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 |
|---|---|---|---|
| | 435082 | A. BUILDING _____ B. WING _____ | 02/02/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY LENNOX | 404 EAST 6TH AVENUE LENNOX, SD 57039 |

| (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<br><br>Surveyor: 29354<br>A COVID-19 Focused Infection Control Survey was conducted by the South Dakota Department of Health Licensure and Certification Office on 2/2/21. Good Samaritan Society Lennox was found not in compliance with 42 CFR Part 483.80 infection control regulation: F880.<br><br>Good Samaritan Society Lennox 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.<br><br>Good Samaritan Society Lennox was found in compliance with 42 CFR Part 483.73 related to E-0024(b)(6).<br><br>Total residents: 37 | F 000 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, | F 880 | Directed Plan of Correction F880<br>Good Samaritan Society Lennox<br>Corrective Action:<br>1. *Residents (1,2,3 &4) room doors or barrier curtains for those identified as Covid-19 positive or suspected will be kept closed except when entering or leaving the room. All staff have been educated by the Director of Nursing and reviewed the facility policy for Covid-19 placement and have acknowledged review by 2/21/21.<br><br>*CNAs B and C reviewed the facility's policy on hand hygiene, handwashing and appropriate glove use. They were educated/re-educated by the Director of Nursing or designee by 2/21/21. Collecting soiled clothes and linen policy and catheter drainage bag emptying policy were reviewed and completed competencies on 2/18/21.<br><br>RN D reviewed the facility's hand hygiene and handwashing policy, as well as the wound-drain system: open, closed and negative-pressure wound therapy policy and completed competency on 2/19/21.<br><br>Identification of Others:<br>2. *All residents with known or suspected Covid-19 have the potential to be affected. ALL facility staff completing their assigned tasks have potential to be affected. Policy education/re-education by the Director of Nursing/Clinical Trainer by 2/19/21.<br><br>*All residents who receive assisted personal cares have the potential to be affected. All facility staff completing assigned resident personal cares have the potential to be affected. Policy education/re-education by Director of Nursing/Clinical Trainer by 2/19/21.<br><br>*All residents having a dressing change have the potential to be affected. All facilitystaff assigned the task of dressing change have the potential to be affected. Policy education/re-education by Director of Nursing(DON)/Clinical Trainer by 2/19/21. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Todd M. Anderson | Administrator | 2/18/21 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435082 | A. BUILDING _____ B. WING _____ | 02/02/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY LENNOX | 404 EAST 6TH AVENUE LENNOX, SD 57039 |

| (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 880 | Continued From page 1<br>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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the | F 880 | System Changes:<br>3. Root cause anaysis answer the 5 Whys:<br>1.) -Tools and equipment are not adequate to meet intended use.<br>-Plastic curtains are on rings and do not always remain fully closed.<br>-Potential staff error and also they slide open when brushed against<br>-Curtains are not affixed to door jams<br>-Better product was not available at time of need, which will be remedied by purchase of magnetic closing curtains.<br>2.) -CNAs didn't understand how they could perform hand hygiene during cares without leaving resident in unsafe positions.<br>-Belief they need to go into bathroom to wash hands for each time hand hygiene was needed.<br>-Lack of hand sanitizer at bedside.<br>-Refill not available for in room dispensers and staff not carrying small bottles.<br>-Staff not wanting to put the bottles in pocket which is considered dirty, which is remedied by purchase of carrying case.<br>3.) -Nurse did not follow the procedure.<br>-Failing to perform hand hygiene after removing gloves and failure to clean surface or use a barrier.<br>-Failed to review procedure prior to dressing change.<br>-Over confidence having been trained in the last three months.<br>-Failure to do a follow up audit of competency after initial training.<br><br>The DON will ensure ALL facility staff are educated and aware of the policy about doors closed for COVID-19 placement for those with known or suspected cases.<br><br>The DON will ensure All facility staff who perform resident personal cares are educated and have demonstrated competency with hand hygiene and handwashing and appropriate disposal of soiled linens, mechanical lift acquisition, placement of Foley catheter.<br><br>The DON will ensure All facility staff assigned task of dressing change are educated and have demonstrated competency with hand hygiene and handwashing and appropriate golve use, and dressing change techniques. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435082 | A. BUILDING _____ B. WING _____ | 02/02/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY LENNOX | 404 EAST 6TH AVENUE LENNOX, SD 57039 |

| (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 880 | Continued From page 2<br>corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 29354<br>Based on observation, interview, and policy review, the provider failed to ensure appropriate infection control practices and protocols were maintained for:<br>*Four of four new admissions (1, 2, 3, and 4) who were quarantined and monitored for signs and symptoms of COVID-19.<br>*Hand hygiene and glove use for one of one observed resident (5) personal care by two of two observed certified nursing assistants (CNA) (B and C).<br>*Hand Hygiene and glove use for one of one observed resident (5) dressing change by one of one registered nurse (RN) (D).<br>Findings include:<br><br>1. Observation on 2/2/21 at 10:40 a.m. at the end of the 100 hallway revealed:<br>*Doors leading into resident 1, 2, 3, and 4's room were open.<br>*There were plastic barrier curtains attached to plastic rods hanging on the entrance to each room.<br>-The plastic barrier curtains were partially open.<br><br>Interview on 2/2/21 at 10:55 a.m. with director of | F 880 | Administrator and DON contacted the South Dakota Quality Improvement Organization (QIN) on 2/16/21 and the QIN recommended review of online training for hand hygeine education along with follow up auditing.<br><br>Monitoring:<br>4.) The DON or designee will conduct at minimum 1 x per week for 4 weeks, appropriate door or barrier curtain closure audit when there is a resident who is suspected or positive for Covid-19 in the facility. Audits will occur across all three shifts. After 4 weeks of successful monitoring, then DON or designee will monitor 1 x per month for 3 months.<br>All monitoring reports will be presented to the QAPI committee by the DON or designee for recommendations.<br><br>The DON or designee will conduct at a minimum 1 x per week for 4 weeks procedural technique monitoring of resident personal care that includes hand hygiene and handwashing and appropriate glove use, appropriate disposal of soiled linens, mechanical lift acuquisition and placement of Foley catheter. After 4 weeks of successful monitoring, then will monitor 1 x per month for 3 months.<br>All monitoring reports will we presented to the QAPI committee by the DON or designee for recommendations.<br><br>The DON or designee will conduct at a minimum 1 x per week for 4 weeks dressing change procedural technique that includes hand hygiene and hand-washing and appropriate glove use, | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435082 | A. BUILDING _____ B. WING _____ | 02/02/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY LENNOX | 404 EAST 6TH AVENUE LENNOX, SD 57039 |

| (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 880 | Continued From page 3<br>nursing (DON) A regarding those rooms revealed:<br>*Resident 1, 2, 3 and 4:<br>-Were new admissions.<br>-Were in the fourteen day quarantine stage.<br>*They did not have any COVID-19 positive residents in the building.<br>*The last COVID-19 positive resident was over a month ago.<br>*Those plastic barrier curtains should have been closed.<br>*If the resident was not a fall risk their room door should have been closed.<br><br>Review of the provider's revised 1/15/21 Emerging Threats-Acute Respiratory Syndromes Coronavirus (COVID)-Enterprise policy and procedure revealed:<br>*"Purpose:<br>-2. To prevent the transmission from person to person of respiratory pathogens."<br>*"Upon identification of any resident with suspected or positive COVID-19, a Contact/Droplet Precautions sign will be posted on the outside of the resident's room.<br>*The resident will be isolated in their room with the door closed as safety allows."<br><br>Review of CDC's https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, Preparing for COVID-19 in Nursing Homes, reviewed on 2/2/21 revealed:<br>*"Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP [healthcare professionals] should wear an N95 or higher-level respirator (or face mask if a respirator is not available), eye protection (ie: | F 880 | appropriate maintenance of clean and soiled, defined barrier.<br>All monitoring reports will be presented to the QAPI committee by the DON or designee for recommendations | 2/21/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435082 | A. BUILDING _____ B. WING _____ | 02/02/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY LENNOX | 404 EAST 6TH AVENUE LENNOX, SD 57039 |

| (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 880 | Continued From page 4<br>goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected."<br><br>2. Observation on 2/2/21 at 12:08 p.m. in resident 5's room with CNAs B and C revealed:<br>*Resident 5 was lying on her left side.<br>*There were two plastic garbage bags on the floor beside the bed.<br>*There were several used wash cloths and towels laying on the floor beside the bed.<br>*CNA B:<br>-Removed her gloves and held them in her left hand.<br>-Pushed the total mechanical lift with both hands over to the bed with those soiled gloves in her left hand.<br>-Discarded the soiled gloves in to a garbage bag.<br>-With her bare hands took the Foley urine bag and hooked it up to the mechanical lift.<br>--The Foley urine bag was located above the residents bladder.<br>*CNAs B and C transferred her from the bed to a recliner with the total mechanical lift.<br>*CNA B with her bare hands:<br>-Removed disinfectant wipes from a container and wiped down the total mechanical lift.<br>-Discarded the soiled wipes into the garbage.<br>*CNA B without performing hand hygiene put on gloves and made her bed.<br>*CNA C:<br>-Took the Foley urine bag and attached it to the recliner.<br>-Removed her gloves and without performing | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435082 | A. BUILDING _____ B. WING _____ | 02/02/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY LENNOX | 404 EAST 6TH AVENUE LENNOX, SD 57039 |

| (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 880 | Continued From page 5<br>hand hygiene left the room.<br><br>Interview on 2/2/21 at 1:08 p.m. with DON A regarding the above observation revealed:<br>*There were several missed hand hygiene opportunities.<br>*Her expectations were:<br>-The Foley urine bag should have been placed below the residents bladder.<br>-Soiled linen should have been placed in a bag and not placed on the floor.<br>-Hand hygiene should have been completed after removing soiled gloves or prior to putting on new gloves.<br><br>3. Observation on 2/2/21 at 1:15 p.m. in resident 5's room with RN D and CNA C revealed:<br>*Resident 5 was in bed lying on her left side.<br>*RN D:<br>-Had on gloves.<br>-Picked up the unopened wound vac supplies that were in plastic wrappers and laid the supplies on an overbed table.<br>--That overbed table had not been disinfected or a barrier laid down.<br>-Pushed another overbed table with two towels on top of it over to the bed.<br>-Picked up a bottle of sterile water and 4x4's.<br>-Poured sterile water over the 4x4's.<br>--The water from those 4x4's dripped on the two towels of the second overbed table.<br>-Took the 4x4's and wiped the area around the perimeter of the stage four pressure ulcer located on her buttock area.<br>-Discarded the soiled 4x4's in to the garbage bag.<br>-Removed her gloves and without performing hand hygiene put on new gloves.<br>-Applied clarion skin prep around the perimeter of the pressure ulcer. | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435082 | A. BUILDING _____ B. WING _____ | 02/02/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY LENNOX | 404 EAST 6TH AVENUE LENNOX, SD 57039 |

| (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 880 | Continued From page 6<br>-Applied Tegaderm around the pressure ulcer area.<br>-Took the plastic chux located under her buttock and wiped around her anal area.<br>-Removed her gloves, washed her hands, and put on gloves.<br>*There were no other breaches in hand hygiene during the remainder of the dressing change and wound vac application.<br><br>Interview on 2/2/21 at 1:15 p.m. with RN D regarding the above dressing change revealed she felt she had done hand hygiene and had done the procedure correctly.<br><br>Interview on 2/2/21 at 1:51 p.m. with DON A regarding the above dressing change observation revealed:<br>*She would expect the clean supplies to stay clean.<br>*She would not intertwine soiled supplies with clean supplies.<br>*Hand hygiene should have been done after removal of soiled gloves.<br>*Hand hygiene and new gloves should have been done before using new products.<br><br>Review of the provider's revised 4/14/20 Hand Hygiene and Handwashing policy revealed:<br>*"During Patient [resident] Care:<br>-2. If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning hands:<br>--a. Before having direct contact with residents.<br>--d. After touching equipment or furniture near the resident.<br>--e. After removing gloves."<br><br>Review of the provider's revised 9/9/20 | F 880 | | |

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 |
|---|---|---|---|
| | 435082 | A. BUILDING _____ B. WING _____ | 02/02/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY LENNOX | 404 EAST 6TH AVENUE LENNOX, SD 57039 |

| (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 880 | Continued From page 7<br>Wound-Drain System: Open, Closed and Negative-Pressure Wound Therapy policy revealed: "3. Create a clean work space on bedside table or bed." | F 880 | | |