PRINTED: 12/16/2020
FORM APPROVED
OMB NO. 0938-0391

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

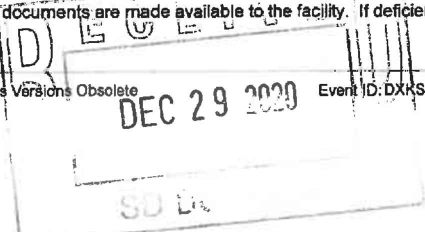
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435037	A. BUILDING ______ B. WING ______	12/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSON HEALTH CARE	1015 MT VIEW RD RAPID CITY, SD 57702

(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: 41895 A COVID-19 Focused Infection Control Survey was conducted by the South Dakota Department of Health Licensure and Certification Office on 12/3/20 and on 12/7/20. Clarkson Health Care was found not in compliance with 42 CFR Part 483.80 infection control regulation: F880. Clarkson Health Care 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. Clarkson Health Care was found in compliance with 42 CFR Part 483.73 related to E-0024(b)(6). Total residents: 37	F 000		
F 880 SS=D	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 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,	F 880	Clarkson Health Care operates in compliance with all relevant regulations and professional standards, in a manner that ensures safe and appropriate care for all residents that we serve. In regards to PPE removal upon exiting an isolation suite, ongoing staff, resident and resident representative education (AK 12/29/2020) has been completed since the beginning of the COVID-19 pandemic in March of 2020. Referenced resident 2 was noted to be COVID positive on 11/20/20, and was released from all precautions on 12/4/2020, the day after survey activity, with no residents in facility currently on isolation for active COVID cases. Staff education was completed by facility management with the staff referenced by the surveyor on 12/5/2020. Director of Nursing/designee will audit isolation area exit processes weekly X8 to ensure ongoing compliance with removing PPE items and completing hand hygiene prior to exiting isolation spaces, if there are any residents on isolation, and will report findings to QA committee monthly until QA committee deems findings to be satisfactory.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Andrea Knoll, LNHA	12/23/2020

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 880	Continued From page 1 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 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.	F 880	In regards to keeping doors closed for residents on COVID-19 isolation, staff education completed for all relevant staff on 12/5/2020. Surveyor noted that staff were frequently entering and exiting the indicated rooms that had doors open during her observations, as cares/resident interactions were ongoing. Surveyor staff did not indicate that she had unanswered questions regarding fall prevention interventions during her facility exit process, nor during the post survey communication that occurred in the days following the survey. Director of Nursing/designee will audit isolation suites weekly x8 weeks to ensure ongoing compliance with maintaining closed doors where indicated, and will report findings to QA committee monthly until QA committee deems findings to be satisfactory.	

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F 880	Continued From page 2	F 880		

§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: 41895
Based on observation, interview, policy review, and Centers for Disease Control and Prevention (CDC) publication Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html related to COVID-19, the provider failed to follow CDC's guidelines related to the COVID-19 pandemic by failing to:
*Remove personal protective equipment (PPE) prior to exiting a sampled resident's room (2) who had been diagnosed with COVID-19 by one of one housekeeper (C) and one of one registered nurse (RN) (D).
*Close all doors to rooms of residents who had tested positive for COVID-19 (2, 3, and 4).

Findings include:

1. Observation on 12/3/20 at 2:55 p.m. outside of resident 1 and 2's shared room revealed:
*Signage instructing how to put on and remove PPE.

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*A plastic container with drawers containing PPE.

Observation and interview on 12/3/20 at 2:55 p.m. of housekeeper C coming out of resident 1 and 2's shared room revealed she:
*Was wearing PPE, which had included a gown, gloves, N95 mask, and face shield.
-She was observed twice with the same PPE on coming out into the hallway to the housekeeping cart.
*Revealed she had seen other staff come into the hallway wearing contaminated PPE so thought it was appropriate.
*Had agreed the PPE she was wearing would have been contaminated so she should have removed her gown and gloves prior to coming out of the resident room.

Observation and interview on 12/3/20 at 3:15 p.m. of RN D coming out of resident 2's room revealed:
*Resident 2 had COVID-19.
*She was wearing a gown, gloves, N95 mask, and face shield.
*She had removed her gloves and gown and placed them into a clear plastic garbage bag she had carried out of the resident room.
*Without performing hand hygiene, she reached into her pants pocket to retrieve her phone.
-She shut the ringer off and returned it to her pocket.
*She agreed she should have removed the gown and gloves prior to exiting the room.
*She agreed she should have performed hand hygiene after removing her gloves and touching her phone.

Interview on 12/3/20 at 3:56 p.m. with administrator A and director of nursing B revealed

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F 880	Continued From page 4	F 880		

they agreed:
*Staff should have removed their gown and gloves prior to exiting room.
*The RN should have performed hand hygiene after removing her gloves and before reaching into her pocket.

On 12/3/20 at 3:56 p.m. the administrator was asked for a policy regarding putting on and removing PPE. She provided an undated CDC publication titled Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19. This revealed:
*The gloves and gown should have been removed prior to exiting the resident's room.
*Hand hygiene should be performed after exiting a resident room.

2. Observations on 12/3/20 between 3:00 p.m. to 3:20 p.m. revealed:
*The doors to resident 2, 3, and 4's rooms had been left open.

Interview on 12/3/20 at 3:20 p.m. with CNA E regarding the above open doors revealed:
*Resident 2, 3, and 4 had been diagnosed with COVID-19.
*The doors should have been closed.

Interview on 12/3/20 at 3:56 p.m. with director of nursing B regarding the above observation of the doors revealed:
*The doors were to be closed on rooms occupied by residents diagnosed with COVID-19.
*Residents 2 and 3 had been a fall risk so those doors should be left open.
-The surveyor had asked for documentation on interventions attempted prior to leaving the doors

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F 880	Continued From page 5 open. -Documentation was not provided prior to exiting the facility at 5:45 p.m. Review of the provider's 11/7/20 COVID Isolation Unit(s) policy and procedure had not addressed the doors being open or closed. Review of the updated 11/4/20 CDC publication Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html accessed on 12/7/20 at 3:00 p.m. revealed a resident with suspected or confirmed COVID-19 should be placed in a private room with the door closed.	F 880		