

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/12/2025
NAME OF PROVIDER OR SUPPLIER  Cambridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135</b></p> <p>Based on record review and interviews, the facility failed to ensure residents who required dialysis services received such services consistent with professional standards of practice for one (#4) of three residents reviewed for dialysis out of 13 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> <li>-Follow the physician's dialysis orders for Resident #4;</li> <li>-Consistently get Resident #4 to his dialysis appointments at his scheduled time; and,</li> <li>-Consistently and thoroughly complete dialysis communication forms between the facility and the dialysis center for Resident #4.</li> </ul> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Hemodialysis Residents Policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 2/11/25 at 12:18 p.m. via email. It revealed in pertinent part,</p> <p>The facility provides residents with safe, accurate, and appropriate care, assessments and interventions to improve resident outcomes in coordination/collaboration with (the) dialysis center.</p> <p>Review and ensure orders upon admission are received for follow-up dialysis center appointments, shunt care, no BP (blood pressure) in arm that has shunt, diet and fluid restriction (physician discretionary).</p> <p>A dialysis communication record is initiated and sent to the dialysis center each appointment; ensure it is received upon return.</p> <p>Post Hemodialysis/ongoing care:</p> <p>Check vital signs post dialysis or per physician's order. Do not take blood pressure on the arm with dialysis shunt. Monitor for signs of postural hypotension. Instruct the resident to change positions slowly for a short time to avoid dizziness and possible falls.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Monitor resident for signs and symptoms of toxic or adverse medication reactions.</p> <p>Documentation:</p> <p>Dialysis communication record</p> <p>Key medical record documentation elements: vital signs, pertinent comments related to resident status and weight.</p> <p>II. Resident #4</p> <p>A. Resident status</p> <p>Resident #4, age less than 65, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included end stage renal disease, hepatitis C, venous hypertension, congestive heart failure (CHF), anemia in chronic kidney disease and hypertension (high blood pressure).</p> <p>The 12/29/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score (BIMS) of 12 out of 15. He was independent with oral hygiene, and toileting. He required set up or clean up assistance with eating, and showers or bathing. He did not reject care from staff.</p> <p>The MDS assessment indicated the resident received dialysis treatments.</p> <p>B. Resident interview</p> <p>Resident #4 was interviewed on 2/12/25 at 4:00 p.m. Resident #4 said he preferred to go to dialysis early in the morning. He said he felt the transportation service that the facility scheduled to pick him up for dialysis was often late, which made him late for his appointments. He said he gave his dialysis communication sheets to whoever was his nurse when he returned to the facility after his dialysis appointments.</p> <p>C. Record review</p> <p>Review of Resident #4's February 2025 CPO revealed the following physician's orders related to dialysis:</p> <p>Check port site to right chest for bleeding during the shift after the resident returns. If bleeding occurs, apply direct pressure until it is controlled. Notify medical provider if bleeding lasts longer than 30 minutes or is severe, ordered 1/21/25.</p> <p>Remove dialysis communication sheet from resident's bag. File the form in his dialysis binder at the nursing station after checking it for follow ups, ordered 1/21/25.</p> <p>File dialysis communication form in resident's dialysis binder at the nursing station after checking it for follow ups, ordered 2/4/25.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Fill in dialysis communication form. Resident to go with it (communication form) at dialysis center, ordered 2/4/25.</p> <p>Review of Resident #4's dialysis care plan, initiated 12/23/24 revealed the resident needed hemodialysis for the disease process.</p> <p>-However, the care plan did not identify what disease process the hemodialysis was needed for.</p> <p>Interventions (initiated 12/23/24) included encouraging the resident to go for the scheduled dialysis appointments on (Tuesday, Thursday, Saturday, regular chair time was at 5:40 a.m. and the resident was to arrive at 5:20 a.m.), monitoring vital signs twice a shift after dialysis on dialysis days and notifying the physician of significant abnormalities.</p> <p>The following intervention was added to Resident #4's dialysis care plan on 2/12/25:</p> <p>Nursing staff was to complete the pre-dialysis communication form before the resident left for dialysis. The dialysis center was to complete the form while the resident was at dialysis. Nurses were to complete the post-dialysis form upon the resident's return from dialysis and review the dialysis part of the form. Any part of the dialysis form required follow-up, and the DON (director of nursing) needed to be notified of any concerns.</p> <p>-The intervention was not added to the care plan until 2/12/25, during the survey.</p> <p>The dialysis communication log books were provided by registered nurse (RN) #1 on 2/11/25 at 5:00 p.m. Each log had three sections on one sheet of paper which revealed the following:</p> <p>The pre-dialysis section was to be filled in by the facility with the date, and the resident's vital signs including, temperature, pulse, respirations, blood pressure and pain. The section also included if a meal or snack was given to the resident to take to the dialysis center. There was a section for additional information such as changes in condition, physician orders and new labs since the resident's last dialysis visit. A nurses' signature was required to validate the information was completed.</p> <p>The middle section of the log was to be filled out by the dialysis center staff. The same information was included as above in the pre-dialysis section. The dialysis center staff filled in the middle section with the current vital signs the resident had while at the dialysis center. A section for additional information included, changes in condition, medications administered, laboratory work (labs) drawn and lab results and other communication.) The middle section included a place for physician orders and recommendations, if any were given and a place for the dialysis nurses' signature.</p> <p>The post-dialysis section was to be completed by the facility when the resident returned after he received dialysis. The post-dialysis section repeated all the vital signs to be recorded again as in the pre-dialysis section. The facility was to fill in the resident's current vital signs and sign again with the nurses' signature, date and time that the post-dialysis information was obtained.</p> <p>Review of Resident #4's dialysis communication logs from 1/2/25 through 2/11/25 revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 1/2/25 Resident #4's dialysis communication form sheet was blank and all three sections of the form were not filled in; and,</p> <p>-The post-dialysis sections were not completed by the facility on 1/4/25, 1/9/25, 1/11/25, 1/14/25, 1/16/25, 1/21/25, 1/23/25, 1/25/25, 1/28/25, 1/30/25 and 2/4/25.</p> <p>Additionally, the dialysis communication forms (from 1/2/25 to 2/11/25) revealed the following communication from the dialysis center to the facility regarding Resident #4's late arrival times for dialysis:</p> <p>-On 1/21/25 the dialysis center communicated Resident #4 missed his make-up time;</p> <p>-On 1/25/25 the dialysis center communicated Resident #4 missed his make-up appointment yesterday (1/24/25);</p> <p>-On 1/28/25 the dialysis center communicated Resident #4 was one and a half hours late to his appointment and the dialysis center questioned how the facility could get the resident to the appointments on time; and,</p> <p>-On 2/4/25 the dialysis center communicated Resident #4 needed to arrive on time for his appointments.</p> <p>III. Staff interviews</p> <p>The dialysis center social worker (DCSW) was interviewed on 2/12/25 at 12:15 p.m. via the telephone. The DCSW said the dialysis center wrote on the communication forms several times for the facility to have Resident #4 be on time for dialysis. The DCSW said the dialysis center called and spoke to the facility's DON several times over the telephone about the facility getting Resident #4 to his dialysis appointments at his scheduled time. The DCSW said the DON told the dialysis center the situation would be fixed and Resident #4 would arrive on time for his appointments. The DCSW said there had been no negative outcomes as of yet, but she said Resident #4 could have physical complications if the facility did not send him to his appointments as the physician ordered.</p> <p>The DCSW said the resident was late to his appointments approximately four times in 2025. The DCSW said the facility had recently fixed whatever the problem was and the resident now arrived on time for his appointments.</p> <p>Registered nurse (RN) #1 was interviewed on 2/11/25 at 4:00 p.m. RN #1 said they were the nurse responsible for Resident #4's care for the day (2/11/25). RN #1 said they did not know whose job it was to complete Resident #4's post-dialysis section when he returned from his dialysis appointments, however, they said it was not their responsibility to complete it.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The NHA and the corporate nurse (CN) were together interviewed on 2/12/25 at 3:30 p.m. The NHA said he was unaware that Resident #4 had been late to some of his dialysis appointments. The NHA said he had not been aware that the post-dialysis sections of the resident's dialysis communication forms were not filled in by the resident's nurse when he returned from dialysis appointments. The NHA said yesterday (2/11/25) he called the dialysis center and set up a meeting with them to remedy the situation and handle any other concerns. He said the problem was the facility nursing staff did not fill in the post-dialysis sections, therefore no one read the dialysis centers' communication notes. He said he asked the nursing staff if anyone remembered talking to the dialysis center, but no nursing staff remembered speaking to the dialysis center over the telephone about Resident #4.</p> <p>The CN provided the nursing staff signatures of attendees and education that had been implemented during the survey (beginning on 2/11/25) about dialysis residents. The CN said the education would be ongoing for the nursing staff about dialysis residents and processes.</p> <p>The NHA said to help correct the situation with the dialysis communication logs, he began a new process on 2/12/25. The NHA said every day when there was a morning meeting, the communication books for residents who went to dialysis the day prior would be reviewed for compliance by management staff. The NHA said the DON or designee would read all of the residents' dialysis binder books weekly to double check everything was handled correctly.</p> <p>The NHA said for the next quarter, the quality assurance and performance improvement (QAPI) meetings would monthly discuss the plan of action and its implementation for residents who received dialysis. The NHA said, moving forward from 2/12/25, whoever was the RN or LPN (licensed practical nurse) for the resident on dialysis days would be responsible for filling out the post-dialysis information when the resident returned from their dialysis appointment. The NHA said the facility also made a change to send residents with a dialysis binder, a book which contained their dialysis communication sheets, and not just a single sheet of paper which could be misplaced.</p>		