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

PRINTED: 01/05/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	12/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(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
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare & Medicaid Services (CMS) on 12/17/20 through 12/18/20. The facility was found to be in substantial compliance with 42 CFR 483.73 related to E-0024 (b)(6).	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare & Medicaid Services (CMS) on 12/17/20 through 12/18/20. The facility was found not to be in substantial compliance with 42 CFR 483.80 Infection Control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Survey Census: 131 Sample Size: 5 Supplemental: 13	F 000		
F 880 SS=E	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.	F 880		1-15-2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dr. Colleen McCarty | TITLE: Interim Administrator | (X6) DATE: 1/14/2021

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 880	Continued From page 1 §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, 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	F 880		

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F 880	Continued From page 2 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. §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: 26006 Based on observations, staff interviews, and record review, the facility failed to ensure 12 of 13 residents (Resident (R) 4, R5, R6, R7, R8, R9, R10, R11, R13, R14, R15, and R16) observed in the special care (secured dementia) unit's common areas maintained adequate social distancing or used masks for source control. This failure placed all 13 of the residents residing on the special care unit, of 131 total residents, at a higher risk for exposure to or spread of infection, including COVID-19. Additionally, the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) when providing care for two (R17 and R18) of 64 residents in the observation (yellow) zones. Findings include:	F 880		

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F 880	Continued From page 3 1. On 12/17/20 at 10:05 AM, the Administrator stated the facility had a designated COVID-19 care unit, and there were currently seven residents who were positive with COVID-19 on that unit. The Administrator explained there were no COVID-19 positive residents residing in the special care unit. The Administrator stated facility group activities and communal dining had been re-started in a limited capacity and with adequate social distancing, in accordance with the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid (CMS) guidance. On 12/17/20 from 11:16 AM to 12:00 PM, observations were conducted of the special care unit TV room and dining room. The residents living on the special care unit had moderate to severe symptoms of dementia, and none of the residents were reliably interviewable. None of the residents observed were wearing a mask/facial covering or carrying tissues/towels in the case of a cough or sneeze. The dining room tables had been pre-set with place settings, and each place setting, except for one that was at a table by itself, was next to another place setting less than six feet away. Two tables had been pushed together to create a long table, and there was an empty table in the dining room that was not being used. The following observations were made: At 11:16 AM, the TV room was observed with three chairs perpendicular to the TV, and three chairs parallel to the TV. The chairs were next to one another with no space in between. R5 and R13 sat in two of the perpendicular chairs next to each other, with less than six feet of distance between them.	F 880		

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F 880	Continued From page 4 At 11:23 AM, R4 approached and sat in the third perpendicular chair and began to touch R5 on the arm and placed a stuffed animal in R5's lap. Though Certified Nurse Aide (CNA) 1 was in the dining room, approximately 10 feet behind the residents, she did not intervene in any way to separate the residents. After approximately one minute, R4 stood up and walked out of the TV room. At 11: 35 AM, R5 and R13 remained in the perpendicular chairs in the TV room, and CNA1 assisted R11 and R14 to sit at the long table in the dining room at two of the place settings, one right next to the other. They were closer than six feet apart. At 11:50 AM, CNA1 and CNA2 began escorting residents from their rooms to the dining room tables. R10 was led by CNA2 to the head of the long table, directly perpendicular to R11. They were closer than six feet apart. At 11:56 AM, R10 left the table and went back to her room. CNA1 and CNA2 continued to escort residents to the dining tables and assist them to sit at the prepared place settings. At 11:57 AM, there were eleven residents in the dining room (R4, R5, R6, R7, R8, R9, R11, R13, R14, R15, and R16) who were not socially distanced from one another. On 12/17/20 at 11:20 AM, CNA1 stated it was impossible to maintain social distancing between residents in the special care unit because of their dementia. She stated they had tried moving the chairs apart in the TV room, but they always got moved back together. She also stated they tried	F 880		

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F 880	Continued From page 5 to spread the dining tables out more, but it "did not work." CNA1 added that they also tried using masks on the residents, but the residents were not compliant. On 12/18/20 at 10:37 AM, the Infection Preventionist (IP) stated she instructed the special care unit staff to keep trying to promote social distancing among the residents. She stated, "They just have to keep trying . . . we can't just give up." The IP stated if the staff consistently redirected residents and created space between the furniture, it would eventually become the new normal. The IP stated she did not have records of education provided on this topic for the special care unit staff; however, stated she provided this instruction verbally "over and over again." The facility's 05/11/20 "Caring for Residents with Dementia during COVID-19 Crisis" policy documented, "Modify the Environment to help with social distancing: Rearrange furniture to create separation [and] Create physical space between staff and residents through the use of objects (place chair at end of table, sit at opposite end of table from resident) . . ." 2. On 12/17/20 at 10:05 AM, the Administrator stated the "yellow zone" in the facility was designated for residents on isolation and increased monitoring for potential exposure to a staff member who tested positive for COVID-19. The Director of Nursing (DON) explained the staff should wear a gown and gloves when entering a yellow zone room in addition to their mask and face shield. Per the 12/17/20 paper "Resident Listing Report," R17 resided in the yellow zone. R17's 12/17/20	F 880		

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F 880	Continued From page 6 "Lab/Diagnostics" note, found in the "Progress Notes" tab of the Electronic Health Record (EHR), documented he tested negative for COVID-19. On 12/18/20 at 11:31 AM, R17's room was observed with a "Yellow Zone" sign, reminding staff to wear a mask, face shield, gown, and gloves when entering the room. CNA3 was monitoring R17's vital signs inside his room. CNA3 had a mask and face shield on but was not wearing a gown or gloves. Upon exiting R17's room, CNA3 stated in the yellow zone, staff were expected to wear the appropriate personal protective equipment (PPE), which included gown and gloves. CNA3 further explained a gown and gloves were needed if any resident care was performed, and stated, "I did not wear gown and gloves, because I was instructed that I did not need to wear them while only checking vitals on residents." Per the 12/17/20 paper "Resident Listing Report," R18 resided in the yellow zone. R18's 12/17/20 "Lab/Diagnostics" note, found in the "Progress Notes" tab of the EHR, documented she tested negative for COVID-19. On 12/18/20 at 11:35 AM, R18's room was observed with a "Yellow Zone" sign, reminding staff to wear a mask, face shield, gown, and gloves when entering the room. Certified Medication Aide (CMA) 1 entered R18's room without a gown or gloves; she was only wearing a mask and a face shield. CMA1 administered oral medications and a supplement to R18. Upon exiting the room, CMA1 stated she should have worn a gown and gloves when entering R18's room. She stated there was no reason she did	F 880		

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F 880	Continued From page 7 not wear them, "other than "I just wasn't going to be in there very long." On 12/18/20 at 11:40 AM, the DON stated staff had been instructed to wear gown and gloves whenever they came in contact with the resident or with anything in the room in the yellow zone. She stated CNA3 and CMA1 should have put on a gown and gloves for the resident care they performed. The DON added staff were never instructed that gown and gloves were not needed while checking vitals.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza	F 883		

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F 883	Continued From page 8 immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Surveyor: 26006 Based on record review and staff interview, the facility failed to determine the vaccination status and/or administer necessary vaccinations upon admission for one (Resident (R) 2) of five residents reviewed for vaccinations. This failure placed R2 at a potentially higher risk for infections, including influenza and pneumonia.	F 883		

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F 883	Continued From page 9 Findings include: Per the Centers for Disease Control and Prevention (CDC), accessed at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html on 12/18/20, "CDC recommends routine administration of pneumococcal polysaccharide vaccine (PPSV23) for all adults 65 years or older. In addition, CDC recommends PCV13 based on shared clinical decision-making for adults 65 years or older who do not have an immunocompromising condition, cerebrospinal fluid leak, or cochlear implant and have never received a dose of PCV13. Clinicians should consider discussing PCV13 vaccination with these patients to decide if vaccination might be appropriate." Per R2's 12/18/20 "Admission Record," found in the Profile tab of the Electronic Health Record (EHR), the facility admitted R2 on 10/23/20 and he was 67 years old. R2's "Clinical - Immunizations" record, found in the immunizations tab of the EHR, documented he received a PCV13 on 09/27/13. There was no documentation to indicate a PPSV23 was offered or discussed with the resident's physician. There was also no documentation regarding influenza vaccination. On 12/18/20 at 1:06 PM, the Infection Preventionist (IP) stated she was unable to find any documentation in R2's record regarding the influenza vaccination and stated this should have been addressed by his nurse on admission. The IP stated she contacted R2's representative, who reported he already had the influenza vaccination	F 883		

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F 883	Continued From page 10 prior to facility admission. The IP stated she did not find any additional documentation in R2's record regarding the pneumococcal vaccination but would follow up with the representative and R2's physician. The facility's 12/01/19 "Immunizations for Residents - Infection Control" policy documented, "Upon admission, each resident and/or resident representative will receive the Vaccination Information Statements (VIS) for influenza and pneumococcal vaccines. Discuss the benefits and potential side effects of vaccinations with the resident and/or resident representative."	F 883		

Coleen McCarty-Interim Administrator
Good Samaritan Society- Sioux Falls Village
3901 S Marion Rd
Sioux Falls, SD 57106

CMS certification No: 435045

Survey Date: 12/18/2020
Start Date of Cycle: 12/18/2020

January 14, 2021 POC for "D" tag

1. Resident R2 was immediately offered the influenza vaccine when non-compliance was found. Due to his cognition status and language barrier his wife and POA was contacted on 12/18/20. At that time the POA refused for R2 to have the vaccine as she states that he received it at the facility he came from prior to admitting to the Village in October 2020. Previous facility called and showed no record of R2 receiving immunization. POA was asked again if we could administer the vaccine and she stated no as she is sure that he had it at prior facility.
2. IP audited all current residents on 12/18/20 to ensure that all immunizations had been offered and/or refused.
3. Admission checklist updated on 1/11/21 to include information regarding asking new admits in more detail about vaccines. Clarification orders also updated on 1/12/21 regarding immunizations and clarifying from physicians if able to have vaccines. All appropriate staff educated on new checklists by 1/15/21.
4. IP or designee will audit all new admissions to ensure that immunizations are offered and received if accepted and ordered by the physician. Monthly for 3 months IP or designee will also audit all residents to ensure all new orders for immunizations have been carried out properly. Each month for at least 3 months this information will be reported to QAPI committee and then as deemed necessary by the QAPI committee.

Dr. Coleen McCarty, Dnt. Administrator
1/14/2021

1/14/2021
CMS cnt # 435045
Survey Date – 12/18/2020
Good Samaritan – Village Sioux Falls, SD
pg 1

Directed Plan of Correction —

1. Corrective Action

The facility will immediately implement an appropriate infection prevention and intervention plan consist with the requirements of §483.80 for the affected staff identified in the deficiency.

The Infection Preventionist (IP) and director of nursing (DON), in conjunction with the medical director, have completed the following:

A. **Reviewed the Centers for Disease Control and Prevention (CDC's) Considerations for Memory Care Units in Long-term Care Facilities at https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html. Information gained form this website was educated out during the week of 1/11/21 to all staff working in the memory care unit.**
B. **Ensure the memory care unit's physical environment is set up to facilitate six feet of space between residents. The common area has been arranged so that recliners/rockers are 6 feet apart and between them is a night stand to try and prevent moving the recliners/rockers together so that social distance is maintained.**
C. **Create a plan for communal dining and activities in the memory care unit that supports six feet of space between residents. A seating chart was initiated on 12/18/2020 that at 4 tables there are 2 residents and at another 2 tables there are 3 residents. A bed side table has been added to the 2 tables with 3 residents in order to help maintain social distancing while dining and while doing activities.**
D. **CNA 1 and CNA 2 were educated on 12/18/20 and during the week of 1/11/21 on how to create/maintain the memory care unit's physical environment to facilitate six feet of space between residents when they are in the common areas. All other staff that work in the memory care unit were also trained during the week of 1/11/21.**
E. **CNA 1 and 2 were educated on how to encourage residents to wear a face covering and social distance when they are in the memory care unit's common areas on 12/18/20 and during the week of 1/11/21 along with all other staff in the nursing home by 1/15/21.**
F. **CNA 3 and CMA 1 were educated to follow the posted personal protective equipment (PPE) requirements in the yellow zone(s) of the facility. Specifically, adding the gown and gloves when entering a resident room (in addition to the facemask and eye protection already worn) on 12/18/20 and again by 1/15/21 along with all other staff in the nursing home.**

2. Identification of Others

The IP and DON, in conjunction with the interdisciplinary team (IDT) reviewed current COVID-19 nursing facility guidelines from the CDC, the Centers for Medicare and Medicaid Services (CMS), and Sanford resources. The IP, DON and applicable IDT members evaluated the facility's compliance with the guidelines. The facility did not identify any further non-compliance that needed an action plan.

The facility identified that all remaining staff required education and training, with demonstrated competency of how to create/maintain social distancing and encourage mask use for residents in the memory care unit and throughout the building; and what PPE is required to be worn when entering a resident's room in the yellow zone. This information was educated to staff by 1/15/21. All new hires/oncoming staff will also be educated on the above information during their orientation.

3. System Changes

A. **DON, IP and applicable IDT members conducted root-cause analysis and identified and addressed the reasons for non-compliance related to the:**
    i. **Failure to facilitate social distancing between residents on the memory care unit.**
    ii. **Failure to encourage mask use by residents on the memory care unit.**

iii. Failure to don a gown and gloves (in addition to a facemask and eye protection) prior to entering a resident's room in the yellow zone.

B. The DON (or designee) and IP educated the staff identified above by 1/15/21 and gave education and training, with demonstrated competency of:
   I. How to create/maintain the memory care unit's physical environment to facilitate six feet of space between residents in the common areas (especially during dining and activities) by keeping furniture in its original location and offering at every meal and every activity the option to social distance.
   II. Communication techniques to encourage residents to wear masks in the memory care unit.
   iii. Knowing what PPE must be worn when entering a resident's room in the yellow zone.

C. The facility leadership will contact the South Dakota Quality Improvement Organization (QIO) to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility. Initial contact was made on 1/7/21 and meeting set up for 1/15/21.

4. Monitoring

Monitoring of approaches to ensure infection control and prevention are effective will include:

A. Weekly for no less than four weeks, the IP, DON and/or designee, or QAPI leader will conduct on-going monitoring via observation to ensure staff are complying with requirements for:
   a. Creating/maintaining the memory care unit's physical environment to facilitate six feet of space between residents in the common areas by measuring areas weekly and doing spot audits to ensure maintaining social distancing.
   b. Encouraging residents to wear masks in the memory care unit by spot auditing staff during interactions to ensure staff are attempting to encourage mask use.
   c. Wearing the required PPE when entering a resident's room in the yellow zone by doing spot audits in yellow zones when we have them and by random quizzing of staff on all wings weekly.

B. After four weeks of monitoring, provided that such monitoring demonstrates expectations are met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring which demonstrate sustained compliance as approved by the QAPI committee and medical director.

5. Correction Date
January 15, 2021

Dr Colleen McCarty, Med Adm. 1/14/2021