STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065294	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAMAR ESTATES, LLC	205 SOUTH 10TH STREET 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)
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure nutritional parameters were maintained for two (#6 and #5) of four residents reviewed for nutritional status out of six sample residents. Specifically, the facility failed to ensure Residents #6 and #5 had accurate food and hydration intake documentation, care plan revisions as needed and their food preferences and refusals were properly communicated with the dietary department. Findings include: I. Facility policy and procedure The Nutrition/Unplanned Weight Loss policy, revised September 2017, was received from the director of nursing (DON) on 8/21/2020. It read in pertinent part: -The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time. -The staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis, and wishes. II.Resident #6 status A. Resident status Resident #6, age 88, was originally admitted on [DATE], and readmitted on [DATE]. According to the August 2020 computerized physician orders, [DIAGNOSES REDACTED]. According to the 7/6/2020 minimum data set assessment, the resident had severe cognitive impairment with a brief interview for mental status score of four out of 15. No mood symptoms were identified. No behavioral symptoms were documented. The resident needed supervision with set-up for eating. The resident was identified with coughing or choking during meals or when swallowing medications. The resident was 65 inches tall and weighed 112 pounds. Weight loss status was no or unknown. B. Resident observation On 8/19/2020 at 10:51 a.m. Resident #6 was observed sitting in her wheelchair in front of her side table. Her meal was on her table, with 50% consumed. The meal intake for breakfast on 8/19/2020 at 8:26 a.m. was documented to indicate the resident ate 76-100% of her meal. C. Resident record review The resident's weights were: 1/15/2020 at 123 pounds, 5/28/2020 at 108 pounds and 6/24/2020 at 112 pounds. A hydration care plan, initiated on 6/24/2019 with no revision, revealed the resident was at risk for dehydration related to occasional vomiting episodes. Interventions included to report poor meal and fluid intake to the physician and registered dietitian (RD). A dietary care plan, initiated on 6/26/2019, and revised 7/7/2020, revealed the resident was on a mechanical diet with thin liquids. Interventions included to notify the physician and power of attorney of weight status, record percentages of all intakes. A 6/22/2020 weight progress note documented that the resident's current body weight was 112 pounds. The resident was documented with supplements three times a day, a high calorie cookie twice a day, and ice cream with two meals a day. -No physician order was identified for the high calorie cookie or ice cream for nutritional intervention. A 6/24/2020 weight progress note documented that the resident's current body weight was 112 pounds. Weight loss indicated due to sporadic intakes. Nutritional supplement offered twice a day, for 4 ounces. Ice cream offered with meals. There was a recommendation to increase supplements to three times a day. A physician order was placed on 6/24/2020 for supplement of choice, 4 ounces, and to record the percentage amount consumed. A dietary progress note on 7/7/2020 documented the resident was ordered a house shake three times a day and at all meals. A care plan meeting on 7/9/2020 documented the resident was on house shake supplements three times a day only. Fluid intakes documented from 7/21/2020 to 8/19/2020 did not reveal the resident refused fluids. The August 2020 electronic Medication Administration Record [REDACTED]. physician progress notes [REDACTED]. physician progress notes [REDACTED]. III. Resident #5 status A. Resident status Resident #5, age 71, was originally admitted on [DATE], and readmitted on [DATE]. According to the August 2020 computerized physician orders, [DIAGNOSES REDACTED]. According to the 8/3/2020 minimum data set assessment, the resident had severe cognitive impairment with a brief interview for mental status score of zero out of 15. Mood symptoms included being tired with little energy. The resident needed total assistance from one person staff for eating. The resident was 59 inches tall and weighed 100 pounds. Weight loss status was yes, loss of 5% or less in the last month or loss of 10% or more in the last 6 months. The resident's edentulous status was not documented in the MDS. B. Resident observation On 8/19/2020 at 10:50 a.m. Resident #5 was observed in her room, sitting up in her wheelchair. On the table was breakfast, consisting of two-thirds full cup or orange juice, two-thirds full cup of milk. There was an untouched bowl of cream of wheat hot cereal. A full mug of ice water was on the table. The side table was not in reach for the resident. The meal intake for breakfast on 8/19/2020 at 8:52 a.m. was documented to indicate the resident ate 0-25% of her meal. C. Resident record review The resident's weights were: 2/27/2020 at 130 pounds, 5/20/2020 at 112 pounds, 6/23/2020 at 100 pounds, and on 7/23/2020 at 100 pounds. A risk for complications, discomfort, and signs and symptoms related to [MEDICAL CONDITION] was initiated on 1/21/2015. The intervention was to weigh the resident weekly. This was not being completed. A hydration care plan, initiated on 1/21/2015, and revised 6/10/2020, revealed the resident was at risk for dehydration related to occasional vomiting episodes. Interventions included to document fluid intake every meal and record. A dietary care plan, initiated on 1/15/2020, and revised 8/6/2020, revealed the resident was on a regular diet and often refused meals. The resident was noted to weigh 100 pounds on 8/6/2020. She was documented with unavoidable weight loss due to decline. Interventions included to continue to offer good nutrition and hydration, and to continue to notify the resident's family and physician of weight loss. Additional interventions included to document refusals, continue snacks and fortified foods. A nutritional assessment by the dietitian (RD), on 5/28/2020, documented that the resident was noted with a current body weight of 112 pounds. A nutritional assessment by the RD, on 6/23/2020, documented that the resident was noted with an 11% weight loss in one month, possibly related to decreased intakes and refused meals, along with a history of [MEDICAL CONDITION]. A nutritional assessment by the RD, on 7/30/2020, documented that the resident was continuing to refuse meals. The resident was compliant with drinking supplements. The RD recommended to increase the supplements to 8 ounces. A physician order was placed on 5/1/2020 for a house supplement 4 ounces, three times a day. This was discontinued on 7/31/2020. It was replaced on 7/31/2020 for a house supplement of 8 ounces, three times a day. Nutritional supplement shakes were observed with the resident's lunch on 8/19/2020 at 12:20 p.m. Fluid intakes documented from 7/21/2020 to 8/19/2020 revealed numerous resident refusals of fluids. physician progress notes [REDACTED]. The physician did not document that the resident had weight loss. No new interventions due to resident refusals were identified by the physician. physician progress notes [REDACTED]. The physician did not document that the resident had weight loss. An 8/6/2020 care conference summary indicated the resident was on comfort care measures, and the resident had a poor appetite. The resident required full assistance at meals. IV.Staff failure to monitor meal intakes On 8/19/2020 at 12:35 p.m. a dietary aide was observed going down the facility hallway after lunch, pushing a cart with multiple bins on it. The aide entered each resident room, gathered up the cups and dishes from each resident, and took them back to the cart. The aide poured out leftover fluids, and scrapped out leftover food. The cups and plates were then put into bins. The aide did not document any intake percentages. On 8/19/2020 at 5:46 p.m. two dietary aides were observed going down the facility hallway after dinner, pushing carts with multiple bins on them. The aides again poured out leftover fluids, and scrapped out leftover food. The cups and plates were then put into bins. The aides did not document any intake percentages. V. Staff interviews Dietary aide (DA #1) was interviewed 8/19/2020 at 11:50 a.m. She said that the dietary staff were serving supplements during mealtime until a month ago. She said they learned that the nurses were also offering supplements, so they decided to stop providing them from the dietary department, and let the nurses do it. The dietary staff were not documenting intakes of

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

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) supplements. Dietary manager (DM) was interviewed 8/19/2020 at 1:50 p.m. She said that since the COVID-19 isolation requirements, they have not had nutritional assessment or risk meetings. She said that the facility had struggled with having access to an RD. She said they tried using house shakes for a while, but the residents did not like them. They went back to the shakes. She said each day the nurses would get them from the kitchen, and store them in the nurse refrigerators. She said all nutritional notes, if completed, would be in the electronic record. Registered nurse (RN #2) was interviewed on 8/19/2020 at 3:50 p.m. She said that she provided Resident #6 with nutritional supplements during meals, because that was when the resident was supposed to get them. She said the resident did not like the shakes much and usually only drank about 25%. She said they had tried different flavors, but the resident still did not like them. She said she let the DM and director of nursing (DON) know. She said the resident mentioned a different brand of shakes, which they tried. The resident continued to refuse. The RN said some residents received shakes between meals, just not Resident #6. She said she gets her first one around breakfast, and the second at lunch. She received a third one around 7:00 p.m. She said the resident was a good eater, and received supervision at meals. She said the nurse can revise the resident's care plan. RN #3 was interviewed on 8/19/2020 at 5:35 p.m. She said that Resident #5 required assistance at meals. She said the resident received supplemental shakes in between meals. She said the supplements should not be provided during meals, in order to ensure there is good meal intake. She said the resident goes up and down with eating compliance. She said the resident was going to be starting on hospice services. The RN said the certified nurse aides (CNA) kept track of meal intakes. DA #2 was interviewed on 8/19/2020 at 5:48 p.m. She said that aides chart the percentages of resident meal intakes for the residents that required hands-on assistance, and document it in the resident chart. She said the dietary aides charted all the percentages and fluid intakes for everyone else. After the observations of dietary aides pouring out drinks and cleaning off plates without documenting anywhere, the aide said that she just remembers how much all of the residents are or drank, and then documents that information after she has collected all of the dirty dishes and cups. She said that since she was familiar with the residents, she felt she could be accurate in her charting. DM was interviewed on 8/19/2020 at 5:56 p.m. She said that Resident #6 should be getting her nutritional supplements in between meals. She said some residents had not liked the shakes. She said she was not aware that Resident #6 did not like the shakes, that it had not been shared with dietary. She said that certified nurse aides would chart the intakes for the residents requiring assistance, and the dietary aides would chart for the rest of the residents. She said they have a log sheet that they should be using, as they document the intakes. They were to always use the logs to document intakes. The nursing home administrator (NHA), DON, and RN #4 were interviewed on 8/19/2020 at 6:15 p.m. They confirmed that nutritional supplements should not be provided during mealtimes, but in between, to ensure the resident had an appetite. They said that the intakes should be documented accurately and by following the appropriate guidance. This included using the log sheet.