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	435110	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS HEALTHCARE CENTER	2000 WESLEYAN BLVD RAPID CITY, SD 57702

(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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/28/23 through 3/2/23. Fountain Springs Healthcare Center was found not in compliance with the following requirements: F583, F658, and F880.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable	F 583	1. Resident 21 has had blinds replaced as well as room 111, 349 and 340. All rooms audited for missing window coverings or broken blinds. Unable to correct deficient practice noted during survey for exposed medical record of resident 27. All residents have the potential to be affected. 2. The ED or designee will educate all nursing staff on providing privacy with resident care as well as reporting of broken blinds or missing window coverings and on the importance of keeping resident medical record confidential and unexposed, keeping medication cart secured. Maintenance will also be educated on replacing broken blinds or window coverings promptly by 4/7/2023. Any staff not in attendance will be educated prior to their next working shift. 3. The ED or designee will audit a random sample of 4 rooms for proper window coverings in proper repair weekly time four weeks and monthly times two months. The ED or designee will do audit 4 random med carts weekly times for weeks and monthly times two months for security and privacy of medical record. The ED or designee will bring the results of the audits to the monthly QAPI for further review or recommendation to continue or discontinue the audits.	4/7/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristine Harvey	Executive Director	3/17/2023

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.

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F 583	Continued From page 1	F 583		

federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
A. Based on observation, interview, maintenance logbook review, and policy review, the provider failed to ensure privacy had been maintained for:
*One of one sampled resident (21) whose window blind had been left open during her personal care.
*Two of two random residents' rooms (111 and 349 B) with window blinds that were missing vertical slats and unable to have been completely closed.
*One of one random resident's room (340 B) that had no window covering.
Findings include:

1. Observation and interview on 2/28/23 between 3:45 p.m. and 4:15 p.m. with certified nurse aide (CNA) (H) and licensed practical nurse (LPN) G in resident 21's room revealed:
*The resident was raised off the seat of her wheelchair by CNA H using a mechanical lift.
*She faced the window and the vertical blinds on that window were opened.
-A sidewalk was visible looking out the window as well as the north end of the facility's parking lot
*LPN G lowered the resident's pants below her buttocks and pulled up her shirt exposing her abdomen.
-She completed a dressing change to a wound on the resident's left side.
*Both CNA H and LPN G agreed the resident's privacy had not been protected with the blinds that had been left open during the wound care.

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*CNA H stated even if the window blinds had been closed the resident's privacy still would not have been protected.
-When the blinds were closed there were two center slats missing leaving an opening large enough to see inside and out of the window.
*Other resident rooms including room 111 had vertical blinds that also had missing slats.
*CNA H was unsure if maintenance director J had been made aware of the privacy issues.

2. Interview on 3/1/23 at 3:30 p.m. with resident 21 revealed she:
*Had not noticed her blinds were left open during her wound care on 2/28/23.
*Was aware her window blinds had missing center slats.

3. Observation on 2/28/23 at 4:30 p.m. of a semi-private room 111 A and 111 B revealed:
*The blinds on the "A" side window of the room were missing four slats.
-Three of those slats sat on the windowsill beneath the blinds.
*The blinds on the "B" side window of the room were missing two slats.
-One of those slats sat on the windowsill beneath the blinds.
*There was a resident currently occupying the "A" side of the room but not the "B".

4. Interview on 3/2/23 at 8:25 a.m. with maintenance director J regarding resident room maintenance revealed:
*Resident rooms were checked monthly for maintenance needs.
-That included looking at window blinds for "something major wrong with them."
*He had replaced "quite a few" of the blinds lately

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but had not known about the condition of the blinds in resident 21's room or in room 111.
*When he assessed window blinds during his room checks they were usually opened so he would not have seen any missing slats.
*Staff were expected to have documented room maintenance issues in the maintenance log at the nurses' station.

Review of the maintenance logbook entries between 1/1/23 and 3/1/23 revealed:
*On 1/3/23: "Put up blind standing by closet in room 349 B."
*On 1/23/23: "Son requests new blinds room 342 B."
*On 2/24/23: "Blinds on small window room 340."

Observation on 3/2/23 at 9:00 a.m. of rooms 349 B, 342 B and 340 revealed:
*There were two center slats missing on the vertical blinds in room 349 B so they were unable to have been closed completely.
*Window blinds in room 342 B had no missing slats and were able to have been completely closed.
*There was no window covering in room 340.

5. Interview on 3/2/23 at 9:10 a.m. with director of nursing C revealed she expected:
*Blinds or privacy curtains to have been closed during residents' personal care.
*Blinds were in good working order to ensure residents' privacy was protected.
*Maintenance director J was promptly notified and there was immediate resolution for any issues regarding resident window coverings.

A Privacy/Dignity policy was requested on 3/1/23 at 2:45 p.m. from administrator A however she

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indicated the facility had no policy.

Review of an updated November 2016 EmpRes Healthcare Management, LLC Notice of Resident Rights Under Federal Law document found in the facility's resident admission packet revealed:
*Residents have the following rights under Federal law:
-"14. The Resident has the right to a dignified existence and self-determination.
-15. The Resident has the right to be treated with respect and dignity."
-"29. The Resident has the right to a safe, clean, comfortable, and homelike environment..."

B. Based on observation, interview, and policy review, the provider failed to ensure:
*One of one sampled resident's (27) medical record was secured and not accessible to other residents, staff, and the public.
*One of one medication cart was locked and medications were not accessible to other residents, staff, and the public by one of one licensed practical nurse (LPN) K during the morning medication pass.
Findings include:

1. Observation on 3/2/23 at 7:44 a.m. of the Dunn hall medication cart computer revealed:
*It was located in the Dunn hallway and there were no staff within view of the medication cart.
*The medication computer screen was facing the hallway and was open to resident 27's medication record.
*That record was visible to any resident, staff, or visitors passing by the medication cart.
*It contained the following:
-The resident's name.
-Diagnoses.

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-Medications.
-Admit date and date of birth.
-Current picture.
-Medical provider.
-Cardiopulmonary status.
-Allergies.
-Diet.
-Room location.
*An unidentified resident had been sitting in his wheelchair in a doorway directly across from the medication cart within view of the computer screen.

2. Continued observation on 3/2/23 at 7:45 a.m. of the same Dunn hall medication cart also revealed:
*The medication cart had been unlocked, allowing residents, staff, and visitors, access to the drawers of the cart.
*Upon surveyor inspection, the drawers had contained:
-All of the Dunn hall residents' prescription medications.
-Various over-the-counter medications.
-Finger stick lancet needles and insulin pen needles.
-Bandage scissors and skin treatment supplies.
-Liquid and injectable medications.
*The unattended medication cart was monitored for three minutes before licensed practical nurse (LPN) K came out of an adjacent room, which was not within view of the cart.

Interview on 3/2/23 at 7:47 a.m. with LPN K regarding the above observations revealed:
*Normally she would not have left the medication cart unlocked and the computer screen open to a resident's medication record.
-She had been called away from the medication

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F 583	Continued From page 6 cart to assist a resident. *Agreed she should have locked the medication cart and computer screen to ensure the residents' information was kept confidential. *Agreed anyone could have had access to the contents of the medication cart. Interview on 3/2/23 at 7:48 a.m. with assistant director of nursing/infection control nurse D and resident care manager/registered nurse (RCM/RN) E regarding the above findings revealed: *It was their expectation the medication cart and the computer screen should have been locked every time a staff member left the cart unattended. *They had provided continued education to staff regarding securing the medication carts and resident's private information. -RCM/RN E voiced staff had been educated and re-educated. A medication cart policy regarding the above findings was requested on 3/2/23 at 12:15 p.m. from division director of clinical operations B. She indicated no such policy existed. Review of the November 2016 EmpRes Healthcare Management, LLC Notice of Resident Rights Under Federal Law document found in the facility's resident admission packet revealed: *"Residents have the following rights under Federal law:" -"11. The Resident has the right to personal privacy and confidentiality, and security of his/her clinical records."	F 583		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658	See next page	

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F 658	Continued From page 7 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure appropriate procedural techniques had been followed for: *One of one sampled resident (15) by one of one resident care manager/registered nurse (RCM/RN) (E) during the removal of her midline intravenous (IV) catheter used for medication administration. *One of one licensed practical nurse (LPN) G during inhaler medication administration for one of one sampled resident (38). Findings include: 1. Observation and interview on 3/1/23 at 1:00 p.m. with RCM/RN E during the removal of resident 15's IV catheter revealed she: *Performed hand hygiene, cleaned the top of the bedside table, laid a barrier on top of that cleaned table, and set her supplies down. *Put on a gown, performed hand hygiene, and applied a pair of gloves. *Had resident 15 seated upright in her wheelchair. *Removed the tape and dressing on top of the IV line in the resident's upper left arm. *Without changing her gloves or cleansing around the IV site, she had the resident exhale while she slowly removed the IV catheter. *Placed a dry gauze pad on the insertion site, and applied pressure until bleeding stopped. *Changed her right glove and placed a sterile	F 658	1. Unable to correct deficient practice noted during survey for resident 15 and 38. All residents have the potential to be affected. 2. The DNS reviewed the policies on peripheral line removal and inhaled medications. The DNS or designee will educate all licensed nurses on proper peripheral line removal per policy by 4/7/2023. The DNS or designee will educate all licensed nurses on inhaled medications per policy by 4/7/2023. All staff not in attendance will be educated prior to their next working shift. 3. The DNS or designee will audit a random sample of four inhaled medications weekly times four weeks and monthly times two months. The DNS or designee will audit one peripheral line removal per month monthly times six months. The DNS or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	4/7/2023

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dressing on top of the insertion site.
*Stated it was not uncommon for the facility to care for residents requiring IV medication administration.
-Needing to remove IV catheter access for those residents who completed their IV medication course occurred about once every other week.
*Had not been trained at the facility to ensure the proper removal of an IV catheter.

Interview on 3/1/23 at 3:45 p.m. with division director of clinical operations B and DON C revealed:
*They had provided a copy of the revised August 2021 Pharmerica Vascular Access Devices and Infusion Therapy Procedures Catheter Removal policy that RNs were expected to follow for IV catheter removal.
-Pharmerica was the pharmacy the provider used for resident medications as well as intravenous therapy needs.

Interview and review of the Pharmerica policy referred to above on 3/1/23 at 4:00 p.m. with RCM/RN E and RCM/RN F revealed:
*They had access to computer-based facility policies but had been unable to locate a facility policy for IV catheter removal.
*They had never seen the Pharmerica policy referred to above and would not have thought to contact Pharmerica with IV catheter removal questions.
*RCM/RN E had not followed the Pharmerica policy when she had discontinued resident 15's IV catheter.

Interview, review of the catheter removal observation referred to above, and review of the Pharmerica policy referred to above on 3/2/23 at

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9:15 a.m. with division director of clinical operations B and DON C revealed:
*Staff would not have known to contact Pharmerica regarding infusion related questions.
*The Pharmerica policy and procedure manual was located in the medication room.
-That manual was found in the medication room unopened and still in its original sealed packaging.
*For midline and PICC (peripherally inserted central catheters) removal RCM/RN E had not:
-Placed the resident in supine flat or Trendelenburg position unless it was contraindicated.
-Removed her gloves and performed hand hygiene after removing the old dressing.
-Cleansed the insertion site with an appropriate antiseptic solution per policy prior to discontinuing the IV catheter.
-Applied a sterile ointment or Vaseline gauze to the insertion site once the catheter was removed and the bleeding had stopped.

2. Observation and interview on 3/1/23 at 10:00 a.m. with LPN G administering resident 38's inhaler revealed she:
*Entered his room and administered his Symbicort inhaler.
*Brought no water for him to swish in his mouth or a cup to spit that water back into after he had used the inhaler.
*The resident had his own mug of water with a straw through the lid on his over-bed table.
*Provided the resident no instruction to "swish and spit" water after he inhaled the medication.
*Knew "swishing and spitting" was expected after inhaler use but sometimes the resident had refused to do that.
-Agreed she still should have offered him a

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means to properly rinse his mouth after inhaler use.

Review on 3/1/23 of resident 38's physician order summary revealed:
*A 2/7/23 order for a Symbicort inhaler.
-Instructions for use included rinsing the mouth with water after use and not swallowing the water.

Interview on 3/1/23 at 11:55 a.m. with resident 38 regarding inhaler use revealed he:
*Had not used an inhaler prior to his admission on 2/2/23.
*Would have "swished and spit" if he was asked to.
*Used a Lifesaver or swallowed some water to rid his mouth of the taste of the inhaled medication.

Interview on 3/2/23 at 9:05 a.m. with director of nursing (DON) C regarding resident 38's inhaler administration revealed she would have expected LPN G to:
*Enter the resident's room with a cup of water for him to use to "swish and spit" after he used the inhaler.
*Provide needed instruction and educated the resident about the reason for "swishing and spitting" after the inhaler use.
*Document and report repeated resident refusals to "swish and spit".

Review of the updated November 2018 Guidelines for Administration of Aerosolized Care (Nebulizers and Inhalers) policy revealed the resident was expected to have been instructed to rinse their mouth after the last puff of medicine, spit out the water, and not swallow it.

F 880 Infection Prevention & Control — F 880

See next page

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F 880 SS=E	Continued From page 11 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; §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	F 880	1. Unable to correct deficient practice noted during survey for resident 63 and 67 regarding hand hygiene. Resident 21 foam wedge was discarded and replaced with cleanable wedge. Unable to correct deficient practice for resident 21 regarding gown use noted during survey. Unable to correct deficient practice of cleaning medical equipment noted during survey. All medication carts have been cleaned. All residents have the potential to be affected. 2. The Medical Director, ED and DNS have reviewed the policy for enhanced barrier precautions, hand hygiene, and cleaning of medical equipment by 3/22/23. The DNS or designee will educate all nursing staff on cleaning of medical equipment, hand hygiene, enhanced barrier precautions and proper gown use, medication cart cleaning and disposing of positioning devices that are not cleanable by 4/7/2023. All staff not in attendance will be educated prior to their next working shift. On 3/17/2023 a call was held with the QIN to discuss the 5 whys. The discussion surrounded the root cause and what was determined to be lack of education and resources readily available for cleaning. The DDCO, ED, DNS and QIN attended the call. See next page	4/7/2023

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F 880	Continued From page 12 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. §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 observation, interview, and policy review, the provider failed to ensure infection prevention and control practices were maintained for the following: *Proper hand hygiene for one of one certified nurse aide (CNA) I during a transition in personal care between two of two randomly observed residents (63 and 67). *Use of an uncleanable foam wedge by one of one sampled resident (21).	F 880	3. The DNS or designee will audit a random sample of four nursing staff for proper hand hygiene, proper gown use, clean medication carts and cleaning of equipment weekly time four weeks and monthly times two months. Staff H, I and L to be randomly included in the audits. The DNS or designee will audit for cleanable positioning devices of four random residents weekly time four weeks and monthly times two months. The DNS or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	

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*Proper gown use for one of one licensed practical nurse (G) (LPN) during wound care and two of two CNAs (H and I) during personal care for one of one sampled resident (21).
*Cleaning of one of one mechanical lift by one of one observed CNA (L).
*Routine cleaning of four of four medication carts.
Findings include:

1. Observation and interview on 2/28/23 at 8:09 a.m. with CNA I revealed:
*He entered resident 63's room without performing hand hygiene before obtaining her blood pressure and pulse oximeter reading.
*Enhanced barrier precaution signage on her room door read: "EVERYONE MUST: Clean their hands, including before entering and when leaving the room."
*He exited her room and without performing hand hygiene and immediately entered resident 67's room.
-Helped him transfer to a wheelchair, transported him out of his room to be weighed, returned him to his room, and assisted him back into bed.
*He exited the room and performed hand hygiene.
*There was enhanced barrier precaution signage on his room door.
*Agreed he had not but should have performed hand hygiene after leaving resident 63's room and before entering resident 67's room.

Review of the updated March 2018 Handwashing/Hand Hygiene policy revealed:
"7. Use an alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:"
-"b. Before and after direct contact with

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residents;"
-"n. Before and after entering isolation precaution settings;"

2. Observation and interview on 2/28/23 at 1:44 p.m. with CNA I in resident 21's room revealed:
*Enhanced barrier precaution signage on her room door read: "Wear gloves and a gown for the following High-Contact Resident Care Activities" that included "changing briefs or assisting with toileting."
*He transferred the resident out of the bathroom with a mechanical lift, lowered her into her wheelchair, removed his gloves, washed his hands, and left the room.
*CNA I stated he had worn gloves while assisting the resident with toileting and washed his hands following that care.
-Gowns were only worn if a resident received wound care.

3. Continued observation and interview with resident 21 revealed:
*A rectangle shaped piece of foam on top of her bed.
*She:
-Used it at night between her upper legs to prevent "skin to skin" contact.
-Tended to sweat and was incontinent of urine.
-Had occasionally rinsed the wedge in water to clean it.

4. Interview on 3/1/23 at 9:20 a.m. with LPN G regarding resident 21's foam piece revealed:
*The resident brought it from home when she was admitted a few months ago.
*She used it between her legs for body "alignment" when she laid on her side.
*There was no cover for the foam and the foam

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was uncleanable.

5. Observation on 2/28/23 at 3:30 p.m. of LPN G and CNA H in resident 21's room revealed:
*LPN G wore a mask and gloves when she changed the dressing on the resident's left side wound.
-Slight bleeding occurred after she had removed the dressing.
*CNA H wore a mask and gloves when she assisted the resident to use the toilet after the wound care was completed.

6. Interview on 3/1/23 at 9:20 a.m. with LPN G regarding gown use with resident 21 revealed she:
*Had known enhanced barrier precautions were followed during personal care with the resident.
*Had not worn a gown during the wound care because she felt the incontinency pad she had placed between the side of the resident's wheelchair and underneath the resident's left leg was sufficient to absorb blood from her wound and keep that blood away from her.
*Had not realized until after she read the enhanced barrier precaution signage on the resident's door that gown use was expected during wound care, changing briefs or assisting with toileting.

7. Interview on 3/2/23 at 12:20 p.m. with assistant director of nursing/infection control nurse D revealed:
*Hand hygiene was expected to have been performed by CNA I upon entering and exiting residents' rooms.
*Resident 21 had a history of a MRSA infection (8/30/22) and unspecified escherichia coli (E-Coli) (2/1/23).

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*The piece of foam she had been using was expected to have a cover on it that was cleanable.
*Gown use was expected by LPN G, CNAs H and I during resident 21's wound care and toileting.

Review of the July 2022 Enhanced Barrier Precautions policy revealed: "2. Enhanced Barrier Precautions requires use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDRO [multi-drug resistant organisms] to hand and clothing of healthcare personnel."

8. Observation and interview on 2/28/23 at 8:15 a.m. of resident 171's transfer with a mechanical lift by CNA L revealed:
*CNA L cleansed and gloved her hands, and was wearing a barrier gown.
*CNA L placed the resident onto a mechanical lift sling and attached the sling to the mechanical lift that had been brought into his room from the hallway.
-She placed his Foley urine catheter bag on his lap.
-The resident then held on to the sling and was lifted off of his bed and was placed into his wheelchair.
*During the mechanical lift transfer CNA L, with those same gloved hands, touched the mechanical lift's handles, sling bars, and the lift control screen.
-CNA L then removed the sling from underneath the resident and placed it on the resident's bed.
-Following the transfer, the mechanical lift was removed from the resident's room and placed into the hallway without being disinfected.
*Following the above observation CNA L stated:
*That was her normal routine for mechanical lift

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transfers.
-The lift slings were for individual use and remained in the resident rooms.
-The mechanical lift was used on multiple residents throughout the day.
*Her normal cleaning routine for the re-usable mechanical lift was once per shift and if it was visibly soiled.

Review of resident 171's care record revealed he:
*Had been receiving intravenous antibiotics after becoming septic from a urinary tract infection and a lung infection.
-Had a peripherally inserted central catheter (PICC) intravenous (IV) line in his left arm.
--This PICC line gave access to the large central veins near his heart.
-Had an indwelling urinary Foley catheter.
*Staff should have been following enhanced barrier precautions for his protection during his personal care.

Review of the provider's May 2015 Cleaning and Disinfecting Resident Care Items and Equipment policy revealed:
*"Procedure:"
-"1.d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment)."
-"3. Durable medical equipment (DME) is cleaned and disinfected before reuse by another resident."

9. Observation and interview on 3/1/23 from 11:40 a.m. through 12:33 p.m. of the medication carts on Simpson and Watson hallways revealed:
*The Simpson and Watson hall carts had multiple small dried white and tan splash marks scattered over the exterior of the cart's drawers and brown flecks along the base of the carts.

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*Registered nurse (RN) M stated she cleaned the top flat surface of the medication cart at the start of her shift.

Interview on 3/1/23 at 2:00 p.m. with director of nursing C revealed she was unsure if there was a medication cart cleaning schedule or a medication cart cleaning assignment task sheet.

10. Observation on 3/2/23 at 10:15 a.m. through 10:45 a.m. of the Watson, Garmin, and Dunn, medication carts revealed:
*The same dried splash marks remained on the exterior of the Watson cart as was noted the day prior.
*The Garmin and Dunn medication carts revealed multiple dried white and tan splash marks scattered over the exterior drawers and the interior drawers had scattered dried multi-colored particles stuck to the bottom surfaces.
*The second drawer of the Dunn hall medication cart had multiple strands of hair laying inside the bottom of the drawer.

Interview on 3/2/23 at 11:00 a.m. with resident care manager/registered nurse E regarding the above findings revealed:
*She was unsure when the medication carts were to have been cleaned.
*It was her expectation for the carts to be cleaned regularly.

A medication cart cleaning policy was requested on 3/2/23 at 12:15 p.m. division director of clinical operations B stated there was no policy.

Interview on 3/2/23 at 12:20 p.m. with assistant director of nursing/infection control nurse D regarding the above findings related to infection

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F 880	Continued From page 19 prevention and control revealed: *Her expectations for disinfecting mechanical lifts was, "They are supposed to wipe down the handles and things between residents." *All staff had access to disinfectant wipes and personal protective equipment. *Her expectation was for the medication carts to be wiped down, inside and out, each shift.	F 880		

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E 000	Initial Comments An emergency preparedness survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 2/28/23 through 3/2/23. Fountain Springs Healthcare Center was found in compliance.	E 000		

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

Kristine Harvey | Executive Director | 03/13/2023

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.