

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the main kitchen and dishroom. Specifically, the facility failed to ensure:-Staff used proper hand hygiene during meal service;-Food was held at the correct temperature;-Kitchen was maintained, in good repair to be able to have a cleanable surface.Findings include: I. Failed to ensure dietary staff performed appropriate hand hygiene during meal serviceA. Professional referenceThe Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 6/17/26. It revealed in pertinent part, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; using tobacco products, eating, or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. (2-301.15)B. Facility policy and procedureThe Handwashing/Hand Hygiene policy and procedure, revised December 2025, was provided by the nursing home administrator (NHA) on 6/11/26 at 3:38 p.m. It read in pertinent part, Hand hygiene is indicated before touching a resident, before preparing or handling food, medications, or parenteral solutions, before clean or aseptic procedures, before moving from on a soiled body site to a clean body site on the same resident, after exposure to blood, body fluids, excretions, or contaminated surfaces, after touching a resident, after touching the resident's environment or belongings, after glove removal, and whenever hands are visibly soiled. Wash hands with soap and water when hands are visibly soiled with blood or body fluids, before eating and after using the restroom, after contact with a resident with infectious diarrhea The use of gloves does not substitute for hand hygiene. Always perform hand hygiene after gloves are removed.C. ObservationsDuring a continuous observation on 6/9/26, beginning at 4:59 p.m. and ending at 5:55 p.m. the following was observed during meal service in the main kitchen:At 5:03 p.m. cook #2 took off his gloves and did not wash his hands before putting on a new pair of gloves. At 5:03 p.m. cook #2 made a bacon, lettuce and tomato (BLT) sandwich wearing gloves, he then dropped french fries into the fryer and took off his gloves he did not wash his hands before putting new gloves on. At 5:16 p.m. cook #2 made a grilled cheese sandwich wearing gloves, he then took his gloves off and put new gloves on without washing his hands in between. At 5:23 p.m. cook #2 changed the song on his cell phone that was sitting on the counter playing music, with his gloved right pinky. He did not change his (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	gloves after touching his phone. At 5:30 p.m. cook #1 wrote down the food temperatures in the temperature binder. He did not wash his hands afterwards. He then went to the food service line and began meal service. At 5:30 p.m. cook #2 opened a drawer with his right gloved hand, he closed the drawer with the same hand then put a piece of sliced cheese on to a burger with the same hand. At 5:32 p.m. cook #2 changed his gloves and did not wash his hands in between. D. Staff interviews The dietary manager (DM) was interviewed on 6/11/26 at 11:28 a.m. He said he expected his staff to wash their hands any time they changed tasks and when they changed their gloves. II. Failure to hold food at the correct temperature A. Professional reference The Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 6/17/26. It revealed in pertinent part, Time/Temperature control for safety food, hot and cold holding at 135 degrees F (farenehit) or higher and 41 degrees F and lower. (Chapter 3) B. Facility policy and procedure The Food Receiving and Storage policy and procedure, revised November 2022, was provided by the NHA on 6/11/26 at 3:38 p.m. It read in pertinent part, The Danger Zone means temperatures above 41 degrees Fahrenheit and below 135 degrees Fahrenheit that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. Potentially hazardous food and time/temperature control for safety foods are stored at or below 41 degrees Fahrenheit, unless otherwise specified by law. C. Observations During a continuous observation on 6/9/26, beginning at 4:59 p.m. and ending at 5:55 p.m. the following was observed during meal service in the main kitchen: At 5:03 p.m. cook #2 made a BLT sandwich. CK #2 left containers of sliced lettuce, sliced tomato, and sliced onion by the meal service table. On another prep table close to the grill there was sliced cheese, shredded lettuce, shredded cheese, hard boiled eggs, and turkey sandwich meat. -The items were not on ice, and continued to be used during meal service. At 5:52 p.m. cook #2 took the temperature of the food items: -The sliced lettuce was 60 degrees F.-The sliced tomatoes were 60 degrees F.-The sliced onion was 59 degrees F.-The shredded cheese was 53 degrees F.-The hard boiled eggs were 63.1 degrees F.-The turkey lunch meat was 56.1 degrees F.-The shredded lettuce was 48.9 degrees F. D. Staff interviews The DM and the registered dietitian (RD) were interviewed together on 6/11/26 at 11:28 a.m. The RD said that they threw all the food away that had been left out during the meal service on 6/9/26. The DM said they normally stored those items on ice during meal service. He said that cook #2 must had forgotten that evening. He said that there was a risk of people getting sick if the food was not held at the correct temperature. III. Failed to ensure the main kitchen was maintained, in good repair to be able to have a cleanable surface. A. Professional reference The Colorado Department of Public Health and Environment Colorado Retail Food Establishment Rules and Regulations, revised 3/16/24, was retrieved on 6/17/26. It revealed in pertinent part, Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials Floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable. Equipment, food-contact surfaces and utensils shall be clean to sight and touch. (Chapter 4, 5 and 6) B. Facility policy and procedure The Kitchen Sanitization policy and procedure, revised November 2022, was provided by the NHA on 6/11/26 at 3:38 p.m. It read in pertinent part, All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seam, cracks, and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners are kept in good repair. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. C. Observations During the initial tour of the kitchen on 6/8/26 at 8:15 a.m. the following was observed: -The floor under the steam tables had several holes that were approximately one foot by three inches and (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	gouges in the floor. -The floor in the dishroom had several holes, chips and large gouges to count, missing from the floor. There was also a large crack that ran from under the dishwasher to the other side of the dishroom.-The window above a food preparation table had a window-mounted air conditioner. The portion over the air conditioner had a piece of fiberglass, being held in place with red duct tape. However, the red tape was coming loose and air was coming in from a hole due to the fiberglass not being flush with the window. There was a piece of cardboard on the other side of the window. Dust and debris were covering the inside of the window, which was directly above the food preparation table.-In the dry storage, there were two large plastic containers on wheels that held flour. The outside of the containers were visibly dirty, with stains and residue from the flour on the outside. The scoops used to scoop the contents out were hanging on the outside of the plastic container by a hook. The scoops were open to air and had residue from the flour on the scoops. During a follow-up visit to the kitchen on 6/9/26 at 4:59 p.m., the window had the same piece of cardboard and the tape was peeling and air was coming in directly from the window, and the dust and cobwebs were there. The preparation table directly underneath the window was being used and had food items sitting on the table. During another follow-up visit to the kitchen on 6/11/26 at 11:28 a.m., the window had the same piece of cardboard, the tape holding the fiberglass was peeling, there was air coming in from the outside and dust and debris covered the inside of the window. In the dry storage area the two plastic containers on wheels with flour were visibly dirty and there was residue on the scoops. D. Staff interviewsThe DM and the RD were interviewed together on 6/11/26 at 11:28 a.m. The DM said that maintenance and the administration were aware of the floor. He said they were coming up with a plan to fix the floor. He said he was not sure of the timeline. He said the air conditioner was recently moved to that window. He said that the taped fiberglass had blown in during a recent storm and that there was a lot of dust and cotton from the cottonwood trees outside. He said the cardboard was in the window to block the sun when the cooks were using the preparation table. He said he would clean the dust and debris from the window. He said that he cleaned the outside of the bins of flour once a month. He said that he had pouches ordered for the scoops but the hooks for them were backordered.		

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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 procedure The 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 interviews Resident #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 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 (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview Certified 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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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to ensure prompt efforts by the facility to resolve grievances the resident may have for one (#33) of two out of 55 sample residents Specifically, the facility failed to make prompt efforts to resolve Resident #33's grievances. Findings include: I. Facility policy and procedure The Grievances/Complaints, Recording and Investigating policy, revised April 2017, was provided by the nursing home administrator (NHA) on 6/11/26 at 4:11 p.m. It read in pertinent part, All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievances. Upon receiving a grievance and complaint report, the grievance officer will begin an investigation into the allegations. The department director will be notified of the nature of the complaint and that an investigation is underway. The grievance officer will record and maintain all grievances and complaints on the Resident Grievance Complaint Log. The Resident Grievance/Complaint Investigation Report Form will be filed with the administrator within five working days of the incident. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within (a blank that was not filled in by the facility) working days of the filing of the grievance or complaint. -The policy failed to have a specific time frame on when the grievance needed to be completed. II. Resident #33A. Resident status Resident #33, age greater than 65, was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included major depressive disorder and type 2 diabetes. The 5/21/26 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. B. Resident #33 interview Resident #33 was interviewed on 6/10/26 at 11:49 a.m. Resident #33 said that several months ago, there were several grievances that were filled out and he did not feel they were addressed. C. Record review A grievance form for Resident #33 was provided by the NHA on 6/9/26 at 3:52 p.m. The grievance form was completed by the assistant director of nursing (ADON) on 5/11/26. The grievance form indicated Resident #33 felt a nurse was not administering all of his medications and did not talk to him. The grievance form documented that the resolution was The grievance form resolution identified that the named nurse was contacted by the director of nursing (DON) on 5/12/26 and that Resident #33 was encouraged to notify management immediately if a similar situation were to occur. The grievance form read the resolution must be reviewed with the grievant and had a line for the grievant to sign upon agreeing with the resolution. -There was no signature from Resident #33, indicating the resolution was not reviewed with or approved by Resident #33. D. Staff interviews Regional clinical resource #2 was interviewed on 6/11/26 at 2:28 p.m. Regional clinical resource #2 said when a grievance was written, it went to the department it pertained to. Regional clinical resource #2 said the NHA was also alerted and would disperse to the appropriate departments. Regional clinical resource #2 said the facility changed the entire grievance policy, process, and grievance form itself recently. Regional clinical resource #2 said the facility discussed the new changes in a QAPI meeting in May 2026. Regional clinical resource #2 said there were a lot of components to the grievance process change and they started a log on 6/3/26. Regional clinical resource #2 said for a grievance form to be considered resolved, the grievant should have signed it. -However, Resident #33 did not have a signature of resolution on the grievance form. The director of nursing (DON) was interviewed on 6/11/26 at 3:15 p.m. The DON said the grievance process included meeting with the resident to find out what the concern was, and filling out the grievance form (continued on next page)		

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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 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1599 Ingalls St Lakewood, CO 80214	
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	avoid LPN #8 whenever she saw him in the facility. C. Record review 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 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 (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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NAME OF PROVIDER OR SUPPLIER Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1599 Ingalls St Lakewood, CO 80214	
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure all drugs and biologicals were properly stored, secured, and labeled in accordance with accepted professional standards in two of two medication carts and two of two medication rooms. Specifically, the facility failed to ensure:-Residents' medications were labeled and dated appropriately with the resident's name and the date the medication was opened; and, -Loose medications were not in the medication carts. Findings include:I. Facility policy and procedureThe Medication Labeling and Storage policy, revised February 2023, was provided by the nursing home administrator (NHA) on [DATE] at 2:05 p.m. It read in pertinent part, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning to or destroying these items. Multi-dose vials that have been opened or accessed (needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.II. ObservationsOn [DATE] at 9:48 a.m. the medication cart on the Broadway unit was observed with registered nurse (RN) #2. The following items were observed:There was one fluticasone propionate 50 microgram (mcg) per actuation (mcg/act) nasal spray bottle stored in an appropriately labeled medication box.-However, the medication bottle inside the box was not labelled with the resident's name or the date the medication was opened for Resident #90. There was one oxycodone (pain medication) 100 milligram (mg) per 5 milliliter (ml) oral suspension bottle stored in an appropriately labeled medication box.-However, the individual medication bottle inside the box was not labelled with the resident's name or the date the medication was opened for Resident #28. There was one small, white round pill found on the bottom of the narcotic drawer (see staff interview below). The pill had a capital M printed on one side and a number two printed on the other side. There was a medication cup with one yellow tablet in the narcotic drawer. There was no name or date on the medication cup (see staff interview below). On [DATE] at 10:01 a.m. the medication room on the Broadway unit was observed with RN #2. The following item was found:An uncovered medication cup labeled Tylenol 500 mg, which contained 27 tablets. There was no expiration date or open date on the cup. On [DATE] at 10:14 a.m. the Main unit medication room was observed with licensed practical nurse (LPN) #5. The following items were found:One Ozempic 2mg/3ml injector pen stored in an appropriately labeled medication box.-However, the individual injector pen inside the box was not labelled with the resident's name or the date the medication was opened for Resident #33. One accessed multi-dose Tuberculin (Tb) purified protein derivative (PPD) 5 Tb units (TU)/0.1ml vial stored in an appropriately labeled medication box.-However, the multi-dose vial inside the box was not labeled with the date the medication was opened. On [DATE] 11:26 a.m. the Swing unit medication cart was observed with LPN #4. The following item was found:One mometasone furoate-formoterol fumarate dihydrate (Dulera) 100-5 mcg/act aerosol inhaler stored in an appropriately labeled medication box.-However, the individual inhaler device inside the box was not labelled with the resident's name or the date the medication was opened for Resident #7.III. Staff interviewsRN #2 was interviewed on [DATE] at 9:48 a.m. RN #2 said Resident #90's nasal spray medication had been discontinued, and she said she was not sure how long a discontinued medication should have remained in the medication cart for. RN #2 said it (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1599 Ingalls St Lakewood, CO 80214	
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was important to ensure the medication bottle was labeled inside its medication box in order to prevent medication errors if the box became lost or damaged. RN #2 removed Resident #90's discontinued medication from the medication cart and placed it in the medication room. RN #2 identified the loose small, white pill in the bottom of the narcotic drawer as Resident #107's Dilaudid medication. She said the resident received three pills per dose, and one of the pills must not have been administered to the resident at some point. RN #2 said the unlabeled medication cup had been prepared for Resident #105. She said the yellow tablet was a Clonazepam 0.5 mg tablet. RN #2 said Resident #105 had been recently removed from nothing by mouth (NPO) status, and she was about to administer the medication. She said it was best practice to label the medication cup with the resident's name if she was not immediately administering the medication. RN #2 was interviewed again on [DATE] at 10:01 a.m. RN #2 said she knew it was wrong to have a medication cup with tablets in the medication storage area. She said she thought a nurse noticed there were only 500 mg Tylenol capsules on the unit, so they brought 500 mg Tylenol tablets to the medication room for the residents who could not take capsules. RN #2 said the tablets should have been covered because it was an infection control issue. RN #2 used a marker to label the identified items in her medication cart and medication room with the residents' names and the dates the medications were opened. LPN #5 was interviewed on [DATE] at 10:14 a.m. LPN #5 said it was important to make sure the individual injector pen was labeled with the resident's name to prevent medication errors if its box became damaged or lost. LPN #5 said the multi-use TB vial was opened, and she did not know what date it was opened. She said it was important to ensure the vial was labeled because multi-use vials were only good for 30 days after it was opened. LPN #5 said a TB vial should not be administered after its best-by date. LPN #5 used a marker to label the identified items in her medication cart and medication room with the residents' names and the dates the medications were opened. LPN #4 was interviewed on [DATE] at 11:26 a.m. LPN #4 said it was important to make sure the inhaler device was labeled inside the box to prevent medication mix ups if the box was lost. LPN #4 used a marker to label the identified items in her medication cart and medication room with the residents' names and the dates the medications were opened. The director of nursing (DON) and regional clinical resource (RCR) #1 were interviewed together on [DATE] at 3:35 p.m. The DON said the individual medication bottles should have been labeled inside their respective medication boxes so the medications did not get mixed up, and so the nursing staff could practice the rights of medication administration. RCR #1 said it prevented staff from documenting that a medication was unavailable because they could not find it. The DON said she would not have expected to find a medication cup with Tylenol tablets in the medication room. She said the facility had plenty of bottles that could have been dated with the open date and to ensure it really was Tylenol being administered from that medication cup. The DON said she would not have expected to see a loose Dilaudid pill or a pre-dispensed clonazepam tablet in an unlabelled medication cup. She said loose pills in the medication cart could be difficult to identify and she would expect her nursing staff to dispose of the medication when it was discovered. The DON said if the nurse could identify who the pill belonged to she would expect them to notify the physician and let them know there was a potential for missing a pill in a dose. The DON said a multi-use vial of TB was typically good for 28 days after opening, but she would have had to review the manufacturer's recommendations for the best-by date. She said if an expired vial had an unknown efficiency and could have created false positive results.		

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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 observation and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infections. Specifically the facility failed to:-Ensure proper infection control practices, including enhanced barrier precautions, were followed during wound care;-Ensure proper hand hygiene during medication administration; and,-Ensure dwell times were followed during the disinfection process of the vital sign tower and resident glucometer. Findings include: I. Wound care 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), (4/2/24), retrieved on 6/16/26, from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high-contact resident care activities. EBP may be indicated for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO. B. Facility policy and procedure The Enhanced Barrier Precautions policy, revised August 2022, was provided by the nursing home administrator (NHA) on 4/9/26 at 4:42 p.m. It read in pertinent part, Enhanced barrier precautions (EBP) are used as an infection prevention and control intervention to reduce the spread of multidrug-resistant organisms (MDRO) to residents. EBP employs targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP 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). (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
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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 Wound Care policy, revised April 2026, was provided by the nursing home administrator (NHA) on 6/11/26 at 4:22 p.m. It read in pertinent part, The purpose of this procedure is to provide guidelines for the care of wounds to provide healing. Equipment and supplies: Dressing material, as indicated such as gauze, tape, and scissors; clean drape; cleaning solution, personal protective equipment such as gowns, gloves, mask as needed. Steps in the procedure: perform hand hygiene; establish a clean field on resident's overbed table, place all items to be used during the procedure on the clean field; place disposable cloth next to the resident to protect the bed linen and other body sites, put on exam gloves; pull one glove over the dressing and discard into appropriate receptacle, remove the second glove; and perform hand hygiene. To clean the wound: Apply clean gloves; place a piece of gauze over the wound, leaving the margins of intact skin exposed; clean the area around the wound usually covered by the dressing, tape, or gauze with antiseptic or soap and water; remove dry gauze from the wound; clean and apply treatments as ordered; apply appropriate dressing, mark tape with initials, date and time and apply to dressing. C. Observations On 6/9/26 at 10:05 a.m. registered nurse (RN) #3 was providing wound care to Resident #4. RN #3 had already begun the dressing change when the observation began. RN #3 was wearing a mask and gloves for the dressing change. The treatment cart was in the resident's room with supplies scattered directly on top of the cart. -RN #3 failed to follow EBP during wound care and failed to have dressing supplies on a clean surface. RN #3 was applied a border dressing to the resident's leg wound. RN #3 then covered the resident with her blankets when finished. -There was no barrier pad under the resident leg to provide a clean working surface. RN #3 cleared the treatment cart of all supplies placing them into a red trash can in the resident's room. RN #3 locked his cart and completed hand hygiene with soap and water. RN #3 left the resident room with the treatment cart. At 10:12 a.m. RN #3 took the cart down the hall to Resident #60's room. RN #3 spoke to the resident and advised he was there to complete her wound care. He began to set up supplies for the residents' gluteal fold and sacrum wound. RN #3 took out one border dressing and one border foam dressing, opened the packaged, dated and initialed them and placed them directly on top of the treatment cart. -RN #3 failed to disinfect the treatment cart or create a clean barrier prior to placing supplies on top (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1599 Ingalls St Lakewood, CO 80214	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the treatment cart. RN #3 sanitized his hands with alcohol based hand rub (ABHR), then applied gloves. He went to the resident's bed and touched the bed control to lay the head of the bed down and raise it to a good working height. RN #3 returned to his treatment cart and opened the top drawer, he opened multiple drawers with gloves on. RN #3 pulled a stack of gauze from the drawer and while he held them, sprayed them with wound cleanser, he then placed them directly onto the bedside table. -RN #3 failed to sanitize the bed side table or apply a barrier pad prior to placing gauze on the bedside table. RN #3 pulled the sheets back from the resident and noticed the resident had a bowel movement and needed to be cleaned up prior to him completing the dressing. RN #3 said he needed to get a certified nurse aide (CNA) to clean the resident up. He locked the cart and pressed the call light. Walking out of Resident #60's room he ran into an unidentified CNA and asked her to clean the resident up. RN #3 said he would return to Resident #60's room once the resident was ready. At 10:20 a.m. RN #3 took the treatment cart to Resident #28's room. -RN #3 failed to disinfect the treatment cart between resident rooms. RN #3 performed hand hygiene with ABHR and applied gloves. RN #3 opened the treatment cart touching the keys from his pocket. He pulled out gauze from a bulk pack in a lower drawer, applied wound cleanser to the gauze and placed it directly onto the resident's bed sheet. -RN #3 failed to place the gauze on a clean working surface. RN #3 removed the old dressing from the resident. He wiped the wound with the gauze that was on the resident's bed. RN #3 completed picture images of the wound. RN #3 returned to the treatment cart, opened the drawers and collected supplies. RN #3 took out a package of collagen (specialized wound treatment) and a border foam dressing. He removed his gloves, applied new ones without performing hand hygiene, took a marker out of pocket to sign and date the new dressing. -RN #3 failed to perform hand hygiene between gloves changes. RN #3 returned to the resident bed placing supplies on to his bed. He opened packages that were on the resident's bed, tore a piece of the collagen off with his hands and applied it to the wound bed, and covered the wound with the bordered foam dressing. -RN #3 failed to place supplies on a clean working surface. RN #3 said the dressing was complete at 10:27 a.m. (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 left Resident #28's room with the treatment cart and returned to Resident #60's room. He entered Resident #60's room with the entire treatment cart. -RN #3 failed to disinfect the treatment cart between rooms. RN #3 washed his hands with soap and water. He raised Resident #60's bed. RN #3 used a X to prepare to take pictures of the residents' wounds. He applied gloves and used his keys to open the treatment cart. RN #3 collected the stickers needed for measurement taken from the top drawer of the treatment cart. He also collected bulk gauze from the drawer and sprayed it with a wound cleanser in his hand. He then went to the resident's bed and positioned the resident in order to take a picture of the right gluteal fold wound. The electronic device used for picture measurements touched the resident bed during the picture process. RN #3 took the gauze and placed it on the resident's bed. -RN #3 failed to have a clean working area for supplies. RN #3 removed his gloves, performed hand hygiene with ABHR and applied new gloves. RN #3 opened several drawers on the treatment cart and collected more gauze, which he sprayed with wound cleanser, then placed the gauze directly onto the top of the treatment cart. RN #3 then pulled out a package of collagen and two border foam dressing. RN #3 opened the dressing and pulled out a maker to initial and date them. He took all of the items to the resident's bed and placed them directly onto the resident bed. -RN #3 failed to place dressing supplies on a clean working surface. RN #3 started with the right gluteal fold wound, cleansed with gauze, he tore open the collagen package and ripped a piece off and applied it to the wound bed. RN #3 then covered the wound with a border foam dressing. RN #3 removed his gloves and applied new ones. -RN #3 failed to perform hand hygiene between glove changes. RN #3 moved to resident's sacral wound. RN #3 took gauze from the supply on the bed, dabbed the wound three times with the same piece of gauze then folded the piece of gauze over and dabbed three more times. -RN #3 failed to clean the wound in a hygienic manner. He packed the wound with collagen and covered it with border foam dressing. RN #3 cleared all trash from the area. Removed his gloves and performed hand hygiene with ABHR. He left Resident #60's room with the treatment cart. RN #3 took the cart into another resident room after completing Resident #60's treatment. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Staff interviews RN #3 was interviewed on 3/11/26 at 10:41 a.m. RN #3 said he had been in the position of wound care nurse for about a month and the facility had assisted him in taking a nine hour training for wound care. RN #3 said he was instructed by the staff development coordinator to apply a mask, gown and gloves only if a resident had a history of having a multi drug resistant organism (MDRO). RN #3 said if the resident did not have a history of MDRO, he just needed to wear gloves for dressing changes. RN #3 said hand sanitization should be done with ABHR or soap and water after every glove change and between residents. He said this was to prevent contamination or infection. RN #3 said he was not aware he failed to perform hand hygiene between all glove changes during wound care observation. RN #3 said his supervisor told him to take the treatment cart with him to every room to ensure he had all the supplies needed for a treatment with him but the supervisor did not tell him to take the cart into the room. RN #3 said he took the cart into the resident's room in order to cut down on walking back and forth to the cart if he missed a supply or needed more supplies while in the resident's room. RN #3 said he wiped down the treatment cart with a disinfectant wipe at the beginning of his shift and at the end of his shift. RN #3 said he did not do it in between resident rooms but would start in the future as it could lead to infection since it was going into multiple resident rooms throughout his shift. RN #3 said he should disinfect the resident's bed side table prior to placing supplies on them or he could use the top of the treatment cart to place supplies. He said supplies should not be placed on the resident's bed or a surface that had not been disinfected. He said the area should be disinfected to prevent the spread of bacteria/infections. RN #3 said supplies that touched a surface that had not been disinfected should be replaced with new supplies. The director of nursing (DON), who was also the infection preventionist, was interviewed on 6/11/26 at 1:15 p.m. The DON said the wound care nurse should wear gloves and a gown during wound care. The DON said other PPE such as a mask and goggles would depend on the type of wound. The DON said gloves should be changed in between wound care. She said the PPE and the glove changes were in place to prevent the spread of infection. The DON said the wound care nurse should clean and sanitize the work area, usually the resident's bedside table, and place a barrier on the work station. The DON said the nurse then should take the needed supplies into the room and place the supplies on the barrier. She said it was not protocol to place supplies on the resident's bed especially if there was no barrier. The DON said the cart should be left at the doorway and if the cart was taken to the room the whole cart would need to be sanitized every time it left a room and before entering the next room. II. Failed to ensure hand hygiene was performed appropriately between residents A. Facility policy and procedure The Handwashing/Hand Hygiene policy, revised December 2025, was provided by the NHA on 6/11/26 at 2:05 p.m. It read in pertinent part, Hand hygiene is the primary means for preventing (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	healthcare-associated infections (HAI) and the transmission of multidrug-resistant organisms (MDRO). This facility requires strict adherence to evidence-based hand hygiene practices for all personnel. Hand hygiene is indicated: before touching a resident; before preparing or handling food, medications or parenteral solutions; before clean or aseptic procedures (for example, before wound care or inserting an intravenous catheter); before moving from work on a soiled body site to a clean body site on the same resident; after exposure to blood, body fluids, excretions or contaminated surfaces; after touching a resident; after touching the resident's environment or belongings; after glove removal; and, whenever hands are visibly soiled. Applying alcohol-based hand rubs: apply a generous amount of product to the palm of one hand and rub your hands together. Follow manufacturers' directions for volume of product to use; and, rub hands together for at least 20 seconds, covering all surfaces of the hands and fingers until the hands are dry. B. Observation During a continuous observation of medication administration on 6/9/26, starting at 4:08 p.m. and ending at 4:23 p.m., the following was observed: At 4:13 p.m. licensed practical nurse (LPN) #2 administered medications to Resident #107. At 4:15 p.m. LPN #2 knocked on Resident #122's door and prepared to measure the resident's blood glucose (sugar) level. -However, LPN #2 did not perform hand hygiene after exiting Resident #107's room and before she entered Resident #122's room. C. Staff interviews LPN #2 was interviewed on 6/9/26 at 4:15 p.m. LPN #2 said she thought she had performed hand hygiene after she exited Resident #107's room. She said it was important to perform hand hygiene between residents to prevent the cross contamination of pathogens between residents. The DON was interviewed on 6/11/26 at 3:35 p.m. The DON said indications for hand hygiene during the medication administration process included before entering the resident's room, after exiting the resident's room and between cares. She said it was important to perform hand hygiene between residents to prevent the spread of infection. III. Failed to ensure staff disinfected the vital signs equipment and glucometers appropriately between residents A. Professional reference (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 6/16/26 from https://www.journalofhospitalinfection.com/article/S0195-6701(21)00105-5/fulltext. It revealed in pertinent part, High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment. According to Super Sani-Cloth Germicidal Disposal Wipe, PDI, (2018), retrieved on 6/16/26 from https://pdihc.com/wp-content/uploads/2018/08/Super-Sani-Cloth-Tech-Data-Bulletin_0619-UPDATE_0716861 Super Sani-Cloth germicidal disposable wipe is a premoistened, nonwoven durable wipe containing a quaternary ammonium chloride/alcohol based solution. Recommended for use in hospitals and other critical care areas where the control of the hazards of cross-contamination between treated surfaces is required. Some organisms are removed from the surface by thoroughly wiping the surface with the wipe. Most remaining organisms are killed within two minutes by exposure to the liquid in the wipe. B. Observations On 6/9/26 at 4:15 p.m. LPN #2 was measuring Resident #122's blood glucose level during medication administration. LPN #2 gathered blood sugar test supplies from the medication cart, knocked on Resident #122's door and identified the resident. LPN #2 donned (put on) gloves and measured the resident's blood sugar. After measuring Resident #122's blood sugar, LPN #2 threw away the trash, doffed (removed) her gloves and performed hand hygiene with hand sanitizer upon exiting the room. Once she returned to the medication cart, LPN #2 unlocked the cart, removed the Super Sani-Cloth wipes and wiped the resident's personal glucometer for less than ten seconds. -LPN #2 did not allow the surfaces of Resident #122's glucometer to remain wet with the Super Sani-Cloth wipe for the recommended two minute dwell time (see professional reference above) before she returned the glucometer to the medication cart. On 6/10/26 at 8:43 a.m. RN #1 donned gloves and used the Super Sani-Cloth wipes to disinfect the blood pressure cuff and pulse oximeter (a non-invasive medical device that clips onto a fingertip to measure the oxygen saturation in your blood) device. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN #1 finished wiping the surfaces of the blood pressure cuff and pulse oximeter device at 8:43 a.m. -RN #1 did not allow the surfaces of the vital signs equipment to remain wet with the Super Sani-Cloth wipe for the recommended two minute dwell time (see professional reference above). C. Staff interviews LPN #2 was interviewed on 6/9/26 at 4:23 p.m. LPN #2 said she did not know what the chemical dwell time was. She opened the bottom drawer of the medication cart, looked at the container and said it was two minutes. She said it was important to follow chemical dwell times to properly disinfect and clean germs from the device. RN #1 was interviewed on 6/10/26 at 9:10 a.m. RN #1 said he did not know what the chemical dwell time was. RN #1 walked to the nurse's station, looked at the container and said the chemical dwell time was two minutes. He said it was important to disinfect the equipment properly to kill pathogens and prevent cross contamination between residents. The DON was interviewed on 6/11/26 at 3:35 p.m. The DON said after measuring a resident's blood glucose, the nursing staff should disinfect the glucometer using the Super Sani-Cloth wipes. She said the wipes had a two minute chemical dwell time, which meant all surfaces of the glucometer and the vital signs equipment should have remained wet for two minutes. The DON said it was important to follow the chemical dwell time to prevent the spread of infection between residents.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review, observations and interviews, the facility failed to ensure prompt action was taken upon the filing of a grievance of a group. Specifically, the facility failed to ensure resident complaints expressed during the resident council meetings were documented on a grievance and resolved to the residents satisfaction. Findings include: I. Facility policy and procedure The Grievances/Complaints, Recording and Investigating policy, revised April 2017, was provided by the nursing home administrator (NHA) on 6/11/26 at 4:11 p.m. It read in pertinent part, All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievances. Upon receiving a grievance and complaint report, the grievance officer will begin an investigation into the allegations. The department director will be notified of the nature of the complaint and that an investigation is underway. The grievance officer will record and maintain all grievances and complaints on the Resident Grievance Complaint Log. The Resident Grievance/Complaint Investigation Report Form will be filed with the administrator within five working days of the incident. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within (a blank that was not filled in by the facility) working days of the filing of the grievance or complaint. The policy failed to have a specific time frame on when the grievance needed to be completed. II. Resident group interview Five residents (#19, #33, #44, #93 and #108) who were identified by the facility and assessment as interviewable, were interviewed together as a group on 6/10/26 at 11:49 a.m. The residents in the group confirmed there were grievances brought up in the resident council meeting. They said they were not informed of how it was resolved. The residents said they did not get a response from the grievance official. The group said there had been several grievances that had been filled out and did not get addressed. The group said when they had problems, they had to keep complaining until someone did something. III. Resident council minutes The April 2026 resident council minutes documented a concern was brought up that there were not enough washcloths. The minutes documented a resident was missing a robe, and another resident had a concern and wanted to talk to someone in person after the meeting. The 5/26/26 resident council minutes documented a concern related to privacy curtains, and complaint about transition service. The 5/26/26 resident council minutes documented, Minutes from previous meeting read and approved. Although no information was documented on the resolution from the April 2026 resident council grievances. A request was made for the grievances related to the April 2026 and May 2026 resident council concerns. They were not provided during the survey. D. Staff interviews The activity director (AD) was interviewed on 6/11/26 at 4:50 p.m. The AD said he was present during the resident council meetings and that he took notes for the council. He said the resident council met monthly. He said he invited the residents and put the announcement on the calendar. The AD said the department heads attended the meeting. He said he had not written any grievances from the complaints received in the April 2026 and May 2026 council meetings. The AD said he did not follow up with the resident who wished to talk privately, he thought nursing followed up with him. The social work consultant was interviewed on 6/11/26 at 5:45 p.m. The social work consultant said there were no grievances found from the April 2026 and May 2026 resident council meetings. E. Facility follow-up On 6/11/26 at 7:06 p.m. the social work consultant said she would review the grievance policy and updated it as needed.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#56) of six residents were free from abuse out of 55 sample residents. Specifically, the facility failed to:-Protect Resident #56 from verbal abuse by licensed practical nurse (LPN) #8; and,-Removed LPN #8 from Resident #56's care following the incident of verbal abuse.Findings include:I. Facility policy and procedureThe Resident 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, Each resident must have the right to be free from physical, mental or sexual abuse, neglect, corporal punishment, involuntary seclusion, and any physical restraints. 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. Incident of verbal abuse by LPN #8 towards Resident #56 on 7/9/25A. Grievance form 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, 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, 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 other than the staff development coordinator's. There was no indication on the grievance that a resolution had been made. -However, LPN #8 continued to be Resident #56's assigned nurse for the next nine months (see record review below). Cross-reference F585: failure to resolve grievances. B. Resident #561. Resident statusResident #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). 2. Resident interviewResident #56 was interviewed on 6/8/26 at 3:17 p.m. She said approximately eight to nine months ago 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 ok 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 sees him in the facility. C. Record reviewThe trauma-informed care plan, revised 5/5/26, revealed Resident #56 had been the victim of domestic abuse both physical and emotional with previous partners. Pertinent interventions included (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offering mental health services as needed and monitoring for signs and symptoms of depression. -Review of Resident #56's electronic medical record (EMR) did not reveal the facility provided the resident with psychological-social follow-up or monitor the resident for ongoing psychological-social changes, such as crying, after the incident of verbal abuse on 7/9/25. Review of the medication administration record (MAR) from 7/12/25 to 4/18/26 revealed LPN #8 administered medications to Resident #56 on 118 days following the verbal abuse incident on 7/9/25. Resident #56's patient health questionnaire-9 (PHQ-9) (a standardized questionnaire to screen, diagnose, and measure depression) score rose from zero in September 2025 to five in November 2025, indicating an increase in depression. D. Staff interviewsThe staff development coordinator was interviewed on 6/10/26 at 4:49 p.m. She 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 nurse's station that morning (7/9/25) she saw that LPN #8 was about a foot away 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 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 to 90 day trial and that the resident was ok with the plan. -However, there was no documentation of the conversation with Resident #56 and Resident #56 requested to not have LPN #8 work with her any longer (see record review and resident interview above). The scheduler was interviewed on 6/10/26 at 5:09 p.m. She said she had only been in the scheduler role since May 2026. She said she worked as a certified nurse aide at the facility before she took the scheduler role. She said she had heard that Resident #56 had requested that LPN #8 no longer work on her hall. She said she was still being trained so she did not have much to do with the situation. She said she tried to accommodate the needs of the residents as best she can. The social services director (SDD) and social services assistant #2 were interviewed together on 6/10/26 at 6:50 p.m. The SDD said she was not aware of the situation between LPN #8 and Resident #56. Social services assistant #2 said she had heard about the situation and was told that the nurse (LPN #8) was going to moved from her hall. Social services assistant #2 said there was no follow-up with the resident after the incident on 7/9/25. Social services assistant #2 said she thought everything was taken care of following the incident.The director of nursing (DON) and the regional clinical resource #1 were interviewed together on 6/11/26 at 9:19 a.m. The DON said she was aware of 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 prior to 6/11/26 and if she had seen it before she would have opened an investigation of verbal abuse. Cross-reference F609: failure to report alleged abuse.		

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NAME OF PROVIDER OR SUPPLIER Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1599 Ingalls St Lakewood, CO 80214	
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and observations, the facility failed to ensure two (#13 and #79) of two residents out of 55 sample residents received treatment and care in accordance with professional standards of practice. Specifically, the facility failed to:-Administer the correct dose of medication and accurately chart administration times for Resident #13; and, -Ensure Resident #79's medications were available for administration.Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2021), E. [NAME], St. Louis Missouri, pp. 607-609. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: The right medication The right dose The right patient The right route The right time The right documentation The right indication Right medication: When preparing medication from bottles or containers, compare the label of the medication container with the MAR (medication administration record). Right documentation: Nurses and other health care providers use documentation to communicate with one another. Many medication errors result from inaccurate documentation. Therefore, always document medication accurately at the time of administration and identify any inaccurate documentation before you give medications. II. Facility policy and procedure The Administering Medications Policy was provided by the nursing home administrator (NHA) on 6/11/26 at 4:22 p.m. The policy read in pertinent part, (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route), of administration before giving the medication. When opening a multi-dose container, the date opened is recorded on the container. III. Resident #13 A. Resident status Resident #13, age less than 65, was admitted to the facility 8/20/24. According to the June 2026 computerized physician orders (CPO), diagnoses included hyperkeratosis of the feet (a thickening of the skin's outer layer caused by an overproduction of keratin, a tough, protective protein), chronic pain and contractures related to rheumatoid arthritis. The 5/21/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. Resident #13 was dependent on staff for dressing, hygiene, rolling in bed, and transferring. The assessment identified that Resident #13 had a limited range of motion and impairments in all extremities. The assessment identified that Resident #13 had pain almost constantly and had scheduled and PRN (as needed) pain medications. B. Resident interview and observations Resident #13 was interviewed on 6/8/26 at 4:34 p.m. Resident #13 said the staff were not always putting cream on her feet as ordered. Resident #13 said when the staff did put the cream on her feet, it helped her dry feet feel better. During the interview, Resident #13's had thick yellow and white crusts covering the soles of both feet. Resident #13 said it had been months since the staff put the cream on her feet. D. Record review Resident #13's skin integrity care plan, initiated 8/22/24 and revised on 3/30/26, revealed Resident #13 had potential for impairment to skin integrity related to mobility limitations, contractures, weakness, discomfort, and incontinence of bowel and bladder. Pertinent interventions included to keep skin clean and dry and to use lotion on dry skin as needed. Review of Resident #13's June 2026 CPO revealed the following physician's orders: Urea External Cream 40% (Urea). Apply to soles of bilateral feet topically two times a day for hyperkeratosis. The order started on 11/11/25. Resident #13's medication administration record (MAR) revealed that RN #3 charted that Resident #13's Urea 40% foot cream was administered on 6/9/26 at 4:06 p.m. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, observations revealed RN #3 did not administer the Urea 40% foot cream to Resident #13 (see observations above). D. Observation and staff interview On 6/9/26 at 4:10 p.m. registered nurse (RN) #3 was administered Resident #13's medications. RN #3 did not administer Resident #13's Urea 40% foot cream. RN #3 was interviewed on 6/9/26 at 4:35 p.m. during medication administration. RN #3 said they were going to administer the Urea cream, but had not yet. RN #3 said Resident #13 should have Urea cream available. RN #3 looked in his medication cart and could not find the cream. RN #3 searched for the cream in a separate cart. RN #3 found the Urea cream in the second cart. RN #3 said Resident #13's order was for 40% Urea cream. The container held 20% Urea cream. RN #3 said Resident #13's order was to apply the cream twice daily. The Urea cream container had Resident #13's name written on it in black marker. The container was PurOrganica 20% Urea cream, which held 4 ounces (oz) total. The container had a date written in black marker which read 9/27/25. RN #3 said the date was the date the medication was first opened. RN #3 said the Urea cream was supposed to be applied to Resident #13's feet. RN #3 said the container was 20% Urea cream but the order was for 40% Urea cream. RN #3 said he would tell the nurses to pay closer attention to the physician's orders. RN #3 said he would call the pharmacy and request for them to deliver the correct dose of medication. RN #3 called the pharmacy at 4:49 p.m. RN #3 said the pharmacy said the insurance did not approve the 40% cream. RN #3 said he would let the director of nursing (DON) know, so that she could overnight the correct cream from online. RN #3 changed his charting on the MAR from given to not given. RN #3 said he changed his charting and wrote a note that explained why he did not give the medication. E. Additional interviews Pharmacist #2 was interviewed on 6/11/26 at 1:06 p.m. Pharmacist #2 said the purpose of the Urea 40% cream was to help with severe dry skin. Pharmacist #2 said the cream was used to shed the top layer of skin and get rid of calluses which promotes normal healing of the skin and help keep the layers of skin softer. Pharmacist #2 said the 20% urea cream would not be as effective as the ordered 40% cream, because it was half the strength of what Resident #13 should have been getting. Pharmacist #2 said if Resident #13 was receiving 20% and not 40% urea cream, it would not be as effective, the treatment duration could last longer. Pharmacist #2 said the facility must have been obtaining the cream from an outside source because the pharmacy never dispensed the medication for Resident #13. Pharmacist #2 said the facility had never requested a dose of the medication from the pharmacy. The director of nursing (DON) was interviewed on 6/11/26 at 6:48 p.m. The DON said the five rights of medication administration were the right resident, right drug, right route, right dose and right time. The DON said she had overnight ordered the correct dose of 40% Urea cream from online and had given the cream to the nurse to administer by the next morning at 9:00 a.m. The DON said she had been (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordering the cream online. The DON said that staff were supposed to let her know when there were only a few applications of cream left so she could re-order the creams. The DON said she ordered two extra creams this time, so when she gave a nurse the last bottle she would know it was time to re-order. IV. Resident #79 A. Resident status Resident #79, age less than 65, was admitted on [DATE]. According to the June 2026 CPO, diagnoses included diffuse traumatic brain injury, chronic obstructive pulmonary disease (COPD - a progressive, incurable lung disease that restricts airflow and makes breathing difficult) and chronic respiratory failure with hypoxia (lack of oxygen in the blood). The 5/7/26 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of four out of 15. He was dependent on staff for toileting, showering and lower body dressing. He required partial/moderate assistance with repositioning and personal hygiene. B. Record review Review of Resident #79's CPO revealed the following physician's order: Sodium chloride (saline) nasal solution 0.65 percent (%). Two sprays in both nostrils two times a day for nasal congestion, ordered 10/31/25. C. Observation and staff interview On 6/11/26 at 8:46 a.m. licensed practical nurse (LPN) #4 was administering medications to Resident #79. LPN #4 labeled a medication cup with the resident's name and began dispensing medications. She said Resident #79's nasal spray was not in the medication cart, and she would have to go downstairs to get a replacement bottle for administration. At 8:53 a.m. LPN #4 administered the medications. -However, LPN #4 did not pause the administration process to try to obtain a replacement bottle, send a message or ask for help to ensure the medication was available to administer. D. Staff interviews LPN #4 was interviewed on 6/11/26 at 12:44 p.m. LPN #4 said she did not administer Resident #79's nasal spray medication and the resident missed the dose. She said she went downstairs after she finished administering the resident her medications, but she did not see a replacement bottle down (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there. LPN #4 said if she did not administer the medication on time and tried to give it later, then it would be too close to the next dose and could potentially have a negative impact on the resident. The DON was interviewed on 6/11/26 at 3:35 p.m. The DON said she would have expected the nurse to pause and obtain the medication to administer immediately. She said the facility had nasal spray medication bottles in stock. The DON said she would educate the nurse to replace an over-the-counter medication when the last of it was used so it would be replaced for the next shift. She said the nursing staff were expected to notify the physician about missed or late administrations of medications due to unavailability.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#8) of four residents received treatment and care in accordance with professional standards of practice out of 55 sample residents. Specifically, the facility failed to obtain physician's orders for Resident #8's wound in a timely manner. Findings include: I. Resident #8A. Resident status Resident #8, age [AGE], was admitted on [DATE]. According to the June 2026 computerized physician's orders (CPO), diagnoses included type 2 diabetes mellitus with diabetic neuropathy and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. The 5/7/26 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident was dependent on staff for upper and lower body dressing, bed mobility and transfers. B. Resident interview and observation On 6/9/26 at 9:45 a.m. Resident #8 was lying in bed with a dressing on his right lower forearm, dated 6/8/26. On his left forearm there was elastic wrap (type of wound dressing) around his arm that was not dated. Resident #8 said he was not exactly sure how the right forearm wound happened, but believed he bumped it on the side table. He said a nurse saw it yesterday (6/8/26) and put the dressing on it. Resident #8 said he remembered the nurse putting the elastic bandage on his left forearm, but was unsure the reason it was there. On 6/10/26 at 2:00 p.m. Resident #8 lying in bed with the same dressing on his right lower forearm, dated 6/8/26. The elastic wrap remained on his left arm, undated. Resident #8 said his right arm had not been addressed since the dressing was placed on 6/8/26 and the left arm dressing had not been done in a few days. C. Record review A progress note, dated 6/4/26 at 5:56 p.m., revealed wound rounds were completed that day. Resident #8 was seen by the wound care team and the note revealed the following orders were recommended: provide treatment to the left abrasion with abdominal pad (medical dressing), Kerlix (wound dressing), and elastic wrap daily and as needed (PRN).-However, review of the June 2026 CPO did not reveal the order from the wound rounds completed on 6/4/26 were entered into the resident's electronic medical record (EMR). A progress note with an effective date of 6/8/26 at 6:11 p.m. was created on 6/10/26 at 2:14 p.m., (during the survey) revealed Resident #8 had a skin tear to the right forearm. The wound was cleansed with wound cleanser and medihoney (sterilized honey used in wound care) was applied.-However, review of the EMR on 6/8/26 revealed there was no physician's order for wound cleanser or medihoney for the right forearm. A progress note, dated 6/10/26 at 12:55 p.m., revealed the interdisciplinary team (IDT) discussed the new skin tear to the right distal forearm. Resident #8 was evaluated by the wound care team and placed on wound care rounds. A progress note, dated 6/10/26 at 2:53 p.m., revealed the new order for the left arm included abdominal pad, Kerlix and elastic bandage. -However, the orders were recommended by the wound care physician on 6/4/26, six days prior. A progress note, dated 6/10/26 at 3:19 p.m., revealed the wound to the left arm was treated per the current wound care physician's orders. A progress note dated 6/10/26 at 3:28 p.m. revealed the skin tear to Resident #8's right arm was cleaned with wound cleanser, medihoney and a bandage was applied. The treatment administration record (TAR) was updated to reflect the treatment orders.-However, the facility failed to timely enter and obtain the physician's orders for the treatment of the wound care for three days after the skin tear occurred. A progress note, dated 6/10/26 at 4:57 p.m., revealed the skin issue on Resident #8's right lateral wrist had not been evaluated. There was partial flap loss. The wound was acquired in-house on 6/8/26. The skin tear on the left elbow with partial flap loss. The wound was acquired in-house on 6/4/26. Review of the June 2026 CPO revealed the following physician's (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1599 Ingalls St Lakewood, CO 80214	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders:Left arm abrasion was to be clean with wound cleanser, pat dry and apply skin prep every day for left upper extremity edema, dated 5/23/26, discontinued date 6/10/26.Clean the left arm abrasion with wound cleanser, pat dry, apply abdominal pad, Kerlix, and and an elastic bandage every day, dated 6/11/26-The facility failed to update the physician's orders in the resident's EMR for seven days after the wound care physician recommended a change.Cleanse skin tear to right arm with wound cleanser, apply medihoney and cover with a bandage every day, dated 6/11/26.-The facility failed to obtain wound care orders for the right arm wound for four days after the skin tear was identified.-Review of Resident #8's comprehensive care plan did not reveal interventions related to the resident's skin issues. D. Staff interviewsLicensed practical nurse (LPN) #2 was interviewed on 6/10/26 at 1:30 p.m. She said she saw the skin tear on Resident #8's right arm on 6/8/26 and put a dressing on the wound at that time. She said when a skin tear was identified, the nurse should complete a change of condition notification, notify the physician for further orders, and notify the wound team for an assessment of the skin tear. LPN #2 said there was a change of condition in Resident's #8 record and thought it was for the skin tear she discovered on 6/8/26, however the change of condition was for another issue. LPN #2 said the left arm was wrapped in the elastic wrap because he had edema in the left arm and fluid was seeping out. She said there was not a wound and the wrap did not need to be changed daily. -However, Resident #8 had a wound on his arm and the orders were changed to reflect the new wound care orders (see record review above).Registered nurse (RN) #3 was interviewed at 2:15 p.m. He said he was not aware of the elastic wrap on Resident #8's arm or the skin tear on Resident #8's right arm. RN #3 said he had observed Resident #8's arms prior to the interview. He said the bandage underneath the elastic bandage was not dated or initialed. RN #3 and LPN #2 were interviewed together at 2:30 p.m. RN #3 said according to the Resident #8's physician's order Resident #8 should not have an elastic wrap and the wound should not be covered. He said he read through the orders and said the treatment on Resident #8's arm was not correct. LPN #2 said she saw an email from the wound care physician with new recommendations for the left arm after on 6/4/26. She said the order was not entered into the EMR.-However, LPN #2 said earlier the left arm did not have a wound and the elastic wrap was placed for Resident #8's edema. See interview above.RN #3 said when there was a new skin issue the identifying nurse should contact the physician for orders, complete a change of condition assessment and notify the wound care team in order. RN #3 said the wound care team assessed new skin issues immediately and relied on the physician's orders to proceed with treatment. RN #3 said the wound care team then recommended if a resident would need to be followed by the wound care physician. RN #3 said the wound care physician rounded on Thursdays with RN # 1 (another wound care nurse). RN #3 said the wound care physician made recommendations and sent the recommendations to the facility. RN #3 said RN #1 entered the wound care physician's orders into the resident's CPO for the nurses to follow. RN #3 said the physician's orders for Resident #8's left arm were missed on 6/4/26 and not entered 6/10/26. The director of nursing (DON) was interviewed on 6/10/26 at 5:40 p.m. The DON said if a new skin tear was identified she expected the nurse to make a note in the risk management that would alert staff members to a change in a resident's condition. The DON said the physician and responsible party should be notified. The DON said the physician would give orders for the nurses to follow until the wound care team can assess. The DON said the bandages should be dated and initialed by the staff providing the care.		

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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 (#7) of two residents reviewed for ancillary services of 55 sample residents. Specifically, the facility failed to ensure Resident #7 received follow-up from the audiologist. Findings include: I. Resident #7A. Resident status Resident #7, age less than 65, was admitted [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included major depressive disorder, hemiplegia (weakness) and hemiparesis (paralysis) following cerebral infarction (stroke), type 2 diabetes mellitus, epilepsy, generalized anxiety disorder and chronic pain syndrome. The 4/8/26 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 dependent on staff for toileting, showering, dressing and transferring between surfaces. The 4/8/26 MDS assessment also revealed the resident used hearing aids. B. Resident interview and observations Resident #7 was interviewed on 6/8/26 at 2:29 p.m. Resident #7 said her hearing aids stopped working about two to four weeks ago, but the audiologist had not been there to see her. Resident #7 was interviewed again on 6/9/26 at 10:59 a.m. Resident #7 said she was able to put her hearing aids in her ears independently and the battery functions properly, but they did not connect or work the way they should. On 6/10/26 at 10:30 a.m. Resident #7 said her hearing aids were still not functioning properly. C. Record review Review of Resident #7's June 2026 CPO revealed the following physician's order: May have Dental, Podiatry, Ophthalmology, Audiology Consults, ordered 12/17/24. Review of Resident #7's progress notes revealed the following documentation: On 2/16/26 at 6:57 p.m. a healthcare practitioner's note documented Resident #7 stated she just received hearing aids on 2/11/26 and she was not happy with them. The note documented the resident had bilateral hearing loss. On 6/10/26 at 4:01 p.m. (during the survey) social services assistant #1 documented this writer sent an email to the audiologist in regard to the resident's hearing aids not working properly. The social services team and the NHA were notified. On 6/11/26 at 6:18 p.m. (during the survey) a social services note documented the audiologist would see the resident on 6/15/26. The resident has been notified. The resident would have a hearing aid check for repair. The 4/10/26 audiology note documented the resident was fit to 80 percent (%) of prescriptive gain based on their hearing loss; the resident was instructed on the proper insertion and removal of hearing aids; a charging case was placed in the resident's room; and, connected aids through the myPhonak app and in bluetooth for media streaming. The resident was able to stream a phone call and media through both hearing aids. Follow up in one month for necessary adjustments. -However, Resident #7 did not receive follow up for approximately two months after the concern was identified. -Review of Resident #7's comprehensive care plan, initiated 10/10/19, did not reveal a person centered care plan for the resident's bilateral hearing loss or hearing aids. III. Staff interviews Certified nurse aide (CNA) #1, CNA #3 and CNA #5 were interviewed together on 6/10/26 at 12:10 p.m. All three CNA staff members said if there was a change in ancillary devices, such as new hearing aids, they would become aware because the nurse would let them know and it was documented in the care plan. The CNAs said they reported any problems with hearing aids to the nurse and an appointment was made for them to be seen. All three CNA staff members said they were unaware that Resident #7 used hearing aids. Registered nurse (RN) #1 was interviewed on 6/10/26 at 2:48 p.m. RN #1 said a change in ancillary services, such as new hearing aids, would be reported to social services and documented in the progress notes. He said the audiologist came to the facility once per month - someone in social (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1599 Ingalls St Lakewood, CO 80214	
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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services was responsible for setting up the residents' appointments. RN #1 said he thought Resident #7 used to use hearing aids, but he did not want to give misinformation. The social services director (SSD) was interviewed on 6/10/26 at 3:05 p.m. The SSD said Resident #7 had always used hearing aids, and she was able to put them in her ears and remove them independently. She said Resident #7 let her know her hearing aids were not working very well, and she said she would get with social services assistant #1 on this. The SSD said audiology was currently going to the facility monthly but was not coming in June 2026. She said the potential negative impact of the resident's hearing aids functioning improperly was the inability to understand, communicate and feeling uncomfortable. Social services assistant #1 was interviewed on 6/10/26 at 3:31 p.m. Social services assistant #1 said she knew that Resident #7's hearing aids were not functioning properly, and she became aware when the resident notified her last month. She said the audiologist was at the facility in May but Resident #7 was not on the list to be seen. Social services assistant #1 said she was responsible for scheduling and coordinating ancillary services and audiology should have had her on the list to be seen in May 2026. She said the audiologist was scheduled to return to the facility in July, but she would see if any audiologists could come to see Resident #7 this month. The SSD was interviewed again on 6/11/26 at 11:39 a.m. The SSD said the audiologist was coming to the facility tomorrow for Resident #7's hearing aids. The director of nursing (DON) was interviewed on 6/11/26 at 3:35 p.m. The DON said the SSD and social services assistant #1 communicated with the ancillary staff to schedule appointments. She said she never knew Resident #7 to complain about her hearing. The DON said properly functioning hearing aids were important not only for the understanding, but so the resident can be involved in conversation, hear correctly and have the confidence that she understood what was being communicated.		

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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 observations, record review and interviews, the facility failed to ensure an environment free from risk of accidents and hazards for two (#55 and #93) of seven residents reviewed for accident hazards out of 55 sample residents. Specifically, the facility failed to:-Ensure Resident #55 was not vaping in the dining room near other residents wearing oxygen; and, -Implement a smoking care plan to ensure safe smoking habits for Resident #93. Finding include: I. Facility policy and procedure The Smoking policy, revised October 2023, was provided by the nursing home administrator (NHA) on 6/11/26 at 3:38 p.m. It read in pertinent part: Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Smoking is not allowed inside the facility under any circumstances. Electronic cigarettes and smokeless tobacco are permitted in designated areas only. The staff consults with the attending physician and director of nursing services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. A resident's ability to smoke safely is re-evaluated quarterly, upon significant change (physical or cognitive) and as determined by the staff. Any smoking-related privilege, restrictions, and concerns are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. II. Resident #55 A. Resident status Resident #55, age less than 65, was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included Wernicke's encephalopathy (acute life-threatening neurological disorder caused by severe deficiency of thiamine), major depressive disorder, emphysema, and nicotine dependence. The 3/26/26 minimum data set (MDS) assessment revealed Resident #55 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. The assessment revealed Resident #55 was independent with most of his activities of daily living (ADL). (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1599 Ingalls St Lakewood, CO 80214	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment indicated he used tobacco. B. Observations On 6/9/26 at 12:40 p.m. Resident #55 was sitting at a table in the dining room. He was sitting at a table with three unidentified residents. The resident on his right was using oxygen via nasal cannula. Resident #55 took a puff off of his e-cigarette. On 6/9/26 at 12:46 p.m. Resident #55 remained at the table with the three other unidentified residents and took another puff off of his C. Record review The smoking care plan, initiated 3/31/25, documented Resident #55 was a safe smoker and was educated on the facility's smoking policy. The care plan documented Resident #55 was able to light his own cigarette, discard ashes appropriately and was able to keep lighter and smoking materials at his bedside. The care plan documented he was able to smoke unsupervised -The care plan did not address the resident's e-cigarette use until 6/9/26 (during the survey). On 6/9/26 (during the survey) Resident #55's care plan was updated to include that he was seen using e-cigarettes in the dining room. The care plan documented education was provided to the resident about the dangers and consequences involved with vaping inside the building. Resident #55 was put on a behavioral achievement plan directed towards routine safety and compliance with the smoking policy. He was put on supervised smoking and would be re-evaluated for unsupervised smoking at the end of two weeks. Review of Resident #55's electronic medical record (EMR) revealed a Smokers Code of Conduct signed by the resident on 5/14/26. Review of Resident #55's EMR revealed a Smokers Code of Conduct signed by the resident on 6/9/26 (during the survey process). D. Staff interviews The NHA was interviewed on 6/9/26 at 12:50 p.m. He said Resident #55 admitted to vaping at the dining room table. He said when he first started in May 2026, he had the social services department review all the residents that smoked and go over the code of conduct with all of them. He said Resident #55 was recently educated on the smoking code of conduct (see above record review). The dietary manager (DM) was interviewed on 6/9/26 at 12:59 p.m. He said he had never seen residents smoking in the dining room before. He said if he was to see it, he would report it immediately to the director of nursing (DON) or the NHA. He said smoking inside was an issue, because there could be people who were allergic to smoke or people could have a hard time breathing. He said it was also a concern because some residents were on oxygen. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dietary aide #1 was interviewed on 6/9/26 at 1:01 p.m. She said she had not seen residents smoking in the dining room before. She said if she were to see it she would report it to her supervisor. She said smoking in the dining room could cause issues for other residents who should be around smoke and for people on oxygen. The assistant director of nursing (ADON) was interviewed on 6/9/26 at 1:33 p.m. He said cigarette smoking inside was not allowed. He said that e-cigarettes and regular cigarettes were treated the same way. He said if a resident was caught smoking inside they were immediately educated, and they would be put on supervised smoking. He said people who were on oxygen should not be smoking with their oxygen on or be around people who are smoking. He said oxygen was an accelerant. He said he had not seen any residents smoking inside, but he had caught residents right after they were smoking inside. He said he had never heard of Resident #55 smoking inside. He said that if a certified nurse aide (CNA) or nurse caught a resident smoking inside they would report it to him, the DON, or the NHA. The DON was interviewed on 6/9/26 at 2:36 p.m. She said Resident #55 had never smoked inside before. She said he had always smoked cigarettes and he had always been really good about going outside and smoking. She said this was the first time she had heard of him having an e-cigarette. III. Resident #93 A. Resident status Resident #93, age less than 65, was admitted on [DATE]. According to the June 2026 CPO, medical diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting the left non-dominant side, dysphagia (difficulty swallowing) and vascular dementia (a decline in thinking and memory skills caused by restricted or blocked blood flow to the brain). The 5/14/26 MDS assessment revealed the resident was moderately cognitively intact with a BIMS score of 12 out of 15. She required substantial/maximal assistance with activities of daily living (ADL) including showering, dressing, toileting and transferring between surfaces. B. Resident interview Resident #93 was interviewed on 6/8/26 at 9:35 a.m. Resident #93 said she smoked sometimes, but she knew she should not do that. C. Record review Review of the facility's smoking list, dated 5/28/26, revealed Resident #93 had been identified as a smoker. Review of Resident #93's progress notes revealed the following documentation: On 8/5/25 at 3:34 p.m. a health care practitioner's note documented Resident #93 reported smoking marijuana recently. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/25 at 4:27 p.m. a nursing progress note documented Resident #93 smoked marijuana periodically. On 12/17/25 at 3:32 p.m. a health care practitioner's note documented Resident #93 stated today she planned to start smoking marijuana again. On 3/17/26 at 10:24 a.m. a physician's progress note documented Resident #93 was reported smoking marijuana last week. The note documented the resident had a history of marijuana use including smoking and taking edibles. The note documented Resident #93 reported using while in the facility. -Review of Resident #93's electronic medical record (EMR) did not reveal a smoking evaluation was completed at the time of the survey. Review of Resident #93's smoking care plan, initiated 6/10/26, revealed the resident continued to enjoy smoking. Resident #93 smoked/vaped intermittently, was a safe smoker with staff setup, and had been educated regarding the facility's smoking policy. Pertinent interventions included instructing the resident about smoking risks and hazards, and about smoking cessation aids that were available; instructing the resident about the facility's policy on smoking: locations, times and safety concerns; Resident #93 could smoke/vape unsupervised after staff setup; Resident #93 was able to: discard ashes appropriately and discard cigarette butts; Resident #93's smoking supplies were stored in the nurse's medication cart as she desired to have them. Resident #93 required staff setup for lighter use related to decreased dexterity (the ability to perform physical actions with the hands) with her diagnosis of hemiplegia; notifying the charge nurse immediately if it was suspected the resident had violated the facility's smoking policy; and, observing clothing and skin for signs of cigarette burns. -However, the smoking care plan was not initiated and the resident was not identified as a supervised or unsupervised smoker until the survey. D. Staff interviews CNA #3 was interviewed on 6/10/26 at 2:00 p.m. CNA #3 said she knew if a resident could smoke supervised or unsupervised, because it would be documented on the 24-hour report. She said the 24-hour report was updated daily with any changes. CNA #3 said the residents' smoking status should be documented on the care plan, but she said she knew it was always on the 24-hour report. She said Resident #93 was an independent smoker, but she was not sure if that was documented on Resident #93's care plan. Registered nurse (RN) #1 was interviewed on 6/10/26 at 2:48 p.m. RN #1 said most of the residents at the facility were supervised smokers, but it depended on the resident. He said there was a list at every nurse's station that documented which resident was a supervised or independent smoker, and social services probably documented that information in the residents' care plan. RN #1 said social services evaluated who was safe to smoke independently and who was not. He said Resident #93 did not really smoke. RN #1 said he did not know if she was an independent smoker and he did not know where the list that documented who his supervised smoking residents was. He said he did not know if Resident #93 had a smoking care plan in place. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1599 Ingalls St Lakewood, CO 80214	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social services director (SSD) and social services assistant #2 were interviewed together on 6/10/26 at 3:05 p.m. Social services assistant #2 said the social services team was responsible for conducting smoking evaluations if the resident indicated that they smoked on admission to the facility. She said if a resident changed their mind and started smoking after admission, the nursing staff needed to alert social services that a smoking evaluation needed to be completed, or sometimes the nursing staff completed the assessment themselves. Social services assistant #2 said the smoking evaluation should be completed before the smoking care plan was initiated, and the nursing staff documented the smoking care plans. She said Resident #93 was an independent smoker, but she did not smoke all the time. Social services assistant #2 said she would have to check Resident #93's care plan to see if the smoking care plan or smoking evaluation was documented. The SSD and social services assistant #2 said it was important to ensure there was a smoking evaluation and smoking care plan in place to ensure resident safety, and in order for the staff to know if the resident was safe to smoke. The DON and regional clinical resource #1 were interviewed together on 6/11/26 at 3:35 p.m. The DON said the SSD performed smoking evaluations on admission, and it was documented in the EMR and in the quarterly MDS evaluations. The DON said she was responsible for completing the smoking evaluations as part of the quarterly evaluations. She said the resident's smoking status should be documented in the care plan. The DON said Resident #93 needed help lighting a cigarette but was able to smoke independently when she did rarely smoke. She said she would have to look in Resident #93's care plan to see if a smoking care plan was documented. The DON said the resident should have a smoking care plan even if the resident smoked intermittently. Regional clinical resource #1 said the smoking care plan was updated on 6/10/26, during the survey.		

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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 ensure two (#53, and #70) of four residents who required respiratory care received care consistent with professional standards of practice out of 55 total sample residents. Specifically, the facility failed to:-Ensure Resident #53 and Resident #70's oxygen flow rate was set per physician's order; and,-Ensure Resident #70's oxygen concentrator was functioning. Findings include:I. Resident #53 A. Resident statusResident #53, age greater than 65, was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and dependence on supplemental oxygen (O2).The 5/20/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident was independent with all her activities of daily living (ADL). The MDS assessment indicated Resident #53 was receiving oxygen therapy.B. ObservationsResident #53 was interviewed on 6/8/26 at 1:20 p.m. Resident #53 was lying on her bed and she was wearing a nasal cannula. There was an oxygen concentrator next to her bed. She was receiving 2.5 liters per minute (LPM) via a nasal cannula.Resident #53 said she received 3 LPM oxygen therapy via a nasal cannula. She said she only had to use oxygen when she was in bed and the oxygen therapy was not continuous. She said she had a hard time breathing when she was laying down. She said her oxygen flow on the oxygen concentrator was set to 2.5 LPM. She said her oxygen concentrator should be set to 3 LPM. At 4:39 p.m. Resident #53 was sleeping in her bed. She was wearing the oxygen and it was set to 2.5 LPM.-However, Resident #53's physician's order indicated the oxygen flow rate was supposed to be 3 LPM (see record review below).C. Record reviewReview of the June 2026 CPO revealed the following physician's orders:-Oxygen therapy at 3 LPM per nasal cannula when in bed, ordered on 4/1/26.-However, observations revealed Resident #53's oxygen was not administered per physician orders (see observations above). The oxygen care plan, revised 5/25/26, revealed the resident had oxygen therapy. The care plan revealed she had the potential for altered respiratory pattern due to inability to maintain an effective airway clearance, related to diagnoses of COPD, emphysema, chronic hypoxic respiratory failure. Pertinent interventions included administering oxygen as ordered. Review of the June 2026 medication administration record (MAR) revealed nursing staff were documenting and signing off that Resident #53 was receiving oxygen at 3 LPM. -However, observations revealed Resident #53's oxygen concentrator was set to 2.5 LPM (see observations above). E. Staff interviewsCertified nurse aide (CNA) #7 was interviewed on 6/8/26 at 1:28 p.m. CNA #7 said Resident #53 received 3 LPM oxygen through a nasal cannula. He said Resident #53 only used oxygen when she was lying in her bed. Licensed practical nurse (LPN) #6 was interviewed on 6/10/26 at 10:10 a.m. She said Resident #53 was receiving 3 LPM oxygen via nasal cannula when she was lying down. She said the concentrator were programmed and they would go back to their programmed setting if it was turned off then back on. She said nurses should check the concentrator setting daily to ensure the ordered O2 therapy was followed. She said Resident #53's oxygen flow should be set to 3 LPM.The director of nursing (DON) was interviewed on 6/11/26 at 11:34 a.m. The DON said Resident #53 would reset her oxygen concentrator especially after her smoke break. She said Resident #53's tendency to adjust her own O2 concentrator flow was not mentioned in the care plan, but the facility would correct that. II. Resident #70A. Resident statusResident #70, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2026 CPO, diagnoses included chronic respiratory failure, chronic diastolic heart failure, (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1599 Ingalls St Lakewood, CO 80214	
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unspecified asthma, obstructive sleep apnea, and dependence on supplemental oxygen The 5/21/26 MDS assessment revealed the resident was cognitively intact for a BIMS score of 15 out of 15. The resident needed assistance with toileting, dressing, bathing, transfers, and mobility. The MDS assessment indicated Resident #70 was receiving oxygen therapy.B. ObservationsOn 6/8/26 at 11:58 a.m. Resident #70's the oxygen flow meter on the concentrator was moving between 6.5 to 8 LPM.At 2:57 p.m. Resident #70's the oxygen flow meter on the concentrator was fluctuating between 6 to 8 LPM.On 6/9/26 8:30 a.m Resident #70's the oxygen flow meter on the concentrator was fluctuating between 6 to 7.5 LPM.At 10:17 a.m. Resident #70's the oxygen flow meter on the concentrator was fluctuating between 6 to 7.5 LPM.At 3:28 p.m. Resident #70's the oxygen flow meter was fluctuating between 6 to 7.5 LPM.On 6/10/26 at 3:47 p.m. Resident #70's the oxygen flow meter was fluctuating between 6 to 7.5 LPM.On 6/11/26 at 10:21 a.m. Resident #70's the oxygen flow meter was fluctuating between 6.5 to 7.5 LPM.C. Record reviewA review of Resident #70's June 2026 CPO revealed the following physician's orders:-Humidified oxygen at 6 LPM continuously per nasal cannula. Ordered on 1/3/26. Review of the oxygen care plan, revised 9/12/26, revealed the resident had the potential for an ineffective respiratory pattern due to need of oxygen therapy, secondary to diagnosis of chronic hypoxic respiratory failure, asthma, seasonal allergies, and obesity hypoventilation syndrome. Pertinent interventions were following the oxygen orders and observing oxygen precautions. Review of the June 2026 medication administration record (MAR) revealed nursing staff were documenting and signing off that Resident #70 was receiving oxygen at 6 LPM. -However, observations revealed Resident #'s 70 oxygen concentration was not administered on a steady 6 LPM flow (see observations above). D. Resident interviewResident #70 was interviewed on 6/9/26 at 3:26 p.m. She said staff have never mentioned that her respirator was broken and that the flow meter ball was fluctuating. She said staff did not checking the flow setting on the concentrator since it was in the bathroom and they always forgot. She said that the oxygen supply company maintained the concentrator once a week. E. Staff interviewsCNA#3 was interviewed on 6/10/26 at 9:11 a.m. CNA #3 said she attempted to read the flow setting. She said she could not tell the flow rate as the flow meter was going up and down. She said the flow meter showed 6.5 LPM. She said the flow meter showed 7.6 LPM a second later. LPN #6 was interviewed on 6/10/26 at 10:10 a.m. She said Resident #70 was receiving 6 LPM. She said it was the nurses responsibility to check the oxygen concentrator to ensure the concentrator was set correctly. LPN #3 was interviewed on 6/10/26 at 11:00 a.m. LPN #3 said staff did not check the oxygen concentrator machine setting daily. The oxygen concentrator when the resident reported they were not getting enough O2. He said every machine should be set to the correct setting and there was no need to adjust the flow daily. The oxygen supply company representative was interviewed on 6/10/26 at 10:50 a.m. He said his title was respiratory practitioner. He said the facility was serviced once a week. He said they replaced oxygen tubing weekly and wiped down the machine. He said he was unsure when the last service day was. He said there was no outstanding order for a faulty oxygen concentrator machine. He said the flow meter should be steady otherwise it would not give the correct oxygen service to the resident. He said a faulty machine should be removed from the floor. The DON was interviewed on 6/10/26 at 10:58 a.m. She said the most recent visit form the oxygen company was on 6/7/26. The DON was interviewed on 6/11/26 at 11:34 a.m. She said if staff noticed malfunctioning equipment the nurse should replace the machine and notify the assistant director of nurses (ADON) or DON. She said an oxygen concentrator should produce steady oxygen flow and should not fluctuate.		

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F 0697 Level of Harm - Minimal harm or potential for 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 manage pain in a manner consistent with professional standards of practice, resident-centered care plans and resident's goals preferences for one (#2) of two residents reviewed for pain out of 55 sample residents. Specifically, the facility failed to: -Complete a thorough assessment of the residents pain, including the site and pain goals; and, -Include person-centered non pharmacological pain interventions on the resident's care plan. Findings include: I. Facility policy and procedure: The Pain-clinical protocol policy, revised in April 2025, was received from the nursing home administrator (NHA) on 6/11/26 at 4:22 p.m. It read in pertinent part, The provider and staff will identify individuals who have pain or who are at risk for having pain. This includes reviewing known diagnoses and conditions that commonly cause pain. It also includes a review for any treatments the residents currently are receiving for pain, including complementary and non-pharmacologic treatments. The staff will reassess the individual's pain and related consequences at regular intervals, at least each shift for acute pain or significant changes in level of chronic pain, and at least weekly in stable chronic pain. The staff will evaluate and report on the resident's use of standing and PRN (as needed) analgesics. If there are more than occasional analgesic requests, the provider will consider changing to regular administration of at least one analgesic with another medication for PRN use, increasing the standing dose of an existing analgesic, and/or adding nonpharmacological measures. II. Resident #2A. Resident status Resident #2, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage affecting left non-dominant side, malignant neoplasm of upper-outer quadrant of the right female breast (a cancerous tumor), malignant neoplasm of nipple and areola right female breast (a cancerous tumor), malignant neoplasm of unspecified site of the left female breast (a cancerous tumor), secondary malignant neoplasm of brain (a cancerous tumor). The 4/8/26 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. The MDS documented the resident required extensive assistance with bathing, dressing, toileting, hygiene, and transferring. She needed set-up assistance with eating and moderate assistance with oral hygiene. The MDS documented the resident was receiving pain medications regimen and received scheduled and as needed (PRN) pain medication. B. Resident observation On 6/8/26 at 10:56 a.m. Resident #2 was lying in her bed. She was drifting in and out of sleep. Resident #2's had her right hand over her breast and the fingers were curled. She appeared to be in pain and said she did not want to speak because she was in pain. C. Resident and representative interview Resident #2's significant other was interviewed on 6/8/26 at 10:56 a.m. He said he visited Resident #2 daily. He said Resident #2 experienced pain daily. He said Resident #2 frequently complained of pain. He said her pain was located in her right breast, knees, and throughout her body. He said Resident #2 received acetaminophen twice daily and oxycodone on an as needed basis. He said her pain medications were often administered late. He said on several occasions Resident #2 waited 40 minutes after requesting oxycodone. He said acetaminophen provided some relief for a while when administered on time. Resident #2 was interviewed on 6/9/26 at 3:10 p.m. Resident #2 said she experienced daily pain since admission because of her cancer. She reported staff assessed her pain level daily. She said her pain level was mostly above six out of ten. She said her acceptable pain level was six but that was not acceptable anymore. She said she reported her pain level was greater than 6 out of 10 on most days to the staff. She said the oxycodone (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1599 Ingalls St Lakewood, CO 80214	
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had not been scheduled. She said she was not aware that she could have requested it to be scheduled. She said the facility did not offer any adjustments to her pain medication regiment prior to that day recently. Resident #2 was interviewed again on 6/11/26 at 9:47 a.m. Resident #2 said the oxycodone had been scheduled two days ago. She said the facility should have scheduled it much earlier. She said her pain has not been managed and that her pain had always been too high since the admission. She said the as needed Oxycodone was not effective earlier to manage her pain. She said she reported pain to the certified nurse aides (CNA) and all the nurses all the time. Resident #2 was interviewed on 6/11/26 at 5:14 p.m. Resident #2 said she spent most of her time in bed or attending medical appointments. She said she did not recall discussing a pain management plan with facility staff. She said the facility did not explain why the oxycodone was not routinely scheduled. She said the facility did not inform her that she was awaiting approval from the primary care physician for scheduled oxycodone prior 6/8/26. She said she was willing to tolerate some pain but the pain had been excessive since the admission. C. Record reviewThe 3/24/26 readmission data collection tool revealed the resident had chronic pain and was currently verbalizing pain. The resident had intermittent pain.The assessment documented pharmacological and non pharmacological interventions were used. The assessment documented the resident's pain interfered with her activities of daily living. -The assessment failed to specify other locations of pain other than back pain. The assessment failed to document person-centered what non-pharmacological pain interventions. The assessment did not include when the pain started and how long the pain lasted. The pain assessment failed to show the resident's pain goal. The 4/7/26 pain evaluation documented the resident had frequent pain in the past five days. The pain occasionally had affected her sleep and frequently affected her day to day activities because of the pain. The assessment failed to include the resident's pain goal.The pain care plan, initiated on 1/20/26, revealed Resident #2 expressed pain. She was at risk for alteration in comfort related to pain secondary to diagnosis of breast cancer, and left hemiparesis status post cerebrovascular accident. The care plan interventions included monitoring/recording reporting her pain, evaluating the effectiveness of her pain medication, completing an evaluation of the effectiveness of her pain regimen to include assessing the need and response to PRN pain medication, reporting to the medical provider if pain medications were not meeting needs, notifying the physician promptly for re-evaluation of my pain regimen if it has been determined that my analgesic is ineffective or pain rating has increased or stayed the same and provide non-pharmacological interventions should be used. -However, the care plan failed to include non-pharmaceutical approaches. D. Staff interviewsLicenced practical nurse (LPN) #3 was interviewed on 6/9/26 at 2:14 p.m. LPN #3 said Resident #2 received Tylenol 325 mg twice daily and oxycodone on an as needed basis. He said opioids were typically ordered on as-needed basis at the beginning to evaluate effectiveness and monitor for potential medication-seeking behaviors. He said Resident #2 consistently reported pain levels above her acceptable pain level. He said Resident #2 should be on scheduled oxycodone. He said due to Resident #2's cancer diagnosis, she was expected to be in more pain than the average resident. He said Resident #2 had been requesting oxycodone regularly every six hours. LPN #6 was interviewed on 6/10/26 at 2:50 p.m. LPN #6 said she assessed for pain levels before administering PRN pain medication. She said Resident #2 was too shy to ask for oxycodone on her own. She said staff always had to ask her if she wanted to take her pain medication. She said if she saw that a resident's pain level was above their acceptable level of pain prior to taking pain meds, she would inform the physician. CNA #1 was interviewed on 6/11/26 at 11:01 a.m. CNA #1 said Resident #2 complained about her pain in her right breast daily. She said Resident #2 often requested her to notify the nurse that she needed pain medication. She said non-pharmateutical interventions (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were to wash Resident #2's face with a washcloth; to place the washcloth on her tumor or to offer a drink. She said Resident #2 only asked for Oxycodone once or twice during her shift. She said Resident #2's body language did not show pain but Resident #2 was not too shy to let her know if she was in pain and needed medication. LPN #7 was interviewed on 6/11/26 at 10:27 a.m. LPN #7 said Resident #2 was receiving cancer treatment and experienced a lot of pain. She said Resident #2 did not complain much about her pain. She said Resident #2 asked for her as needed oxycodone when her pain was too high. She said it was a good indicator to have an as needed pain medication scheduled if a resident asked for pain medication day after day. She said Resident #2 was not shy to ask for her oxycodone when her pain was unbearable. She said Resident #2's pain assessment level had been consistent for a long period of time. She said that was probably the reason the oxycodone was scheduled recently. The director of nursing (DON) was interviewed on 6/11/26 at 11:40 a.m. The DON said Resident #2 was alert and oriented and capable of requesting her medication when needed. She said the nursing staff assessed the resident's pain level daily. She said residents could choose whether to take PRN medication. The DON said the process for transitioning a medication from as needed to scheduled use varied based on the resident's circumstances. She said the physician determined when a PRN medication should be transitioned to a scheduled medication. She said the physician would discuss the change with the resident before making that decision. The DON said Resident #2 recently began cancer treatment and may have been in the evaluation waiting period for oxycodone.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#7) of two residents reviewed for ancillary services out of 55 sample residents received dental services timely. Specifically, the facility failed to ensure Resident #7 was provided with assistance to obtain replacement dentures. Findings include: I. Facility policy and procedure The Availability of Dental Services policy, revised August 2007, was provided by the nursing home administrator (NHA) on 6/11/26 at 4:22 p.m. It read in pertinent part, Oral healthcare and dental services will be provided to each resident. Dental services are available to all residents requiring routine and emergency dental care. Social services will be responsible for making necessary dental appointments. All requests for routine and emergency dental services should be directed to social services to assure that appointments can be made in a timely manner. Residents with lost or damaged dentures will be promptly referred to a dentist. II. Resident #7A. Resident status Resident #7, age less than 65, was admitted [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included major depressive disorder, hemiplegia (weakness) and hemiparesis (paralysis) following cerebral infarction (stroke), type 2 diabetes mellitus, epilepsy, generalized anxiety disorder and chronic pain syndrome. The 4/8/26 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 dependent on staff for toileting, showering, dressing and transferring between surfaces. She required substantial/maximal assistance with personal and oral hygiene, including inserting and removing dentures into and from the mouth, and managing denture soaking and rinsing of the equipment. B. Resident interviews and observations Resident #7 was interviewed on 6/8/26 at 2:29 p.m. Resident #7 said she was told by the dentist she was eligible for a free, one time replacement of her dentures. She said she had not been seen for a while and she did not know the status of the replacement dentures. Resident #7 said she wanted to wear dentures, and they would be especially helpful when she ate tough meat served by the facility. On 6/9/26 at 10:59 a.m. Resident #7 was not wearing dentures. On 6/10/26 at 10:30 a.m. Resident #7 was not wearing dentures. Resident #7 was interviewed again on 6/10/26 at 4:23 p.m. Resident #7 said she received a letter from Medicaid, dated 2/3/26, which approved the replacement of a complete set of dentures. She said this afternoon was the first she had heard about the replacement dentures going through an appeal process. C. Record review Review of Resident #7's June 2026 CPO revealed the following physician's order: May have Dental, Podiatry, Ophthalmology, Audiology Consults, ordered 12/17/24. Review of the 6/30/25 dental visit notes revealed Resident #7 lost her upper and lower dentures that were made on 12/1/21. Review of the 1/28/26 dental visit notes revealed Resident #7 was seen on 1/28/26. Resident #7 lost her upper and lower dentures that were made on 12/1/21. Periapical xrays (an xray that captures the entire length of one or two teeth, from the chewing surface to the root tip and the surrounding jawbone) taken for Once in a Lifetime program replacement. Review of Resident #7's progress notes revealed the following documentation: On 2/5/26 at 4:54 p.m. a social services note documented the resident saw the dentist on 1/28/26. The dentist was trying to get another set of dentures made for the resident. On 4/15/26 at 10:40 a.m. a communication with the resident note documented the registered dietitian (RD) review for weight management - spoke with the resident about her goals. The resident mentioned she was supposed to get dentures. -However, the RD did not notify social services that Resident #7 was wondering about the status of her replacement dentures. On 6/10/26 at 5:15 p.m. (during the survey) a social services note documented the resident shared that she had not had a (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow up regarding dentures that the facility's dentist was making under the Once in a Lifetime program. This writer asked for more information for follow up. The resident stated, It was not something I really wanted and there was not much I needed dentures for, but once the dentist was in the building and told me about the program and how he could make better dentures now than he did back then, I got excited. I have a letter that I was approved. The resident shared when the dentist came to see her at that time to see how her dentures were fitting and found they were lost - that was when he informed the resident of the Once in a Lifetime Program (according to records, xrays were taken on 1/28/26 to send for once in a life replacement). On 6/10/26 at 6:20 p.m. (during the survey) a social services note documented this writer went to follow up on the progress with the facility's dentist. The dentist had stated that he went through a couple of appeals and dentures were not made because Medicaid would not pay for them. This writer thought he was speaking of Resident #7, but the dentist corrected himself and stated that he had appealed for other residents but did not proceed with Resident #7 because he had a history of not getting paid by Medicaid after approval and dentures were made. This writer told the dentist that our facility will pay for dentures when a resident's insurance did not cover it. The dentist further stated he did not think it would be an issue as the resident was able to eat fine and did not express a need or want for dentures since losing the last set he made. This writer requested documentation of resident's dental visits and for an invoice to expedite payment to have these dentures made as the resident was showing interest in having them now. The dentist will send it this evening. The dentist said he can rush them and they can be done in about four weeks. This writer will continue to follow. On 6/11/26 at 12:05 p.m. the social services director (SSD) provided an email from the accounts payable manager which said she spoke to the facility's dentist to confirm the facility would send payment for Resident #7's replacement dentures. The email revealed the dentist said he would get started on the replacement dentures. -However, follow up about Resident #7's replacement dentures was not provided for six months. III. Staff interviews Certified nurse aide (CNA) #1, CNA #3 and CNA #5 were interviewed together on 6/10/26 at 12:10 p.m. CNA #1 said when a new resident was admitted to the facility, the CNAs documented the residents' belongings including glasses, dentures, hearing aids and clothes on an inventory list. CNA #1, CNA #3 and CNA #5 said when dentures were misplaced or lost they reported it to the nurse and looked everywhere for them. All three CNA staff members said Resident #7 did not use dentures, and the potential negative impact of a resident being without their dentures was that they could not eat well. Registered nurse (RN) #1 was interviewed on 6/10/26 at 2:48 p.m. RN #1 said when a new resident was admitted to the facility, the nursing staff documented items that were brought with the resident on an intake form. He said when dentures were misplaced or lost, the staff reported it to social services for them to follow-up. RN #1 said he did not know for sure, but he did not think Resident #7 had dentures or should have had dentures. He said a resident would struggle to eat and possibly lose weight if they were without their dentures. The RD was interviewed on 6/10/26 at 2:55 p.m. The RD said when she performed interviews with the residents she would ask them if they used dentures, and if they did only sometimes she would document that information in a progress note. The RD said Resident #7 did not have dentures on 4/15/26 but the resident tolerated a regular texture diet. She said she reported Resident #7's concern about her replacement dentures. She said she usually messaged the dentist and social services. The RD said a resident would possibly lose weight and have decreased oral intake if they were without their dentures. -However, the RD did not provide documentation of the notification of Resident #7's replacement dentures until after survey exit (see facility follow-up below). The SSD was interviewed on 6/10/26 at 3:05 p.m. The SSD said if a resident used dentures, it should be documented in the residents' care plan. She said if dentures were (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	misplaced or lost, it would get reported to social services and they would help the resident look for the dentures and set up an appointment with the dentist. The SSD said if Medicaid would not pay for the replacement, the facility would pay for it. She said Resident #7 used to have dentures and was on a program for a replacement. The SSD said she spoke to the dentist recently, and he was going through a third appeal process. She said she just spoke to Resident #7 and she was aware of the status of her replacement dentures as of today. The SSD said she reminded the dentist that if Medicaid would not pay for the replacement the facility was obligated to replace them. Social services assistant #1 was interviewed on 6/10/26 at 3:31 p.m. Social services assistant #1 said she managed the ancillary services. She said the dentist was just at the facility and she spoke with him - he said he was on the third appeal for the replacement dentures. SSA #1 said it was possible that Resident #7 only knew about the approval and not the appeals. The SSD was interviewed again on 6/10/26 at 6:40 p.m. The SSD said she clarified with the facility's dentist, and Resident #7 was not going through an appeal process. He said he was confused with other residents. She said Resident #7's dentures were denied by Medicaid even though they were originally approved. The SSD said she told the dentist that the facility can pay for dentures if Medicaid refused to pay, and there was no reason a resident should go without their dentures. She said the new dentures have been expedited and should arrive within four weeks. The SSD said there was a missed opportunity for staff to follow up on the status of Resident #7's replacement dentures, and the RD should have notified her about the dentures. The SSD was interviewed a third time on 6/11/26 at 11:39 a.m. The SSD said the dentist was coming to the facility on 6/15/26 to get impressions for a new set of dentures. She said the xrays for the new dentures were already taken. The director of nursing (DON) and regional clinical resource #1 were interviewed together on 6/11/26 at 3:35 p.m. The DON said if a new resident was admitted with dentures it would be documented on the admission evaluation form completed by nursing staff. She said the RD would verify if the resident used dentures on their initial assessment and it would be documented in a RD note so ancillary services were aware. The DON said staff would be aware of the resident's denture use because it was documented on the 24-hour report, which was updated every morning to reflect changes in the facility. She said if dentures were misplaced or lost, staff notified social services to get the resident on the ancillary services list and notified the dietitian to monitor for adverse reactions. The DON said Resident #7 did not currently have dentures. She said there should have been communication from the dietitian to the interdisciplinary team to notify social services to obtain replacement dentures. Regional clinical resource #1 said Resident #7 could have experienced psychosocial impact by not feeling heard about her desire for replacement dentures. IV. Facility follow-up Regional clinical resource #1 provided documentation of the RD requesting from the facility's dentist an estimate for new dentures for Resident #7 on 1/30/25 at 7:10 a.m. The SSD was carbon copied (cc'd) on the email. On 1/30/25 at 10:13 a.m. the facility's dentist responded via email and said it looked like Resident #7 had her dentures made in 2021, so unfortunately Medicaid would not cover them again until 2028. The total for a new set of dentures was going to be \$2,903.00. The SSD was cc'd on the email. -However, the resident still had not received replacement dentures in June 2026.		