STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435082	A. BUILDING _____ B. WING _____	**10/19/2020**

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

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.** Based on observation, interview, and policy review, the provider failed to follow policies and procedures related to coronavirus (COVID 19) regarding: *Closing the doors for four of four currently positive residents (1, 2, 3, and 4) who had COVID-19. *Three of three observed staff including physical therapy assistant (D), activities assistant (E), and occupational therapy assistant (F) disinfecting their faceshields after care with positive residents (2, 3, and 4). Findings include: 1a. Observation on 10/19/20 at 2:00 p.m. of the hallway located on the east/west side of the building revealed: *Resident 1, 2, 3, and 4's rooms had: -Red tape around the door frame. -Droplet precaution signs were on the doors. -The doors were opened. *Resident 5's room had: -Yellow tape around the door frame. -The door was opened. -The room was located next to and across the hall from residents, 1, 2, 3, and 4's rooms. b. Observation on 10/19/20 at 2:31 p.m. revealed: *Physical therapy assistant D leaving resident 2's room. -She did not disinfect her faceshield after contact with resident 2, who was COVID-19 positive. c. Observation on 10/19/20 at 2:35 p.m. revealed: *Activities assistant E was leaving resident resident 4's room. -She did not disinfect her faceshield after contact with resident 4, who was COVID-19 positive. d. Observation on 10/19/20 at 2:36 p.m. revealed: *Occupational therapy assistant F was leaving resident3's room. -She did not disinfect her faceshield after contact with resident 3, who was COVID-19 positive. e. Interview on 10/19/20 at 3:20 p.m. with director of nursing B and infection preventionist registered nurse C revealed: *The residents with the red tape around their doors were currently positive for COVID-19. *Yellow tape around the door meant the resident was negative but had been exposed to COVID-19. *The doors were opened because they felt it was a safety issue and a resident's right to keep the door opened. *The staff disinfected their faceshields at the end of their shifts. 2. Review of the provider's 9/16/20 policy, Emerging Threats-Acute Respiratory Syndromes Coronavirus (COVID)-Enterprise revealed the following was recommendations for infection prevention of individual rooms: *Upon identification of any resident with suspected or positive COVID-19, a Droplet Precautions sign will be posted on the outside of the resident's room. The resident will be isolated in their room with the door closed (include roommate if applicable). *When caring for positive and negative COVID-19 residents, the caregiver will wear the N95 mask for the entire shift and practice reuse. The face shield will be cleaned when moving from providing care for positive COVID-19 resident to providing care for negative COVID-19 residents.

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.