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	06/11/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, record review and interviews, the facility failed to provide care to each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 12 (#2, #8, #13, #35, #37, #50, #69, #74, #92, #33 #44, #43, #93, #103 and #57) out of 55 sample residents.Specifically, the facility failed to respond to call lights in a timely manner for Resident #2, Resident #8, Resident #13, Resident #35, Resident#37, Resident #50, Resident #69, Resident #74, Resident #92, Resident #33, Resident #44, Resident #43, Resident #93, Resident #103 and Resident #57. Findings include:I. Facility policy and procedureThe Call System, Residents Call policy, revised September 2022, was provided by the assistant director of nursing (ADON) on 6/11/26 at 4:22 p.m. It read in pertinent part, Residents are provided with a means to call staff for assistance throughout a communication system that directly calls a staff member or a centralized work station. Calls for assistance are answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance are addressed immediately. Call light response times are reviewed as part of the QAPI (quality assurance process improvement) program.II. Resident interviewsResident #69 was interviewed on 6/8/26 at 9:47 a.m. Resident #69 said it was hard to get a CNA to answer the call light at night. He said there was only one CNA for 30 residents on site during the night shift. He said he filed a complaint before regarding the call light response time. He said he had to wait 40 to 45 minutes to get assistance last week. He said the staff told him they were busy with other residents and that there was only one CNA on site. He said he was sure about his waiting time, because he checked the timing on his tablet.Resident #8 was interviewed on 6/8/26 at 10:15 a.m. Resident #8 said the call light response time could take up to an hour. He said by the time the call light was answered he often forgot what was the reason for calling for assistance.Resident #2 was interviewed on 6/8/26 at 10:50 a.m. Resident #2 said it was hard to find a nurse when needed. Resident #2 said the call light response time could take up to 30 minutes. Resident #92 was interviewed on 6/8/26 at 11:20 a.m. Resident #92 said call light response time can be very long; it could take up to 30 minutes or even more. She said the slow call light response time bothered her. Resident #50 was interviewed on 6/8/26 at 2:21 p.m. Resident #50 said the staff did not answer her call light timely. Resident #35 was interviewed on 6/8/26 at 2:43 p.m. Resident #35 said she had to wait for the certified nurse aides (CNA) to respond to her call and it often took 30 minutes to get assistance. Resident #37 was interviewed on 6/8/26 at 3:00 p.m. Resident #37 said the call light response time was slow. She said it could take between one to two hours for the call light to be answered. Resident #74 was interviewed on 6/8/26 approximately at 3:20 p.m. She said her family had to ask several times for the CNAs to assist her even though she used her call light. She said the residents are not checked in on often enough and they do not pay attention to make sure her call light is within her reach. Resident #13 was interviewed on 6/8/26 at 4:33 p.m. Resident #13 said it took 30 minutes for staff to respond to her call lights. Resident #33 was interviewed on 6/10/26 at 11:59 a.m. Resident #33 said on Saturday night he had to wait an hour and 15 minutes and he was not happy about it. Resident #33 said it should not take longer than 15 minutes to answer a call light. Resident #33 said the CNAs did not answer lights for residents who were outside of their assigned group of (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents. Resident #44 was interviewed on 6/10/26 at 12:00 p.m. Resident #44 said generally, the night shift staff response time was terrible. Resident #93 said staff take hours to answer the call light. Resident #93 said sometimes she was waiting and had to go to the bathroom so bad she was in pain. Resident #93 said certain CNAs are worse than others. Resident #43 was interviewed at 12:00 p.m. Resident #43 said the day shift staff on her side of the building were more untimely than the night shift staff. Resident #43 said she had to ask for help again an hour and a half later.III. Record reviewsAn audit of call light response times from 3/29/26 to 4/29/26 was provided by the nursing home administrator (NHA) on 6/10/26 for Resident #57. Review of the call light response during this period revealed the following call light response times: The call light was activated and not answered for 15 to 20 minutes, 20 timesThe call light was activated and not answered for 20 to 30 minutes, 25 timesThe call light was activated and not answered for 30 to 40 minutes, 18 timesThe call light was activated and not answered for 40 to 50 minutes, four times. An audit of call light response times from 5/18/26 to 6/7/26 was provided by the NHA on 6/10/26 for Resident #13. Review of the call light response during this period revealed the following call light response times: The call light was activated and not answered for 15 to 20 minutes, 25 timesThe call light was activated and not answered for 20 to 30 minutes, 35 timesThe call light was activated and not answered for 30 to 40 minutes, 14 timesThe call light was activated and not answered for 40 to 50 minutes, four times. An audit of call light response times from 5/18/26 to 6/8/26 was provided by the NHA on 6/10/26 for Resident #103. Review of the call light response during this period revealed the following call light response times: The call light was activated and not answered for 15 to 20 minutes, seven timesThe call light was activated and not answered for 20 to 30 minutes, six times.The call light was activated and not answered for 30 to 40 minutes, three times.The call light was activated and not answered for 40 to 50 minutes, two times. The call light was activated and answered for 50 to 60 minutes, one time.An audit of call light response times from 5/18/26 to 6/8/26 was provided by the NHA on 6/10/26 for Resident #74. Review of the call light response during this period revealed the following call light response times: The call light was activated and not answered for 15 to 20 minutes, 20 times.The call light was activated and not answered for 20 to 30 minutes, 32 times.The call light was activated and not answered for 30 to 40 minutes, 10 times.The call light was activated and not answered for 40 to 50 minutes, one time. An audit of call light response times from 5/18/26 to 6/8/26 was provided by the NHA on 6/10/26 for Resident #70. Review of the call light response during this period revealed the following call light response times: The call light was activated and not answered for 15 to 20 minutes, 20 times.The call light was activated and not answered for 20 to 30 minutes, 35 times.The call light was activated and not answered for 30 to 40 minutes, 20 times.The call light was activated and not answered for 40 to 50 minutes, five times.The call light was activated and not answered for 50 to 60 minutes, six times. An audit of call light response times from 5/18/26 to 6/8/26 was provided by the NHA on 6/10/26 for Resident #93. Review of the call light response during this period revealed the following call light response times: The call light was activated and not answered for 15 to 20 minutes, seven times.The call light was activated and not answered for 20 to 30 minutes, 24 times.The call light was activated and not answered for 30 to 40 minutes, six times.The call light was activated and not answered for 40 to 50 minutes, nine times.The call light was activated and not answered for 50 to 60 minutes, four times. An audit of call light response times from 5/18/26 to 6/8/26 was provided by the NHA on 6/10/26 for Resident #2. Review of the call light response during this period revealed the following call light response times: The call light was activated and not answered for 15 to 20 minutes, five times.The call light was activated and not answered for 20 to 30 minutes, five times.The call light was activated and not answered for 30 to 40 minutes, two times.The call light was activated and not answered for 40 to 50 minutes, one time.The call light was activated and not answered for 50 to 60 minutes, two times. An audit of call light response times from 5/18/26 to 6/8/26 was provided by the NHA on 6/10/26 for Resident #69. Review of the call light response during this period revealed the following call light response times: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The call light was activated and not answered for 15 to 20 minutes, three times.The call light was activated and not answered for 20 to 30 minutes, six times.The call light was activated and not answered for 30 to 40 minutes, three times.The call light was activated and not answered for 50 to 60 minutes, one time. An audit of call light response times from 5/18/26 to 6/8/26 was provided by the nHA on 6/10/26 for Resident #33 . Review of the call light response during this period revealed the following call light response times: The call light was activated and not answered for 15 to 20 minutes, two times.The call light was activated and not answered for 20 to 30 minutes, two times.The call light was activated and not answered for 30 to 40 minutes, one time.IV. Staff interviewCertified nurse aid (CNA) #1 was interviewed on 6/10/26 at 2:33 p.m. CNA #1 said Resident #70 complained the most about the slow call light response time. She said she had never filed grievance in Resident #70`s behalf nor she felt she needed to offer Resident #70 to file a grievance.Licensed practical nurse (LPN) #7 was interviewed on 6/11/26 approximately 4:00 p.m. LPN #7 said an acceptable response time was around ten minutes. She said staff response time was usually faster than ten minutes. She said staff triaged phone calls and an emergency call light activation took priority. The NHA interviewed on 6/11/26 approximately at 5:00 p.m. The NHA said he was newly employed at the facility within the last 30 days. He said that the long call light response times were brought to his attention. He said he was aware of the problem and was working on a resolution. He said he needed to discuss the problem with QAPI first and then make plans for remediation.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 report alleged violations of physical abuse to the State Survey and Certification Agency in accordance with state law for three (#56, #79 and #74) of six residents reviewed for abuse out of 55 sample residents. Specifically, the facility failed to:-Ensure an incident of alleged verbal abuse for Resident #56 was reported to the State Survey Agency;-Ensure an incident of alleged sexual abuse for Resident #79 was reported to the State Survey Agency; and,-Ensure an incident of alleged injury of unknown origin for Resident #74 was reported in a timely manner to the State Survey Agency. Findings include: I. Facility policy and procedure The Abuse Prevention policy and procedure, undated, was provided by the nursing home administrator (NHA) on 6/8/26 at 12:58 p.m. It read in pertinent part, All employees who have reasonable cause to believe a resident has suffered abuse are responsible for reporting that information to the executive director or upon his/her absence, to a supervisor. If to a supervisor, he/she shall pass along the information to the executive director immediately. II. Resident #56 A. Resident status Resident #56, age less than 65, was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included right-sided hemiplegia and hemiparesis following cerebral infarction, history of traumatic brain injury, and anxiety disorder. The 3/12/26 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 independent with most of her activities of daily living (ADL). B. Resident interview Resident #56 was interviewed on 6/8/26 at 3:17 p.m. Resident #56 said approximately eight to nine months ago, licensed practical nurse (LPN) #8 would not give her her scheduled pain medications. She said he got right in her face and yelled at her. She said he scared her when he got in her face. She said she had requested that he no longer be her nurse after the incident, but he continued to be her nurse for approximately six months afterwards. She said it caused her a lot of depression and anxiety because he continued to be her nurse. She said it made her feel like the facility cared more about his well-being than her well-being, because they did not do anything. She said because the facility did not do anything, it made her feel like LPN #8 felt it was okay to treat her that way. She said she felt that when LPN #8 got in her face and yelled at her, it was abusive behavior. She said she continued to avoid LPN #8 whenever she saw him in the facility. C. Record review (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A grievance form was filled out on 7/9/25 at 6:30 a.m. by the staff development coordinator. The grievance documented Resident #56 was crying due to attempting to explain her Oxycontin was not being administered as ordered. The grievance documented LPN #8 insisted the resident's Oxycontin was PRN (as needed), however Resident #56's medication was in fact scheduled. The form documented LPN #8 was in Resident #56's face when the staff development coordinator arrived. The grievance outcome/resolution documented that LPN #8 was asked to step back, reconsider his approach with Resident #56 and to lower his voice and walk away if the situation escalated. The outcome/resolution documented LPN #8 would apologize to Resident #56. At the bottom of the grievance, in a different handwriting, it was documented that Resident #56 requested that LPN #8 no longer be her assigned nurse due to him approaching her in the same manner previously. There were no other signatures on the grievance form other than the staff development coordinator's. There was no indication on the grievance form that a resolution had been made. -The facility failed to report the allegations of verbal abuse to the State Agency. Cross-reference F600 for failure to protect residents from abuse. D. Staff interviews The staff development coordinator was interviewed on 6/10/26 at 4:49 p.m. The staff development coordinator said Resident #56 felt that she was not getting her pain medication timely and consistently from LPN #8. She said Resident #56 also felt like LPN #8 was not addressing her pain fairly and appropriately. She said when she arrived at the nurses' station that morning (7/9/25), she saw that LPN #8 was about a foot away from from Resident #56's face and was hollering at her. The staff development coordinator said LPN #8 was not being respectful. She said he made Resident #56 cry and made her fearful. She said she felt she had to intervene because both LPN #8 and Resident #56 raised their voices and were disturbing the other residents. She said she did not consider the incident to be abuse, because LPN #8 did not hit Resident #56. She said she also allowed LPN #8 a 60-day to 90-day trial to see if he could improve his medication pass with Resident #56. She said that she was monitoring his medication pass by looking at the narcotics sheet. She said there was no documentation of the education or discussion with LPN #8. She said she did speak with Resident #56 about the 60-day to 90-day trial and that the resident was okay with the plan. The director of nursing (DON) and regional clinical resource #1 were interviewed together on 6/11/26 at 9:19 a.m. The DON said she was aware of the situation between LPN #8 and Resident #56. She said she had spoken to LPN #8 and he had told her that he was concerned that Resident #56 was under the influence. The DON said he raised his voice because he wanted to make sure that Resident #56 was understanding him. She said that when she spoke to LPN #8, she directed him to have another nurse give Resident #56 her medications. She said he was no longer to administer Resident #56's medications. She said that she expected to have the nurse that gave the medications to the resident to also pull the medications, that way there would be no questions as to who gave the medications. She said that she had not seen the grievance form regarding Resident #56's concern prior to 6/11/26 and if she had seen it before, she would have opened an investigation of verbal abuse and reported the alleged abuse. III. Resident #79 A. Resident status (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #79, age less than 65, was admitted on [DATE]. According to the June 2026 CPO, diagnoses included traumatic brain injury (TBI), adjustment disorder with mixed mood and depressed mood, chronic obstructive pulmonary disorder (COPD - lung disease), and emotional lability. The 5/7/26 MDS assessment revealed Resident #79 had severe cognitive impairment with a BIMS score of four out of 15. Resident #79 was dependent on staff for most of his ADLs. B. Facility investigation The facility's investigation was provided by the NHA on 6/9/26 and revealed the following: On 5/14/26 certified nurse aide (CNA) #10 reported to the DON that he saw Resident #79 performing oral sex on his guardian in Resident #79's bathroom on 5/1/26. The investigation documented CNA #10 was afraid to report it because Resident #79's guardian had seen that it was him who saw them. He said the guardian knew what vehicle he drove and was afraid of retaliation from the guardian. The investigation documented CNA #10 thought it was okay because the guardian and Resident #79 were dating. The investigation documented CNA #10 saw a change in Resident #79's behavior after the incident. CNA #10 said the resident would push his guardian away or pull away from his guardian and had increased agitation when his guardian was around. The investigation documented that the social services director (SSD) and social services assistant #2 met with Resident #79 on 5/14/26. They asked him if his guardian ever touched him, and Resident #79 said Yes. They asked Resident #79 to demonstrate using his hand to show them where his guardian would touch him. Resident #79 used his right hand and placed it outside of his pants on his penis and groin area and stated like this. They asked Resident #79 if it was okay for his guardian to touch his penis and Resident #79 stated No. They asked Resident #79 if his guardian had ever placed his mouth on his penis and Resident #79 stated No. They asked Resident #79 if his guardian ever asked him to place his mouth on his guardian's penis and Resident #79 stated No. The investigation documented a capacity for sexual consent assessment was done on 5/14/26. The assessment documented that Resident #79 had a BIMS score of four which meant he had severe cognitive impairment and a TBI. The assessment documented that Resident #79 did not want his penis touched by his guardian. The assessment documented that Resident #79 could say no, but struggled with reasoning. It documented that Resident #79 confused his wants and needs based on the expectations of others. The assessment documented that if Resident #79 did not want to be touched, he would make statements that justified why he allowed it. The investigation documented a meeting with the SSD, the DON, the assistant director of nursing (ADON) and Resident #79's guardian on 5/15/26. The investigation documented they met with Resident #79's guardian to discuss the newly implemented supervised visitation policy during the duration of the investigation. They explained to the guardian that an allegation of sexual abuse was made. They said until the investigation was completed and he was deemed safe to be alone with Resident #79, he was only allowed to meet with Resident #79 in the dining room or on the front patio, both being supervised areas. The investigation documented Resident #79's guardian got visibly upset and yelled that he cared for Resident #79 and he would never do such a thing and that they did not want him there for Resident #79 like the other places! The investigation documented that Resident #79's guardian was getting more aggressive and was warned that if he continued to behave in an aggressive manner, they would have to ask him to leave. It documented that Resident #79's guardian then abruptly got up and began to walk towards Resident #79's room. The SSD, the DON and the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADON followed him for supervision and safety. The guardian then started to yell at Resident #79 and said I can't see you anymore because of them, you know why, someone said I had you in the bathroom and you were sucking my dick! Management intervened right away, telling the guardian that it was inappropriate and asked him to leave. He then forcefully removed his hat from Resident #79's head and told him, You won't see me ever again. He then left the building accompanied by the ADON. The DON and the SSD stayed with Resident #79 and assessed his psychological and social well-being. The investigation summary documented that a staff member witnessed Resident #79 and his guardian in the bathroom. The guardian was having oral sex performed on him by Resident #79. Resident #79 was deemed unable to give sexual consent per assessment. Resident #79 continued to make his needs known. He was able to move on his own throughout the facility and able to make decisions within his day-to-day life. Due to his TBI, his mentation fluctuated and at times resembled that of a young child. Resident #79 called everyone mom and dad. The court was notified and guardianship was immediately suspended. Resident #79 still wanted contact with his guardian and it was explained to both Resident #79 and his guardian that visits were to be supervised. The investigation documented that the courts appointed a temporary guardian. The investigation documented that all staff were made aware that if Resident #79's guardian came to visit, the visit was to be supervised. All staff were retrained on reportable occurrences and the SSD would continue to monitor Resident #79's psychological and social well-being. -However, the incident was not reported to the State Agency until 5/14/26, 13 days after CNA #10 witnessed the incident. C. Staff interviews CNA #10 was interviewed on 6/10/26 at 10:08 a.m. CNA #10 said that on 5/1/26 he was looking for Resident #79 for his restorative program. He said it was close to lunch time and the only reason he looked in the bathroom was because he knew Resident #79 was beginning to be able to take himself to the toilet. He said he knocked and opened the door and he saw the guardian on the toilet with his pants all the way down and Resident #79 was in his wheelchair performing oral sex on his guardian. He said he quickly closed the door and apologized. He said Resident #79 seemed willing to do it. He said he had heard that Resident #79 and his guardian were a couple from management. He said he told the abuse coordinator, who was the DON. He said he only told her because Resident #79 began to behave differently. He said he saw Resident #79 getting aggressive and pushing his guardian away the rest of that day (5/1/26). He said he did go on vacation that week and when he got back the following week was when he told the DON. He said Resident #79's birthday was during the week that he got back from vacation and he had wished Resident #79 a happy birthday and his guardian did not know it was Resident #79's birthday. He said the fact that his guardian did not know Resident #79's birthday, mixed with the fact that Resident #79 was pushing his guardian away, prompted him to tell the DON about the incident. He said he did get immediate education on reporting abuse the day that he told the DON. The DON and regional clinical resource #1 were interviewed together on 6/11/26 at 9:19 a.m. The DON said that she had been the abuse coordinator for the facility for two years. She said she would soon be sharing the role with the NHA. She said she was aware that Resident #79 and his guardian had a romantic relationship prior to the resident living at the facility. She said she did immediate training with CNA #10 about abuse and reporting. She said that the facility recently had training with all staff on abuse. She said she was planning to touch on abuse in their monthly meetings with staff. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Resident #74 A. Resident status Resident #74, age [AGE], was admitted on [DATE]. According to the June 2026 CPO, diagnoses included hemiplegia (a form of paralysis that causes the complete or partial loss of voluntary muscle movement on one side of the body), vascular dementia, aphasia (a neurological language disorder that impairs a person's ability to communicate, speak, read, or write), and hypertension (high blood pressure). The 4/8/26 MDS assessment revealed Resident #74 had severe cognitive impairments with a BIMS score of three out of 15. Resident #74 was dependent upon staff for upper and lower body dressing, personal hygiene, rolling left and right in bed and transferring. The assessment revealed Resident #74 did not have verbal or physical behaviors directed toward others. B. Resident interview Resident #74 was interviewed on 6/10/26 at 4:50 p.m. Resident #74 said Resident #123 had given her a bruise. C. Record review Review of the facility's investigation report timeline revealed CNA #2 worked on 3/7/26 at about 4:00 p.m. and noticed a bruise on Resident #74's face and reported it to the nurse. According to the investigation, CNA #2 was the first staff member to report the bruise. Review of the State Agency reporting portal revealed the facility reported the incident on 3/9/26. The report documented the incident occurred on 3/8/26. -However, the facility's investigation revealed the bruise was noted by CNA #2 on 3/7/26 at approximately 4:00 p.m. -The facility failed to report the injury of unknown origin to the State Agency until 3/9/26, over 24 hours after the bruise was noticed. D. Staff interviews CNA #2 was interviewed on 6/11/26 at 12:56 p.m. CNA #2 said she asked Resident #74 how she got the bruise (on 3/7/26). CNA #2 said the resident did not say anything, and just looked at CNA #2. CNA #2 said she did not want to press Resident #74 further regarding how she got the bruise. CNA #2 said she reported the bruise to the nurse right after talking to Resident #74. The DON was interviewed on 6/11/26 at 7:48 p.m. The DON said Resident #74's facial bruise was of unknown origin at the time CNA #2 reported it to the nurse. The DON said after she spoke to the regional consultant, she was under the impression that it could be reported within 24 hours as there was no immediate harm or death. The DON said the facility initiated the investigation, but did not report to the State Agency until the next day. The DON said she made these decisions based on the direction of her previous consultant.