

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  06/24/2025
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)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews, the facility failed to assess, arrange, and document discharge services for one (#1) of one resident reviewed out of three sample residents.</p> <p>Specifically, for Resident #1, the facility failed to:</p> <ul style="list-style-type: none"> <li>-Assess oxygen therapy discharge needs for the resident; and,</li> <li>-Ensure home health services were confirmed for the resident prior to discharge.</li> </ul> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Discharge Planning Process policy and procedure, revised May 2025, was provided by the nursing home administrator (NHA) on 6/24/25 at 5:20 p.m. The policy read in pertinent part,</p> <p>The discharge process should effectively transition residents to post-discharge care and minimize clinical or other factors related to the possibility of readmission.</p> <p>The discharge planning process shall:</p> <ul style="list-style-type: none"> <li>-Provide and document sufficient preparation and orientation to residents in a form and manner that the resident can understand, to ensure safe and orderly transfer or discharge from the facility;</li> <li>-Ensure the discharge needs of each resident are identified on admission, and a discharge plan for each resident is developed and implemented promptly;</li> <li>-Include re-evaluation of residents to identify changes that require a modification of the discharge plan, and update the discharge plan to reflect changes;</li> <li>-Involve the interdisciplinary team (IDT) in developing the discharge plan;</li> <li>-Involve the resident and resident representative in developing the discharge plan, and inform the resident and resident representative of the final plan. If participation of the resident or the resident representative is not practicable, an explanation shall be documented in the resident's medical record;</li> </ul> <p>(continued on next page)</p>

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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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-If the resident indicates an interest in returning to the community, the facility shall document any referrals made; and,</p> <p>-The facility shall update the resident's comprehensive care plan and discharge plan in response to information received from referrals to local contact agencies or other appropriate entities.</p> <p>The facility shall document on a timely basis the resident's needs and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The result of the evaluation must be discussed with the resident or representative. All relevant information must be incorporated into the discharge plan.</p> <p>II. Resident #1</p> <p>A. Resident status</p> <p>Resident #1, age greater than 65, was admitted on [DATE] and discharged to her home on 5/16/25. According to the May 2025 computerized physician orders (CPO), diagnoses included endocarditis (infection of a heart valve), enterocolitis (colon infection), sepsis (body systemic infection), emphysema and chronic obstructive pulmonary disease (respiratory diseases), heart failure and pulmonary hypertension (high blood pressure in the lungs).</p> <p>The 5/2/25 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 13 out of 15. Resident #1 required substantial to maximum assistance from staff for standing and partial to maximum assistance from staff for ambulation.</p> <p>The MDS assessment documented the resident had no oxygen therapy or use of oxygen at admission.</p> <p>B. Record review</p> <p>The pneumonia care plan, initiated 4/24/25, revealed Resident #1 had pneumonia. Pertinent interventions included oxygen therapy as ordered (initiated 4/24/25).</p> <p>The respiratory care plan, initiated 4/24/25, revealed Resident #1 had difficulty breathing related to COPD and respiratory failure. Pertinent interventions included providing oxygen as ordered (initiated 4/24/25).</p> <p>The care plan failed to include an oxygen use plan of care or a discharge planning needs assessment for oxygen services at home.</p> <p>Review of Resident #1's May 2025 CPO revealed the following physician's order:</p> <p>Apply oxygen via nasal cannula at 2 liters per minute (LPM) to keep oxygen saturations (level of oxygen in the blood) at or above 90% (percent). Ordered 4/25/25.</p> <p>Review of Resident #1's electronic medical record (EMR) revealed the resident used supplemental oxygen administered by nasal cannula for 42 of 47 assessments.</p> <p>(continued on next page)</p>

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Discharge summary, dated [DATE], documented Resident #1 should use 2 LPM of oxygen via nasal cannula.</p> <p>-However, review of Resident #1's electronic medical record (EMR) revealed there were no physician's orders or home health referrals for oxygen equipment for the resident after discharge from the facility.</p> <p>The physician's discharge order, dated 5/14/25, read Ceftriaxone (antibiotic), 2 grams (gm), intravenously at bedtime until 5/23/25.</p> <p>-However, review of Resident #1's EMR failed to reveal documentation to indicate the facility confirmed a start date for home health services prior to discharging Resident #1.</p> <p>-The home health Patient Information Report, was provided by the NHA on 6/24/25 at 1:18 p.m. The report documented the home health provider received the referral on 5/16/25 and started services for Resident #1 on 5/20/25, four days after the resident was discharged from the facility.</p> <p>-The facility failed to ensure Resident #1 would have home health services in a timely manner, to include oxygen therapy and antibiotic therapy, per the discharge summary and physician's orders (see above), upon the resident's discharge from the facility on 5/16/25.</p> <p>III. Staff interviews</p> <p>The social services assistant (SSA), the director of nursing (DON) and the NHA were interviewed together on 6/24/25 at 2:30 p.m.</p> <p>The SSA said she arranged for home health services by sending a referral to Resident #1's insurance provider. She said she visually confirmed the referral facsimile (fax) transmitted, but she did not confirm receipt that the insurance company received the referral or that they had authorized the home healthcare services for antibiotic administration at home.</p> <p>The DON said Resident #1 used oxygen while admitted to the facility. The DON said the facility discharge process started with a review by the IDT. The DON said the IDT documented discharge needs and then the SSA was responsible for arranging services for residents when they were discharged from the facility.</p> <p>The DON said she was unable to locate a discharge needs assessment for oxygen for Resident #1 or documentation to indicate a referral had been made for home oxygen for the resident.</p> <p>The DON said if home services were unavailable at discharge, the resident's discharge should be canceled, and a physician should be contacted for review. The DON said the physician was not notified that home health services were not arranged before Resident #1's discharge. The DON said Resident #1 should have received her antibiotic medication from the home health provider on 5/16/25 after she arrived home.</p> <p>The NHA said Resident #1 had a history of noncompliance with oxygen use before admission to the facility. The NHA said the facility had not completed a discharge needs assessment for home oxygen because she probably had oxygen at home.</p> <p>(continued on next page)</p>		

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