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	06/17/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, record review and interviews, the facility failed to ensure three (#8, #6 and #1) of six residents reviewed for abuse out of 12 sample residents were kept free from abuse. Specifically, the facility failed to: -Protect Resident #9 from physical abuse by Resident #2; -Protect Resident #6 from physical abuse by Resident #2; and, -Protect Resident #1 from physical abuse by Resident #2. Findings include: I. Incident of physical abuse by Resident #2 towards Resident #8 on 1/30/25 A. Facility investigation The facility investigation, dated 1/30/25, was provided by the nursing home administrator (NHA) on 6/17/25 at 11:45 a.m. The investigation revealed the following: On 1/30/25 Resident #2 pushed Resident #8 in the coffee area of the dining room. Resident #8 fell and landed on her bottom. Resident #8 did not have any signs of injury or pain. The residents were separated and assessed, and several staff members and nearby residents were interviewed. The incident was witnessed and reported by a facility staff member, who said Resident #2 was cleaning the coffee area when Resident #8 walked by. The staff member said Resident #2 then pushed Resident #8 and she fell onto her bottom. The staff member said an intervention that helped Resident #2 was to keep the coffee area clear of people. The investigation indicated Resident #2 did not have a history of behaviors and did not have a behavior care plan. The investigation indicated Resident #2 had been involved with a physical occurrence in July 2024. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The investigation revealed Resident #8 was not fearful but said she was startled and confused as to why Resident #2 pushed her. An interview with Resident #8, conducted on 1/31/25, revealed Resident #8 was getting coffee and did not know what happened. Resident #8 said she was shaken up but okay. Resident #2 was interviewed on 1/31/25. Resident #2 said Resident #8 was in his way and he tried to get her out of the way. Resident #2 said he did not intend to hurt Resident #8. The facility concluded the allegation of physical abuse was unsubstantiated as there were no marks or signs of injury on Resident #8 and there was no intent to harm Resident #8 by Resident #2. Resident #8 and Resident #2's care plans were updated. -However, physical abuse occurred due to Resident #2 pushing Resident #8 to the ground. B. Resident #2 (assailant) 1. Resident status Resident #2, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included fracture of left femur, acute and chronic respiratory failure, unspecified symptoms and signs involving cognitive function and awareness and metabolic encephalopathy (a change in how the brain works due to an underlying medical condition). The 4/7/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of five out of 15. The resident was independent for most activities of daily living (ADL). The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others. 2. Observations On 6/16/25 at 2:01 p.m. Resident #2 was sitting in his wheelchair in front of the coffee maker in the dining room. An unidentified resident walked past Resident #2 and began speaking with him. Resident #2 began to swing his arm out and gesture at the other resident. Resident #2 yelled at the resident to put some expletive clothes on. The other resident told Resident #2 not to be jealous of him and walked away. -No staff members were present in the dining room at the time of observation. 3. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The behavior care plan, initiated 12/7/24 and revised 3/26/25, revealed Resident #2 had a behavior problem due to his disease process. Resident #2 had poor impulse control and may unintentionally become physical by what may appear or be perceived to be pushing or grabbing another person when attempting to make his way through, when others were in his way, or when trying to express his thoughts. Pertinent interventions included frequent checks as needed, discussing Resident #2's behavior and explaining why it was inappropriate, intervening as necessary to protect the rights and safety of others, encouraging the resident to communicate his thoughts verbally, anticipating his needs, redirecting as needed and offering the resident coffee. The mood care plan, revised 2/24/25, revealed Resident #2 had a mood challenge due to his disease process and had the potential to become agitated/physical with anyone who was in his way. Pertinent interventions included behavioral health consults as needed, assisting Resident #2 and his family in identifying strengths and positive coping skills, and monitoring/recording his mood. A progress note, dated 1/30/25 at 3:22 p.m., revealed a nursing staff member entered the dining room and found Resident #8 on the floor and Resident #2 standing up out of his wheelchair. The nurse assessed Resident #8, separated the residents and put each resident on 15-minute checks. The unit manager and the NHA were notified. Resident #2 was assessed and did not have any pain or signs of injury. The director of nursing (DON), the physician, the nurse manager and Resident #2's representative were notified. An interdisciplinary team (IDT) note, dated 1/31/25 at 1:04 p.m., revealed Resident #2 had an incident of physical aggression on 1/30/25. The root cause of the incident was poor impulse control. Interventions put into place included frequent checks, educating and encouraging Resident #2 on successful coping and interaction with peers, to which the resident verbalized understanding. A progress note, dated 2/1/25 at 9:34 a.m., revealed a social services staff member made an incident report regarding Resident #2 pushing a female resident down on 1/30/25. There were no injuries and Resident #2 could not recall the incident. 4. Resident representative interview Resident #2's representative was interviewed on 6/17/25 at 8:56 a.m. The resident's representative said Resident #2 had issues with other residents and had been aggressive a few times. The resident's representative said the facility was trying to move Resident #2 upstairs where it was less hectic. The resident's representative said the facility had been renovating the room they wanted Resident #2 to move into. The resident's representative said Resident #2 did not want to move rooms, but they hoped once they showed him his new room he would get used to the change. The resident's representative said Resident #2 tended to stay around the kitchen area and help with cleaning up the coffee area. The resident's representative said Resident #2 hit another resident once and pushed another resident down. The resident's representative said she did not know of any triggers Resident #2 had, but thought the incidents were caused by people crowding around the area or Resident #2's dementia. C. Resident #8 (victim) 1. Resident status (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #8, age [AGE], was admitted on [DATE]. According to the June 2025 CPO, diagnoses included major depressive disorder and dementia. The 6/3/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of ten out of 15. The resident was independent for most ADLs. The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others. 2. Record review A progress note, dated 1/30/25 at 5:51 p.m., revealed Resident #8 had a witnessed fall in the dining room. Resident #8 was getting paper towels when a resident (Resident #2) pushed her to the ground. Resident #8 said she fell on her buttocks. Resident #8 had no new skin issues at the time and reported a pain of 1 from her buttocks on a pain scale of 1-10. Resident #8 was placed on 15-minute checks starting at 2:00 p.m. that afternoon (1/30/25). A progress note, dated 2/1/25 at 9:39 a.m., revealed a social services staff member made an incident report regarding another resident pushing Resident #8 down. Resident #8 said she was not sure why the other resident pushed her. An IDT note, dated 2/6/25 at 11:41 a.m., revealed Resident #8 had a gait imbalance and unsteady gait which caused her to fall. -However, Resident #8 was pushed by Resident #2 which caused her to fall to the ground. An IDT note, dated 2/6/25 at 4:40 p.m., revealed Resident #8 had an incident in which she received physical aggression on 1/30/25. The root cause was unable to be determined. Per Resident #8 she was trying to get paper towels at the time of the incident. Interventions put into place included maintaining safety, frequent checks and educating Resident #8 to request staff assistance as needed with getting paper towels. An IDT note, dated 2/6/25 at 4:47 p.m., revealed Resident #8 had a witnessed fall on 1/30/25. The root cause was physical aggression, as Resident #8 was pushed by Resident #2. Interventions put into place included maintaining safety, frequent checks and educating Resident #8 to request staff assistance as needed. II. Incident of physical abuse towards Resident #6 by Resident #2 on 2/21/25 A. Facility investigation The facility investigation, dated 2/21/25, was provided by the quality mentor (QM) on 6/16/25 at 4:21 p.m. The report revealed the following: On 7/21/24 there was an altercation between Resident #6 and Resident #2. The residents were separated and placed on frequent checks. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #6 was interviewed on 2/21/25 at 12:00 p.m. Resident #6 said he was walking in the dining room and cleaning tables when Resident #2 came up behind him, hit his back and tried to push him from behind. Resident #6 said Resident #2 hit him for no reason. Video footage of the incident was reviewed by the NHA on 2/22/25 but the camera did not capture a good view of the incident. Resident #2 was interviewed on 2/21/25. Resident #2 said he wanted to go out to smoke but Resident #6 was blocking his way. Resident #2 said he tried to get Resident #6's attention by tapping his back. An interview on 2/21/25, with a nursing staff member who witnessed the incident, revealed Resident #6 was cleaning the tables in the dining room when Resident #2 was trying to get outside to smoke and Resident #6 was blocking his way. Resident #2 tapped Resident #6's back to tell him to get out of the way. A second interview with the nursing staff member on 2/22/25 revealed Resident #2 tapped Resident #6 on the back to get past him then pushed him out of the way. The nursing staff member said she saw Resident #2 get angry quickly and knew to intervene and get people out of his way. An interview with a housekeeping staff member who witnessed the incident revealed Resident #2 hit Resident #6's back then pushed him. The housekeeper said she was not sure if Resident #2 wanted to hurt Resident #6 but that he wanted to get past Resident #6. The facility's investigation concluded Resident #2 tapped Resident #6's back before pushing him and Resident #2 had a history of agitation. The facility concluded the allegation of physical abuse was unsubstantiated due to there not being any signs of injury, no harm or intent to harm, and no fear from the victim. Follow-up actions included a medication review for Resident #2, bringing the resident to a safe space if agitation was noted, and providing frequent checks or offering Resident #2 to go outside to smoke. -However, physical abuse occurred due to Resident #2 pushing Resident #6. B. Resident #2 (assailant) 1. Record review A progress note, dated 2/21/25 at 11:33 a.m., revealed at 9:00 a.m. that morning Resident #2 was going outside to smoke. Resident #6 was in Resident #2's path to go outside and he grabbed Resident #6 by his shoulder and pushed him out of the way to go smoke. The residents were separated, Resident #2 went into his room and was placed on 15-minute checks. A provider note, dated 2/21/25 at 8:04 p.m., revealed the nursing staff had reported to the provider that Resident #2 had an altercation with another resident (Resident #6) outside while smoking. Resident #2 had pushed the other resident (Resident #6), but there were no injuries to either resident. The note documented there was discussion with the facility staff about ordering Hydroxyzine (medication used to treat anxiety) as needed to have available when Resident #2 felt aggressive or anxious. Resident #2 could not remember the altercation to discuss it with the provider during the visit. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An IDT note, dated 2/24/25 at 3:26 p.m., revealed Resident #2 had an incident of physical aggression on 2/21/25. The root cause of the incident was poor impulse control. Resident #2 said he was trying to get by and did not push anyone. Interventions put into place included frequent checks as needed, encouraging Resident #2 to communicate his thought process verbally, provide redirection as needed, and submit laboratory work as ordered. A social services progress note, dated 3/6/25 at 5:35 p.m., revealed Resident #2 was at baseline and able to make some needs known. The note documented Resident #2 could become quickly and easily aggressive and could become physically aggressive. Resident #2 was not always easily redirectable. A progress note, dated 4/10/25 at 10:33 a.m., revealed Resident #2 and another resident were at the coffee machine in the dining room when Resident #2 kicked the other resident in the leg. A social services staff member asked why Resident #2 kicked the other resident, but Resident #2 could not recall why or that the event happened. A progress note, dated 4/10/25 at 10:41 a.m., revealed Resident #2 was observed kicking another resident on the leg. Resident #2 was educated on not touching, kicking, or being verbally aggressive to other residents. Resident #2 verbalized understanding of the education provided. A psychiatric pharmacy review note, dated 2/25/25 at 1:06 p.m., revealed Resident #2 was taking an anti-anxiety medication, Hydroxyzine 10 milligram tablets. An order was given to give one tablet by mouth every twelve hours as needed. Resident #2's behaviors included being resistant to care, breaking the facility's smoking policy, and he could become physically and verbally aggressive. C. Resident #6 (victim) 1. Resident status Resident #6, age less than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included mixed receptive-expressive language disorder (difficulty understanding and expressing language), hemiplegia and hemiparesis (paralysis on one side of the body) and dysarthria (a motor speech disorder that makes it difficult to articulate words clearly). The 5/14/25 MDS assessment revealed the resident had moderate cognitive impairments with both short and long-term memory problems through staff assessment. The resident was independent for all ADLs. The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others. 2. Record review A progress note, dated 2/21/25 at 11:19 a.m., revealed a facility staff member notified a member of the nursing staff of an incident involving Resident #6. Resident #6 did not have any injuries noted and did not complain of any pain or discomfort. An IDT note, dated 2/24/25 at 9:30 a.m., revealed Resident #6 had received physical aggression on 2/21/25. Interventions put into place included maintaining safety and frequent visual checks. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Incident of physical abuse towards Resident #1 by Resident #2 on 4/11/25 A. Facility investigation The facility investigation, dated 4/11/25, was provided by the QM on 6/16/25 at 4:21 p.m. The report revealed the following: On 4/11/25 at 9:40 a.m. it was reported that Resident #2 kicked Resident #1 in the leg to get him out of his way but did not intend to harm him. The residents were separated, Resident #2 was placed on frequent checks, the police and ombudsman were notified, and interviews of staff and residents were completed. The investigation documented Resident #2 had a history of using physical touch as a way to communicate. Resident #2's care plan for behaviors included interventions such as keeping others clear from Resident #2, offering the resident coffee and anticipating his needs. An interview with Resident #1 on 4/17/25 revealed Resident #1 did not recall the incident and did not have any issues with anyone at the facility. Resident #2 was assessed on 4/16/25. An interview with Resident #2 revealed the resident wanted to get Resident #1 out of his way so he kicked him to tell him to move. An interview with a nursing staff member who witnessed the incident revealed Resident #2 kicked Resident #1 in the leg and told him to move. The nursing staff member said Resident #2 was redirectable with coffee and cigarettes. The facility's investigation concluded Resident #2 had a history of physical behaviors. The facility staff said Resident #2 was impulsive and liked to drink coffee and smoke. Interventions for Resident #2 included offering him coffee and keeping other residents clear of him in common areas. The facility concluded the allegation of physical abuse was unsubstantiated as there were no marks on Resident #1, no pain, and no harm. Resident #2 was offered a room change to a different floor of the building. -However, physical abuse occurred due to Resident #2 kicking Resident #1. B. Resident #2 (assailant) 1. Record review A progress note, dated 4/11/25 at 12:07 p.m., revealed Resident #2 kicked Resident #1 in the dining room at the coffee station because the resident was in Resident #2's way. The residents were immediately separated, moved to a safe location and checked for injury. No injuries or pain were reported and no visible marks were seen. A social services staff member followed-up with Resident #2 on 4/11/25 and provided education that it was never appropriate to kick other residents or staff when they were around him. Resident #2 voiced agreement to not kick anyone. The note documented Resident #2 reported no memory of the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An IDT note, dated 4/14/25 at 9:43 a.m., revealed Resident #2 had an incident of physical aggression on 4/10/25. The root cause of the incident was poor impulse control. Resident #2 said he was trying to get by and did not push anyone. Interventions put into place included frequent checks as needed, encouraging Resident #2 to respect others'space and ask others verbally instead of being physical, providing redirection as needed, and encouraging the resident to engage in positive interactions. A progress note, dated 4/14/25 at 1:49 p.m., revealed Resident #2 was started on 15-minute checks for safety after an altercation with another resident in the dining room. Both residents involved reported no physical contact was made between them. Both residents denied feeling fear and reported they felt safe. A progress note, dated 4/14/25 at 5:03 p.m., revealed a clarification that no altercation took place since there was no contact made, both residents reported there was physical contact. Both residents denied feeling fear and reported they felt safe. A progress note, dated 4/14/25 at 8:21 p.m., revealed Resident #2 was in the dining room waiting near the coffee machine when Resident #7 was standing near the coffee machine. Resident #7 did not move out of Resident #2's way so he grabbed her walker and shook it to get her attention. Resident #2 denied touching Resident #7. Both residents reported there was physical contact. Both residents denied feeling fear and reported they felt safe. An IDT note, dated 4/15/25 at 10:41 a.m., revealed Resident #2 had an incident on 4/10/25 during which he touched another resident's walker. The root cause of the incident was poor impulse control. Interventions put into place included offering Resident #2 coffee as needed and encouraging Resident #2 to keep a safe distance. A progress note, dated 5/5/25 at 11:38 a.m., revealed a social services staff member had called Resident #2's representative to inform her of a room change notification. A provider note, dated 5/13/25 at 1:24 p.m., revealed Resident #2 had intermittent aggression. Resident #2 had not had any recent altercations per the nursing staff and had an order for Hydroxyzine as needed. A psychiatric pharmacy review note, dated 4/29/25 at 9:12 a.m., revealed Resident #2 was not taking any psychoactive medications. Resident #2's behaviors included hitting others, pulling at other residents ' walkers and pushing his way through crowded areas. No medication changes were recommended by the provider but a room move to another floor in the facility was mentioned. A room change notification, undated, revealed Resident #2 was to move from the first floor to the second floor of the facility, effective 5/6/25, for the health and safety of Resident #2 and other residents. The room change notification was signed by Resident #2's representative on 4/4/25. C. Resident #1 (victim) 1. Resident status Resident #1, age [AGE], was admitted on [DATE]. According to the June 2025 CPO, diagnoses included dementia, mood disorder, unsteadiness on feet and history of traumatic brain injury. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 5/16/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of nine out of 15. The resident required staff supervision or touching assistance for most ADLs. The MDS assessment documented the resident did not have physical or verbal behaviors directed at others or other behavioral symptoms not directed toward others. 2. Record review A progress note, dated 4/10/25 at 5:45 p.m., revealed Resident #1 was getting coffee in the dining room and Resident #2 was waiting for his turn to get coffee when Resident #2 became impatient and kicked Resident #1 on the leg. Resident #1 did not have any bruising on assessment and denied pain or discomfort. Both residents were separated and continued monitoring was initiated. A progress note, dated 4/11/25 at 11:59 a.m., revealed Resident #1 was kicked by Resident #2 in the dining room at the coffee station on 4/10/25. The residents were immediately separated, moved to a safe location and checked for injury. Resident #1 did not report any injury or pain, and no visible marks were seen. The NHA interviewed Resident #1 and he was not fearful of Resident #2. A member of the social services team followed up with Resident #1 on 4/11/25 and the resident reported feeling safe and had no memory of the incident. An IDT note, dated 4/14/25 at 9:50 a.m., revealed Resident #1 had received physical aggression on 4/10/25. Interventions put into place included maintaining safety and frequent checks as needed. IV. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 6/16/25 at 11:04 a.m. CNA #1 said Resident #2 had a temper with both the facility staff and other residents. CNA #1 said if someone was in Resident #2's way he would yell at them or push them. CNA #1 said Resident #2 did not have behavioral incidents often and the last incident was several months before. CNA #1 said Resident #2 was somewhat redirectable. CNA #1 said if Resident #2 wanted to go out to smoke but it was not time for a scheduled smoke break, the nursing staff could tell him to wait, but Resident #2 would be agitated. CNA #1 said Resident #2 was stubborn. CNA #1 said Resident #2's temper was sporadic and not able to be predicted. CNA #1 said when Resident #2 had a temper, the nursing staff knew to move other residents out of his way. Licensed practical nurse (LPN) #1 was interviewed on 6/16/25 at 1:49 p.m. LPN #1 said she had only heard of one resident-to-resident incident at the facility. LPN #1 said Resident #2 had grabbed Resident #7's walker to get her out of the way of the coffee maker. LPN #1 said after this incident, the facility staff had to file a report, initiate 15-minute checks on both residents and ensure they both felt safe. LPN #1 said Resident #2 had occasional outbursts but often forgot any education the staff gave him on how to control his outbursts. LPN #1 said Resident #2 had not had any issues with any other residents that she knew of. LPN #1 said Resident #2 was usually pretty chilled out. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Restorative nurse aide (RNA) #1 was interviewed on 6/16/25 at 3:10 p.m. RNA #1 said Resident #2 had a temper and sometimes exploded at other residents. RNA #1 said Resident #2 lashed out whenever another resident was over by the coffee maker when he was there, and Resident #2 would yell at the residents and push them. RNA #1 said Resident #2's behavior was not able to be predicted and these incidents happened every two months or so. RNA #1 said whenever the facility staff saw Resident #2 was getting frustrated they would tell him to calm down. The social services assistant (SSA) and the social services director (SSD) were interviewed together on 6/17/25 at 9:50 a.m. The SSA said Resident #2 was independent, easygoing and very redirectable. The SSD said Resident #2 got impatient and liked coffee. The SSD said if the area by the coffee maker in the dining room got too packed with people Resident #2 would push himself into other residents to get through. The SSD said Resident #2 had to be redirected and reminded to be patient and not push people. The SSD said the facility was moving Resident #2 upstairs so he would not have as much traffic to get through to get his coffee. The SSD said Resident #2 was going to be moved to a different unit at the end of the week. The SSA said the activities personnel did their group activities in the main dining room, so the staff members had paid more attention to Resident #2 and helped him get his coffee. The SSA said Resident #2's behaviors also surrounded smoking and getting outside to smoke. The SSD said the facility staff had talked to Resident #2 and provided him with education on being patient. The SSD said the staff asked Resident #2 if they could get his coffee and try to anticipate his needs. The SSD said the facility staff had been educated to ask Resident #2 if they could get things for him to anticipate his needs and avoid conflict with other residents. The SSD said Resident #2 was going to have a room change in May 2025 but the roommate pairing would not have been good for the resident, so they were waiting for another availability. The SSD said Resident #2 did not want to move upstairs because he liked living downstairs. The SSD said the change seemed to be the issue for Resident #2, but once he moved he would be okay. The SSD said moving rooms was the best choice for Resident #2 for his independence and the safety of others. The SSD said when it was time for a smoke break the staff reminded Resident #2 early so he would be the first one to the smoking area to avoid the crowd. The SSD said crowds seemed to be a trigger for Resident #2. The DON was interviewed on 6/17/25 at 10:07 a.m. The DON said she had not seen any behaviors with Resident #2. The DON said Resident #2 became frustrated easily but was redirectable. The DON said there was one instance in which Resident #2 was on his way to smoke and got frustrated with another resident. The DON said Resident #2 tried to tell the other resident to move but expressed it as something different. The DON said Resident #2 did not mean to push anyone and said he did not push anyone. -However, the facility investigation revealed Resident #2 was witnessed pushing Resident #8 on 1/30/25 and he pushed Resident #6 on 2/21/25 (see record review above). The DON said Resident #2's behavioral interventions included providing redirection and offering him snacks and coffee. The DON said it was hard to tell what triggered Resident #2's frustration, and she said she wished she knew what his triggers were. (continued on next page)

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	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Care Center	1685 Eaton St Lakewood, CO 80214

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA was interviewed on 6/17/25 at 10:32 a.m. The NHA said Resident #2 had some incidents in which he had gotten aggravated in the dining room when there was a lot of commotion. The NHA said Resident #2 had a few instances where he had kicked someone's leg to get them out of the way of the smoking area. The NHA said Resident #2 never really threatened or gestured at anyone. The NHA said Resident #2 had a significant decrease in behaviors recently. The NHA said the facility still planned to move Resident #2 upstairs where there was less activity and could have documented more to show he was safe downstairs for the time being. The NHA said the facility staff had been anticipating Resident #2's needs more, offering him coffee and trying to intervene before he could be impulsive. The NHA said Resident #2's triggers were sensory, such as having a lot of people in his way when he wanted to accomplish a task. The NHA said Resident #2 got anxious to get outside around smoking times. The NHA said after the incident in January 2025, the providers completed a medication review for Resident #2 to see what could be adjusted. The NHA said after the incident in February 2025 they tried to adjust the external stimuli for Resident #2 and keep him away from crowds. The NHA said after the incident in April 2025 they began looking at moving Resident #2's room, anticipating his needs, and did a psychiatric pharmacy review. The NHA said anticipating Resident #2's needs seemed to work well so they were not as pressed to move him upstairs at that point. The NHA said the facility was protecting other residents by anticipating Resident #2's needs, identifying when other residents were crowding around him, and ensuring that all floor staff were aware of the resident's triggers. The NHA said the nursing staff knew Resident #2 could have an extra cigarette, or reward him with extra cigarettes if his behavior improved. -However, not all floor staff members were aware of Resident #2's triggers (see interviews above). The NHA said he did not substantiate any of the incidents involving Resident #2 as abuse as they did not cause any harm or fear with any of the residents. The NHA said Resident #2 did not intend or want to hurt anyone but tried to move them out of the way or let them know they were in his way.