

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065294	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2023
NAME OF PROVIDER OR SUPPLIER Lamar Estates, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 205 S 10th St Lamar, CO 81052	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** V. Resident #13</p> <p>A. Resident status</p> <p>Resident #13, age above 65, was admitted on [DATE]. According to the September 2023 computerized physician orders (CPO), the diagnoses included rhabdomyolysis (breakdown of muscle tissue), dementia, anxiety disorder, Parkinson's disease and essential tremors (shaking).</p> <p>The 6/28/23 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) of four out of 15. He had disorganized thinking. He required extensive assistance with bed mobility, transfers, walking in room and corridor, locomotion on and off the unit, dressing, toilet use and personal hygiene. He required supervision with eating. He received a mechanically altered diet as well as a therapeutic diet. He had broken or loose fitting dentures. He had mouth or facial pain, discomfort or difficulty with chewing.</p> <p>B. Record review</p> <p>A physician's order dated 7/20/23 at 3:45 p.m., revealed the resident was admitted to hospice.</p> <p>The resident's plan of care was reviewed on 9/25/23 at 9:59 a.m. it did not reveal a care plan that addressed his hospice needs.</p> <p>C. Staff interviews</p> <p>Certified nurse aide (CNA) #1 was interviewed on 9/27/23 at 3:13 p.m. She said the facility staff did all the activities of daily living (ADL) for the hospice resident. She said the hospice staff gave the shower and did pain management. She said there was not a care plan to follow. However, she communicated with the hospice staff verbally. She said hospice staff had a sign in sheet that they signed when visiting a resident.</p> <p>Registered nurse (RN) #1 was interviewed on 9/27/23 at 3:15 p.m. She said she communicated directly with the hospice staff during their visits. She said he did not have a hospice care plan in place. She said she was not sure if a care plan was required.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The director of nursing (DON) was interviewed on 9/27/23 at 3:47 p.m. She said there was a hospice communication binder at the nurses station. She said the staff communicated with hospice in person and/or via the phone. She said all residents on hospice must have a care plan. She said it was important to have a hospice care plan in place to identify care needed, the residents goals and measure the outcome of the interventions. She said she would immediately audit residents on hospice services and assure they had a care plan in place.</p> <p>Based on observations, record review and interviews, the facility failed to ensure comprehensive person-centered care plans were developed in accordance with professional standards of practice for three (#13, #15 and #19) of twelve reviewed out of 24 sample residents.</p> <p>Specifically, the facility failed to ensure a comprehensive care plan was initiated for:</p> <ul style="list-style-type: none"> -Resident #15 for depression; -Resident #19 for urinary catheter care; and, -Resident #13 for hospice care and services. <p>Findings include:</p> <p>I. Facility policy</p> <p>The Care Plan, Comprehensive Person-Centered policy, March 2022, was received from the nursing home administrator (NHA) on 3/ 27/23 at 4:59 p.m. The policy documented in pertinent part:</p> <p>A comprehensive, person-centered care plan that includes measurable objectives and timelines ato meet the resident's physical, psychological and functional needs is developed and implemented for each resident;</p> <p>The interdisciplinary team (IDT), in conjunction with the resident develops and implements a comprehensive, person-centered care plan for each resident;</p> <p>The comprehensive, person-centered care plan is developed within seven days;</p> <p>The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment;</p> <p>The comprehensive care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychological well-being and reflects the standards of practice for problem areas and conditions.</p> <p>II. Resident #15</p> <p>A.Resident status</p> <p>Resident #15, over the age of 65, was admitted on [DATE]. According to the September 2023 computerized physicians orders (CPO), diagnoses included major depressive disorder and a history of falling.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 7/14/23 minimum data set (MDS) assessment document the resident had no cognitive impairment as evidenced by a brief interview for mental status (BIMS) with a score of 15 out of 15. She required extensive, two-person assistance for bed mobility, transfers, toileting and locomotion on and off the unit. The resident was administered antidepressant medication when admitted to the facility.</p> <p>B. Record review</p> <p>The record review revealed the resident was prescribed and administered the antidepressant medication, fluoxetine, 20 milligrams (mg) one time a day on 4/21/23.</p> <p>The comprehensive care plan, initiated on 4/24/23 was reviewed and the care plan failed to identify individual needs that included a focus, goal and interventions for the care of the resident's depression.</p> <p>III. Resident #19</p> <p>A. Resident status</p> <p>Resident #19, over the age of 65, was admitted on [DATE]. According to the September 2023 CPO, diagnoses included multiple sclerosis, diabetes, bone cancer, above the knee amputation, colostomy, urostomy (urinary catheter) and low back pain.</p> <p>The 6/16/23 minimum data set (MDS) assessment documented the resident had no cognitive impairment as evidenced by a brief interview for mental status (BIMS) with a score of 15 out of 15. She required supervision from staff for bed mobility, transfers, locomotion on and off the unit, dressing, eating, toileting and personal hygiene. The resident had a urinary catheter at the time of her admission.</p> <p>B. Record review</p> <p>The comprehensive care plan, initiated on 3/26/23 was reviewed and the care plan failed to identify individual needs that included a focus, goal and interventions for the care of the Resident's urinary catheter including her supra pubic urinary catheter.</p> <p>IV Staff interviews</p> <p>Certified nurse aide (CNA) #1 was interviewed on 9/27/23 at 2:55 p.m She said she was aware Resident #19 had an urinary catheter.and the resident cared for her catheter. The CNA said she did not know about care she should provide such as monitoring for resident's urine amount or signs or symptoms of a urinary tract infection. She said she would notify the nurse if the resident had concerns about her urinary catheter.</p> <p>The CNA was interviewed regarding Resident #15. She said she was unaware the resident had depression and was unaware if the resident had individual needs regarding depression. The CNA said if she noticed changes in the resident's mood she would notify the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Registered nurse (RN) #1 was interviewed on 3/27/23 at 3:49 p.m. She said and she said she was unaware of specific monitoring or care staff provided for Resident #19's urinary catheter. Resident #19 should be monitored for any signs or symptoms of infection, urinary tract infection, dehydration and whether the catheter was draining urine as expected.</p> <p>RN #1 was interviewed regarding Resident #15. She said she was aware the resident received antidepressant medication. The RN said she was unaware if the resident had specific needs for her depression and what triggered the depression for the resident.</p> <p>The director of nursing (DON) was interviewed on 9/27/23 at 4:10 p.m. She said resident care plans reflected individual care required by each resident. The DON said resident status was monitored by staff and care plans should be prepared and updated when required. The DON said the care plan was important because it was used by facility staff to ensure care was provided correctly to meet the needs of each resident.</p> <p>The DON said for a urinary catheter the staff should monitor skin integrity, hydration status, patency and positioning of the urinary catheter, catheter comfort and ability to provide self-care.</p> <p>The DON said when a resident has depression the care plan should include information specific to the resident that identified causes of depression, triggers to avoid or manage and mood management.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on record review and staff interviews the facility failed to provide services for six (#2, #3, #6, #12, #15 and #17) out of nine sample residents according to professional standards of practice.</p> <p>Specifically, the facility failed to clarify physician's orders with dose information for the administration of topical skin medications for Residents #2, #3, #6, #12, #15 and #17.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>A. The Diclofenac gel drug information was accessed on 9/26/23 on the Physicians Drug Reference website at https://www.pdr.net/drug-summary/Voltaren-XR-diclofenac-sodium-2033. Diclofenac is a nonsteroidal anti-inflammatory (NSAID) medication that could be prescribed in intravenous, oral, topical, and ophthalmic formulations.</p> <p>The use of analgesic and antipyretic properties increases the risk of serious gastro-intestinal events and may increase serious cardiovascular events; use the lowest dose of the shortest time.</p> <p>The topical dosage of diclofenac gel is prescribed as four grams (four and one half inches) topically four times a daily, with a maximum of 16 grams a day per lower extremity joint) and/or two grams (two and one fourth inches) topically four times daily per upper extremity joint. Do not exceed a total dose of 32 grams over all affected joints.</p> <p>B. The Icy Hot drug information was accessed on 9/26/23 on the Federal Drug Administration (FDA) website at https://fda.report/DailyMed/40c8c02f-fa5f-4e80-81a0-48271fa6f94b.</p> <p>Icy hot is used for temporary relief of aches and pain and is used only on the skin.</p> <p>Icy hot should be used as directed on the label or as prescribed by the physician. The active ingredient in icy hot is menthol and if over used, could lead to burning pain, swelling, and blistering of the skin where it was applied. The topical medication should not be applied more than four times daily.</p> <p>C. The Salonpas Lidocaine Plus cream drug information was accessed on 9/26/23 on the FDA website at https://fda.report/DailyMed/364924d3-fac3-4f4e-9b40-decd4ec48245. The cream contains lidocaine four percent and was used on the skin for temporary pain relief. Lidocaine cream should be used as directed on the label. If too much lidocaine was absorbed, symptoms of dizziness and agitation may occur and toxicity may lead to cardiovascular or respiratory failure.</p> <p>II. Facility policy</p> <p>The Medication Administration policy, dated April 2007, was received by the nursing home administrator on 9/27/23. The policy stated in pertinent part:</p> <p>Documentation must include, as a minimum:</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. Name and strength of the drug;</p> <p>b. Dosage;</p> <p>c. Method of administration;</p> <p>d. Date and time of administration;</p> <p>e. Reason why medication was withheld or refused;</p> <p>f. Signature and title of the person administering the medication;</p> <p>g. Resident response to the medication.</p> <p>III. Record review</p> <p>Resident #15 had a physician order for muscle rub cream 10-15%. The order directed the medication to be applied every six hours and failed to include a dose.</p> <p>Resident #6 had a physician order for Voltaren gel one percent. The order directed the medication to be applied every six hours and failed to include a dose.</p> <p>Resident #3 had a physician order for muscle rub cream 10-15%. The order directed the medication to be applied every six hours and failed to include a dose.</p> <p>Resident #17 had a physician order for Icy Hot cream. The order directed the medication to be applied every six hours and failed to include a dose.</p> <p>Resident #12 had a physician order for muscle rub cream. The order directed the medication to be applied every six hours and failed to include a dose.</p> <p>Resident #2 had a physician order for Salonpas Lidocaine Plus cream four-10%. The order directed the medication to be applied every six hours and failed to include a dose.</p> <p>IV. Interviews</p> <p>Registered nurse (RN) #1 was interviewed on 9/27/23 at 3:49 p.m. She said that she was unaware diclofenac gel required a measured dose. She said she used a dime-sized amount of muscle rub and Lidocaine cream. She said if an order for medication was missing the dosage, the nurse should contact the physician for the correct dosage.</p> <p>The director of nursing (DON) was interviewed on 9/27/23 at 4:10 p.m. She said she was unaware the physician orders for Voltaren, Lidocaine and muscle rub did not include the dosage information. The DON said medication orders should contain dosage information and the nurse should contact the physician if the dosage information was not available.</p>