STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065296	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Care Center	1685 Eaton 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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on record review and interviews, the facility failed to develop and implement an effective discharge plan for one (#1) of three residents reviewed for discharge planning out of 12 sample residents. Specifically, the facility failed to: -Ensure consistent efforts in the discharge planning process were made, which resulted in the potential delay in Resident #1's discharge to another facility; -Ensure Resident #1's representative received consistent communication regarding Resident #1's discharge planning process; and, -Ensure the discharge planning process was documented in Resident #1's electronic medical record (EMR). Findings include: I. Facility policy and procedure The Social Service policy and procedure, dated 8/31/22, was provided by the corporate consultant (CC) on 7/21/24 at 7:30 p.m. via email. The policy read in pertinent part, Social services members are responsible for planning, organizing, and directing all administrative and operational activities of the social services department in accordance with current federal, state, and local standards, guidelines and regulations, and the facility's established policies and procedures. Assisting residents in planning for discharge by coordinating service delivery with the nursing staff and by assessing availability and facilitating use of financial and social support services in the community. Coordinating transfers (other than medical transfers) within and out of the facility and assist residents in adjusting to intra-facility transfers. II. Resident #1 A. Resident status (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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included anoxic brain damage, acute respiratory failure with hypoxia, aphasia, unspecified intracranial injury without loss of consciousness and the need for assistance with personal care. The 7/19/24 minimum data set (MDS) assessment identified the resident had severe cognitive impairment. The staff assessment for mental status revealed the resident had short and long term memory problems. She was not identified to have inattention or disorganized thinking. Resident #1 had unclear speech and was rarely understood. According to the MDS assessment, she did not exhibit behaviors or rejections of care. She was dependent on staff for all of her activities of daily living (ADL). The MDS assessment did not identify the resident's overall goal for discharge was to discharge to another facility. According to the MDS assessment, there was not an active discharge plan in place to return to the community, however, the MDS assessment also indicated a referral to a local contact agency was made. -Review of of Resident #1's EMR identified the resident's representative wanted a discharge to another facility. -Provided records did not identify referrals and follow up were conducted between 2/26/24 and 6/6/24 when requested by the resident's representative (see below). III. Resident's representative interview Resident #1's representative was interviewed on 8/21/24 at 9:49 a.m. The resident's representative said Resident #1 was admitted to the facility in 2021 with the anticipation of discharging the resident to another facility within a year. She said she wanted Resident #1 to move closer to her so the representative could increase the frequency of family visitations. She said the distance of the resident to the representative was becoming a hardship. The resident's representative said Resident #1 had been denied admission by some facilities because of her age, payor status, and/or high care needs. She said she had declined a facility that accepted Resident #1 because she saw the facility and felt it was not clean and did not feel they could meet her needs. The resident's representative said she was concerned that efforts to pursue her request for transfer to another facility had been delayed because of inconsistent staff and lack of follow through from the facility. The resident's representative said she started working with the facility's corporate health plan liaison (HPL) who was in the process of helping her in the discharge/transfer process but she was told the HPL was no longer handling the facility's referrals. She said the position was left open for a while and no one was handling the referrals to other facilities. She said the facility's social service department had very little to do with the discharge and referrals process. She said the facility later hired an admissions coordinator (AC) who said she was going to help her with the discharge process. The resident's representative said she then found out the AC was no longer at the facility. She said the facility had very little communication with her on the status and/or efforts made to provide assistance with Resident #1's discharge plan. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's representative said last winter (2023/2024) there was a virtual meeting conducted with facility #3. She said the HPL said the meeting went well but the resident's representative said she did not hear anything more until she contacted facility #3 a couple of months ago and was told that facility #3 had staffing changes and did not have records of a request for a referral or documentation of the prior meeting. The resident's representative said the former AC at the resident's current facility did not know anything about the other facility referral so the resident's representative asked her to do another referral to that facility. The resident's representative said she provided the AC with a list of eight other facilities she wanted more information on as potential transfer facilities but she was not provided anymore information of the status of referrals. The resident's representative said no one was telling her if and why Resident #1 had been denied admission from the listed facilities or if all the referrals were sent out. She said she had not been provided communication or updates. She said she attended a care conference but the attendance was small and little was known about the status of Resident #1's discharge plan. She said the social service director (SSD) requested another list from her on potential facilities and he gave her a list of potential facilities but she said she was not aware of any other steps toward a discharge for Resident #1. IV. Record review Resident #1's discharge care plan, initiated and revised on 7/17/24, documented Resident #1's representative wished for discharge in the future to a facility closer to the resident's representative. The care plan read the healthcare proxy denied possible transition to other communities that had accepted Resident #1. The discharge care plan intervention, initiated on 6/25/21 and revised on 5/16/23 directed the facility to establish a pre-discharge plan with the resident/family/caregivers and evaluate the progress and revise the plan . The discharge care planned intervention, initiated on 6/25/21 and revised on 5/16/23 directed the facility to prepare and give the resident, family member/caregiver contact numbers for all community referrals. The discharge care plan intervention, initiated on 6/25/21 and revised on 7/17/24, directed the facility to review possible facilities with family and make referrals as necessary. A 11/6/23 text message between the resident's representative and the health plan liaison (HPL) was provided by the CC on 8/21/24 at 2:23 p.m. via email. The text read a virtual meeting would be conducted on 11/6/23 with facility #3. The following email chain between the former social service assistant (SSA) and the HPL on 1/30/24 was provided by the CC on 8/21/24 at 11:55 via email. The email read Resident #1's representative requested a transfer to facilities closer to the location where the resident's representative lived. The resident was very friendly, compliant, easy-going and dependant with all ADLs. According to the email, a referral was attached to the email and the resident's representative could be offered video greetings and an in-person meeting. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A second 1/30/24 email between the director of care transitions (DCT), the HPL and the former SSA read the resident was accepted to facility #1 in the past but the resident's representative declined the facility because she did not like it. According to the email, the DCT asked if the resident's representative would be open to facility #1 again. The DCT said facility #6, facility #9, facility #2 and facility #10 could be an option. A follow up email on 1/30/24 between the former SSA, the DCT and the HPL read the former SSA did not think the resident's representative would be interested in facility #1 again. The SSA asked if the DCT and the HPL could send the referrals to the listed facilities or if that was something he should do. The DCT responded to the SSA that she sent the HPL Resident #1's information and would let the SSA know. A follow up email on 1/30/24 identified the senior director of care transitions (SDCT) requested the community director of care transitions (CDCT), the former SSA, the DCT, and the HPL to work on finding a facility for Resident #1. The 1/30/24 social service progress note documented the former SSA received an email from the DCT. The email stated a referral would be sent to a liaison in the resident representative's preferred area. A second 1/30/24 social service note read referrals were emailed to the facility's corporate community referrals. An email chain between 2/2/24 and 2/5/24 between facility #2, the HPL and the CDCT was provided by the CC on 8/21/24 at 11:55 a.m. via email. The email chain identified a referral was sent to facility #2 but the family declined and wanted to see if another facility was available to take Resident #1. A 2/2/24 text message between the resident's representative and the HPL was provided by the CC on 8/21/24 at 2:23 p.m. The text message read the resident's representative requested referrals for facility #5, facility #6, facility #8 and facility #9. A 2/5/24 email between the HPL and the CDCT was provided by the CC on 8/21/24 at 11:55 a.m. via email. According to the email, the CDCT requested the HPL to forward information to whichever facility she felt the family may be interested in. The follow up email, dated 2/5/24, read the HPL could assist with the request. A 2/7/24 and 2/8/24 text message between the resident's representative and the HPL read the resident's representative requested to find out what the status was of facility #4. A 2/8/24 follow up text message between the resident's representative and the HPL read the HPL would send a referral to facility #4. A 2/26/24 email between the HPL and the CDCT was provided by the CC on 8/21/24 at 11:55 a.m. via email. The email read the HPL was going to send an updated referral packet to the CDCT and requested community director of transition to send it to facility #3 and facility #8. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/26/24 social service note read a referral was sent to community transitions to request a referral be sent to facility #3 and facility #4. The facility #4 referral/discharge/admission spreadsheet was provided by the CC on 8/21/24 at 2:23 p.m. via email. The spreadsheet read Resident #1 was denied admission at facility #4 on 2/26/24 because the facility did not have enough mechanical lifts. -Review of the progress notes, provided text messages and emails between 2/26/24 and 6/6/24 did not identify any referral follow up with suggested or requested facilities. -Review of the progress notes, provided text messages and emails between 2/26/24 and 6/6/24 did not identify communication with the resident's representative on the status of the suggested and requested facilities for potential transfer. A 6/6/24 email between the HPL and the NHA was provided by the NHA on 8/21/24 at 12:41 p.m. via email. The HPL informed the NHA that the resident's representative was asking for a follow up. According to the email, the resident's representative wanted to know if the facility had sent out the referrals. A 6/6/24 email between the social service director (SSD) and the HPL was provided by the NHA on 8/21/24 at 12:41 p.m. via email. The SSD wrote he would talk to the admissions coordinator (AC) and find out what referrals could be sent out and he would also talk to Resident #1's representative the next time she was at the facility. The 6/24/24 care transitions note read Resident #1's representative had come in to the admissions office to discuss potentially moving Resident #1 to another facility closer to her. She said she had been asking for months and was tired of the back and forth drive between her location and the facility's location. According to the note, the AC would send out a referral to facility #3 and follow up in a day or two to see the status of the referral. The 7/19/24 social service note read the AC sent out a referral to facility #3 because it was too hard for the resident's representative to drive to the resident's current facility. According to the note, admissions would follow up. -Review of the progress notes and provided emails identified there was no documented follow up with the resident representative's request or referral status communicated regarding facility #3 between 6/24/24 and 7/19/24. The 7/22/24 social service note read admissions contacted facility #5 per the request of the resident's representative and would like to transfer Resident #1 to the facility. The note read the resident was denied admission due to the resident's payor status. -The 7/22/24 social service note did not identify the resident's representative was informed of the denial of admission by facility #5. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 7/25/24 to 7/27/24 text message chain between the resident's representative and the director of nursing (DON) was provided by the CC on 8/21/24 at 3:05 p.m. via email. The text chain identified that, on 7/25/24, the resident's representative texted the DON to ask if she had any information regarding the referral status of facility #3. The DON texted back and wrote she contacted the facility and the information was shared with the facility's DON. The resident's representative texted back that she contacted facility #3 on 7/26/24 and found out Resident #3 was denied admission but she did not know why. A 7/29/24 email was provided by the NHA on 8/21/24 at 12:41 p.m. between the NHA, the CDCT, the DCT and another corporate representative. The email read the resident's representative was looking for placement for Resident #1. The NHA requested assistance from the corporate representatives. According to the email, facility #3 denied admission of the resident. A 7/29/24 email was provided by the NHA on 8/21/24 at 12:41 p.m. between the AC and the NHA. The email read the resident's representative gave a list of facilities to the AC that she would like the AC to look into because two of the facilities could not accept Resident #1. According to the email, the AC was going to follow up with the facilities and follow up with the resident's representative. -Progress notes, facility provided text messages and emails did not identify additional follow up with the facilities or communication with the resident's representative between 7/29/24 and 8/13/24. The following 8/13/24 email chain was provided by the NHA on 8/21/24 at 12:41 p.m. A 8/13/24 email between the NHA, the SSD and the corporate representatives read the NHA asked if the team could help find placement for Resident #1. The 8/13/24 email between the SSD, the NHA, and the corporate representatives read the SSD had given a list of facilities in the resident representative's area. According to the email, the resident representative had not gotten back to him regarding the referral options. The SSD wrote the resident's representative told him at the last care conference that she had a list of referral options but had not provided a list to him. The 8/13/24 email between the NHA, the SSD and the corporate representatives read the NHA informed the SSD that the resident's representative provided the list of requested referrals to the AC. The NHA asked the SSD if he called the resident's representative to follow up and directed him to call her if he had not already done so. The 8/13/24 email between the SSD, the NHA and the corporate representatives read the SSD checked in the office of the AC and did not find the referral list and would contact the resident representative and ask her to send him the list so he could start sending out the referrals. The 8/13/24 social service note read Resident #1's representative would send a list of places she wanted social services to send referrals to for discharge. The 8/19/24 social service note read the (current) SSA contacted facility #6 and confirmed there were no open beds at that time. The SSA attempted to contact facility #7 but was not able to reach anyone. Facility #4 was contacted and a referral was sent. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review social service notes between 8/19/24 and 8/21/24 did not identify additional attempts were made to contact facility #7. The 8/21/24 at 12:49 p.m social service note, documented during the survey, revealed the SSA contacted facility #2 to follow up with the referral sent on 8/19/24. According to the note, a voicemail was left and the facility was waiting for a response back. The 8/21/24 at 1:00 p.m social service note read the SSA received a call back from facility #7 on 8/21/24 (during survey) and obtained the facility's fax number and faxed the referral. V. Staff interviews The SSD and the NHA were interviewed together on 8/21 at 9:32 a.m. The SSD said the former AC handled the referrals over the past few months. He said the HPL handled the referrals prior to the AC and he documented what he was made aware of in the progress notes. The SSD said when a resident or their representative requested a transfer to another facility, a referral would be sent to the requested facility and other appropriate facilities if needed. The SSD said the facility would follow up with the potential admitting facility and inform the resident and/or their representative of the referral status. The SSD said he and his new SSA were handling referral requests for the past few weeks since the AC left her position. The NHA said the referral process for Resident #1 was started in 2021 when the resident's representative requested the resident to be transferred to another facility. The NHA said referrals were sent out and Resident #1 was either denied admission by the referral facilities or the family did not like the facility. The NHA said, in the last month, the resident's representative started to request again for Resident #1 to be transferred to another facility. The SSD said he provided the resident's representative with a list of potential facilities Resident #1 could be referred to but the resident representative did not respond right away. He said once she did respond, referrals were sent out last week (week of 8/12/24). -However, review of the provided emails identified the requested 8/13/24 referral list was the second list provided to the facility from the resident's representative in a month's time as identified in the above 7/29/24 and 8/13/24 emails. The known 7/29/24 facility referral list was not looked at to proceed with the referral process until 8/13/24, resulting in an additional delay. The CC was interviewed on 8/21/24 at 12:40 p.m. The CC said Resident #1 had been denied admission by some facilities because of her high care needs. The CC said the resident was accepted at facility #1 and facility #2 but the family declined. The CC said the facility should have done a better job documenting the discharge efforts but the facility was currently still sending out referrals. The CC and the NHA were interviewed together on 8/21/24 at 3:38 p.m. The CC said facility #3 denied admission for Resident #1. The CC said the facility did not have adequate documentation to show the denials and communication to the referral facilities and the resident's representative. The CC said the facility had reached out to facility #7 and facility #6 and they had a waiting list. She said the facility would try facility #4 again. (continued on next page)

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