DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435117	A. BUILDING _____ B. WING _____	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DEUEL COUNTY	913 COLONEL PETE STREET CLEAR LAKE, SD 57226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 42477 A COVID-19 Focused Infection Control survey was conducted on 7/22/21 and 7/23/21. Good Samaritan Society Deuel County was found not in compliance with regulations F725 and F880. Good Samaritan Society Deuel County was found in compliance with 42 CFR Part 483.10 resident rights and 42 CFR Part 483.80 infection control regulations F550, F562, F563, F583, F882, F885, and F886. A COVID-19 Focused Emergency Preparedness survey was conducted on 7/22/21 and 7/23/21. Good Samaritan Society Deuel County was found in compliance with 42 CFR Part 482, Subpart B, Subsection 483.73 related to E-0024(b)(6). Total residents: 30	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	F 725	Root Cause Analysis revealed two potential causes of deficient practice, (1) supplemental staff brought in to help during COVID-19 outbreak went on break and had not been sufficiently trained on communication expectations (2) Non-nursing staff do not routinely answer bathroom call lights and the dietary staff aware of the light mistakenly assumed whomever assisted resident to toilet would promptly return to assist resident off the toilet. Resident 1 medical record was reviewed and R1 was interviewed for preferences regarding bowel plan. Care plan has been update to reflect bowel plan toileting every other day before bed by 8/18/2021. Resident 2 has significant cognitive impairment and is unable to meaningfully express needs. R2s record review shows history of hallucinations and delusions from which R2 cannot be redirected and refusal of medications. Psychoactive medication regimen has been referred to PharmD for recommendations for alternative routes by 8/13/2021. Nurses to document R2 mood/behaviors twice daily and offer baby doll for comfort. All other residents have the potential to be impacted is staff do not respond promptly to call lights.	8/18/2021

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

Alexis Luke | Administrator | 8/13/2021

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 725	Continued From page 1 types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, anonymous concern review, and Emergency Staffing Strategies review, the provider failed to ensure there was enough staff to respond promptly to residents' needs. Findings include: 1. Review of anonymous concern received by the South Dakota Department of Health revealed: *The resident's in the facility were not receiving a timely response by staff. *Residents were waiting with their call lights on and not receiving timely response from staff. *Residents requiring more assistance were not receiving the help they needed. *The concerned individual felt they were short staffed CNAs. Interview on 7/22/21 at 8:45 a.m. with RN consultant B revealed: *They had 30 residents in their building. *They have recently had 12 residents who tested positive for COVID-19. *One positive resident had recently passed away. *Two residents are in the hospital.	F 725	By 8/18/21, all staff will be educated on the obligation to answer call lights and responsibility to notify a nurse if they cannot meet the residents need. By 8/18/21, all nursing staff will have received education on teamwork and hand-off communication prior to leaving or break. Education provided by Administrator or Designee. Staff not present educated via written information and quiz by end of next shift. Going forward, written education will be provided to supplemental staff as part of the on-boarding process. Social services or designee will audit by observation and resident interview staff responsiveness to resident needs, and audit for completion of onboarding education. Audits will occur weekly x4, monthly x2. Social services or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring.Substantial compliance will be achieved by 8/18/2021.	

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F 725	Continued From page 2 *They currently had a ratio of about one staff for every five or six residents. *They were not currently short staffed. Observation and interview on 7/22/21 at 9:40 a.m. of the facility's 300 hallway revealed: *The only staff observed were dietary aides E and F. -They were collecting room trays. *This surveyor could hear audible yelling from the end of the hallway. *Dietary aide E came out of room 304, stating that resident 1 was very upset. *This surveyor asked why the resident was upset, dietary aide E replied: -"He said staff left him on the toilet for over twenty minutes." *Dietary aide E and F said that they are short CNAs. *The dietary aides were trying to help out where they could because CNAs were able to answer call lights very fast. Continued observation on 7/22/21 from 9:40 a.m. through 10:00 a.m. revealed: *Resident 2 in room 311 continued to cry out for help. *There was 20 minutes observed without staff stopping in to check on her. Interview on 7/22/21 at 11:30 a.m. with administrator A and nursing consultant B revealed: *They did not have a way to retrieve staff response time for call lights. *They were going to have extra help arrive next week in response to a staffing request they sent out. *This surveyor asked if the extra staff could arrive	F 725		

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F 725	Continued From page 3 sooner. *They stated that they could not. *They had not noticed call lights being on for an extended amount of time. Review of the provider's undated Emergency Staffing Strategies revealed: *"During a conventional staffing period, no residents have tested positive for contagion. Having a positive test indicated need to move to contingent staffing plan." *Contingent staffing strategies included: -"Decrease in available staff causes disruption in delivery of care and changes in workflow." -"Staff under self-isolation unable to return to work for 7 to 14 days." -"Marked increase in overtime." -"1-5 residents are positive or suspected to have COVID1-9 [COVID-19]" *Adjustments to workflow: *"Reduce bathing to 1 time per week." *"Review incentives for staff willing to increase scheduled hours." *"Upskill."	F 725		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880	Directed Plan of Correction Good Samaritan Society Deuel County F880 Corrective Action: 1. Time cannot be turned back to a time prior to the identification of lack of: *appropriate screening of anyone (staff or visitor) for COVID-19 before entering the facility. *appropriate N-95 fit-testing of all who are required to wear during COVID presence in facility. *appropriate work practice to minimize infection spread by dietary and environmental services when working around those residents who have been quarantined or isolated because of COVID-19. -Use of cleaning cloths. -Disposal of bags of trash. *appropriate disinfection and maintenance between quarantined and/or isolated residents of multi-resident use equipment. Administrator, interim DON, and Infection control nurse were provided education/re-education	8/18/2021

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F 880	Continued From page 4 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880	by Sanford Health Lead Infection Preventionist Consultant on 8/10/2021 The administrator and interim DON in consultation with the medical director and infection control nurse and whomever else identified will review, revise, create as necessary policies and procedures about: *Appropriate screening of all (staff and visitors) for COVID-19 before entering the facility. *Appropriate N-95 fit-testing of all who are required to wear during COVID presence in facility. *Appropriate work practice to minimize infection spread by dietary and environmental services when working around those residents who have been quarantined or isolated because of COVID-19. -Use of cleaning cloths. -Disposal of bags of trash. *Appropriate disinfection and maintenance between quarantined and/or isolated residents of multi-resident use equipment policy. *Necessary infection control and prevention plan that includes effective compliance. All applicable policy and procedures reviewed and no revision necessary. All staff who provided above care and services to residents will be educated/re-educated by administrator and infection Preventionist on policy and procedure by 8/18/2021. Staff not present this day to recieve written education and quiz by end of next shift. Identification of Others: 2. ALL residents have the potential to be affected if staff do not adhere to: *Appropriate screening of all who enter the facility. *Appropriate N-95 fit-testing for all who are required to wear. *Appropriate work practice to minimize infection spread when utilizing cleaning cloths and disposing of bags of trash by dietary and/or environmental services when working around residents who have been quarantined or isolated because of COVID-19. *Appropriate disinfection and maintenance between quarantined and/or isolated residents of multi-resident use equipment.	

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F 880	Continued From page 5 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, record review, policy review, and Centers for Disease Control and Prevention guidance review, the provider failed to follow infection control practices when providing care for COVID-19 quarantined residents which included, ensuring: *All people who entered the building were screened for signs, symptoms, and the potential exposure of COVID-19. *All staff who provided care for COVID-19 positive and potential COVID-19 positive residents had been fit-tested for N95 masks. *Two of two dietary staff (E and F) followed appropriate infection control practices when providing care for quarantined residents. *Patient equipment was disinfected after use on quarantined residents. *Housekeeping staff H followed appropriate infection control practices when cleaning quarantined resident's rooms. Findings include:	F 880	ALL staff completing the care and/or assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by administrator and Infection Preventionist by 8/18/2021. System Changes: 1. Root cause analysis conducted answered the 5 Whys: An RCA was completed for each finding cited in the deficiency. A lack of infection control support and inconsistent education were the primary factors leading to the deficient practice. The Infection Preventionist resigned at the start of the outbreak, leading to gaps in communication and front-line staff unsure who to take their infection control questions to. New leaders made assumptions about what training had been completed. Administrator, interim DON, infection control nurse, medical director and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency.Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 7/30/21 and discussed resources available to LTC facilities. Assisted with a fish-bone and five why analisis QIN provided links to quality improvement tools and training resources to ensure compliance.	

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F 880	Continued From page 6 1. Observation and interview on 7/22/21 at 8:30 a.m. of the facility's main entrance revealed: *Surveyor entered into the facility via the main entrance. *Surveyor was greeted by an unidentified staff member leaving the building. *This surveyor introduced herself to the staff member. *Business office coordinator D greeted staff member and surveyor. *Surveyor introduced herself to business office coordinator D. -She stated she would notify the administrator A and registered nurse (RN) consultant B of my entrance. *The staff member brought surveyor to licensed practical nurse (LPN) I. *This surveyor introduced herself to LPN I. *The unidentified staff member, business office coordinator D, and LPN I did not screen this surveyor for signs and symptoms, or possible exposure to COVID-19. Interview on 7/22/21 at 8:45 a.m. with RN consultant B revealed: *They had 30 residents in their building. *They have recently had 12 residents who tested positive for COVID-19. *One positive resident had recently passed away. *Two residents are in the hospital. *They had a designated COVID-19 wing which was located on the 200 hallway. *100 and 300 hallway were all quarantined, or presumptive COVID-19 positive residents. *Staff are not fit-tested, they are working with a clinic to arrange fit-testing. *They are not currently short of supplies. 2. Observation and interview on 7/22/21 at 8:55	F 880	Monitoring: 2. Administrator, interim DON, infection contro l nurse, and whomever else determined necessary will conduct auditing and monitoring for areas identified above. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum weekly for 4 weeks, administrator, DON, and/or infection prevention nurse making observations across all shifts to ensure staff compliance with: *Necessary infection control and prevention plan that includes compliance in the above identified areas. *Any other areas identified thru the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or infection control person, or whomever else is determined necessary, to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director. Substantial compliance will be achieved by 8/18/2021	

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F 880	Continued From page 7 a.m. of the 300 hallway revealed: *There were three quarantined resident's doors open. *RN G stated this was to ensure the residents did not choke while they were eating. *RN G peeked her head into a resident room to ask if they were finished eating, she was not wearing a face shield. 3. Observation and interview on 7/22/21 at 9:05 a.m. of the 100 hallway revealed: *Environmental services technician M came out of a quarantined resident's room with a bag of trash. *She placed the bag of trash on top of her house keeping cart. *Two dietary aides E and F were collecting room trays from residents. *They would go into a quarantined resident's room with a rag to wipe off the bedside table residents were eating on and then: -Would bring that same rag out into the hallway and put on their dietary cart. -They would spray one side of the rag with a disinfectant, and bring it into another resident's room. *Surveyor asked Dietary aide E what kind of disinfectant they were using, she did not know. *Dietary Aides E and F stated they used that same rag for all resident's rooms. *When they brought the rag out of the resident's room they laid it on top of their dietary cart. *Dietary aide F was observed going into a resident's door way to retrieve a room tray, she then: -Walked back down to the dietary cart. -She did not take off her gown, gloves or disinfect her face shield. *Surveyor asked Dietary aide F why she did not	F 880		

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F 880	Continued From page 8 remove her gown, gloves and disinfect her face shield, she stated: -She was not aware if she needed to change her gown, face shield, and gloves since she was only inside the doorway of the resident's room. 4. Further observation on 7/22/21 at 9:15 a.m. on the 100 hallway revealed: *Restorative nurse aide K had been using a vitals cart to take quarantined residents' vitals. *She had used the same clipboard, pen, and paper in all the quarantined residents' rooms. -She did not disinfect those items. *She did not disinfect the vitals cart after two encounters with quarantined residents. 5. Observation and interview on 7/22/21 at 9:35 a.m. of the 300 hallway revealed: *Dietary aides E and F were collecting room trays and using the same soiled rag. *Environmental services technician H went into room 313. *She was not properly wearing her N95 mask. *It was visibly not sealed on her face. *The bottom of her glasses were underneath the N95 mask. *Surveyor asked if she had been fitted for her mask. *She said a couple of days ago someone performed a "seal test." *She did not perform a seal test today. *She had reached into her housekeeping cart with the same soiled gloves she was using to clean the quarantined resident's room. *Wearing her soiled gloves she had used her keys to open the cart, grabbed bottles of disinfectant, and returned them to the cart and did not clean them off. *Restorative nurse aide K came out of room 307	F 880		

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F 880	Continued From page 9 with a vitals cart, she did not disinfect it. 6. Interview on 7/22/21 at 10:30 a.m. with administrator A and administrator in training C revealed: *Administrator A was responsible for making sure everyone was screened prior to coming into the building. *Surveyor asked who looks over the staff screenings to make sure everyone had signed in and did not have symptoms. *She stated that was her responsibility. *Certified nursing assistant (CNA) N tested positive for COVID-19 at work on 7/20/21. -Review of provider's staff and visitor screening log revealed CNA N was not screened in when she worked in the building on 7/20/21. 7. Interview on 7/22/21 at 11:30 a.m. with nurse consultant B and administrator A revealed: *They agreed staff should not be using the same soiled rag in all of the resident's room. *They were going to address it with dietary immediately. *They agreed vital carts and equipment used on residents needs to be disinfected prior to using on another resident. *They agreed face shields were to be disinfected after contact with quarantined residents. 8. Review of the provider's July 2021 Emerging Threats-Acute Respiratory Syndrome Coronavirus (COVID) Enterprise policy revealed: *Fit testing for N95 respirators would be completed initially for people caring for COVID-19 positive residents. *All equipment in the resident's room is considered contaminated. *Clean and disinfect equipment with an EPA	F 880		

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F 880	Continued From page 10 (environmental protection agency) approved cleaner before removing equipment from the resident room. 9. Review of the Centers for Disease Control and Prevention's March 2021's COVID-19 guidance for nursing homes revealed: *Employers should provide personal protective equipment (PPE) in accordance with occupational safety and health administration (OSHA) standards. *A respiratory program should include medical evaluations, training, and fit testing. *Screen and triage everyone entering the healthcare facility for signs and symptoms of COVID-19. *The fit of the medical device used to cover the wearer's mouth and nose is critical preventing exposure to others.	F 880		