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	06/11/2026

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 - 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 observations, record review and interviews, the facility failed to ensure one (#39) of four residents reviewed out of 37 sample residents were kept free from resident-to-resident physical abuse.Specifically, the facility failed to protect Resident #39 from physical abuse by Resident #58.Findings include:I. Facility policy and procedureThe Community Standard Operating Abuse policy and procedure, dated February 2024, was provided by the nursing home administrator (NHA) on 6/11/26 at 7:12 p.m. It read in pertinent part, The community does not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including staff members, other residents, volunteers, and staff of other agencies serving the resident, family members, legal guardians, resident representative, sponsors, friends, or any other individuals. Resident abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment of a resident resulting in physical harm or pain, mental anguish, deprivation of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Willful means the individual must have acted deliberately, not that he or she must have intended to inflict injury, or harm. Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms. II. Incident of physical abuse by Resident #58 towards Resident #39 on 4/28/26A. Facility investigationThe facility abuse investigation report was provided by the NHA on 6/10/26 at 9:45 a.m.The investigation documented the incident occurred on 4/28/26 at 9:30 a.m.The investigation revealed that Resident #58 went to visit Resident #39's roommate. Resident #39 grabbed Resident #58 and told him to leave. Resident #58 hit Resident #39 in the face. This took place in the hallway in front of Resident #39's bedroom door. Resident #58 was verbally redirected away from the location. The residents were placed on frequent checks by the facility. The local police, the physician and all appropriate parties were notified. Resident #39 did not want his emergency contact notified.The investigation documented Resident #39 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #39 had no history of behaviors and had a visible injury of a swollen cheek following the incident.The investigation documented Resident #58 was cognitively intact with a BIMS score of 15 out of 15 and had a history of behavior issues related to entering others residents' rooms to steal items. Resident #58 was alert and oriented to person, place, situation and time. Resident #58 was mobile without the use of assistive devices.The investigation documented that the incident was witnessed by staff. The victim (Resident #39) and the assailant (Resident #58) were assessed by a nurse on 4/28/26. Resident #39 sustained a swollen cheek and facial pain. Resident #39 declined over-the-counter pain medication. The investigation documented that Resident #39 was interviewed by social services assistant #1. Resident #39 said Resident #58 went to visit Resident #39's roommate for a cigarette. Resident #39 requested that Resident #58 not enter his room. Resident #39 then grabbed Resident #58's shirt, was hit in the face by Resident #58, and then Resident #58 left the scene.The investigation documented that licensed practical nurse (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 - Few	(LPN) #5 interviewed Resident #58 on 4/28/26. Resident #58 said he went downstairs to see a guy, heard someone yell, and swing at him, so he hit back and left. The investigation documented Resident #58 was placed on frequent checks. Resident #39's roommate was being moved, so Resident #39 had no reason to be around the assailant. Resident #58 had been educated not to enter other residents' rooms and not to ask for or buy cigarettes from other residents. Resident #39's roommate had also been educated not to sell or hand out cigarettes to anyone. The social services director (SSD) interviewed seven facility residents and six facility staff members. The interviewed residents said they had no concerns about physical abuse. The facility staff members said they felt they were sufficiently trained to handle situations of physical abuse.-However there were no updates to Resident #58's behavioral care plan to prevent further recurrence (see record review below). The investigation documented contact between the residents but concluded that the outcome was inconclusive and the abuse allegation was unsubstantiated.-However, abuse occurred because Resident #58 hit Resident #39 in the face, which resulted in a swollen cheek and facial pain for Resident #39.B. Resident #58 (assailant)1. Resident statusResident #58, age greater than 65, was admitted on [DATE]. According to the June 2026 computerized physician orders (CPO), diagnoses included peripheral arterial disease (a circulatory condition in which narrowed arteries reduce blood flow to your limbs), hyperlipidemia (high cholesterol), anxiety disorder, schizophrenia, chronic obstructive pulmonary disease (COPD), and chronic bronchitis.The 3/31/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. He was dependent on staff assistance for toileting hygiene and personal hygiene and was independent with eating and mobility.The assessment revealed Resident #58 had no behaviors towards himself or others during the assessment look-back period.2. Resident interviewResident #58 was interviewed on 6/9/26 at 4:40 p.m. Resident #58 said he went downstairs to visit a friend. Resident #58 said that while he was downstairs, another resident, identified as Resident #39, began shouting at him and then swung at him. Resident #58 said he hit Resident #39's face and left the area. 3. Record reviewResident #58's behavior care plan, initiated 12/27/24 and revised 12/1/25, revealed the resident had a tendency to wander into other resident's rooms and use their bathrooms. Interventions included providing the resident with redirection when he wandered/roamed into other resident's rooms/bathrooms, providing the resident with an alternate activity when he was aimlessly roaming and social services was to provide one-to-one supervision when the resident was unable to be redirected. -However, the care plan failed to include interventions to address Resident #58's documented history of entering other residents' rooms in search of cigarettes and taking their personal items.The 5/4/26 at 3:47 p.m. interdisciplinary team (IDT) behavioral note revealed the root cause of Resident #58's physical aggression was a disease process related to a personality disorder. No treatment was recommended, and the interventions put in place were encouraging the resident to avoid entering his peers' rooms uninvited, monitoring the resident's behavior episodes and attempting to determine the underlying cause, considering location, time of day, persons involved, and situations, documenting behavior and potential causes, and frequent checks as needed. -However the IDT note interventions were not updated in Resident #58's care plan (see care plan above).C. Resident #39 (victim)1. Resident statusResident #39, age [AGE], was admitted on [DATE]. According to the June 2026 CPO, diagnoses included multiple sclerosis, narcolepsy without cataplexy (a chronic neurological sleep disorder), nicotine dependence, dermatitis, a history of falling, and hypertension (high blood pressure).The 5/11/26 MDS assessment revealed Resident #39 was cognitively intact with a BIMS score of 15 out of 15. He was independent with eating, personal hygiene, toileting, transfers and use of a manual wheelchair.The assessment revealed Resident #39 had no behavioral symptoms, rejection of care or wandering behaviors.2. Resident interviewResident #39 was interviewed on 6/8/26 at 5:34 p.m. Resident #39 said another resident, identified as Resident #58, attempted to enter his room without invitation. Resident #39 said that he immediately held Resident #58's shirt to prevent him from entering the room and asked him to leave. Upon receiving the request (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to leave, Resident #58 struck Resident #39 directly in the right eye. Resident #39 said that the physical altercation resulted in a visible injury, specifically a black eye. 3. Record reviewResident #39's behavioral care plan, revised 4/30/26, revealed he had a preference for questioning other residents if, according to his perception, they were doing things out of the ordinary. Interventions included educating the resident to avoid confrontation with other residents and notifying staff of any misunderstandings with other residents.The 5/4/26 at 4:08 p.m. IDT risk management note revealed Resident #39 was a victim of physical aggression, which required treatment with no referrals made. The proposed interventions included educating the resident to notify staff of any misunderstandings with other residents, educating the resident to avoid confrontation with other residents, and conducting frequent checks as needed. A physician's note, dated 5/4/26 at 10:16 a.m., revealed Resident #39 was seen by a physician. The physician's note revealed that Resident #39 reported a physical altercation with another resident (Resident #58) after the other resident entered his room uninvited. The other resident then punched him in the right eye. Resident #39 developed ecchymoses (bruising) under the right eye. III. Staff interviewsSocial services assistant #1 was interviewed on 6/11/26 at 12:25 p.m. Social services assistant #1 said she was informed Resident #39 was hit in the face by Resident #58 (on 4/28/26). Social services assistant #1 said she was involved in the investigation of the incident. Social services assistant #1 said she reviewed the documentation for both residents, gathered statements regarding the physical altercation, and ensured that necessary safety interventions were implemented immediately following the incident. Social services assistant #1 said she did not determine the conclusion of the investigation. The SSD was interviewed on 6/11/26 at 12:35 p.m. The SSD said following the resident-to-resident altercation between Resident #39 and Resident #58 on 4/28/26, staff informed management immediately so an investigation could begin. The SSD said the NHA was out of the facility and asked her to initiate and complete the facility investigation. The SSD said because the incident involved physical aggression, the facility interviewed the staff present and other residents, and worked to identify the root cause of the incident. The SSD said the facility staff initiated frequent checks of Resident #58 and Resident #39 following the incident. The SSD said the incident of abuse was unsubstantiated due to inconclusive evidence. The SSD said the NHA, who was the facility's abuse coordinator, determined the outcome of the investigation. The NHA was interviewed on 6/11/26 at 1:15 p.m. The NHA said that in his role as the facility's designated abuse coordinator, he was responsible for reviewing and determining the outcome of any allegations of abuse. The NHA said that he unsubstantiated the allegation of abuse following the investigation of the incident between Resident #58 and Resident #39. He said that while the evidence confirmed physical contact took place between the two residents, it was his clinical and administrative opinion that Resident #58 lacked the willful intent to harm Resident #39. The NHA said abuse required a determination of willful intent, and because he determined the physical contact resulted from a reactive behavioral escalation rather than an intentional act of abuse, the allegation did not meet the criteria for substantiated abuse. IV. Facility follow-upOn 6/11/26 at 5:31 p.m. the NHA provided a Past Noncompliance Form related to the 4/28/26 incident between Resident #58 and Resident #39. The form documented the following:The staff development coordinator completed education with staff on 5/1/26 regarding stepping in and intervening when residents were entering other residents' rooms uninvited.Additionally, the form documented the chief executive officer or a designee would make two observations a week for one week, one observation weekly for three weeks and then one observation monthly for two months to ensure staff intervened when residents entered other residents' rooms. The audit would be documented on a written log.-However, the facility did not provide documentation of the education, including staff signatures and there was no documentation provided by the facility of the ongoing audits and results.