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	04/02/2024

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 0622 Level of Harm - Actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on record review and interviews, the facility failed to ensure a facility-initiated discharge procedure for non-payment was followed for one (#140) of three residents reviewed for discharge out of 34 sample residents. Resident #140, who had a diagnosis of urinary tract infection, atrial fibrillation (abnormal heart rhythm), type II diabetes mellitus, history of falling, depression and anxiety disorder, was admitted to the facility on [DATE] and discharged on [DATE]. The facility failed to provide preparations for a safe and orderly facility-initiated discharge for non payment. The resident chose not to transition to long term care (LTC) insurance. Resident #140 was found down on the floor of his motel room three days after the facility discharged him. The facility failed to provide the resident with a 30 day discharge notice and failed to notify the ombudsman of the discharge. Cross-reference F623 failure to notify the ombudsman so that protection, support, assistance and representation could have been provided to the resident. The facility failed to provide/refer home health services to the resident to continue his work with physical therapy (PT), occupational therapy (OT) and nursing care to provide wound care treatment for wounds to his feet and toes. The facility failed to provide and document resident education for wound care to his feet and toes and failed to provide and document the issuance of wound care supplies. Due to the facility's failure, the resident was found down on the floor of his motel room for three days by the driver hired to take the resident from the facility to the motel. He had gone back to check on the resident three days later out of concern for the resident's ability to care for himself. The resident was admitted to the hospital via emergency medical services (EMS) on 3/11/24 and was there as of 4/1/24 due to the lack of capacity to make medical or discharge decisions. Findings include: I. Facility policy and procedure (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	04/02/2024

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 0622 Level of Harm - Actual harm Residents Affected - Few	The Discharge Planning policy and procedure, dated 2/29/24, was provided by regional clinical resource (RCR) on 4/1/24 at 3:47 p.m. It read in pertinent part, In cases where the resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or is determined be unsafe, the interdisciplinary team will treat this situation similarly to refusal of care: Discuss with the resident, (and/or their representative, if applicable) and document the benefits and/or risks, review alternative options, and document refusals of other options that could meet the resident's needs. If discharge to community is determined to not be feasible, the facility will document in the clinical record who made the determination and why. An active individualized discharge plan will address, at a minimum: -Discharge destination, -Identified needs, such as medical, nursing, equipment, educational, or psychosocial needs. -Caregiver/support person availability and the resident's or caregiver's/support person's capacity and capability to perform required care. II. Resident status Resident #140, age 80, was admitted on [DATE] and discharged on [DATE] to a motel. According to the March 2024 computerized physician orders (CPO), diagnoses included urinary tract infection, atrial fibrillation (abnormal heart rhythm), type II diabetes mellitus, history of falling, depression and anxiety disorder. The 1/15/24 admission 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. He was dependent with shower/bathing, upper and lower body dressing, toileting hygiene, bed mobility and transfers. He was able to walk 10 feet once standing with set up help. The resident used a manual wheelchair. The 3/8/24 discharge MDS assessment revealed a BIMS score of 14 out of 15. He was independent with shower/bathing, upper and lower body dressing, toileting hygiene, bed mobility and transfers. Walking 10 feet was not attempted due to medical conditions or safety concerns. He was independent with a manual wheelchair. Active discharge planning was already occurring for the resident to return to the community. No referral had been made to the local contact agency and the reason was referral not wanted. -However, the discharge MDS assessment of the resident's functional abilities differed from the physical therapy (PT) and occupational therapy (OT) discharge assessments (see record review below). III. Hospital representative interview (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	04/02/2024

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 0622 Level of Harm - Actual harm Residents Affected - Few	The hospital clinical social worker (HCSW) was interviewed on 4/1/24 at 12:07 p.m. She said the resident was still in the hospital and did not have the capacity to make medical/discharge decisions at this time nor had he throughout his entire admission. The HCSW said it was only on 3/26/24 that the providers felt he had capacity to designate a decision maker and his medical power of attorney (MDPOA) was now the driver who found the resident down in the motel. IV. Record review -Review of the comprehensive care plan revealed the resident did not have a care plan related to his discharge plan. The physician order dated 2/21/24 revealed, Wound care right lateral foot: cleanse with wound cleanser, pat dry, apply medihoney to wound bed cover with bordered gauze. The physician order dated 2/29/24 revealed, Wound care: right proximal heel: cleanse with sound cleanser, air dry, skin prep peri wound, medihoney gel to wound bed, cover with foam island dressing. The physician order dated 2/29/24 revealed, Wound care: right 2nd toe: paint with betadine and leave open to air. The physician order dated 3/6/24 revealed, Wound care: left 2nd toe: cleanse with wound cleaner, pat dry, apply medihoney to wound bed and cover with bordered gauze. The physician order dated 3/7/24 revealed, Wound care: right heel: cleanse with wound cleanser, air dry, skin prep peri wound, xeroform to wound bed and cover with bordered gauze. The physician order dated 3/8/24 revealed, Okay to discharge resident to the community on 2/8/24, revised 3/8/24. -However, there was no documentation that wound care supplies were issued to the resident at discharge with instructions on how to perform wound care with a return demonstration. -Home health nursing for wound care was not ordered for the resident. -Review of the PT/OT notes revealed there was no home evaluation completed prior to discharge. Review of the 3/6/24 OT discharge summary, with dates of service from 1/14/24 to 3/6/24 revealed the discharge reason was per physician or case manager. The short-term goals of safely completing toileting with moderate assistance with use of durable medical equipment (DME) as needed was not met, maximum assistance has continued to rely on certified nurse aide (CNA) assistance for brief changes. Resident was able to complete lower body dressing with moderate assistance with use of assistive equipment and compensatory strategies as needed. Resident was able to safely complete bathing with minimum assistance with use of DME and compensatory strategies as needed. (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	04/02/2024

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 0622 Level of Harm - Actual harm Residents Affected - Few	Goal of the resident self-propelling wheelchair independently in order to access items needed for participation in ADLs and other functional tasks was not met, patient requires assistance to manage wheelchair over any kind of uneven surface, in tight spaces, and around obstacles. The long term goal of completing all ADL related transfers with modified independence with least restrictive assistive device (AD) in order to reduce risk of falls was not met, resident required contact-guard (CGA) to minimum assistance. Discharge location was other homeless shelter. Assistance/support to be provided was none. Functional skills assessment at discharge was, eating set-up or clean-up assistance; oral hygiene supervision or touching assistance; toileting hygiene dependent; shower/bath partial/moderate assistance; upper body dressing partial/moderate assistance; lower body dressing substantial/maximal assistance; putting on/off footwear substantial/maximal assistance. Discharge recommendations: OT recommended that patient convert to LTC, but despite education from IDT (interdisciplinary team) patient has consistently refused this and will now be discharging to a homeless shelter. OT recommends HH (home health) as available. -However, the resident was discharged without a home health referral. Review of the 3/7/24 PT discharge summary, with dates of service from 1/11/24 to 3/7/24 revealed the discharge reason was exhausted benefits, patient declines treatment. The short-term goals of five times sit to stand was not met, patient is unable to complete without physical assistance. The short-term goal of patient will decrease risk for falls as evidenced by a decrease (improved) score on the TUG (timed up and go) to two minutes was not met, patient is unable to participate. The long-term goal of patient will ambulate 200 feet with rollator with modified independence was not met, ambulates 20 feet with two wheel walker and contact guard to minimum assistance. Discharge location was other (hotel). Assistance/support to be provided was none. Functional skills assessment at discharge, bed mobility Independent; transfers sit to stand partial to moderate assistance; chair/bed to chair transfer partial to moderate assistance; toilet transfer partial to moderate assistance; ambulation 10 feet with partial to moderate assistance. Resident uses a wheelchair. Picking up objects partial to moderate assistance. Progress and response to treatment, patient demonstrates minimal progress as patient continues to require assistance for activities of daily living (ADLs) and functional skills. Discharge recommendations: patient not deemed safe to discharge from facility without assistance. -However, the facility discharged the resident without assistance. -Review of all the progress notes revealed there were no IDT or care conference notes related to discharge planning. (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	04/02/2024

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 0622 Level of Harm - Actual harm Residents Affected - Few	The discharge summary (undated) listed the current functional status as partial/moderate assistance for sit to lying and lying to sit transfers, eating and oral hygiene; supervision or touching assistance for sit to stand transfers, chair/bed to chair transfers, toilet transfers, walking 50 feet with two turns once standing. The dietary summary of stay revealed in pertinent part, He is anxious about his upcoming discharge with no changes in his housing situation. The resident has bilateral foot ulcers. His ulcers are being followed by the wound care team and no signs of infection noted. He also worked with PT/OT and is now able to transfer with minimal assistance. They are now discharging him home. The social services summary revealed other (insurance) as the reason for the initiated discharge. Reason for discharge listed as, end of insurance coverage. Discharge goal, return to the community. Will the resident have a caregiver after discharge? No. Comments, The Veterans Administration (VA) was unable to accept so the facility bought resident hotel room for three nights. Home health services? No. Nurse note dated 3/8/24 revealed, Taxi came to pick the resident up and take him to (brand name) motel in Aurora. Left at 1500 (3:00 p.m.) and left with all of his belongings, discharge packet, medication and times. Skin is intact but his both feet that had frost bites, and his dressing were changed before he left. Denied any pain when asked. Resident signed the discharge packet before he left. Hospital emergency department and admission notes, dated 3/11/24, revealed in pertinent part, Patient presented after being found down. He states that he was non ambulatory but was told he would have to leave his post-acute facility because of insurance. States that the facility paid for three days at a motel and discharged him. He ended up lowering himself to the ground when he got there he could not get up. The only symptom he endorses is dysuria (pain or burning with urinating) of unknown time-course. Patient reports that he was trying to transfer, however he ended up on the ground. No fall or head strike. Unable to get up due to weakness. Remained on the ground for three days until a friend found him and brought him to the emergency department. Noted that he had previously been in rehab however his insurance ran out and he was sent to a motel room. Reports dysuria and hematuria (blood in urine). The hospital progress note dated 3/13/24, Patient's prior provider reported history of cognitive impairment and lack of insight however patient was discharged to motel without any support. Patient continues to lack capacity today as he is agreeable to placement but cannot name any downside and has assigned a virtual stranger as MDPOA and again cannot name any downsides of this decision. Patient reports feeling much better today. He didn't remember who we were today but he was in shock when we saw him yesterday. He remembers being discharged to the motel and living in his car prior to the (rehab) stay. He reported that the (rehab) didn't give him any other option than to discharge to the motel and he was scared of being on his own. He could not identify how he could have gotten food or other care. -The resident was admitted to the hospital on 3/11/24 and was there as of 4/1/24 due to the lack of capacity to make medical or discharge decisions. (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	04/02/2024

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 0622 Level of Harm - Actual harm Residents Affected - Few	V. Staff interviews The social services director (SSD) was interviewed on 3/28/24 at 8:47 a.m. The SSD said he processed the discharge for Resident #140. The SSD said he was hoping that the resident would stay for LTC, but he did not want to. The SSD said the resident did not qualify with the VA so he arranged for the motel for three days. The SSD said he did not have any IDT or care conference notes but a lot of information was discussed in the morning meeting. However, he said the team did not do a good job of documenting the discussions. The SSD said adult protective services (APS) was called but they declined to open a case. The SSD said he did not contact/refer to home health services because he thought they did not go to motels. The SSD said Resident #140 did not have a cell phone but thought he would use the motel phone for his needs. The SSD said for food he thought the resident would order it like he did before when he was homeless. The undated discharge summary documented for the resident to call 911 if he did not feel well. -However, the resident had no cell phone and was on the floor and unable to reach the motel phone. The business office manager (BOM) was interviewed on 3/28/24 at 9:01 a.m. She said she spoke with the resident on multiple occasions and the resident did not want to stay in the LTC. He wanted to go to the community. She said the resident did not want to pay his patient liability and was over-resourced and did not want to spend down in order to qualify for Medicaid. The BOM said the discharge date was determined by the resident's managed care insurance company. She said according to the resident's managed care insurance company he had reached his maximum potential. The BOM said she provided the resident notice regarding his discharge from therapy and told him how to appeal. She said the resident needed to discharge from the facility or go private pay because he did not want to activate Medicaid. The BOM said she did not issue a facility-initiated discharge notice from the facility for non-payment. The director of nursing (DON) was interviewed on 3/28/24 at 12:14 p.m. The DON said she reviewed all of Resident #140's notes. The DON said she talked to the wound care nurse (WCN) and the WCN had educated Resident #140 however she had not documented her education. The DON said she did not see any documentation about issuing Resident #140 wound care supplies at discharge. The DON said she had started nursing education the night before regarding the proper discharge process including documentation of wound care education and teaching others about medication. The DON said she was not sure why home health services were not ordered she thought it would have been. Licensed practical nurse (LPN) #3 was interviewed on 3/28/24 at 2:48 p.m. She said she was the nurse who discharged Resident #140 on 3/8/24. She said she recorded the discharge in the nurses notes and reviewed the medications with him. She said she did not document she educated the resident and Resident #140 did not do a return demonstration about the wound care. LPN #3 said she did not document that wound care supplies were offered to the resident and he said he did not need it because he was not going to do his wound care. LPN #3 said she did not know why the facility did not order home health care for the resident because they usually did. LPN #3 said Resident #140 used a wheelchair to get to the cab at discharge. The RCR was interviewed on 4/1/24 at 2:55 p.m. She said the facility did not issue a facility initiated discharge notice to Resident #140 beyond the discharge from therapy and the signed discharge summary on the day of discharge. (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	04/02/2024

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 0622 Level of Harm - Actual harm Residents Affected - Few	IV. Facility follow-up The DON provided the following educational information on 3/28/24 at 1:14 p.m. It read in pertinent part, Will report on discharges monthly during QAPI. Nurse education of requirements of hospital discharge paperwork requirements and bed hold policy. Topic: transfer to hospital; against medical advice (AMA); another facility; discharge to death process. Staff sign-in sheet provided. Transfer to hospital education and Discharge to another facility education. The facility physician (PHY) provided his discharge summary to the facility on [DATE] at 1:36 p.m. The progress note was dated 3/5/24 and read in pertinent part, Reason for Appointment: DC (discharge) planning. History of Present Illness: Follow-up: Patient with multiple hospitalization s due to failure to thrive. Planning to discharge back into the community despite not having any stable housing. Discussion with the patient regarding the risk of progressive decline with unstable housing and unpredictable care in the community but he is not willing to consider staying long-term or transitioning to the assisted living due to concerns about losing his income. He reports having income from both Social Security, veterans administration and a pension he has. Patient verbalizes understanding that his decision to discharge back to the motel and partially living out of his car is fraught with risk. Recent hospitalization with frostbite. Wounds to both lower extremities with significant improvement. No signs of infection. Continues to have episodes of blood in the urine but this is significantly decreased since cutting back on the Eliquis (anticoagulant) dosing. No significant drop in his hemoglobin in the interim. Denies any pain with urination. No Dizziness. Denies shortness of breath or increased oxygen requirement. He has been making some progress with therapy. Able to ambulate for short distances with a walker. No fall reported during today's visit. Medication list verified in the facility MARS (medication administration record). Recent labs reviewed. Discussion with facility staff. Treatment: Clinical Notes: Failure to thrive in adult-patient unlikely to thrive on his own in the community but does not want to be institutionalized as yet. Discussion at length with the patient regarding the risk of discharging since he does not have any reliable caregivers or other residents in the community. Agreed with the patient that we will call back if he finds himself struggling in the community for readmission to the facility. Housing instability-patient living between his current motels. Not willing to transition to long-term or assisted living facility due to concerns regarding his income being taken by the facility. Likelihood of him not feeling well was discussed with the patient and he verbalizes understanding.

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	04/02/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on record review and staff interviews, the facility failed to ensure one (#140) of three residents and/or their responsible person and the ombudsman were provided a written discharge notice to include the reasons for the move in a language and manner they would understand out of 34 sample residents. Specifically, the facility failed to provide Resident #140 an appropriate written notice of discharge from the facility that included: -The reason for transfer or discharge; -The effective date of transfer or discharge; -The location to which the resident was transferred or discharged ; -A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; -Information on how to obtain an appeal form and assistance in completing the form and submitting the appeal-hearing request; and, -The name, address (mailing and email) and telephone number of the Office of the State. In addition, the facility failed to provide notice to the ombudsman of Resident #140's discharge. Findings include: I. Facility policy The Admission Agreement policy, dated 2018, was provided by the regional clinical resource (RCR) on 3/31/24 at 5:54 p.m. It read in pertinent part, Nonpayment of invoices or failure to arrange for payments from a payment source will result in your discharge. You will receive a written notice of your impending discharge at least thirty (30) days before the effective date of such discharge. As a resident of our facility, you may not be transferred or discharged from our facility against your wishes except for the following reasons: You fail to pay for your stay at our facility after reasonable and appropriate notice, including your failure to submit the necessary paperwork for third-party payment after the third-party payor (including Medicare and Medicaid) denies the claim and you refuse to pay for your stay. We will provide you with written notification thirty (30) days in advance of the planned (non-emergency) transfer or discharge. The written notice also will contain a statement regarding your right to appeal the decision and any other information required by applicable Federal or state law. (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	04/02/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. Resident status Resident #140, age 80, was admitted on [DATE] and discharged on [DATE] to a motel. According to the March 2024 computerized physician orders (CPO), diagnoses included urinary tract infection, atrial fibrillation (abnormal heart rhythm), type II diabetes mellitus, history of falling, depression and anxiety disorder. The 1/15/24 admission 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. He was dependent with shower/bathing, upper and lower body dressing, toileting hygiene, bed mobility and transfers. He was able to walk 10 feet once standing with set up help. The resident used a manual wheelchair. The 3/8/24 discharge MDS assessment revealed a BIMS score of 14 out of 15. He was independent with shower/bathing, upper and lower body dressing, toileting hygiene, bed mobility and transfers. Walking 10 feet was not attempted due to medical conditions or safety concerns. He was independent with a manual wheelchair. The assessment indicated active discharge planning was already occurring for the resident to return to the community. The assessment indicated no referral had been made to the local contact agency and the reason was referral not wanted. III. Record review Record review revealed the facility failed to provide a written notice for the facility initiated discharge to Resident #140 to include his appeal rights and failed to send a copy of the notice to a representative of the office of the state long-term care ombudsman. On 4/1/24 at 2:55 p.m. documentation of the discharge notice that was provided to the resident and notification of the ombudsman were requested from the facility. -However, the facility failed to provide documentation of the discharge notice and notification to the ombudsman (see interviews below). The resident was discharged on [DATE] to a motel paid for by the facility for three days without home health services. The resident was admitted to the hospital on 3/11/24 after being found by the driver who dropped him off at the motel (cross-reference F622 for transfer and discharge requirements). The social services summary revealed other (insurance) as the reason for the initiated discharge. Reason for discharge was listed as, end of insurance coverage. Discharge goal, return to the community. Will the resident have a caregiver after discharge? No. Comments, The Veterans Administration (VA) was unable to accept so the facility bought resident hotel room for three nights. Home health services? No. (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	04/02/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse note dated 3/8/24 revealed in pertinent, Taxi came to pick the resident up and take him to (brand name) motel in (name or city). Left at 1500 (3:00 p.m.) and left with all of his belongings, discharge packet, medication and times. Skin is intact but his both feet that had frost bites, and his dressings were changed before he left. Denied any pain when asked. Resident signed the discharge packet before he left. Hospital emergency department and admission notes, dated 3/11/24, revealed in pertinent part, Patient presented after being found down. He states that he was non ambulatory but was told he would have to leave his post-acute facility because of insurance. States that the facility paid for three days at a motel and discharged him. The hospital progress note dated 3/13/24, Patient's prior provider reported a history of cognitive impairment and lack of insight however patient was discharged to motel without any support. IV. Staff interviews The social services director (SSD) was interviewed on 3/28/24 at 8:47 a.m. The SSD said he did not contact the ombudsman or issue a facility discharge notice. The regional clinical resource (RCR) was interviewed on 4/1/24 at 2:55 p.m. The RCR said the facility did not issue a facility initiated discharge notice to the resident or notify the ombudsman.

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	04/02/2024

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on record review and interview, the facility failed to maintain medical records on each resident that were accurately documented for one (#11) out of 18 residents reviewed out of 34 sample residents. Specifically, the facility failed to ensure Resident #11's medical orders for scope of treatment (MOST) form corresponded with physician orders for resuscitation orders. Finding include: I. Facility policy and procedure The Advanced Directives policy and procedure, reviewed [DATE], was provided the the regional clinical resource (RCR) on [DATE]at 3:48 p.m. It read in pertinent part, The advance directive and cardiopulmonary resuscitation (CPR) decisions will be reviewed in writing on admission and annually, when requested by the resident or as needed. II. Resident #11 A. Resident status Resident #11, age less than 65, was admitted on [DATE] and readmitted [DATE]. According to the [DATE] computerized physician orders (CPO), the diagnoses included respiratory failure, chronic obstructive pulmonary disease (COPD) and schizoaffective disorder. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. He was independent with eating, toileting, personal hygiene, bed mobility and transfers. B. Record review The MOST form, dated [DATE] by the resident and signed and dated by advanced practice nurse (APN) on [DATE], revealed the resident wished to receive CPR (cardiopulmonary resuscitation). The March CPO revealed an order for Resident #11's code status as do no resuscitation (DNR), ordered [DATE]. -The electronic medical record physician order did not correspond with the directive on the MOST form, after the resident was readmitted . III. Staff interviews (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	04/02/2024

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #2 was interviewed on [DATE] at 11:00 a.m. He said the admitting nurse was responsible for obtaining the signatures for the MOST form. He said it was his responsibility for making sure the forms were filled completely and accurately. He said he was responsible for ensuring the physician orders accurately reflected the resident's wishes in the MOST form. He said there was discrepancy between the MOST form and the physician order for Resident #11. The nursing home administrator was interviewed on [DATE] at 1:35 p.m. He said the health information manager was responsible for completing MOST form audits to ensure completeness and accuracy. They currently did not have a health information manager. The director of nursing (DON) was admitted on [DATE] at 2:01 p.m. If a resident returned after a hospitalization the MOST form needed to be reviewed and completed. If the resident's wishes changed after readmission and if their wishes changed a new MOST form needed to be completed. A review and audit of MOST forms were conducted during quarterly care conferences. She said the facility conducted monthly audits of the MOST forms and the unit manager was responsible for ensuring this was completed. She said in an emergency it was important MOST form and the electronic medical record were accurate and matched so there was no confusion during an emergency.

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	04/02/2024

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 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** 48113 Based on observations, interviews and record review, the facility failed to assist residents with making appointments and arranging transportation for vision services for one (#14) resident reviewed for vision/ancillary services out of 34 sample residents. Specifically, the facility failed to offer and make an appointment for optometry services for Resident #14. Findings include: I. Facility policy The Ancillary Services policy and procedure, revised 9/29/23, was provided by the nursing home administrator (NHA) on 4/1/24 at 3:47 p.m. It revealed in pertinent part, any resident needing or requesting ancillary services such as dental, vision, audiology and podiatry will have their needs met timely. The facility will keep available a provider for ancillary services and/or assist the resident with utilizing the provider of their choice. Ancillary services are available to all residents requiring routine and emergency ancillary services care. Social Services and or designee will be responsible for ensuring residents needing ancillary services receive needed/requested services in a timely manner. The facility staff designee will coordinate transportation and appointments with all other pertinent parties to ensure Ancillary service appointments are met. Records of ancillary services will be kept in the resident's medical record for a period of one year. II. Resident status Resident #14, age greater than 65, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included bipolar disorder, schizoaffective disorder, type 2 diabetes, hypertension and depression. The 12/22/23 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. He was independent with eating, toileting and used a walker for mobility. The 12/22/23 MDS assessment revealed the resident had adequate vision but did not wear any corrective lenses. III. Resident observation and interview Resident #14 was interviewed on 3/27/24 at 2:06 p.m. The resident was wearing glasses at the time of the interview. Resident #14 said he had a hard time seeing. He said his vision had become blurry and it was hard to read any documents or words on the television. He said he needed to wear his glasses all the time to see and without them he could not see and he never knew he could get his prescription updated. (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	04/02/2024

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #14 said he had told nursing staff he needed to see the eye doctor a few months ago but no staff had followed up with him about an appointment. He said his vision was worse since she was admitted and he would love to see the eye doctor and get a new prescription or updated glasses in order to see again. IV. Record review The March 2024 CPO revealed the following physician's order: The resident may have dental, podiatry, audiology and optometry care as needed. Ordered 4/20/23 -Review of Resident #14's care plan, revised 12/11/23, revealed the resident did not have a care plan in place for vision and or corrective lenses. -Review of Resident #14's electronic medical record (EMR) did not reveal the resident was offered or provided access to optometry services. The 12/22/23 MDS assessment was revised on 3/28/24 (during the survey). The MDS revision on 3/28/24 revealed the resident wore corrective lenses and had adequate vision. The resident's care plan was updated on 4/1/24 (during the survey), the care plan revealed Resident #14 has impaired visual function. He reports that he has trouble seeing with his current glasses. Interventions included: Arrange consultation with eye care practitioners as required, ensure appropriate visual aids (glasses) are available to support resident's participation in activities, identify/record factors affecting visual function. V. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 3/28/24 at 3:58 p.m. CNA #1 said she was unsure if Resident #14 wore glasses or if he had impaired vision. She said if the resident complained to her about impaired vision she would let the nurse know. She said sometimes it was hard to remember to tell the nurse if she got busy and had to provide care to other residents. Licensed practical nurse (LPN) #3 was interviewed on 3/28/24 at 4:04 p.m. LPN #3 said she was aware Resident #14 had to wear glasses in order to see and without them he had difficulty seeing. She said if the resident complained of vision problems she would notify the social services director (SSD) so he could put the resident on the list to be seen by the eye doctor. The SSD was interviewed on 3/28/24 at 4:27 p.m. The SSD said residents and/or the residents' responsible party should be offered ancillary services upon admission and every quarter during the care plan conference. He said the resident should also have a care plan in place if a resident worse glasses or had any corrective lenses and or had impaired vision. He said he was unable to find documentation to indicate Resident #14 and/or his representative were offered optometry services since the resident's admission on 11/27/23. (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	04/02/2024

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 3/28/24 at 4:35 p.m. The DON said if a resident experienced changes in their vision or had impaired vision the nursing staff should contact the physician for orders. She said nursing staff should notify the SSD in order to place the resident on the ancillary services list to ensure the resident was seen by the optometrist. The DON said she needed to provide an all staff education related to ancillary services.

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	04/02/2024

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 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** 48113 Based on observations, record review and interviews, the facility failed to ensure one (#14) resident reviewed for ancillary services out of 34 sample residents received routine dental care obtaining routine and 24-hour emergency dental care. Specifically, the facility failed to refer Resident #14 to the dentist to obtain dentures and address his mild teeth pain. Findings include: I. Facility policy The Ancillary Services policy and procedure, revised 9/29/23, was provided by the nursing home administrator (NHA) on 4/1/24 at 3:47 p.m. It revealed in pertinent part, any resident needing or requesting ancillary services such as dental, vision, audiology and podiatry will have their needs met timely. The facility will keep available a provider for ancillary services and/or assist the resident with utilizing the provider of their choice. Ancillary services are available to all residents requiring routine and emergency ancillary services care. Social Services and or designee will be responsible for ensuring residents needing ancillary services receive needed/requested services in a timely manner. The facility staff designee will coordinate transportation and appointments with all other pertinent parties to ensure Ancillary service appointments are met. Records of ancillary services will be kept in the resident's medical record for a period of one year. II. Resident status Resident #14, age greater than 65, was admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses included bipolar disorder, schizoaffective disorder, type 2 diabetes, hypertension and depression. The 12/22/23 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. He was independent with eating, toileting and used a walker for mobility. The assessment revealed the resident did not have any mouth or facial pain, discomfort or difficulty with chewing. III. Resident observation and interview Resident #14 was interviewed on 3/27/24 at 2:06 p.m. The resident's teeth were observed. The resident's top set of teeth had four incisors remaining with one chipped. Resident #14 said he had a hard time chewing food due to pain and missing teeth. He said since he was admitted he wanted to see the dentist and told nursing care staff who admitted him. He said he needed partial dentures for his top set of teeth in order to eat foods he liked such as apples. Resident #14 said he had mild teeth pain since February 2024 that remained unaddressed. (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	04/02/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Record review The March 2024 CPO revealed the following physician's order: The resident may have dental, podiatry, audiology and optometry care as needed. Ordered 4/20/23. -Review of Resident #14's care plan, revised 12/11/23, revealed the resident did not have a care plan in place for dental care and or oral hygiene. -Review of Resident #14's electronic medical record (EMR) did not reveal the resident was offered or provided access to dental services. The resident's care plan was updated on 4/1/24 (during the survey), the care plan revealed Resident #14 reported he has oral/dental health problems. He has consented to be seen by the dentist. Interventions included: coordinate arrangements for dental care, transportation as needed/as ordered, monitor,document and report as needed any signs or symptoms of oral and dental problems needing attention: pain (gums, toothache, palate), teeth missing, loose, broken, eroded, and decayed. V. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 3/28/24 at 3:58 p.m. CNA #1 said she was unsure if Resident #14 had missing teeth or if he wanted dentures. She said if the resident complained to her about tooth pain then she would let the nurse know. She said sometimes it was hard to remember to tell the nurse if she got busy and had to provide care to other residents. Registered nurse (RN) #1 was interviewed on 3/28/24 at 4:04 p.m. RN #1 said she was aware Resident #14 had missing top teeth. She said if the resident complained of tooth pain and or a request for dentures she would notify the social services director (SSD) so he could put the resident on the list to be seen by the eye doctor. The SSD was interviewed on 3/28/24 at 4:27 p.m. The SSD said residents and/or the residents' responsible party should be offered ancillary services upon admission and every quarter during the care plan conference. He said the resident should have a care plan in place for dental care if he had missing teeth and or tooth pain. The SSD said he was unable to find documentation to indicate Resident #14 and/or his representative were offered dental services since the resident's admission on 11/27/23. The director of nursing (DON) was interviewed on 3/28/24 at 4:35 p.m. The DON said if a resident experienced tooth pain and or had concerns about their teeth then the nursing staff should contact the physician for orders. She said nursing staff should notify the SSD in order to place the resident on the ancillary services list to ensure the resident was seen by the dentist. The DON said she needed to provide an all staff education related to ancillary services.