

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2020
NAME OF PROVIDER OF SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER		STREET ADDRESS, CITY, STATE, ZIP 401 WEST SECOND STREET SIOUX FALLS, SD 57104	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the provider failed to conduct a screening assessment for COVID-19 for one of one sampled resident (1) upon his return from a [MEDICAL TREATMENT] treatment and visitation with family in a community with substantial spread of COVID-19. Findings include: 1. Observation on 6/16/20 at 9:30 a.m. revealed the provider was screening individuals when they entered the building. There was one entrance that all staff, residents, and visitors had to enter and exit from the building. While completing the entrance conference on 6/16/20 at 9:40 a.m. with director of nursing (DON) B and administrator A revealed they had one resident that had tested positive for COVID-19 after he was transferred to the hospital on [DATE]. Further interview with DON B and administrator A on 6/15/20 at 11:00 a.m. while at the facility revealed: *Resident 1 continued to be hospitalized . *After [MEDICAL TREATMENT] on 6/5/20 he had family take him to various locations in the community prior to returning him to the facility. *No additional screening or assessing for potential COVID signs/symptoms had been completed upon his return from [MEDICAL TREATMENT] on 6/5/20. *On 6/11/20 he was transferred to the hospital due to difficulty breathing. *No further documentation revealed additional precautions had been implemented to prevent further spread of COVID-19 among residents and staff in the facility. Phone interview on 6/15/20 at 3:45 p.m. with registered nurse (RN) C regarding resident 1's return to the facility on [DATE] revealed: *She was concerned when he did not return as expected, she made calls, and discovered he was with his daughter. *She was present when he returned to the unit on 6/5/20 at approximately 5:00 p.m. -She was unsure of the exact time he returned, but she had documented physician orders [REDACTED].*He should have had a screening assessment when he returned to the unit, but she was unable to find documentation in the medical record. *She stated he should have had a COVID-19 screening when he entered the building prior to returning to the unit. *She could tell he had a haircut when he returned. *She had not assessed for potential contacts or risk of exposure during the time he was out in the community. Phone interview on 6/15/20 at 3:57 p.m. with DON B regarding resident 1 revealed: *He had not been screened when he returned from his [MEDICAL TREATMENT] on 6/5/20. *He should have had vital signs taken upon his return from [MEDICAL TREATMENT]. *No COVID-19 screening assessments were completed for residents when returning from medically necessary appointments. Review of resident 1's progress notes from 6/5/20 through 6/11/20 revealed he had: *[DIAGNOSES REDACTED]. -End stage [MEDICAL CONDITION]. -Chronic [MEDICAL CONDITION]. -Diabetes mellitus type 2. *No COVID screening assessment documented. *A nonproductive cough with occasional phlegm. *Shortness of breath. *Chills most of the day. *Weakness and required additional assistance to transfer from his recliner to the wheelchair. *Oxygen saturation (O2) levels at 85% on 1.5 liters of oxygen, so it was increased to 2 liters and his oxygen level increased to 93%. *A complaint of being cold. *Complained his legs were hurting. *An increase in his oxygen level to only 83% after he had a nebulizer treatment and an increase in his oxygen. *Been transferred to the hospital on [DATE] at 12:35 a.m.</p> <p>Review of the provider's revised 4/30/20 Emerging Threats-Acute Respiratory Syndromes Coronavirus (COVID-19) policy revealed: *Purpose: -To provide guidance to healthcare personnel working in healthcare settings who had the potential for exposure to patients (residents) presenting with an emerging respiratory threat including coronavirus. -To prevent the transmission from person-to-person of respiratory pathogens. -To prepare for emerging threat of COVID-19. -To provide guidance for screening of suspected COVID-19 cases. *Residents were screened at least daily for exposure and symptoms using a screening process. *There was no documentation to screen or assess residents who had returned from medically necessary appointments and community outings.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.