STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY SCOTLAND	**130 6TH STREET SCOTLAND, SD 57059**

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 ensure two of two wound care dressing changes for two of two sampled residents (6 and 22) had been completed using appropriate infection control practices by one of one licensed practical nurse (LPN) (C). Findings include: 1a. Observation and interview on 3/4/20 at 10:20 a.m. with LPN C during and following resident 22's wound care revealed: *She brought the wound supplies into his room in a plastic tray. *She stated he had opened wounds to his right third finger they were treating with a calcium alginate dressing, covered by foam, and then wrapped with gauze. *After washing her hands she put on gloves and then used a pair of bandage scissors to remove the gauze wrap and dressing from his finger. *When she was done with the potentially contaminated bandage scissors she put them back into the tray with her clean wound supplies. -She then cleaned the wound areas with wound cleaner and gauze. *After the wound cleaning she removed her gloves, sanitized her hands, put on new gloves, and then opened the packages of the calcium alginate dressing and the foam dressing. -She set the calcium alginate dressing and foam dressings on the outsides of their packages and used the potentially contaminated scissors to cut the dressings into the size she wanted to put on the wound. *She then put those cut pieces of calcium alginate onto the opened wounds, followed by the foam dressing, wrapped the finger with a gauze dressing, and then put tape over the gauze to secure it. *She then removed her gloves, washed her hands, and brought the plastic tray of wound supplies back out to the treatment cart. -She set the potentially contaminated scissors on the top of the medication cart. *She indicated the above process was her usual practice. *She had not considered: -The outsides of the dressing packages as unclean or potentially contaminated.-The bandage scissors as potentially contaminated after she had used them to remove the old dressing. *After further discussion she agreed: -The bandage scissors should have been cleaned and disinfected prior to using them to cut the clean dressings that were used directly on the wounds and following use when they would have been potentially contaminated. -The outsides of the packages were potentially contaminated. --She should not have set the clean dressings on those surfaces prior to using them directly on the wounds. -Dressing changes should have been done with proper infection control practices in an attempt to protect the resident from a possible infection. *She was unsure if she had training in the past on dressing change techniques. -She indicated she learned from other nurses and her own experience. b. Observation and interview on 3/4/20 at 11:09 a.m. with LPN C during and following resident 6's wound care revealed: *She brought the wound supplies into the room in a plastic tray. *There were no dressings in place to remove since the resident had just been seen by the practitioner. *After LPN C washed her hands she put on gloves and used wound cleanser and gauze to clean the resident's bilateral buttock wounds. *She removed her gloves, sanitized her hands, opened the package of calcium alginate dressing, and then set the dressing on the outside of the package. -With her bare hands she held the calcium alginate dressing, used scissors to cut pieces for the wound, and then set those pieces back onto the outside of the package. *After the above process she stated she should not have done that and sanitized her hands before putting a pair of gloves on. *She then put the above potentially contaminated cut pieces of calcium alginate dressings on the resident's right buttock wounds. *She cut more pieces of the calcium alginate and put those on the resident's left buttock wounds. *With her same gloves on she grabbed a large roll of Omnifix tape out of the tray, used the scissors to cut pieces of tape, and put that roll back into the plastic tray with the clean dressing supplies. -She used the cut pieces of tape to secure the calcium alginate dressings to the resident's wounds. *After the dressing change we discussed the above process and she confirmed: -The dressing should not have been set on the outside of the package since that could have been potentially contaminated. -She should not have touched the calcium alginate dressing with her bare hands since it was used to directly cover the opened wound. -The roll of tape should not have been touched with potentially contaminated gloves. Interview and policy review on 3/4/20 at 1:19 p.m. and again at 2:23 p.m. with registered nurse/infection control nurse B regarding the above observations revealed:*She confirmed dressing changes should have been completed with appropriate infection control practices to protect the residents from potential infection. *The outside of packages should have been considered potentially contaminated, and the dressings used for wounds should not have been set on them. *The bandage scissors should have been considered potentially contaminated after using them on the old dressing. -They should have been cleaned and disinfected prior to using them for cutting clean wound dressings. *All staff had completed infection control training. *Competencies had not been done to ensure nursing staff were completing dressing changes appropriately. *The policy for dressing changes had not been followed. -That policy included a competency that evaluated staffs' clinical skills related to wound dressing changes. Interview on 3/4/20 at 4:05 p.m. with director of nursing A regarding the above concerns revealed:*She expected staff to have followed their policy for dressing changes. *Dressing changes should have been completed using appropriate infection control practices to protect the residents from potential infection. Review of the provider's revised October 2017 Wound Dressing Change policy revealed:*The purpose was: -To promote wound healing. -To help wound remain free of infection. *The procedure included to: -7. Remove soiled dressing and discard in plastic bag, avoiding contact and thus contamination of other surfaces. Remove gloves and discard in same plastic bag. Perform hand hygiene. -8. Create field with equipment/dressing wrappers. Use sterile technique if required. -9. Open all supplies and pour solution if ordered. -10. Put on gloves. -11. Assess wound and surrounding area to ensure the selection of the appropriately-sized dressing. -14. Remove dressing from inner wrapper, avoiding finger contact with the dressing .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE