STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065202	A. Building B. Wing	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedars Healthcare Center	1599 Ingalls St Lakewood, CO 80214

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews, the facility failed to ensure one (#7) of six residents reviewed for quality of care out of seven sample residents, received treatment and care in accordance with professional standards of practice.IMMEDIATE JEOPARDYResident #7 was admitted on [DATE] with diagnoses of Parkinson's disease (a progressive disease that causes symptoms such as tremors, stiffness and slow movement), epilepsy without status epilepticus (seizure lasting longer than five minutes, or two or more seizures without the resident gaining consciousness in between them), chronic respiratory failure, dependence on supplemental oxygen and cognitive communication deficit.On 6/26/25, Resident #7 experienced seizure activity that lasted longer than 30 minutes. During the seizure activity, the resident was observed to be having seizures by several staff members. The nurse practitioner (NP) was notified three times, by three different staff members, during the resident's seizure activity, however the NP did not ask staff to obtain vital signs or conduct any assessment of the resident. The NP did not give staff a physician's order to send Resident #7 to the emergency department (ED) until the resident had been experiencing seizure activity for over 30 minutes.When emergency medical services (EMS) arrived at the facility, Resident #7's airway was compromised, and he required an artificial airway placement (a medical device inserted into the trachea (windpipe) to maintain or restore a patient's airway, especially when they cannot breathe effectively on their own). Resident #7 was admitted to the intensive care unit (ICU) and placed on a ventilator. On 6/26/25, Resident #7 experienced a situation of serious harm. The facility's failure to implement a plan to ensure staff were trained on how to monitor residents for seizure activity, how to identify seizure activity and respond timely and appropriately when a resident was experiencing seizures to ensure the incident did not reoccur created the potential for serious harm to Resident #7 and other residents with a seizure disorder if the situation was not immediately corrected. ADDITIONAL FAILURES FOR RESIDENT #7Further review of Resident #7's electronic medical record (EMR) revealed Resident #7 readmitted to the facility following his hospitalization for seizure activity on 7/7/25. On 7/9/25 a physician's order was given for midazolam (an anticonvulsant medication for breakthrough seizure activity), however, the facility failed to ensure the medication was obtained from the pharmacy until 7/15/25, six days after the medication was obtained. Additionally, the facility failed to ensure nursing staff were trained on how to appropriately administer the midazolam medication to Resident #7 in the event the resident experienced another seizure episode. Specifically, the facility failed to:-Provide timely assessment and intervention during a change of condition for Resident #7; and,-Obtain Resident #7's breakthrough seizure medication in a timely manner after a new physician's order was given on 7/9/25 and ensure staff were trained on how to administer the medication to the resident.Findings include:IMMEDIATE JEOPARDYI. Findings of Immediate Jeopardy On 6/26/25, at 1:33 p.m. a care conference was held with the resident's representative. The resident's representative reported to the clinical team that she was concerned whether or not the resident's seizure medications were effective for Resident #7, as he had had several seizures in the last hour. After the care conference conference, around 1:49 p.m., registered nurse (RN) #3 called the NP and received a verbal physician's orders for lab work for Resident #7. -However, RN #3 did not check on the resident and did not assess him for seizure activity. At 2:00 p.m. RN #2 was notified by a dietary staff member of Resident #7's emergency. RN #2 went to Resident #7's room and observed Resident #7 having seizure activity. -However, RN #2 did not complete or document the resident's vital signs or overall condition. RN #2 contacted the same NP a second time, at approximately 2:20 p.m. and reported the seizure activity for Resident #7. The NP said she needed to review the resident's chart and would call back. -However, the NP did not call back within the next 10 minutes. At 2:30 p.m. the NP was called a third time by licensed practical nurse (LPN) #4 to notify the NP about Resident #7's seizure activity that had been occurring for more than 30 minutes. The NP gave a physician's order to send the resident to the hospital via EMS. Resident #7 was admitted to the ICU and placed on a ventilator. The director of nursing (DON) was interviewed on 7/10/25 at 3:20 p.m. The DON said Resident #7 had a history of behaviors. The DON said the resident would stare at the wall and not respond to staff if the staff were not providing his care as he preferred. The DON said Resident #7 had Parkinson's tremors, and when he was first discovered on 6/26/25, he had tremors. The DON said when the staff realized the tremors were worse, they called EMS.Staff interviews on 7/14/25 (during the survey) revealed that staff was not able to recognize the difference between the resident's Parkinson's tremors and seizure activity. The staff said they had not

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to maintain medical records in accordance with accepted professional standards and practices for two (#1 and #2) of six residents out of seven sample residents. Specifically, the facility failed to accurately document the administration of scheduled medications for Resident #1 and Resident #2. Findings include:I. Facility policy and procedureThe Administering Medications policy, dated April 2019, was provided by the director of nursing (DON) on 7/15/25 at 10:06 a.m. The policy read in pertinent part, Medications are administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted may prepare, administer, and document the administration of medications. The director of nursing services (DON) supervises and directs all personnel who administer medications and/or have related functions. Medications are administered by prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: - Enhancing the optimal therapeutic effect of the medication; -Preventing potential medication or food interactions; and-Honoring resident choices and preferences, consistent with their care plan. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the medication administration record (MAR) space provided for that drug and dose. The individual administering the medication signs the resident's MAR on the appropriate line after giving each medication and before administering the next ones. As required or indicated for a medication, the individual administering the medication records in the resident's medical record:-The date and time the medication was administered;-The dosage;-The route of administration;-The injection site (if applicable);-Any complaints or symptoms for which the drug was administered;-Any results achieved and when those results were observed; and,-The signature and title of the person administering the drug.The Leave of Absence (LOA) policy, revised 8/1/24, was provided by the DON on 7/15/25 at 10:06 a.m. The policy read in pertinent part, This policy applies to all healthcare providers involved in the preparation of a resident for a leave of absence medications.A physician should provide an order indicating the resident may take a leave of absence, along with a list of medications to be taken during the leave. The facility nurse and prescriber should review the list of current medications, the total number of doses required for each medication, and the length of time the resident will need the medication. The facility should have the resident sign for the receipt of medications for the leave of absence. The facility should chart the following on the MAR:-Quantity of each medication released to the resident or responsible party,-Date medication is released to the resident or responsible party,-Time medication is released to the resident or responsible party, and,-Name of the person receiving the medication. The facility should record the release of controlled substances that require tracking on a separate inventory sheet for the leave of absence. When the resident returns to the facility, the nurse should count all doses of controlled substances and document the doses used while on leave of absence.II. Resident #1A. Resident statusResident #1, age greater than 65, was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included panic disorder, anxiety, schizoaffective disorder (mental illness), iron deficiency anemia, protein-calorie malnutrition, dementia, fibromyalgia (pain disorder) and chronic pain. The 4/16/25 minimum data set (MDS) assessment revealed Resident #1 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #1 was independent with all activities of daily living (ADL). B. Resident #1's family member interviewA family member for Resident #1 was interviewed via telephone on 7/10/25 at 11:14 a.m. The family member reported she picked Resident #1 up for a pass on 5/19/25 to 5/22/25. She said the facility provided her with medications for one day, but did not provide a list of the medications because she was not Resident #1's designated representative. The family members reported that the medications received on 5/19/25 were incorrect medications. The family member said she returned to the facility on 5/20/25 and then received additional medications for 5/20/25. The family member said the medications received for 5/20/25 were correct but were different from the medications received for 5/19/25.C. Record reviewReview of Resident #1's MARS and treatment administration records (TARS), from 2/1/25 to 7/15/25, revealed there were multiple days when the resident's medications did not include staff documentation to indicate the medications were administered to the resident. Additionally, there were multiple days when the entry for