STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435072	A. BUILDING _____ B. WING _____	**09/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SEVEN SISTERS LIVING CENTER	**1201 HWY 71 SOUTH HOT SPRINGS, SD 57747**

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	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, policy review, Covid Staffing Plan review, and Special COVID-19 Clinical Meeting notes review, the facility failed to ensure infection control policies and procedures for COVID-19 reflected and were followed for: *Appropriate communication and training of staff utilizing personal protective equipment (PPE) when those materials changed and required an altered process for donning and doffing to ensure no contamination occurred. *Removal of isolation gowns for one of one observed unlicensed assistive personnel (UAP) D. *Appropriate delineation of who was to perform screening of residents for signs and symptoms (S/S) of COVID-19 for four of four sampled residents (1, 2, 3, and 4). Findings include: 1. Observation and interview on 9/1/20 at 4:17 p.m. with UAP D revealed: *She had given resident 5, who had been diagnosed with [REDACTED]. *She was wearing the appropriate personal protective equipment. *She had on a yellow plastic isolation gown; it resembled plastic garbage bag material. *The gown did not have an opening in the back, so she had to pull it on over her head. *When she attempted to remove the gown she reported she could not pull it off over her head without contaminating herself. *She ended up tearing the plastic gown a piece at a time. The material did not tear easily. *She had agreed she was unable to remove the gown without contaminating herself. *The gowns were new, and that was the first time she had used one. *They usually had blue gowns that tied in the back. *No one had shown her how to appropriately remove this yellow plastic type of gown. Interview on 9/1/20 at 4:26 p.m. with certified nursing assistant (CNA) E revealed: *She agreed she was unable to remove the yellow plastic gown without contaminating herself. -The yellow gowns were new today. *They usually had blue gowns that tied in the back. *She knew where to get more of the blue gowns and was going to go and get some. *No one had shown her how to appropriately remove this yellow plastic gown. Interview on 9/1/20 at 4:54 p.m. with assistant director of nursing C revealed he had not seen the yellow plastic gowns before. He did not know the staff were having trouble using them without contaminating themselves. Telephone interview on 9/2/20 at 8:55 a.m. with director of nursing (DON) B revealed she had not seen the yellow plastic gowns. She was not aware of the above problem. 2a. Review of resident 1's medical record revealed: *She had tested positive for COVID-19 on 8/30/20. *There was no documentation prior to or after the [DIAGNOSES REDACTED]. *There was no documentation on the day of the positive test result whether resident was having any S/S of COVID-19. b. Review of resident 2's medical record revealed: *He had tested positive for COVID-19 on 8/29/20. *He had only been assessed for S/S of COVID-19 on 8/27/20 and on 8/28/20 after potential exposure to someone with COVID-19. *On the day of his positive test result he had a wet cough and runny nose. *There was no other documentation he had been screened for S/S of COVID-19. c. Review of resident 3's medical record revealed: *He had tested positive for COVID-19 on 8/29/20 and did not have S/S of COVID-19. *There was no documentation he had been screened for S/S of COVID-19 before or after the positive test result. d. Review of resident 4's medical record revealed: *She had tested positive for COVID-19 on 8/31/20 and did not have S/S of COVID-19. *There was no documentation she had been screened for S/S of COVID-19 before or after the positive test result. e. Interview on 9/1/20 at 3:40 p.m. with CNA G revealed the CNAs did: *A temperature check on every resident every shift and reported those to the nurse. *Not ask residents about S/S of COVID-19. Interview on 9/1/20 at 4:30 p.m. with licensed practical nurse (LPN) F revealed: *Residents had their temperatures taken twice a day by the CNAs. *They did not ask residents about S/S of COVID-19. *She did not go into resident's rooms who had been positive for COVID-19. -She was assigned both COVID-19 positive and negative residents and did not want to put the other residents at risk by going into those rooms. -She was not able to be fit tested for an N95 mask. -There was a Powered Air Purifying Respirator (PAPR) available for her to use. --She had never wore one before. --She had not been trained on how to use it. -She had not assessed the residents who had tested positive for COVID-19. -If needed she would have assessed them from the doorway. Interview on 9/1/20 at 4:54 p.m. with assistant director of nursing/infection preventionist C revealed: *All residents should have had their temperature taken twice a day. -Those should have been documented along with S/S in their medical records by a nurse. *He agreed this was not being completed. Telephone interview on 9/2/20 at 8:55 a.m. with DON B revealed: *They were checking all residents' temperatures and asking about S/S of COVID-19 twice a day. *They only documented if the resident had S/S of COVID-19. *The CNAs were to be asking the questions about S/S of COVID-19 and taking the temperatures, if a concern was identified they were to report it to the nurse. *The nurse should have assessed residents with COVID-19 daily and documented that assessment. *Since LPN F was not fit tested another nurse should have assessed the residents who had COVID-19. Review of the provider's 7/7/20 Interim Policy for Admission and Care Management during COVID-19 Pandemic revealed, Patient/residents will be monitored for fever and respiratory symptoms with temperatures taken twice a day. Review on the provider's 8/31/20 COVID Staffing Plan revealed: *All employees working with Covid positive residents must wear an N95 (mask). *Nurse will go to care for these (COVID-19 positive) residents when nursing assessment is needed, and the nurse will wear all the appropriate PPE (personal protective equipment). Nurse must decontaminate before going to South hall or other negative residents. Review of the provider's 8/31/20 Special COVID-19 Clinical Meeting notes revealed: *Staff are completing the exposure sheet with symptom monitoring and temperature twice/day. *All staff caring for positive patients (residents) must wear an N95 and will dispose after each shift.

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.