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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165211	A. BUILDING _____ B. WING _____	C 12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OTTUMWA	2035 WEST CHESTER AVENUE OTTUMWA, IA 52501

(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
F 000	INITIAL COMMENTS Correction date: 1/15/21 The following deficiency relates to the Focused Infection Control Survey and Complaints #93581 and #94584 ending on December 16, 2020. Complaint #93581-C was substantiated. Complaint #94584-C was substantiated. See Code of Regulations (42-CFR) Part 483, Subpart B-C.	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. §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;	F 880		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vani Tschantz | TITLE: Administrator 1/20/21 | (X6) DATE

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165211	A. BUILDING _____ B. WING _____	C 12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OTTUMWA	2035 WEST CHESTER AVENUE OTTUMWA, IA 52501

(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
F 880	Continued From page 1 §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 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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165211	A. BUILDING _____ B. WING _____	C 12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OTTUMWA	2035 WEST CHESTER AVENUE OTTUMWA, IA 52501

(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
F 880	Continued From page 2 §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: Based on observations, record review and staff interviews, the facility failed to utilize the appropriate Personal Protective Equipment (PPE) to help prevent the spread of COVID. The facility reported a census of 85. Findings include: During an interview on 12/10/20 at 1:45 p.m., the Director of Nursing (DON) stated the facility had four categories of halls which required the following transmission based precautions: a. Green Hall, dedicated to asymptomatic and or recovered from COVID. Staff required to utilize a face mask and face shield at all times and use good hand hygiene practices. b. Gray Hall, dedicated to newly admitted or readmissions from the hospital. Residents are in private rooms and placed on a 14 day quarantine to monitor for signs or symptoms of illness. Staff required to utilize a face mask, face shield and gown at all times and use good hand hygiene practices. c. Yellow Hall, dedicated to those with known exposure to COVID. Residents in private rooms and placed on a 14 day quarantine to monitor for signs or symptoms of illness. Staff required to utilize a face mask, face shield and gown at all times and use good hand hygiene practices. d. Red Halls, dedicated for actively positive for	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165211	A. BUILDING _____ B. WING _____	C 12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OTTUMWA	2035 WEST CHESTER AVENUE OTTUMWA, IA 52501

(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
F 880	Continued From page 3 COVID. Residents may share a room depending on availability for private rooms. Staff required to utilize an N95 face mask, face shield and gown at all times and use good hand hygiene practices. The DON stated they have dedicated staff for each hall to avoid exposure from staff to residents. Staff on Red Hall remain on their assigned hall throughout their shift and then leave through the back entrance. Staff assigned to Yellow, Gray and Green Halls work exclusively on those halls and are not permitted to cross over onto another hall. The DON stated they have been very lucky to be able to maintain a dedicated staff strategy. During an observation on 12/10/20 at 10:15 a.m., revealed Staff A (Therapy Assistant) in Resident #4's room assisting her to get ready for an appointment. Resident #4 resided on Yellow Hall (14 day quarantine or COVID exposure) and required full PPE. Staff A failed to utilize a gown or gloves during her physical contact with Resident #4. Staff B (Nurse Aide) entered the room and had full PPE on. Staff A donned a gown. Staff A removed her gown and propelled Resident #4 to the front entrance for transport to her appointment. Staff A reentered the facility and walked back to Resident #4's room. Staff A gathered her therapy supplies and walked to the therapy department. Staff A failed to perform hand hygiene at any point during the observation, including after removing her gown and returning to the therapy department. During an interview on 12/10/20 at 10:20 a.m. Resident #4 stated she was upset Staff A completed therapy before her appointment this morning. Resident #4 stated Staff A failed to	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165211	A. BUILDING _____ B. WING _____	C 12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OTTUMWA	2035 WEST CHESTER AVENUE OTTUMWA, IA 52501

(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
F 880	Continued From page 4 utilize a gown during her therapy session this morning. During an interview on 12/10/20 at 10:00 a.m. Staff B (Nurse Aide) stated she is worked 500 Hall (Gray Hall) but there was an exposure to COVID and the hall is now Yellow Hall. Staff B stated all rooms are private and staff are required to wear full PPE, gowns, gloves, masks and shields when in physical contact with the resident.	F 880		

Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purpose of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the SOM.

F880 483.80 Infection Control

On 12/10/2020 Staff A failed to utilize a gown or gloves during her physical contact with Resident #4. Staff A failed to perform hand hygiene. Staff A was immediately sent home to change before interacting with any other resident and immediately re-educated to proper PPE and hand hygiene.

This has the potential to affect all residents.

All staff were re-educated using the *CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: PPE Lessons.* All staff were re-educated to correct Hand Hygiene procedure.

Audits will be completed to ensure all staff are using proper PPE, hand hygiene and infection control practices. This will be done weekly x 4, monthly x 2 and then quarterly x 2. All results of audits will be brought to the monthly QAPI meeting for further review and/or recommendations.

Compliance Date: January 15th, 2021.