STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065009	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST PAUL HEALTH CENTER	1667 ST PAUL ST DENVER, CO 80206

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 -** Minimal harm or potential for 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** Based on record review and interviews, the facility failed to permit resident to remain in the facility, and not transfer or discharge the resident from the facility for one (#1) of three sample residents. Specifically, the facility failed to permit the resident to return to the facility after he was discharged to the hospital for a medical condition. Cross-reference F623-Failed to notify Resident #1 and the resident representative of the transfer and discharge. Findings include: I.Facility standards The Involuntary Discharge policy, revised 12/2019, was provided by the nursing home administrator (NHA) on 7/7/2020, and read in part, The facility will provide reasonable advance notice (written notice 30 days before an involuntary transfer or discharge) to the resident and family member or resident representative of its intent to transfer or discharge a resident unless the situation was emergent. If emergent, notice shall be made as soon as practicable. Emergent situations are as follows: -When the safety of residents in the facility is endangered. -When the health of the residents in the facility is endangered. -When an immediate transfer or discharge is required by the residents urgent medical needs. II. Resident status Resident #1, age 63, was admitted on [DATE] and discharged on [DATE] to the hospital. According to the June 2020 computerized physician orders [REDACTED]. According to the 6/22/2020 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. Resident #1 required extensive assistance of one person with all activities of daily living. III. Record review The resident's comprehensive care plan, initiated 3/12/19 did not include a plan for discharge. According to the nurses' progress notes, on 6/22/2020 residents experienced elevated blood pressure and difficulty breathing. The resident ' s physician was notified and the resident was sent to the emergency room for evaluation. The progress note dated 6/24/2020 revealed that the resident's medical power of attorney (MDPOA) was given a notice of involuntary discharge when Resident #1 was still in the hospital. According to amended emergency discharge notice to the MDPOA, dated 7/2/2020, the resident was emergently discharged because the facility was unable to meet your psychosocial and medical needs. The notice did not mention any specific medical or psychosocial needs that facility was not able to meet. A letter from resident ' s primary care physician, dated 6/29/2020 read that Resident #1 was under the care of this physician for the last year. During this time, I have observed several incidents in which the high quality and safe care could not be provided due to the actions and behavior of (MD)POA. There were no notes by social services regarding any specific medical or psychosocial needs that facility was not able to meet, and that led to emergent discharge. The letter from medical director, dated 6/29/2020 summarized that physicians were in disagreement with MDPOA with the overall care for Resident #1. -No specific emergent needs were listed that would have triggered a need for an emergent discharge. IV. Staff interviews The NHA was interviewed on 7/7/2020 at 12:10 p.m. She said the facility could no longer take care of the needs of Resident #1 due to constant interference in care by resident ' s MDPOA. She said resident ' s MDPOA made physicians uncomfortable and threatened by questioning and refusing orders that they prescribed. She said the facility made an effort to find another placement for the resident, but MDPOA frequently changed her mind and did not follow through on her previous statements. The NHA said that the social services director was on maternity leave and was not involved in discharge. She said the letter of discharge was to be provided by her. She believed the discharge was urgent as the facility was not able to meet the resident's needs. At the time of the survey, the social services director was not available for an interview. The DON was interviewed on 7/7/2020 around 2:10 p.m. She said she was familiar with the Resident #1. She said nursing staff experienced difficulties with MDPOA on a daily basis as MDPOA would make requests that were not in the best interest of the resident. She said some of that was documented in nursing notes, but not during care conferences because MDPOA changed her mind frequently about staying or choosing another facility. She said the resident was discharged to the hospital for a medical condition.
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** Based on record review and interviews, the facility failed to notify one resident (#1) out of three sample residents, at least 30 days before the resident was transferred or discharged . Cress reference: F-622 failure to permit the resident to return to the facility after he was discharged to the hospital for a medical condition. Specifically, the facility failed to notify Resident #1 and the resident representative of the transfer and discharge. Findings include: I. Facility standards The Involuntary Discharge policy, revised December 2019, was provided by the nursing home administrator (NHA) on 7/7/2020, and read in part, The facility will provide reasonable advance notice (written notice 30 days before an involuntary transfer or discharge) to the resident and family member or resident representative of its intent to transfer or discharge a resident unless the situation was emergent. If emergent, notice shall be made as soon as practicable. Emergent situations are as follows: -When the safety of residents in the facility is endangered. -When the health of the residents in the facility is endangered. -When an immediate transfer or discharge is required by the residents urgent medical needs. II. Resident status Resident #1, age 63, was admitted on [DATE] and discharged on [DATE] to the hospital. According to the June 2020 computerized physician orders [REDACTED]. -Resident #1 was not allowed to return to the facility after being sent to the hospital for an evaluation. Cross-reference F622-Transfer and discharge requirements According to the 6/22/2020 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. Resident #1 required extensive assistance of one person with all activities of daily living. III. Record review The resident's comprehensive care plan, initiated 3/12/19 did not include a plan for discharge. According to the nurses' progress notes, on 6/22/2020 the resident experienced elevated blood pressure and difficulty breathing. The resident ' s physician was notified and the resident was sent to the emergency room for evaluation. -The transfer was urgent, the discharge was not emergent. The progress note dated 6/24/2020 revealed that the resident's medical power of attorney (MDPOA) was given a notice of involuntary discharge when Resident #1 was still in the hospital. According to amended emergency discharge notice to the MDPOA, dated 7/2/2020, the resident was emergently discharged because the facility was unable to meet your psychosocial and medical needs. -The notice provided to the MDPOA did not mention any specific medical or psychosocial needs that facility was not able to meet. A letter from resident ' s primary care physician, dated 6/29/2020 read that Resident #1 was under the care of this physician for the last year.

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) During this time, I have observed several incidents in which the high quality and safe care could not be provided due to the actions and behavior of (MD)POA. There were no notes by social services regarding any specific medical or psychosocial needs that facility was not able to meet, and that led to emergent discharge. The letter from medical director, dated 6/29/2020 summarized that physicians were in disagreement with MDPOA with overall care for Resident #1. -No specific emergent needs were listed that triggered the resident requiring an emergent discharge. IV. Staff interviews The NHA was interviewed on 7/7/2020 at 12:10 p.m. She said the facility could no longer take care of the needs of Resident #1 due to constant interference in care by resident ' s MDPOA. She said resident ' s MDPOA made physicians uncomfortable and threatened by questioning and refusing orders that they prescribed. She said the facility made an effort to find another placement for the resident, but MDPOA frequently changed her mind and did not follow through on her previous statements. NHA said that the social services director was on maternity leave and was not involved in discharge. She said the letter of discharge was provided by her. She believed the discharge was urgent as the facility was not able to meet the resident's needs. At the time of the survey, the social services director was not available for an interview. The DON was interviewed on 7/7/2020 around 2:10 p.m. She said she was familiar with the Resident #1. She said nursing staff experienced difficulties with MDPOA on a daily basis as MDPOA would make requests that were not in the best interest of the resident. She said some of that was documented in nursing notes, but not during care conferences because MDPOA changed her mind frequently about staying or choosing another facility. She said the resident was discharged to the hospital for a medical condition.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, 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 disease and infection such as coronavirus (COVID-19) in two out of five halls observed for infection control practices. Specifically, the facility: -Failed to isolate presumptive positive residents, with a potentially infectious disease in private rooms while having available rooms in the building; -Failed to follow appropriate donning and doffing procedures for residents on isolation precautions. Findings include: A. Facility policies A copy of the Infection Prevention policy, dated 7/1/2020, was provided by the director of nursing (DON) on 7/7/2020, and read in part, all new admissions to our community must be placed in a private room and remain on droplet isolation precautions for 14 days after admission. All staff must don full PPE (gown, gloves, face mask and face shield) every time you enter an isolation room. A copy of the Reusing N95 masks policy, dated 7/1/2020, was provided by the director of nursing (DON) on 7/7/2020, and read in part, remove face shield (if applicable) and clean with disinfecting wipes before placing in labeled paper bag for storage. Remove the N95 mask, taking care not to touch the outer surface of the mask and place it in a labeled paper bag. B. Observations On 7/6/2020 at 11:15 a.m. occupational therapist (OT) assistant observed doffing personal protective equipment (PPE) in isolation room [ROOM NUMBER]. After removing all PPE, the OT assistant was observed removing the gait belt from the room and hanging it on the side railing outside of the room. The OT assistant was interviewed upon exiting the room [ROOM NUMBER]. She said the gait belt was used for resident in room [ROOM NUMBER]. She said it was her personal gait belt and she intended to use it for other residents. She said after thinking about it she realised that it was not safe as the belt was in contact with the resident in isolation and should be left in the room. She returned the gait belt to the room. She said she was not familiar with the infection control nurse in the building and she did not recall receiving any in-person education on infection control. She said all education was online and was intended as a self study. On 7/6/2020 at 11:01 a.m. a certified nurse assistant (CNA) #1 was observed exiting isolation room [ROOM NUMBER]. After removing her gown and gloves, she washed her hands and removed her face shield. Upon removal she tucked the face shield between the wall and wooden railing on the wall and continued to remove her mask. After that she proceeded to clean the equipment that was used in the isolation room and left her face shield tucked between the wall and wood railing. CNA #1 was interviewed after she walked away from room [ROOM NUMBER]. She recalled the proper way of removing PPE and said that she forgot to clean the face shield. She said she was supposed to clean it after every use with chlorine wipes and place it back into the PPE unit on the door. On 7/6/2020 at 12:48 p.m. CNA #2 entered isolation room [ROOM NUMBER] with a meal tray. She did not put on any PPE as she entered the room. She positioned the tray on the table and left the room. CNA #2 was interviewed after she left the room [ROOM NUMBER]. She said both residents in room [ROOM NUMBER] were on isolation precautions as they both were newly admitted residents. She said she was aware that she was supposed to put PPE on but she did not do it because she believed both residents were tested and they both tested negative for COVID-19. She added that she did not touch anything in the room and thought it was not necessary to put PPE on. On 7/6/2020 at 1:08 p.m. a licensed practical nurse (LPN) #1 observed leaving isolation room [ROOM NUMBER]. After exiting she removed her gown and gloves in the hallway and went back to the room to throw it away. After she removed goggles and a KN95 mask, she placed it on top of the med cart, sanitized her hands and made a telephone call. After that she picked up her KN95 mask and goggles from the med cart and went to the med room. LPN #1 was interviewed after she returned from the medication room. She was able to recall a proper procedure for removing PPE and said that she should have removed her gown and gloves in the room, not in the hallway. Regarding the mask she said she should have placed it in a dedicated paper bag immediately after removing it. By placing it on the medication cart she contaminated the cart with potential pathogens that were present on the mask. On 7/6/2020 at 1:23 p.m. an activities assistant #1 observed entering three feet into isolation room [ROOM NUMBER]. He did not put on any PPE when he entered the room. He asked both residents if they would like to participate in an activity and left the room. Right after leaving isolation room [ROOM NUMBER], he entered non isolation room [ROOM NUMBER] and offered activity to residents. Activities assistant #1 was interviewed immediately after exiting room [ROOM NUMBER]. He said when he entered the isolation room [ROOM NUMBER], he stayed at the threshold which was right at the door and did not cross that threshold. He said he knew it was an isolation room and he should have put proper PPE on prior to entering the room. He said he just spaced out because the door to the room was open. F. Staff interviews LPN #1 was interviewed 7/6/2020 second time around 1:30 p.m. She said both newly admitted residents were residing in the same room. She said one of them was admitted a few days before the other one. She said it was a management's decision to put both residents in the same room. The director of nursing (DON) was interviewed on 7/7/2020 at 2:37 p.m. She was interviewed in the presence of an infection control preventionist. Regarding proper PPE technique she said her expectations for nurses and CNAs were to follow proper donning and doffing. She provided logs revealing that staff received education on infection control. In addition she demonstrated a flyer that was attached to every isolation cart as a reminder on proper donning and doffing techniques. She said she will provide additional education to all nurses and CNAs. Regarding newly admitted residents she said, both residents in room [ROOM NUMBER] were tested negative for COVID-19 few days prior to the discharge and that was the reason why they both were placed in the same room. She said moving forward every newly admitted resident will be placed in a private room.