STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065294	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lamar Estates Nursing Center	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)
F 0887 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to have a system in place to ensure all residents were offered and received an updated COVID-19 vaccination which matched the current variants.Record review revealed the facility was in outbreak status when nine residents tested positive for COVID-19 on 1/13/26. Within the next 14 days, an additional seven residents tested positive for COVID-19. Record review revealed the residents' electronic medical records (EMR) did not include documentation prior to the outbreak on 1/13/26 that indicated that residents or their representatives were provided education regarding the potential benefits and potential risks associated with the updated COVID-19 vaccine and there was no documentation of the COVID-19 vaccine being administered to residents or if residents did not receive the vaccine due to medical contraindication or refusal. Specifically, the facility failed to:-Document in the EMRs of 10 current residents (#2, #6, #7, #10, #12, #13, #15, #17, #21 and #23) that the residents had been provided education on 5/6/25 after the residents' said they wanted to receive the updated COVID-19 vaccine; -The facility failed to administer the COVID-19 vaccine to residents who consented to have the vaccine in May 2025 for Resident #2, Resident #6, Resident #7, Resident #10, Resident #12, Resident #13, Resident #15, Resident #17, Resident #21 and Resident #23 prior to the COVID-19 outbreak on 1/13/26; and, -The facility failed to document in the residents' EMRs whether education had been provided prior to the outbreak about the updated COVID-19 vaccine to the remaining residents (14) at the facility. Findings include:I. The facility's COVID-19 statusThe facility confirmed a positive case of COVID-19 on 1/13/26 when Resident #8 was hospitalized with altered mental status and diagnosed with COVID-19. All of the residents were tested and an additional eight residents tested positive on 1/13/26. By 1/14/26, an additional five residents tested positive for COVID-19 and one resident tested positive on 1/16/26. The facility was still following outbreak guidance when an additional resident tested positive for COVID-19 on 1/28/26. By 1/28/26, 16 of 24 residents and nine staff members had tested positive for COVID-19.II. Immediate jeopardyA. Findings of immediate jeopardyObservations, record review and resident and staff interviews from 1/26/26 to 1/29/26 revealed multiple failures in the facility's vaccine administration section of the infection control program, including failure to document in the residents' EMRs if/when the facility offered the COVID-19 vaccination to the residents, if the residents consented or refused the vaccination and if the facility provided education to the residents' who refused the COVID-19 vaccination on the risks versus benefits. On 5/6/25 15 residents consented to receive the updated COVID-19 vaccination when it became available. The vaccine was available for administration to facility residents by October 2025. The facility's plan was to provide a list to the pharmacist of all residents who wanted to receive the updated COVID-19 vaccine, in order for the vaccine to be administered when the pharmacist was at the facility. The facility had not provided the vaccination list to the pharmacist by the time the COVID-19 outbreak began on 1/13/26. All of the residents who had indicated on 5/6/25 that they wanted the updated COVID-19 vaccination when it was available had not received the (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 0887 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	vaccination. B. Record reviewResident #4's EMR revealed her last COVID-19 vaccination occurred on 12/16/21. Resident #4's EMR did not reveal documentation of the facility providing education to Resident #4 about the updated COVID-19 vaccine prior to the COVID-19 outbreak on 1/13/26.Resident #4's EMR revealed she tested positive for COVID-19 on 1/13/26.C. Staff interviewThe IP was interviewed on 1/27/26 at 9:01 a.m. The IP said Resident #4 was administered an antiviral medication (Paxlovid) after the onset of COVID-19. The IP said the NP had evaluated residents to determine who was at higher risk for complications and recommended Resident #4 receive the antiviral medication.XX. Resident #8A. Resident statusResident #8, age greater than 65, was admitted on [DATE]. According to the January 2026 CPO, diagnoses included pressure ulcer right buttocks, urinary retention, dysphagia (difficulty swallowing) and hypothyroidism.The 12/31/25 MDS assessment identified Resident #8 had moderate cognitive impairment with a BIMS score of nine out of 15. The MDS assessment revealed the resident required set-up assistance for eating and dressing, supervision for toileting, hygiene and transfers and moderate assistance for showering. The MDS assessment indicated the resident was not up to date on the COVID-19 vaccination. B. Record reviewResident #8's EMR did not reveal documentation of the facility providing education to Resident #8 about the updated COVID-19 vaccine prior to the COVID-19 outbreak on 1/13/26.Resident #8's hospital admission record was provided by the DON on 1/27/26 at 2:45 p.m. The hospital history of present illness, dated 1/13/26 at 10:36 a.m., revealed Resident #8 was transferred to the hospital due to altered mental status. The resident's temperature on admission to the hospital was 101.8 degrees Fahrenheit (F). The emergency department note plan revealed Resident #8's altered mental status was secondary to (a result of) acute pyelonephritis (upper urinary tract infection) and COVID-19 infection.C. Staff interviewThe DON was interviewed on 1/27/26 at 12:50 p.m. The DON said Resident #8 was diagnosed with COVID-19 at the hospital on 1/13/26. The DON said other residents tested positive for COVID-19 on the same date. The DON said Resident #8 had fallen, but did not initially want to go to the hospital. She said he later decided to go to the hospital and he was admitted to the hospital with a COVID-19 infection and UTI (urinary tract infection).XXI. Additional staff interviewsThe IP was interviewed on 1/27/26 at 9:00 a.m. The IP said updated COVID-19 vaccinations should have been addressed in October 2025. The IP said residents had not been educated about the COVID-19 vaccine since November 2024. The IP said she started a list of residents to see who might want the updated COVID-19 vaccine, and then she said she focused on providing the flu shot administrations. The IP said she spoke with the pharmacist who told her to let the pharmacist know when the IP had a resident list together for those residents who wanted updated COVID-19 vaccines. The IP said once the COVID-19 outbreak began on 1/13/26, she did not notify the medical director or the NP that no residents had received the updated vaccine.The IP said after the COVID-19 outbreak began, the NP evaluated residents' comorbidities and ordered antiviral medications for Resident #1 (who had a lot of symptoms of COVID-19), Resident #4, Resident #11 and Resident #16. The IP said she spoke with the NHA after the outbreak began about updated COVID-19 vaccines that were not offered and a performance improvement plan (PIP) was initiated around 1/20/26. The IP said there was no documentation that residents were educated and offered, or received the updated COVID-19 vaccine at any time in 2025.The NHA was interviewed on 1/27/26 at 9:45 a.m. The NHA said she was aware that some residents who wanted the updated COVID-19 vaccine had not received it, but was not made aware of the extent of residents who did not receive the vaccine. The NHA said she would expect the physician to be notified if there were residents who wanted the vaccine in the fall of 2025 and had not received them before the outbreak began on 1/13/26.The NP was interviewed on 1/27/26 at 10:05 a.m. The NP said when the facility notified her of the COVID-19 outbreak on 1/13/26, she was not informed that none of the residents had received updated COVID-19 vaccines. The NP said she was not certain if the updated vaccine was offered to residents. The NP said the facility had mentioned at a facility meeting that COVID-19 vaccines were going to be offered. The NP said typically COVID-19 vaccines were offered with the flu vaccine in the (continued on next page)

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F 0887 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	fall. The NP said it might have prevented worsening of symptoms if residents who wanted the updated COVID-19 vaccine had received them. The NP said residents who tested positive for COVID-19 and were immobile or at high risk for complications were treated with an antiviral medication.The medical director was interviewed on 1/27/26 at 12:10 p.m. The medical director said prior to the COVID-19 outbreak, he thought the facility had offered and was tracking vaccine administrations, including COVID-19 vaccinations. The medical director said the facility had contacted him when the outbreak began, however, the facility did not notify him th

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F 0791 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#3) of four residents reviewed for ancillary services out of 27 sample residents received 24-hour emergency dental care. Resident #3 was admitted on [DATE]. On 11/24/25 the resident lost a filling from her tooth. Resident #3 reported the issue to the nurse. The tooth became jagged from the missing filling. Resident #3 reported pain, difficulty eating and that a sore developed on her tongue. The facility failed to assist the resident with dental services for 34 days, resulting in the resident's continued pain. On 12/30/25, the resident saw the dentist and had immediate relief following the dentist smoothing the tooth. Specifically, the facility failed to ensure Resident #3 was provided timely dental services after reporting a missing filling. Findings include:I. Facility policy and procedureThe Dental Services policy, revised December 2016, was provided by the nursing home administrator (NHA) on 1/29/26 at 7:31 p.m. It read in pertinent part, Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Routine and 24-hour emergency dental services are provided to our residents through: referral to the resident's personal dentist; referral to community dentists or referral to other health care organizations that provide dental services. Social services representatives will assist residents with appointments, transportation arrangements and for reimbursement of dental services under the state plan, if eligible.II. Resident #3A. Resident statusResident #3, age [AGE], was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included urinary retention, recurrent urinary tract infection (UTI), and bilateral lower extremity edema (fluid buildup). The 1/10/26 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. She was independent with eating, required partial to moderate assistance with lower body dressing and supervision to touching assistance with upper body dressing. The MDS assessment indicated the resident had no dental issues. B. Resident interviewResident #3 was interviewed on 1/26/26 at 1:30 p.m. Resident #3 said she lost a tooth filling on Monday (11/24/25) and told the nurse the next day. She said the tooth had a jagged edge and started to cause pain on her tongue. Resident #3 said she had notified the nursing staff on several occasions and was told an appointment was going to be made by the social services director (SSD). She said she spoke to the SSD more than once to request a dental appointment. Resident #3 said after a month she was frustrated she had not been in to see the dentist and her tongue was hurting from the sore caused by the jagged edge of her tooth. Resident #3 said it was becoming more difficult to eat with the sore spot on her tongue. She said she filed a complaint hoping the complaint would be addressed. C. Record ReviewResident #3's progress notes revealed the following:A progress note, dated 11/26/25, documented the resident reported her missing filling to the medication nurse. Resident #3 complained it was rubbing on her tongue and making her tongue sore. The note documented the SSD would be updated. A social services progress note, dated 11/28/25, documented the SSD had left a message at a dentist's office for a missing filling and the tooth rubbing on her tongue bothering her.-However, there was no documentation in the resident's electronic medical record (EMR) addressing a follow-up call to the dentist. Resident #3 was admitted to the hospital on [DATE] and returned 12/15/25 for an unrelated medical issue. A progress note, dated 12/17/25, documented the SSD met with Resident #3 and a dentist appointment was requested related to the lost filling, 21 days after the resident first reported the missing filling to the nurse. A progress note, dated 12/25/25, documented Resident #3 had requested a dental appointment for the sore on her tongue to the nurse. The nurse documented a sore/lesion on the left lateral aspect of her tongue and documented Resident #3 said she reported the broken tooth over a month ago. The nurse left a note with the SSD and the director of nursing (DON). A progress note, dated 12/28/25, documented Resident #3 notified the nurse the tooth was cutting into her tongue and requested a (continued on next page)

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F 0791 Level of Harm - Actual harm Residents Affected - Few	dental appointment. The note documented a message was left for the SSD. A progress note, dated 12/29/25, documented the activity director (AD) made an appointment for Resident #3 at a local dentist due to the urgency of the missing filling and the sore on her tongue. -The appointment was scheduled for 12/30/25, 34 days after Resident #3 first reported the missing filling.A dental note, dated 12/30/25, documented Resident #3 was seen for a sore spot on her tongue due to a broken tooth. The tooth was smoothed and no longer sharp on her tongue. Resident #3 needed warm salt water rinses to help heal the sore spot on her tongue, which could take about two to three weeks.A progress note, dated 1/1/26, documented Resident #3 had immediate relief once the tooth's sharp edge was smoothed down. III. Staff interviewsThe AD was interviewed on 1/29/26 at 9:09 a.m. The AD said she assisted with transportation by getting the residents to their appointments and gathering the needed records for the appointment. She said she did not typically make the appointments as appointments went through the SSD's office. The AD said she made the dental appointment for Resident #3 because Resident #3 continued to complain about her sharp tooth and the sore on her tongue for over a month without any resolution. She said Resident #3 told the AD she had voiced this complaint to the nurses and to the SSD. The AD said she was able to get an emergency appointment the next day after calling. The SSD was interviewed on 1/29/26 at 10:00 a.m. The SSD said if residents needed medical appointments, the request was made through the SSD's office because she managed the transportation schedule. She said she received requests verbally or in writing from staff and/or the residents. The SSD said she made appointments based on the availability of the office and if the situation needed urgent attention. She said a missing filling and pain would be an urgent visit. The SSD said she was not aware Resident #3 was in pain from the missing filling until the end of December 2025 when the resident filed a complaint. -However, the 11/28/25 social services progress note, documented by the SSD, revealed the resident's tooth was rubbing on her tongue and bothering her (see record review above). The SSD said when she was notified of Resident #3's tooth needing a repair, she called and left a message with a dental office on 11/28/25 but did not follow up with a second call to schedule an appointment. The SSD said she called another dental office on 12/17/25, at the request of the resident, but the office was closed at the time of the call and she did not make a follow-up call to schedule the appointment. The SSD said there was no system in place to remind her of appointments but she should have followed up with the resident and made a dental appointment.-There was no progress note indicating the SSD made a call to a second dental office on 12/17/25 in Resident #3's EMR.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on record review and interviews, the facility failed to complete a performance review of every certified nurse aide (CNA) at least once every 12-months and provide regular in-service education based on the outcome of these reviews for five of five CNA.Specifically, the facility failed to complete annual performance reviews and provide regular in-service education which was based on the outcome of the reviews for CNA #1, CNA #3, CNA #4, CNA #5 and CNA #6. Findings include:I. Record reviewAnnual performance reviews were requested on 1/27/26 at 5:27 p.m. for CNA #1, CNA #3, CNA #4, CNA #5 and CNA #6.The facility was unable to provide annual performance evaluations for the five CNAs requested above (see interview below).The facility provided documentation on 1/28/26 at 2:43 p.m. that the CNAs above completed 12 hours annual in-service education. The facility did not base the education upon CNA annual evaluations as the annual evaluations had not been completed (see interviews below).II. Staff interviewsThe nursing home administrator (NHA) and the director of nursing (DON) were interviewed together on 1/28/26 at 10:54 a.m. The NHA said the facility had no records to provide for completion of CNA performance evaluations. The DON said a previous administrator instructed the DON to not complete annual CNA performance evaluations because the CNAs were not going to receive raises. The DON said annual CNA performance evaluations have not been done since she began working at the facility more than two years ago. The DON said CNA #1, CNA #3, CNA #4, CNA #5 and CNA #6 had worked at the facility for more than one year.The DON said annual performance evaluations should be completed for every CNA. The NHA said it was important to complete annual performance evaluations to understand the employees' competencies and provide appropriate training for deficits and to assist the employees with reaching performance goals.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection for one of one unit. Specifically, the facility failed to:-Ensure correct transmission based precautions signage was posted on resident rooms;-Ensure staff wore appropriate personal protective equipment (PPE) while providing care to a resident requiring droplet precautions;-Follow infection control wound care guidelines for dressing changes;-Ensure housekeeping staff performed hand hygiene after glove removal and nursing staff used hand hygiene during medication administration; and,-Clean pulse oximetry equipment after contamination. Findings include:I. Facility policy and procedureThe Infection Control policy, revised October 2018, was provided by the nursing home administrator (NHA) on 1/29/26 at 12:12 p.m. It read in pertinent part, The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The objectives of our infection control policies and procedures are to prevent, detect, investigate and control infections in the facility; maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors and the general public; establish guidelines for implementing isolation precautions, including standard and transmission based precautions; establish guidelines for the availability and accessibility of supplies and equipment necessary for standard and transmission based precautions; maintain records of incidents and corrective actions related to infections; and provide guidelines for safe cleaning and reprocessing of reusable resident care equipment.II. Failure to post correct transmission based precaution signageA. ObservationsOn 1/26/26 at 11:50 a.m. there was a contact isolation sign on the door of room [ROOM NUMBER].-The resident in room [ROOM NUMBER] required droplet precautions (see interview below).On 1/26/26 at 11:55 a.m. observed contact isolation sign on the door of room [ROOM NUMBER].-The resident in room [ROOM NUMBER] required enhanced barrier precautions (EBP) (see interview below)B. Staff interview and observationThe infection preventionist (IP) was interviewed on 1/26/26 at 4:30 p.m. The IP said the room [ROOM NUMBER] signage should be for droplet precautions. The IP said she would change the signage to the correct precautions.The IP said the room [ROOM NUMBER] signage should be for EBP. The IP said she would change the signage to the correct precautions.The IP interviewed again on 1/29/26 at 1:30 p.m. The IP said if the transmission based precautions signs were incorrect, staff might not wear the correct PPE and this could increase the risk of disease transmission.-At the time of interview, the facility had been in a COVID-19 outbreak since 1/13/26.III. Failed to ensure staff wore appropriate PPE while providing care to a resident in droplet precautionsA. Professional referenceAccording to the Centers for Disease Control (CDC), Coronavirus Disease Factsheet, Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or suspected COVID-19, (6/30/20), retrieved on 2/4/26 from https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf Identify and gather the proper PPE to don. Perform hand hygiene using hand sanitizer. Put on isolation gown. Tie all of the ties on the gown. Put on a NIOSH- approved N95 filtering facepiece respirator or higher (use a facemask if not available). If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under the chin. Both your mouth and nose should be protected. Put on face shield or goggles. Put on gloves. HCP (health care provider) may now enter patient room.B. Facility policy and procedureThe Personal Protective Equipment policy, revised October 2018, was provided by the NHA on 1/29/26 at 12:12 p.m. It read in pertinent part, Personal protective equipment provided to our personnel includes but is not necessarily limited to gowns/aprons/lab coats, gloves, masks and eye wear (goggles and/or face shields). Training on the proper donning, use and disposal of PPE is (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided upon orientation and at regular intervals. Employees who fail to use PPE when indicated may be disciplined in accordance with personnel policies.C. ObservationsOn 1/26/26 at 12:33 p.m. an unidentified certified nurse aide (CNA) entered room [ROOM NUMBER]. The resident in room [ROOM NUMBER] required PPE for droplet precautions for COVID-19 (per IP interview above). The CNA entered the room wearing a gown, gloves and a surgical mask.-The CNA was not wearing an N-95 mask or a protective eye shield.On 1/26/26 at 12:36 p.m. an unidentified CNA entered room [ROOM NUMBER] wearing a gown, gloves and a surgical mask. -The CNA was not wearing an N-95 mask or a protective eye shield.D. Staff interviewThe IP was interviewed on 1/26/26 at 5:00 p.m. The IP said the facility had ample supply of N-95 masks and staff should be wearing these masks and face shields in the rooms of residents who required droplet precautions. The IP said when staff did not wear N-95 masks it could increase the risk of transmission of COVID-19.IV. Failed to follow wound care guidelines for dressing changesA. ObservationsOn 1/28/26 at 2:20 p.m. wound care was observed for Resident #4. Registered nurse (RN) #1 and the director of nursing (DON) entered Resident #4's room with wound care supplies for two dressing changes of wounds that were approximately two inches apart.-During the dressing change, RN #1 used the same gauze to pat dry both wounds.On 1/28/26 at 2:40 p.m. wound care was observed for Resident #23. When RN #1 prepared supplies for the dressing change. RN #1 used ungloved hands to pick up gauze and saturate the gauze with saline for the dressing change. -During the dressing change, RN #1 used the same gauze to clean the wound.B. Staff interview and observationThe DON was interviewed on 1/28/26 at 3:15 p.m. The DON said though Resident #4's wounds were in close proximity, the wounds should have been cleaned using a different gauze for each wound. The DON said RN #1 should have worn gloves when touching the gauze during preparation for Resident #23's dressing change.The IP was interviewed on 1/29/26 at 1:38 p.m. The IP said Resident #4's wounds should have been cleaned separately to ensure there would be no cross contamination of the wounds. The IP said RN #1 should have worn gloves to prepare the gauze for cleansing Resident #23's wound.V. Failed to ensure housekeeping and nursing staff used hand hygiene appropriatelyA. Observations and staff interviewsOn 1/28/26 at 9:49 a.m. housekeeper (HK) #1 was observed cleaning room [ROOM NUMBER]. HK #1 changed her gloves twice while cleaning the room and did not perform hand hygiene between glove changes.HK #1 was interviewed on 1/28/26 at 10:15 a.m. HK #1 said she forgot to use hand hygiene when changing her gloves.On 1/29/26 at 10:15 a.m. RN #1 was preparing an insulin medication at the medication cart for Resident #22. A transporter walked by the nurse with another resident who was in a wheelchair. The transporter handed RN #1 a packet of paperwork. RN #1 took the packet and set the papers aside. RN #1 then returned to preparing the insulin medication for administration.-RN #1 did not use hand hygiene between holding the paperwork and preparing the insulin medication.RN #1 was interviewed on 1/29/26 at 10:41 a.m. RN #1 said she should have used hand hygiene after touching the other resident's paperwork prior to her preparing Resident #23's insulin medication.B. Staff interviewsThe housekeeping supervisor was interviewed on 1/29/26 at 11:48 a.m. The housekeeping supervisor said HK #1 should have used hand hygiene between glove changes to prevent infection.The IP was interviewed on 1/29/26 at 1:38 p.m. The IP said she would have expected HK #1 to remove gloves and then use hand hygiene prior to replacing gloves. The IP said hand hygiene education is provided frequently to staff. The IP said RN #1 should have used hand hygiene after she touched the paperwork so as not to contaminate the medications she was preparing.VI. Failed to clean pulse oximetry equipmentA. ObservationOn 1/29/26 at 9:12 a.m. RN #1 was checking Resident #6's oxygen saturation level using the pulse oximetry equipment. RN #1 said she was having difficulty reading the level on the equipment. RN #1 removed the pulse oximeter probe from Resident #6's finger and placed it on RN #1's finger. RN #1 said it was working on her finger. RN #1 then removed the pulse oximeter probe from her finger and placed it back on Resident #6's finger.-RN #1 did not clean the pulse oximeter probe after it had been on her finger.B. Staff interviewRN #1 was interviewed on 1/29/26 at 10:40 a.m. RN #1 said she should have cleaned the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop and implement a comprehensive person-centered care plan for two (#2 and #20) of five residents reviewed for unnecessary medications out of 27 sample residents. Specifically, the facility failed to:-Develop and implement a comprehensive care plan for Resident #2's pain medications and anxiety medications; and, -Develop and implement a comprehensive care plan for Resident #20's depression medications Resident #2 and Resident #20. Findings include:I. Facility policy and procedureThe Care Plan's Goal and Objectives policy, revised in April 2009, was provided by the social services director (SSD) on 1/29/26 at 6:30 p.m. It revealed in pertinent part, Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment. Goals and objectives are entered in the resident's care plan so that all disciplines have access to this information and can report whether the desired outcomes are being achieved. II. Resident #2A. Resident statusResident #2, age [AGE], was admitted on [DATE], According to the January 2026 computerized physician orders (CPO), diagnoses included depression, chronic pain syndrome, generalized anxiety disorder, type 2 diabetes mellitus, rheumatoid arthritis, history of long-term use of opiate analgesics, dementia and cellulitis (infection) of the right lower limb.The 12/23/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of four out of 15. She was admitted to hospice in June 2025, required full assistance with bathing, dressing, personal hygiene, toilet use, and transfers using a Hoyer lift. B. Record review Review of the January 2026 CPO revealed the following physician's orders:Morphine sulfate 15 milligrams (mg). Give one tablet by mouth two times a day for pain, ordered on 8/20/25.Lorazepam .5 mg. Give one tablet by mouth three times a day related to anxiety, ordered on 12/10/25.Review of Resident #2's comprehensive care plan, revised on 11/14/25, did not reveal a care plan focus related to the resident's pain or anxiety. The care plan did not include side effects or behaviors to monitor related to the resident's anxiety. C. Staff interviewsRegistered nurse (RN) #1 was interviewed on 1/29/26 at 3:14 p.m. RN #1 said Resident #2's morphine was prescribed for pain and the lorazepam was for anxiety. RN #1 said medication side effects monitoring included respiratory rates and sedation levels. RN #1 said the care plans were updated by the infection preventionist (IP).The IP was interviewed on 1/29/26 at 6:41 p.m. She said she did not know Resident #2 did not have a care plan that addressed the resident's pain or anxiety. She said she would update the resident's comprehensive care plan. The IP said she was responsible for creating and updating care plans. The director of nursing (DON) was interviewed on 1/29/26 at 6:02 p.m. She said she did not know that Resident #2's comprehensive care plan did not address pain or anxiety. III. Resident #20A. Resident statusResident #20, age [AGE], was initially admitted on [DATE], and re-admitted on [DATE]. According to the January 2026 CPO, diagnoses included anxiety disorder, Parkinsonism, depression, systemic erythematosus lupus, low back pain, and sequelae of periprosthetic osteolysis of the internal prosthetic right knee joint. The 1/8/26 MDS assessment revealed the resident was cognitively intact, with a BIMS score of 14 out of 15. She required assistance with bathing, dressing, grooming, feeding and toileting.B. Record review Review of the January 2026 CPO revealed the following physician's order:Duloxetine 60 mg. Give one capsule daily for depression, ordered on 1/16/25.Review of the comprehensive care plan did not reveal a care plan focus related to the use of the duloxetine. C. Staff interviewsThe IP was interviewed on 1/29/26 at 6:42 p.m. She said she did not know why Resident #20's care plan did not address the use of duloxetine. The DON was interviewed on 1/29/26 at 6:03 p.m. She said she did not know there was not a care plan for Resident #20's duloxetine use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065294	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lamar Estates Nursing Center	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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#22) of one resident reviewed for insulin administration out of 27 sample residents was kept free from significant medication errors.Specifically the facility failed to ensure the insulin pen was primed prior to an insulin medication administration for Resident #22 Findings include:I. Professional referenceAccording to the manufacturer Sanofi-Aventis, Lantus Solostar (insulin glargine), May 2025, Instructions for Use, retrieved on 2/3/26 from https://products.sanofi.us/Lantus/Lantus.pdf. Always do a safety test before each injection to check your pen and the needle to make sure they are working properly and make sure that you get the correct Lantus dose. Select two units by turning the dose selector until the dose pointer is at the two mark. Press the injection button all the way in. When insulin comes out of the needle tip, your pen is working correctly.II. Facility policy and procedureThe Medication Errors policy (undated) was provided by the nursing home administrator (NHA) on 1/29/26 at 7:31 p.m. It read in pertinent part, A medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with provider's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. A significant medication-related error is defined as: requiring medication discontinuation or dose modification, requiring hospitalization, or extending a hospitalization, resulting in disability, requiring treatment with a prescription medication, resulting in cognitive deterioration or impairment, life threatening and/or resulting in death. Medication errors are managed according to facility policy.III. Resident #22A. Resident statusResident #22, age [AGE], was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO), diagnoses included respiratory failure, kidney disease, heart failure and diabetes.The 1/16/26 minimum data set (MDS) assessment identified Resident #22 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment revealed the resident required set-up assistance with eating, personal hygiene and toileting, moderate assistance for showering and supervision for transferring.B. Record reviewReview of Resident #22's January 2026 CPO revealed the following physician's order:Insulin Glargine subcutaneous solution 100 units per ml, inject 23 units subcutaneously two times per day, ordered 11/14/25.C. ObservationOn 1/29/26 at 10:10 a.m. registered nurse (RN) #1 was preparing an insulin medication for Resident #22, insulin glargine. RN #1 obtained the resident's insulin pen from the medication cart, cleaned the tip of the insulin glargine pen with an alcohol pad, applied a new needle and then dialed the insulin pen to 23 units. RN #1 entered Resident #22's room, advised the resident of the insulin medication, cleaned the resident's abdomen on the left side with an alcohol swab, removed the safety cap and administered the injected medication. -RN #1 failed to perform a safety test by priming the resident's insulin pen per manufacturer's directions (see professional reference above) prior to administering the medication.D. Staff interviewsRN #1 was interviewed on 1/29/26 at 10:40 a.m. RN #1 said she did not know that she should prime the insulin pen prior to administering the medication to the resident. RN #1 said she had worked at the facility for eight months, and had not learned that it was necessary to prime the insulin pen prior to dialing the dose to be administered. She said she did not know why priming the pen should be done.The director of nursing (DON) was interviewed on 1/29/26 at 10:49 a.m. The DON said it was important to prime the insulin pen prior to giving a dose of insulin to ensure the resident would receive the correct dose. The DON said if the pen was not primed prior to giving a dose of insulin, the dose could be incorrect, and it could affect the resident's blood sugar levels. The DON said she would review the education RN #1 had received for the process of administering insulin medications.

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	065294	A. Building B. Wing	01/29/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure proper storage of medications for one of one medication storage room and one of one medication storage cart.Specifically, the facility failed to:-Date a resident's semaglutide pen with the date it was opened; -Discard medication that had expired; and,-Discard undated opened medication (tuberculin purified protein) from a medication refrigerator. Findings include:I. Professional referenceAccording to the manufacturer, Novo Nordisk, How to Store Your Ozempic pen, [DATE], retrieved on [DATE] from https://www/ozempic.com/how-to-take/ozempic-pen.html, After first use, store your pen in use for 56 days at room temperature between 59 degrees Fahrenheit (F) and 86 degrees F or in a refrigerator between 36 degrees F to 46 degrees F.According to the manufacturer, JHP Pharmaceuticals, Aplisol prescribing information, November, 2013, retrieved on [DATE] from https://www.fda.gov/files/vaccines%2C%20blood%20%26%20biologics/published/Package-Insert---Aplisol.pdf Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency.II. Facility policy and procedureThe Storage of Medications policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 12:12 p.m. It read in pertinent part, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.III. Observations and interviewsOn [DATE] at 3:15 p.m. the medication cart was observed with licensed practical nurse (LPN) #1 and the director of nursing (DON). The following medications were found:-A used Ozempic (semaglutide) injectable pen for Resident #11, which was not labeled with the date it was opened. -An unopened Glutose 15 gel tube (a medication used to treat low blood sugar) with an expiration date of [DATE].LPN #1 said the Ozempic medication should be labeled with the date it was opened. LPN #1 said the Glutose gel should be discarded and she removed the medication from the medication cart.The DON said she checked with the pharmacist and the Ozempic pen had been delivered on [DATE]. The DON said the pharmacist advised the DON to label the pen as opened on [DATE] to ensure it would not be stored opened longer than 56 days.The DON said the Glutose 15 medication should have been discarded upon expiration and might not be as effective if used after the expiration date. On [DATE] at 3:35 p.m. the medication storage room was observed with the DON. The following medication was found:-A used vial of tuberculin purified protein derivative (Aplisol) 5 TU/.1 milliliters (ml). The vial was not labeled with the date it was opened.The DON said the medication should be labeled with the date it was opened and should be discarded 28 days after opening. The DON said the tuberculin purified protein might not be as effective if used after the recommended discard date.