26 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. She was independent with eating, dependent with toileting, moderate assistance with personal hygiene and transfers. The assessment revealed the resident was receiving oxygen therapy.B. ObservationsOn 3/10/26 at 10:45 a.m., certified nursing assistant (CNA) #3 walked into Resident #21's room with a portable oxygen tank and hung it behind the resident's wheelchair. Resident #21's nasal cannula (tubing device that delivers oxygen through the nose) was in her nose, connected to a room oxygen concentrator with a setting of 4 liters per minute (LPM) of oxygen. CNA #3 transferred the cannula from the room concentrator to the portable tank and set it to 4 LPM of oxygen. Resident #21 asked the CNA how many liters of oxygen she was on and CNA #3 replied 4 LPM. Resident #21 told the CNA to reduce the amount of oxygen from 4 LPM to 2 LPM and CNA #3 complied without verifying with the nurse to ensure the resident received the required amount according to Resident #21's physician's order.On 3/11/26 at 9:04 a.m. Resident #21 was sitting in her wheelchair in her room. The nasal cannula was in the resident's nose and the portable oxygen tank was on and set at 2.5 LPM of oxygen.On 3/12/26 at 10:14 a.m. Resident #21 was lying in bed in her room. The resident was connected to the oxygen concentrator via a nasal cannula in her nose, and the concentrator was set at 4 LPM of oxygen. Registered nurse (RN) #4 and CNA #4 confirmed the concentrator was set at 4 LPM.C. Resident interviewResident #21 was interviewed on 3/10/26 at 3:16 p.m. Resident #21 said she used oxygen continuously at all times. She said she was not sure how many liters of oxygen her physician's order wa,s but knows that 4 LPM was probably too much. She said she did not know what oxygen setting her oxygen concentrator was currently set on. She said CNA #3 set her portable tank to 4 LPM earlier in the morning and she thought that was a little too much due to her condition of COPD.D. Record reviewThe respiratory care plan, initiated 8/28/25, revealed Resident #21 had an altered respiratory status related to COPD, chronic respiratory failure, and asthma. Interventions included administering medication and metered-dose inhalers as ordered, monitoring for effectiveness and side effects, monitoring for signs and symptoms of respiratory distress and reporting to the medical director (MD) as needed.-A review of Resident #21's electronic medical record (EMR) revealed she was on room air on 12/12/25 with an oxygen saturation level of 93%. On 12/14/25 she received 22 LPM with an oxygen saturation level of 95%. On 12/15/25 she received 2 LPM with a saturation level of 93%. On 3/6/26 she received 2 LPM with a saturation level of 98%.-Review of the EMR revealed Resident #21 was consistently receiving 2 LPM of oxygen.Review of Resident #21's March 2026 CPO revealed a physician's order for continuous 1 LPM oxygen via nasal cannula to maintain the resident's oxygen saturation at or above 90%, dated 8/28/25.-However, observations on (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/10/26, 3/11/26 and 3/12/26 revealed Resident #21 was receiving 2.5 and 4 LPM of oxygen, not 1 LPM as ordered by the physician (see observation above).III. Staff interviewsCNA #4 was interviewed on 3/12/26 at 10:50 a.m. CNA #4 said Resident #21's room concentrator was set at 4 LPM since the beginning of her shift at 6:00 a.m. CNA #4 said she did not know how many liters of oxygen the resident was supposed to be receiving. She said CNA's were not permitted to change the liter flow of residents' oxygen concentrators. She said she did not inform the nurse when she noticed the resident was receiving 4 LPM of oxygen.RN #4 was interviewed on 3/12/26 at 11:00 a.m. RN #4 said Resident #21 had a diagnosis of COPD, asthma and was recovering from pneumonia. RN #4 said Resident #21's physician's order indicated the resident was to receive 1 LPM of oxygen. RN #4 confirmed that Resident #21 was on an incorrect LPM of oxygen. She said she did not verify the concentrator setting at the beginning of her shift at 6 a.m. RN #4 said she should have verified the concentrator's LPM during her morning rounds.The director of nursing (DON) was interviewed on 3/12/26 at 11:10 a.m. The DON said it was necessary to follow the physician's oxygen orders because oxygen was considered a form of medication. She said CNA's were not allowed to change the liter flow of an oxygen concentrator. The DON said nurses were able to change the liter flow of oxygen orders when necessary, document the changes and inform the physician. The DON said that insufficient or excessive oxygenation could result in medical complications for a resident. She said she would immediately provide education to all nursing staff to ensure all oxygen orders were followed.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#56) of three residents reviewed for dementia care received the appropriate treatment and services to attain or maintain the highest practicable physical, mental and psychosocial well-being out of 62 sample residents Specifically, the facility failed to assess Resident #56 to determine if she was able to consent to a romantic relationship with a diagnosis of dementia. Findings include:I. Facility policy and procedureThe Care of Dementia policy, revised April 2025, was provided by the nursing home administrator (NHA) on 3/12/26 at 8:39˜p.m. It revealed in pertinent part, It is the policy of this facility that all residents will have an individualized plan of care and have the least restrictive approaches to care. Staff are offered specialized training in the care of the dementia population, appropriate approaches to care, and managing behaviors. The interdisciplinary staff will initiate a thorough clinical assessment. The monitoring of mood, behavior, or any psychosocial-related issues to identify possible underlying medical problems that may be causing the behavioral problems. The interdisciplinary team will review findings of evaluations and develop a plan of care addressing the resident's needs. The physician will be involved in the plan of care and make any changes to the medical regimen as necessary. The facility will offer to staff specialized training regarding the dementia disease process utilizing nationally recognized dementia care guidelines as the basis of the education, including what to expect with progression of the disease, care of this specialized population, approaches to intervening in a crisis situation, and managing/monitoring behaviors. II. Resident #56A. Resident statusResident #56, age [AGE], was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included dementia with other behavioral disturbance and cognitive communication deficit.The 12/22/25 minimum data set (MDS) assessment documented the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. She required one person's assistance as needed for transfers, bathing, and toileting. B. ObservationsOn 3/10/26, at 4:10 p.m. Resident #56 was in a common area. She talked to Resident #102 for a few minutes, then she spent time alone. On 3/12/26 at 10:20 a.m. Resident #102 knocked on Resident #56's bedroom door, but she did not open it. At 11:10 a.m. Resident #102 knocked on Resident #56's bedroom door again, but a staff member redirected Resident #102 and took him to a different area. At 11:25 a.m. Resident #56 looked for Resident #102, then they spent time together in the living room. C. Record reviewThe dementia care plan, revised on 3/21/24, documented Resident #56 was at risk for impaired cognitive function and impaired thought processes related to dementia. Interventions included administering medications as ordered, engaging in simple activities that avoid overly demanding tasks, giving step by step instructions as needed to support cognitive function, keeping routine consistent and trying to provide consistent care givers as much as possible to decrease confusion, and documenting and report to physician any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, and level of consciousness and mental status.The behavioral care plan, revised on 3/24/25, documented Resident #56 had potential for behavior problems related to her dementia. Interventions included anticipating and meeting needs, approaching calmly, assisting to develop more appropriate methods of coping and interacting, encouraging to express feelings appropriately, providing opportunity for positive interaction, stopping and talking with her as passing by, explaining all procedures before starting and allowing her to adjust to changes, reasonably discuss behavior by explaining her why the behavior was inappropriate or unacceptable, praising any indication of progress or improvement in behavior, and providing a program of activities of interest to the resident.-Review of Resident #56's comprehensive care plan that Resident #56 and Resident #102 were involved in a romantic relationship. The 11/18/25 nursing progress note (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented Resident #56 was found naked in Resident #102's bedroom, right after dinner. A staff member spoke to her, she got dressed and came out of this room. Resident #56 spent the rest of the evening watching television in the living room. The director of nursing (DON) was aware of the incident. -Cross-reference F609: failure to timely report an incident of potential sexual abuse to the State Agency.-Review of the electronic medical record (EMR) did not reveal documentation did not reveal that the facility assessed Resident #56 to determine the resident could consent to a sexual relationship. III. Staff interviewsCertified nurse aide (CNA) #6 was interviewed on 3/11/26 at 4:27 p.m. CNA #6 said Resident #56 was able to make her own decisions, even though she was sometimes confused. CNA #6 said she believed Resident #56 was able to give her consent to have a relationship with Resident #102. Licensed practical nurse (LPN) #3 was interviewed on 3/11/26 at 4:55 p.m. LPN #3 said Resident #56 was able to make decisions and give her consent to have a relationship. LPN #3 said sometimes Resident #56 was confused, and a week ago, the resident was unable to follow instructions.The nursing home administrator (NHA), the director of nursing (DON), and the social services director (SSD) were interviewed on 3/12/26 at 5:23 p.m. The NHA said the facility staff were aware of the relationship between Resident #56 and Resident #102. He said Resident #56 had cognitive impairment and was diagnosed with dementia and Resident #102 also had cognitive impairment, but not as much, as was diagnosed with Parkinson's disease. The DON said shE did not think Resident #56 could consent to a sexual relationship with Resident #102 due to her cognitive status.The SSD said she felt Resident #102 was able to consent, however the concern would be if Resident #56 could consent. The SSD said there was no written documentation that consent had been evaluated for either resident.