STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065388	A. BUILDING _____ B. WING _____	05/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST ANDREWS VILLAGE-LTC	2670 S ABILENE ST AURORA, CO 80014

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 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 staff interviews, the facility failed to ensure medications and biologicals were properly stored and secured in two out three medication rooms. Specifically, the facility failed to ensure only licensed nursing staff had access to medications and treatments stored in the medication rooms. Findings include: I. Facility policy The Medication Storage policy, revised 10/19/18, was provided electronically by the director of nursing (DON) on 6/1/2020 at 3:00 p.m. It read in pertinent part: All medications shall be stored correctly under certain conditions. Medications shall be stored in an orderly manner in cabinets, and drawers of sufficient size to prevent crowding. All medications including treatment items will be stored in a locked cabinet or drawer in the resident's apartment, inaccessible to residents and visitors. All medications shall be kept locked only accessible to community associates authorized to dispense or administer medications. II. Observations and staff interviews A. Unit one On 5/28/2020 at 10:36 a.m. a certified nurse aide (CNA #1) was observed to enter the unit one medication room using the keypad code entry. -At 10:37 a.m. a physical therapist (PT #1) and an additional unidentified staff member were observed to enter the unit one medication room using the keypad code entry. They used the sink to wash their hands and exited the medication room. -At 10:38 a.m. the medication room was observed. An unlocked cupboard in the room was observed to contain two bottles of folic acid and one bottle of liquid Tylenol. -At 10:38 a.m. a registered nurse (RN #1) was interviewed and stated the medications were kept in the room to be returned to the pharmacy. She stated all the staff have the code to get in the room to get to the hard charts and wash their hands at the sink. She stated the medications should be locked in a cupboard but the observed cupboard was not locked. She stated there were four medication rooms in the facility, though one unit had no residents so was not in use at that time. B. Unit two On 5/28/2020 at 10:55 a.m. the unit two medication room was observed. The medication room contained a basket on the countertop containing a card with 60 Carvedilol (beta blocker) tablets and a card with 22 one-and-a-half tablets of [MEDICATION NAME] (antidepressant medication). The medication room also housed the unit's treatment cart which was unlocked and full of resident treatment medications. -At 10:58 a.m. a licensed practical nurse (LPN #1) was interviewed and stated all staff had the code to get into the medication room and all staff entered the room for various reasons, but mostly to wash their hands at the sink and access resident paper charts which were also stored in the room. She stated the medications observed in the bin on the countertop should have been locked up in a cabinet, but the treatment cart was never locked. III. Interviews On 5/28/2020 at 11:30 a.m. the DON was interviewed and stated all staff had access to the medication rooms because the rooms were used to store resident charts and printers and each medication room had a sink where staff could wash their hands. She stated all medications in the medication rooms should be kept in cabinets and drawers and should be locked. She also stated the treatment carts should be locked and medications and treatments should only be accessible to licensed nurses.
F 0837 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility's governing body failed to appoint an administrator who was licensed by the state. Specifically, the facility failed to ensure the temporary nursing home administrator license was valid and did not expire. Findings include: I. Entrance interview On [DATE] at 10:00 a.m. the entrance conference was conducted with the facility executive director (ED) and the director of nursing (DON). They stated that the DON was acting as the nursing facility's administrator (NHA) at the time of the survey and the facility had active job listings posted for a permanent licensed nursing home administrator. II. Record review On [DATE] at 10:30 a.m. a review was conducted on the state licensing website. The website showed the DON had applied for a temporary NHA license for emergency situations on [DATE] but the temporary license had expired as of [DATE]. II. Interviews On [DATE] at 10:40 a.m. the DON was interviewed and stated she had been granted a temporary NHA license in December and the license was valid for 90 days. She stated she had tried to renew the license online in March, but was unable to get the license extended online and then COVID-19 started and the process was overlooked. On [DATE] at 11:30 a.m. the ED was interviewed and stated the temporary licenses were valid for 90 days and could be granted for two 90-day terms. He stated the renewal of the DON's temporary NHA license was put on the back burner due to COVID-19 and they would work on getting the renewal immediately. On [DATE] at 11:50 a.m. the DON was interviewed again and she stated when she could not renew the license online in March, she had informed the ED she could not renew online and asked for help to renew the license, but help was not provided. On [DATE] 2:00 p.m. the DON was interviewed over the phone and stated the license could not be renewed by the licensing board due because it had lapsed, so the parent corporation was working on getting an interim NHA to come to the facility until a permanent NHA could be hired, though this had not happened yet.
F 0839 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Employ staff that are licensed, certified, or registered in accordance with state laws.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure professional staff was licensed, certified, or registered in accordance with applicable state laws. Specifically, the facility failed to ensure the acting nursing home administrator's license was valid. Findings include: I. Entrance interview On [DATE] at 10:00 a.m. the entrance conference was conducted with the facility executive director (ED) and the director of nursing (DON). They stated that the DON was acting as the nursing facility's administrator (NHA) at the time of the survey and the facility had active job listings posted for a permanent licensed nursing home administrator. II. Record review On [DATE] at 10:30 a.m. a review was conducted on the state licensing website. The website showed the DON had applied for a temporary NHA license for emergency situations on [DATE] but the temporary license had expired as of [DATE]. II. Interviews On [DATE] at 10:40 a.m. the DON was interviewed and stated she had been granted a temporary NHA license in December and the license was valid for 90 days. She stated she had tried to renew the license online in March, but was unable to get the license extended online and then COVID-19 started and the process was overlooked. She confirmed she did not have a valid NHA license. On [DATE] at 11:30 a.m. the ED was interviewed and stated the temporary licenses were valid for 90 days and could be granted for two 90-day

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

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.

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F 0839 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) terms. He stated the renewal of the DON's temporary NHA license was put on the back burner due to COVID-19 and they would work on getting the renewal immediately. He confirmed the facility did not currently have an NHA with a valid license. On [DATE] 2:00 p.m. the DON was interviewed over the phone and stated the license could not be renewed by the licensing board because it had lapsed, so the parent corporation was working on getting an interim NHA to come to the facility until a permanent NHA could be hired, though this had not happened yet.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on record review, observations and interviews, the facility failed to ensure infection control procedures were followed to prevent the spread of infectious diseases such as COVID-19. Specifically, the facility failed to ensure personal protective equipment (PPE) was stored properly for re-use. Findings include: I. Professional reference According to the Centers for Disease Control (CDC) extended use of isolation gowns, revised 6/4/2020, https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html, (6/4/2020): Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same health care provider (HCP) when interacting with more than one patient . II. Observations and staff interviews On 5/28/2020 at 10:32 a.m. a certified nurse aide (CNA #1) was observed exiting an isolation room. She stated she wore a gown, gloves and face shield when caring for the residents on 14- day isolation. She stated she hung her gown on the hook in the resident room to re-use the gown the next time she entered the room. She stated there was one gown for the nurse and one gown for the CNA. She opened the door to the isolation room and two gowns were observed, hanging on top of each other on the same hook. She stated there was only one hook but they tried to remember which gown belonged to which staff member. Three additional isolation rooms were observed and all of the rooms had two gowns hanging on top of each other on the same hook. At 10:44 a.m. the registered nurse (RN #1) was interviewed and stated they do not write their names on the gowns to identify which gown is for which staff member. She stated she tried to hang her gown offset a little bit to tell them apart. She stated when they doffed their gowns they turned them inside out so potentially infected surfaces would not touch each other while hanging on the same hook. III. Interviews On 5/28/2020 at 11:30 a.m. the director of nursing (DON) was interviewed and stated the staff were reusing gowns and hanging them on the hook installed in the room. She stated there should only be one gown in each room unless the resident needed two staff to assist and then there would be two in each room. She stated the staff were not writing their names on the gowns to tell them apart and stated there was only one hook installed in each room, so multiple gowns could be on the same hook. She stated the facility would get additional hooks in the resident rooms and would label them for the staff members to tell the gowns apart.