STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435104	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761

(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: 40788 A COVID-19 Focused Infection Control Survey was conducted by the South Dakota Department of Health Licensure and Certification Office on 7/28/20. Good Samaritan Society New Underwood was found not in compliance with 42 CFR Part 483.80 infection control regulation: F880. Good Samaritan Society New Underwood was found in compliance with 42 CFR Part 483.80 infection control regulations: F884 and F885. Good Samaritan Society New Underwood was found in compliance with 42 CFR Part 483.73 related to E-0024(b)(6). Total residents: 36	F 000	Staff member E and G were educated for dwell time and proper cleaning procedures for disinfecting on July 28th, and staff member F was educated on July 29th. Housekeeping staff member C & D were educated on July 29th on proper cleaning and dwell time procedures. The facility will discontinue using the Sani Cloth AF3 germicidal wipes on all surfaces except for the small medical equipment where using the peroxide multi surface cleaner is not deemed safe for the equipment. The facility starting on 8-14-20 will use only peroxide multi surface cleaner on all high touch surfaces in common areas and resident rooms such as hard surfaces at a ratio of 6 oz per gallon for a 3 minute disinfecting dwell time or 45 seconds for COVID-19 kill time according to Eco-Lab. By 8-14-20, education wil be done for all staff on the new procedure of using peroxide multi surface cleaner for all high touch surfaces in common areas and resident rooms such as hard surfaces. If staff are unavailable during these education sessions they will be educated during their first shift back to work. The facility administator or designee will audit for contact time for peroxide multi surface cleaner and staff knowledge of proper contact time for 5 audit per week x 4 weeks then 5 audit per month x 3 additional months. The QAPI committee will review and if necessary recommend improvements for the audits to ensure compliance for contact time and knowledge of staff.	8/14/20
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	F 880	Staff were educated on a one on one basis to fill the visitor screening tool out correctly on 7/29/20. Audits were conducted starting on 7/29/20 to ensure the staff are filling out the visitor screening tool correctly. In addition, all staff will be educated on visitor screening procedures 8/14/20. If staff are unavailable during these education sessions they will be educated during their first shift back to work. The visitor screening log will also be audited to ensure staff are completing the screening tool correctly and if necesssary, allowing or not allowing visitors. The facility administrator or designee will audit for completeness and correctness every day x 10 days, then 5 visitors per week x 4 weeks then 5 visitors per month x 3 months. The facility administator or designee will report to the QAPI committee their findings and if necessary the QAPI committee will make suggestions for improvements if the audit shows non-compliance on visitor screening tool.	8/14/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kyle Richards	Executive Director	08/13/20

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 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 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	Staff member G was educated on the use of a gown along with mask, gloves and eye protection for contact/droplet precautions on 7/29/20. Proper PPE will be worn by all staff and will be in compliance from the facility procedure. All staff will be educated on PPE requirements where residents are in transitional area (grey zone) and not suspected or confirmed to be COVID-19 by 8/14/20. The facility administrator or designee wil aduit PPE compliance by staff. There will be a minimum of 5 audits per week across all shifts x 4 weeks then an additional 5 audits per month x 3 additional months for proper PPE use and staff knowledge of the PE requirements. The facility administrator or designee will report to the QAPI committee their findings and if necesssary the QAPI committee will make recommendations for improvements if the audit shows non-compliance on PPE being worn by staff. The door was closed for resident 1 until clarification was sought for the policy on 7/31/20. No other residents were affected since no other residents were present in the grey zone at the time. Staff will be educated on the door status when the resident is on the grey zone for quarantining and observing for COVID symptoms by 8/14/20.The door to individual resident room may be open if assessed and based on care needs it is determined for safety or other resident need, the need is reflected on the individual care plan. If staff are unavailable during these education sessions they will be educated during their first shift back to work. There will be 5 audits done per week x 4 weeks then 5 audits per month x 3 months for knowledge by staff on door closure requirements for resident rooms.The facility administrator or designee will report to the QAPI committee their findings and if necessary the QAPI committee will make recommendations for improvements if the audit shows non-compliance on door closure by staff.	8/14/20 8/14/20

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F 880	Continued From page 2 §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: 40788 Based on observation, interview, review of a Centers for Disease Control (CDC) publication, facility informational sheet review, and policy review, the provider failed to ensure infection control procedures and practices were followed for: *Management of one of one sampled new resident (1) admission to the facility. *The use of Sani Cloth AF3 germicidal wipe according to the manufacturer's recommendations for coronavirus disease 2019 (COVID-19) by one of one observed licensed practical nurse (LPN) (E) and one of one observed certified nurse aide (CNA) (F). *The use of Peroxide Multi Surface Cleaner and Disinfectant (virucidal) according to the manufacturer's recommendations for COVID-19 by one of one housekeeper (C). *Accurate visitor screening for COVID-19 for twenty-one of twenty-one randomly selected visitors. Findings include: 1. Observation on 7/28/20 at 10:35 a.m. of resident 1's room revealed: *A sign posted on the outside of her room door that indicated she required contact/droplet	F 880		

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F 880	Continued From page 3 precautions. -It stated everyone who entered the room must wear a gown, mask, gloves, and face shield or goggles. *The door to the room was open. *Occupational therapist (OT) G had sat beside the resident and worked on a fine motor skill activity with her. -She had worn a mask, gloves, and eye protection but no gown. Interview on 7/28/20 at 11:05 a.m. with OT G revealed: *She confirmed she had not worn a gown during her therapy session with resident 1. *She stated she had worn a gown if she toileted the resident or expected to encounter bodily fluids from the resident. Observation on 7/28/20 at 11:15 a.m. of resident 1 revealed the door to her room was open, and she was alone. Interview on 7/28/20 at 11:50 a.m. with interim director of nursing (DON) B regarding resident 1 revealed: *She would have expected all staff to wear the recommended personal protective equipment (PPE) as indicated on the signage on the resident's door prior to entering the room. *She stated the resident's door should probably be closed at all times. -She said the door had been kept open, because the resident was a fall risk. -Her room was at the end of a hall. Interview on 7/28/20 at 12:35 p.m. with administrator A revealed: *The facility's cohorting plan had not addressed	F 880		

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F 880	Continued From page 4 room door closures for residents who required isolation. *The facility had not tried alternative means to keep resident 1's door closed and maintain her safety. Review of the undated informational sheet Talking Points the facility used when communicating with hospital admissions staff regarding new facility admissions revealed: "We recently set up a special cohort zone in our building where we will place patients [residents] who are discharged from the hospital to our facility. These individuals will be isolated for 14 days before transitioning out of the cohort zone, which is in line with CDC guidance. Within the 14 days, we'll monitor closely for signs or symptoms of COVID-19." Review of the 7/24/20 Cohorting Plan for SNFs (skilled nursing facilities) revealed: "All nursing homes should consider establishing a transitional zone for new admissions, returning residents from the hospital or those who are traveling in and out of the nursing home. Transitional zones/units are established to quarantine those residents who are at somewhat higher risk of getting exposed to COVID-19 but have no known exposure to COVID-19." Review of the 7/15/20 updated CDC publication Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic revealed: *2. Patient (resident) Placement: -"If admitted, place a patient with suspected or confirmed SARS-CoV-2 [COVID-19] infection in a single-person room with the door closed."	F 880		

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F 880	Continued From page 5 2.a. Observation and interview on 7/28/20 at 10:40 a.m. with LPN E after she exited resident 2's room revealed: *She had taken his vital signs. *She used separate Sani Cloth AF3 cloth wipes to wipe the blood pressure cuff, stethoscope, and pulse oximeter she had used with that resident. -She wiped the above items between five and seven seconds each before she placed them into the vitals cart. *She stated the contact time for the disinfectant was three minutes. -That three minutes was a combination of the time the equipment needed to be wet and the time required for the equipment to dry. b. Observation and interview on 7/28/20 at 10:50 a.m. with CNA F after he exited resident 3 and 4's room with a mechanical lift revealed: *He had used a mechanical lift to provide care for one of those residents. *He used a Sani Cloth AF3 cloth wipe to wipe the lift. *He wiped the lift between fifteen and thirty seconds. *He stated the contact time for the disinfectant wipe was between five and ten minutes. -That five to ten minutes included the wipe down time and the time allowed before using the lift with another resident. c. Interview on 7/28/20 at 11:50 a.m. with interim DON B regarding Sani Cloth AF3 use to disinfect medical equipment revealed: *She confirmed the wet time for the Sani Cloth AF3 was three minutes. -She expected the surfaces of the equipment that was disinfected remain wet for that period of time to be effective.	F 880		

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F 880	Continued From page 6 *She referred to the 7/1/19 Blood Glucose Testing, Monitoring, Cleaning and Disinfectant policy for guidance on cleaning and disinfection of the medical equipment referred to above. Review of the 7/1/19 Blood Glucose Testing, Monitoring, Cleaning, and Disinfectant policy revealed: *"General Cleaning and Disinfecting: 4.a. A germicidal disposable wipe supplied by the Society's preferred vendor or a dilution of 1 mL [milliliter] household bleach in 9 mL water (1:10 dilution) [one to ten] should be used to disinfect the blood glucose meter." *There was no reference regarding the disinfection of the other medical equipment referred to above. Surveyor: 29162 3. Observation and interview on 7/28/20 from 10:40 a.m. through 10:50 a.m. with housekeeper C revealed she: *Had been been standing beside her cleaning cart on the two hundred hallway. *Had a square container of virucidal on the cart. *Stated she cleaned: -The handrails and door knobs twice a day with the virucidal disinfectant. -The surfaces in residents' rooms, door knobs, and handrails by wiping over them with a virucidal cleaning cloth one time. *Had been unaware of the surface wet time for the virucidal to be effective against COVID-19. Interview on 7/28/20 at 11:55 a.m. with housekeeping supervisor D revealed: *She confirmed he surface wet time for the virucidal disinfectant to have been effective against COVID-19 had been five minutes.	F 880		

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F 880	Continued From page 7 *She agreed the handrails and door knobs had not remained wet with the virucidal disinfectant for five minutes. *She thought all the other surfaces in the residents' rooms would have been wet with the virucidal disinfectant for five minutes. *Had not monitored or timed the surface wet time of the virucidal when cleaning. *She was unaware of the five minute wet time for the effectiveness of virucidal disinfectant. Review of the last revised March 2016 Environmental Cleaning principles revealed no mention of the use of Peroxide Multi Surface Cleaner and disinfectant. 4. Review of twenty-one randomly selected COVID-19 Visitor Screening Questionnaire forms revealed: *Two of twenty-one had no name documented. *Seven of twenty-one had not been signed by the visitor. *Four of twenty-one had not been signed by the staff member completing the screening. *Nine of twenty-one had incorrectly answered the screening questions. *Four of twenty-one had not acknowledged having received instruction for a safe visit. *Seven of twenty-one had not been documented as having passed the screening process to have visited. Interview on 7/28/20 at 11:50 a.m. with administrator A and interim DON B revealed they agreed the COVID-19 Visitor Screening Questionnaires had not been completed for the above twenty-one visitors' forms.	F 880		