

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

ORIGINAL

PRINTED: 05/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435110</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/30/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FOUNTAIN SPRINGS HEALTHCARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2000 WESLEYAN BLVD RAPID CITY, SD 57702</b>
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(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
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F 000	INITIAL COMMENTS  Surveyor: 32572 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/29/14 through 4/30/14. Fountain Springs Healthcare was found not in compliance with the following requirements: F176, F281, F332, F368, F371, and F441.	F 000	Addendums noted with an asterisk per 5/21/14 telephone to facility administrator. KGS/DDH/MF	
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE  An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, record review, and policy review, the provider failed to ensure 3 of 14 sampled residents (10, 11, and 14) and 2 of 2 randomly observed residents (18 and 19) self-administering medications had been assessed and considered safe to self-administer medications. Findings include:  1. Observation on 4/29/14 at 6:05 p.m. in the Simpson dining room of licensed practical nurse (LPN) L administering pills to resident 14 revealed: *She set the medication cup in front of the resident and walked out of the dining room. *The resident put the pills onto a napkin and took each pill one at a time. *The nurse had not been in the dining room.	F 176	*Resident 10, 11, 14, 18, & 19 will be assessed for self administration of medications on or before 6-19-14. No residents were affected by this practice. All residents who receive medications have the potential to be affected.  *All nurses and medication aides will be inserviced by the DON or designee on the self administration of medication policies and procedures by 5-28-14.  *The DON or designee will complete written audits on the self administration/observe the medication	6-19-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Man B. Saloner</i>	TITLE <i>Administrator</i>	(X6) DATE <i>5-21-14</i>
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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 176	Continued From page 1  Review of resident 14's complete medical record revealed: *She had not been assessed to self-administer medications. *No physician's order to self-administer medication. *Nothing in her care plan in regards to self-administration of medications.  Interview on 4/30/14 at 3:30 p.m. with the director of nursing regarding resident 14 confirmed: *The resident should not have been self-administering medications. *She expected an assessment, physician's order, and self-administering medications care planned in order for the resident to safely self-administer medications.  Surveyor: 32573 2. Observation on 4/29/14 at 4:50 p.m. upon entering the Miller wing revealed resident 11 sitting in her wheelchair in the hallway. Several pills and a glass of water had been placed on the small wheelchair tray on her right side. The nurses with the medication cart were at the other end of the hallway near the dining room.  Review of resident 11's medical records revealed no self-administration assessments nor indication she had been capable to self-administer medications.  Interview on 4/30/14 at 2:35 p.m. with registered nurse J revealed there were no residents that should have been self-administering medications in the Miller wing. The nurses would watch over	F 176	pass weekly x4 and monthly x2. The DON will report to Administrator monthly x3 and to the QA Committee quarterly. The QA Committee will determine when monitoring is to cease.		

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F 176	<p>Continued From page 2</p> <p>resident 11 as she took her medications. Resident 11 would get upset if the nurses stood too close to her.</p> <p>Interview on 4/30/14 at 3:55 p.m. with the director of nursing revealed she expected the staff to remain close enough to intervene if necessary while residents took medications. She confirmed standing at the other end of the hallway had not been appropriate. She confirmed she would have considered that self-administration.</p> <p>Surveyor: 32572</p> <p>3. Observation on 4/29/14 at 12 noon revealed LPN C left resident's 10's medications in a cup at the table for her to take at a later time. She then left the dining room. At that table sat resident 10's husband who had visual difficulty and two other residents with diminished cognitive (thinking) status.</p> <p>4. Observation on 4/29/14 at 6:10 p.m. revealed unlicensed assistive personnel (UAP) placed resident 18 and 19's medications which were in a cup at the table for them to take at a later time. She then left the dining room.</p> <p>Review of resident 10, 18, and 19's medical records revealed: *No self-administration assessments had been completed. *No resident self-administration of medications had been on the care plans. *No physicians order stating the residents may self-administer medications.</p> <p>5. Interview on 4/30/14 at 2:08 p.m. with the director of nursing (DON) confirmed: *There were no residents who self-administered</p>	F 176			

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F 176	<p>Continued From page 3</p> <p>medications within the building.</p> <p>*The process for a resident to self-administer medications included:</p> <ul style="list-style-type: none"> <li>-An interdisciplinary assessment.</li> <li>-A physician's order the resident may self-administer medications that was obtained prior to the resident self-administering medications.</li> <li>-Residents who self-administered medications needed to be able to read the label on the medication.</li> <li>-Residents who self-administered needed to know the side effects of the medication being self administered.</li> <li>-Residents who self-administered needed to know the diagnosis or condition for which they were receiving that medication.</li> </ul> <p>Review of the provider's undated Self-Administer of Drugs policy revealed:</p> <p>***1. Resident may not be permitted to administer or retain any medication in their room unless so ordered, in writing, by the attending physician."</p> <p>***2. Should the resident's attending physician permit the resident to administer his/her medication(s), the following conditions will apply:"</p> <p>"a. The physician's order must be obtained prior to self-administering."</p> <p>***6. Residents who are permitted to administer his/her medication(s) are responsible for maintaining a record of such administration, or for informing the staff/charge nurse when such medication(s) were taken, so he/she may maintain a record of administration."</p> <p>Review of the provider's revised July 2013 Medication Pass policy revealed "8. Witness that the resident swallows/ingests administered medications, (unless plan states otherwise)."</p>	F 176			

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F 281 SS=D	<p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, record review, interview, and policy review, the provider failed to ensure: *The treatment cart containing multiple residents prescription creams had remained locked on the Garman hallway. *Appropriate documentation of the use of a Wanderguard for 1 of 2 sampled residents (1) with a Wanderguard. *Appropriate documentation of a medication for 1 of 17 sampled residents (3). Findings include:</p> <p>1. Observation on 4/29/14 at 7:20 a.m. on the Garman hallway revealed: *An open door to a small storage room that contained an unlocked treatment cart. *No staff had been present. *Hibiclens and hydrogen peroxide had been on top of the cart. *The treatment cart had six unlocked drawers. *Those drawers contained multiple residents treatment supplies and multiple prescription creams including Triamcinolone, Bacitracin, Voltaren, and Ketoconazole.</p> <p>Interview on 4/30/14 at 3:30 p.m. with the director of nursing (DON) revealed the door to the small storage room that contained the treatment cart should have been pulled closed and locked. It should have only been unlocked if an authorized</p>	F 281	<p>F 281</p> <p>*1. The nurse who left the treatment unlocked was instructed by the DON to lock the cart on 4-30-14.</p> <p>2. Resident #1s wanderguard documentation cannot be legally corrected past the due date.</p> <p>3. Resident #3s documentation cannot be corrected past the due date.</p> <p>No residents were affected by this practice. All residents have the potential to be affected by this practice.</p> <p>*All nurses and medication aides will be inserviced by the DON or designee on the security of medication and treatment carts and the proper documentation of medications by 5-28-14.</p> <p><i>wanderguards to include resident 1</i> <i>KEASBDDH MF</i></p> <p>*The DON or designee will complete written audits on cart security and documentation of medications and treatments weekly x4 and monthly x2. The DON will report to the</p>	6-19-14

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F 281	<p>Continued From page 5</p> <p>staff member had been standing in front of the cart.</p> <p>Review of the provider's undated Storage of Chemicals and Biologicals policy revealed treatment carts should have been locked when not in direct supervision of the appropriate staff.</p> <p>2. Review of resident 1's 4/14/14 physician's orders revealed an order to monitor her Wanderguard each shift for placement and function.</p> <p>Review of resident 1's March and April 2014 treatment administration records revealed: *Monitor Wanderguard to right wrist. Check every shift for placement and function (there were three shifts per day). *In March 2014 it had not been documented as checked on eleven shifts. *In April 2014 it had not been documented as checked on nine shifts.</p> <p>Interview on 4/30/14 at 3:30 p.m. with the DON confirmed resident 1's Wanderguard should have been checked for placement and function, and documented on every shift.</p> <p>Surveyor: 32573</p> <p>3. Review of resident 3's medical records revealed a physician's order started 3/9/12 for Enbrel solution 25 mg/0.5 ml subcutaneous to be given once a week for rheumatoid arthritis.</p> <p>Resident 3's medical administration record (MAR) revealed the week of 4/7/14 through 4/13/14 Enbrel had not been recorded as given. There was a blank space on 4/8/14 when the dose should have been given.</p>	F 281	<p>Administrator monthly. The DON will report to the QA Committee quarterly, The QA Committee will determine when monitoring is to cease.</p>	

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F 281	Continued From page 6	F 281		
F 332 SS=E	<p>Interview on 4/30/14 at 3:55 p.m. with the director of nursing revealed the nurse that had been administering medications that day remembered giving resident 3 the dose. The nurse had overlooked signing the MAR.</p> <p><b>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</b></p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, and policy review, the provider failed to ensure medications were administered according to the six rights for medication administration for 11 of 26 medications administered by 3 of 5 licensed practical nurses (LPN) B, C, and D for 4 of 7 residents (20, 21, 22, and 23) for the following: *LPN D had administered nine medications outside of the one hour before the scheduled time frame for two randomly sampled residents (21 and 22). *LPN B had administered an eye drop improperly to one resident (23). *LPN C had pre-signed an eye ointment prior to administering the medication to resident 20. *The medication cart on Miller wing had been in the hallway unattended with medications sitting on the top and residents within the area. Findings include:  1. Observation on 4/29/14 at 3:40 p.m. revealed</p>	F 332	<p>F 332</p> <p>*1. LPN D was verbally counselled by the DON on 4-30-14 regarding the facility's medication administration policy. She was written counselled on 5-16-14 after receipt of the survey.</p> <p>2. LPN B was written counselled by the DON on 5-19-14 regarding the proper administration of eye drops* to include resident no. K618DDOH/IMF</p> <p>3. LPN C was counselled by the DON on 5-20-14 re: proper signing of medications* for residents to include resident no. K618DDOH/IMF</p> <p>4. LPN A was written counselled on 5-19-14 by the DON regarding the proper storage of medications.</p> <p>No residents were affected by this practice. All residents have the potential to be affected by this practice.</p>	6-19-14

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F 332	<p>Continued From page 7</p> <p>LPN D had administered five medications to resident 21 that had been scheduled by the physician to be given at 5:00 p.m., 6:00 p.m., and 8:00 p.m.</p> <p>Observation on 4/29/14 at 3:50 p.m. revealed LPN D had administered four medications to resident 22 that had been scheduled by the physician to be given at 5:00 p.m. and 7:00 p.m.</p> <p>Interview with LPN D at that time confirmed that had been her routine. She stated she gave the medications all at once to the residents when they were more alert after a nap.</p> <p>2. Observation on 4/30/14 at 7:45 a.m. revealed LPN B had administered an eye drop to resident 23. The tip of the dropper had touched the resident's upper eye lid. He did not clean the tip of the dropper before he capped the bottle thus contaminating the eye drops.</p> <p>3. Observation on 4/29/14 at 2:00 p.m. revealed LPN C had administered an eye ointment to resident 20. She had pre-signed the medication prior to administration.</p> <p>Interview with LPN C at that time revealed she had pre-signed the medication prior to administering it, because it had been change of shift time and the report would look as if she had an outstanding medication.</p> <p>4. Observation on 4/30/14 at 7:25 a.m. revealed the medication cart sitting outside the dining room on Miller hallway. The medication cart had been unattended and had the medications (vitamin D oral solution and sodium chloride eye drops sitting on the top of it. There had been residents</p>	F 332	<p>*The DON or designee will provide the nurses and medication aides inservice education regarding the proper storage and administration of medications on or before 5-28-14. * of medications in the cart KE/SDD/HMF</p> <p>*The DON or designee will complete written audits on medication storage and administration weekly x4 and monthly x2</p> <p>The DON will report to the Administrator monthly. The DON will report to the QA Committee quarterly, The QA Committee will determine when monitoring is to cease.</p> <p>*to include audits of medication administration to residents no, ni, no &amp; no. KE/SDD/HMF</p>		

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F 332	<p>Continued From page 8</p> <p>going to breakfast and passing the cart on the way to the dining room. LPN A correctly stored the medications at 7:32 a.m. after she returned to the cart.</p> <p>5. Interview on 4/30/14 at 2:08 p.m. with the director of nursing (DON) confirmed she would have expected the nurses to follow the six rights of medication administration. The nurses would have contacted the physician to have the medication time changed and not have administered the medications until the scheduled time. They would not have touched the eye dropper to the resident's eye lid or if they had it would have been cleaned prior to recapping the bottle. The medication would have been signed after administration. She confirmed nurses needed to make sure medications were secured prior to leaving the medication cart.</p> <p>Review of the provider's revised June 2013 Medication Administration using the electronic medical record (EMR) policy revealed "The medication will be compared against the MD (medical doctor) order in the EMar (electronic medication administration record) to assure it is the correct medication, route, time to administer and dose."</p> <p>Review of the provider's revised July 2013 Medication Pass policy revealed:            **3. Medications must be administered in a timely manner and in accordance with the physician's written/verbal orders."            **10. Initial MAR/eMAR at appropriate box for med, date, and time."            **12. Medications must be administer within one hour before or after time indicated when using Unit Dose (pre-packaged system)."</p>	F 332			

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F 332	Continued From page 9  Review of the provider's undated Eyedrops policy revealed: **8. Do not let tip of dropper or tube touch eye or other surface." **9. If the tip was contaminated, wipe with alcohol pledget. Air dry. Apply cap."  Review of a resolution issued by the South Dakota Board of Nursing at its September 12-13, 2006 meeting revealed: *Approved nursing education programs in the state had verified the standard for documentation of medication administration taught in nursing education was that documentation occurred following the administration of medication. *It was the position of the South Dakota Board of Nursing that the standard for safe administration of medication included the practice of documenting medication following administration to the patient.  Review of the provider's revised July 2013 Storage of Medications policy revealed "5. Compartments containing medications are locked when not in use. Trays or carts used to transport such items are not left unattended."	F 332			
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME  Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.  There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.	F 368	F 368  *Residents #1-12 and 14's past documentation cannot be corrected. No residents were affected by this practice. All residents have the	6-19-14	

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F 368	<p>Continued From page 10</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on group interview, record review, and staff interview, the provider failed to give bedtime (hour of sleep [HS]) snacks every evening for 13 of 14 sampled residents (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 14). Findings include:</p> <p>1a. Group interview on 4/29/14 at 10:00 a.m. with ten residents in attendance revealed not all residents had been offered a snack before bedtime every evening. The residents stated they would like to be offered a snack every evening before bed.</p> <p>b. Review of resident 3's HS snacks documentation from 4/1/14 through 4/29/14 revealed the resident had no documentation of being offered a bedtime snack on 4/6/14. She had been offered an HS snack on 4/28/14 at 2:25 p.m. Supper had not been served yet, so that would not be considered an HS snack.</p> <p>c. Review of resident 8's HS snacks documentation from 4/1/14 through 4/29/14 revealed the resident had no documentation of being offered a bedtime snack on 4/13/14.</p>	F 368	<p>potential to be affected by this practice.</p> <p>*The DON or designee will complete in-service training to Dietary and Nursing staff regarding the bedtime snack policy and the proper documentation of the HS snacks on or before 5-28-14.</p> <p>*The DON or designee will complete written audits on the documentation of bedtime snacks weekly x4 and monthly x2. She will report to the Administrator monthly x3. The DON will report to the QA Committee quarterly. The QA Committee will determine when monitoring is to cease.</p> <p><i>* for all residents to include residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, &amp; 14. K6/SDBH/MF</i></p>	

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F 368	Continued From page 11  d. Review of resident 11's HS snacks documentation from 4/1/14 through 4/29/14 revealed the resident had no documentation of being offered a bedtime snack on 4/6/14.  e. Review of resident 12's HS snacks documentation from 4/1/14 through 4/29/14 revealed the resident had no documentation of being offered a bedtime snack on 4/6/14 and 4/26/14. She had been offered a bedtime snack on 4/25/14 at 3:51 p.m. Supper had not been served yet, so that would not count as an HS snack. Surveyor: 32333 f. Review of resident 1's HS snack documentataion from 4/1/14 through 4/29/14 revealed it had been offered or given six times before the supper meal. There had been no HS snack documentation two times.  g. Review of resident 6's HS snack documentation from 4/1/14 through 4/29/14 revealed it had been offered or given seven times before the supper meal. There had been no HS snack documentation two times.  h. Review of resident 14's HS snack documentaion from 4/1/14 through 4/29/14 revealed it had been offered or given nine times before the supper meal. There had been no HS snack documentation six times.  Surveyor: 32572 i. Review of resident 4's HS snacks documentation from 4/1/14 through 4/29/14 revealed: *HS snack had been documented as taken twice	F 368			

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F 368	<p>Continued From page 12 (4/7 and 4/19) before the evening meal had been consumed. *No documentation of an HS snack had been given or refused on 4/6/14.</p> <p>j. Review of resident 5's HS snacks documentation from 4/1/14 through 4/29/14 revealed: *HS snack had been documented as taken five times before the evening meal had been consumed. *No documentation of HS snacks given or refused on 4/14, 4/20, and 4/21/14.</p> <p>k. Review of resident 10's HS snacks documentation from 4/1/14 through 4/29/14 revealed: *HS snack had been documented as taken seven times before the evening meal had been consumed. *No documentation of HS snacks had been given or refused on 4/12/14 and 4/13/14.</p> <p>Surveyor: 28057 l. Review of resident 2's HS snacks documentation from 4/1/14 through 4/29/14 revealed: *Resident 2 had no documentation of being offered a bedtime snack on 4/16/14 and 4/21/14. *She had been offered an HS snack on 4/8/14 at 2:41 p.m. and on 4/22/14 at 4:26 p.m. *Supper had not been served yet, so those would not be considered an HS snack.</p> <p>m. Review of resident 7's HS snacks documentation from 4/1/14 through 4/29/14 revealed: *She had no documentation of being offered a bedtime snack on 4/6/14 and 4/26/14.</p>	F 368		

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F 368	<p>Continued From page 13</p> <p>*She had been offered an HS snack on 4/7/14 at 2:52 p.m., 4/12/14 at 3:10 p.m., and on 4/16/14 at 2:54 p.m.</p> <p>*Supper had not been served yet, so those would not be considered an HS snack.</p> <p>n. Review of resident 9's HS snacks documentation from 4/1/14 through 4/29/14 revealed:</p> <p>*She had no documentation of being offered a bedtime snack on 4/8/14, 4/16/14, 4/21/14, and 4/24/14.</p> <p>*She had been offered an HS snack on 4/8/14 at 2:36 p.m.</p> <p>*Supper had not been served yet, so those would not be considered an HS snack.</p> <p>o. Interview on 4/29/14 at 7:30 a.m. with cook G confirmed the supper meal had been served in the Miller unit at 5:00 p.m. and at 6:00 p.m. in the main dining room and in the Simpson unit.</p> <p>Interview on 4/29/14 at 11:35 a.m. with cook H confirmed frequently a large amount of the ordered HS snacks were returned to the kitchen the next day. That day the following snacks had been returned:</p> <p>*From the 300 wing:</p> <ul style="list-style-type: none"> <li>-Thirteen Mighty Shakes.</li> <li>-A fruit cup.</li> <li>-Fruit juice.</li> <li>-Several Nutri Grain bars.</li> </ul> <p>*From the 500 wing:</p> <ul style="list-style-type: none"> <li>-Twelve Mighty Shakes.</li> <li>-Fruit juice.</li> <li>-Packets of graham crackers.</li> <li>-Several Nutri Grain bars.</li> </ul> <p>Interview on 4/30/14 at 6:10 p.m. with certified</p>	F 368		

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F 368	Continued From page 14 nursing assistant (CNA) K confirmed some of the evening CNAs had taken the snack cart around to all of the residents, but not all of them had done that on a regular basis. She had only taken the ordered snacks around to those residents. She had relied on the rest of the residents who had not received an ordered snack to ask for a snack if they had wanted one.  Review of the provider's 3/1/13 Bedtime Snacks policy revealed all residents were to have been offered a bedtime snack. The nurse or designee had been responsible to have offered the residents a snack with their evening medication. The nurse manager or designee was to have audited at least two residents per week to ensure they had been offered a bedtime snack on a routine basis.	F 368			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, and policy review, the provider failed to ensure one of two observed meals had been prepared and served in	F 371	F 371  *1. On 4-30-14, Cook G was educated on the sanitary use of hot pads and the importance of completely covering the food, including the sides of the food and not just the top, before leaving the kitchen. 2. On 4-30-14, Cook G was also educated on the importance of checking food temperatures at 2 hours and 4 hours to assure it is cooling in a safe amount of time. 3. The wood shelf below the preparation	6-19-14	

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F 371	<p>Continued From page 15</p> <p>a safe and sanitary manner and environment by one of two cooks (G). Findings include:</p> <p>1. a. Observation on 4/29/14 at 11:54 a.m. revealed cook G had dropped the hot pads he had been using on the floor. He continued to use those same hot pads after he had picked them up off of the floor. He had carried hot pans of potato wedges with those soiled pads and had touched some of the potato wedges on the pan. He had also carried pans of steamed broccoli during the meal service with those same pads.</p> <p>b. During the same time frame he had placed a pan of plated pie slices on a cart. He then used inverted water glasses to support another pan of pie slices above the first pan of slices. He covered the top pan with a piece of parchment paper. The slices on the bottom pan had been exposed as the above pan and parchment paper had not covered them. He then pushed the cart down the hallway to the Simpson dining room from the kitchen with the bottom pan of pie slices exposed.</p> <p>c. Interview on 4/30/14 at 2:20 p.m. with the dietary manager confirmed she had expected hot pads to be put in the laundry if they had been dropped on the floor. She agreed the bottom pan of pie slices had not been covered adequately when they had been transported on the cart down the hallway.</p> <p>Review of the provider's undated Transportation of Food policy revealed all food items were to have been covered during transportation. It had also stated food was to have been prepared in a sanitary manner. It had not specifically addressed the use and cleaning of hot pads.</p>	F 371	<p>table, the metal shelf below the steam table, the drip pan for the stove griddle, the ice machine in the kitchen, and the side of the stove were cleaned on 4-30-14. The ceiling in the dish room was painted on 5-5-14. New dairy board will be installed in the corner of the dish room. 4. The ice machine in the nutrition room was cleaned on 5-2-14. No residents were affected by this practice. All residents have the potential to be affected by this practice.</p> <p>*All Dietary staff was inserviced on the items listed above on 5-1-14. The cleaning of the shelving was added to the cooks' daily duties. The cleaning of the other areas was added to the weekly cleaning lists and the policies will be updated. The kitchen has been added to the preventative maintenance quarterly checklist.</p> <p>The Dietary Manager or designee will monitor daily x1 week, weekly x3 weeks and monthly x2. She will report to the Administrator monthly x3. The</p> <p><i>the above listed areas for compliance</i> KES/SDOCH/ME</p>	

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F 371	<p>Continued From page 16</p> <p>2. Observation on 4/29/14 at 12:00 noon revealed cook G had placed two pans of hot pork meat from the stove into the cooler. Observation and interview on 4/29/14 at 2:15 p.m. with cook H confirmed the pork had cooled to 90 degrees Fahrenheit (F). He said meats being cooled were covered and put into the cooler. They were not checked again to ensure they had cooled off in the correct amount of time. After he had checked a chart hanging in the kitchen he agreed the meat should have been at 70 degrees F or less in two hours time from the start of the cooling process. He placed the pans on top of ice in the cooler. The temperature had gone down to 50 degrees F by 3:10 p.m.</p> <p>Interview on 4/30/14 at 11:30 a.m. with cook G confirmed he had not routinely checked the temperature of food when he had been cooling them in the cooler.</p> <p>Interview on 4/30/14 at 2:20 p.m. with the dietary manager confirmed foods being cooled had to be checked to ensure they had cooled in a safe amount of time for serving later.</p> <p>Review of the provider's undated Cooling Food policy had revealed hot cooked food was to have been cooled to 70 degrees F or lower in two hours.</p> <p>3. Observation and interview on 4/29/14 at 5:45 p.m. during a tour of the kitchen with the dietary manager confirmed: *A wood shelf below the food preparation table had been soiled with visible crumbs and food debris (photos 1 and 2). *The metal shelf below the steam table had been</p>	F 371	<p>Administrator will report to the QA Committee quarterly. The QA Committee will determine when monitoring is to cease.</p>	

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F 371	<p>Continued From page 17</p> <p>soiled with food debris and crumbs (photo 8). *The drip pan for the stove griddle had been soiled with grease and food debris (photo 3). -It had not been used since a week ago. *The ice machine in the kitchen had been soiled with lime deposit down the side of the machine (photo 7). -It had been several months since it had been cleaned. *The side of the stove had a large amount of cooked-on, blackened film on the side of the stove (photo 4). *The walls in the dish washing room had a blackened film around the edges where it had met the dishwasher and counters (photo 5). *The ceiling in the dishwashing room had been rusty and soiled with multiple stains (photo 6). *She had agreed those areas had needed to be cleaned or painted and maintained on a regular basis.</p> <p>Review of the provider's undated Cleaning Schedule and Cleaning Lists revealed all of the above areas were to have been initialed as cleaned when that had been completed. It had not addressed who was to clean the areas or how often.</p> <p>Review of the provider's undated Clean Dishwashing room revealed the walls were to have been washed quarterly or more often if needed. It had not stated who was to have cleaned the walls. It had not addressed the ceiling in that room.</p> <p>Surveyor: 32333 4. Random observations on 4/29/14 and 4/30/14 of the ice machine in the nourishment room on the Watson Way hallway revealed it had a white</p>	F 371			

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F 371	Continued From page 18 build-up on it. It appeared to be lime build-up on the front and openings of the machine.  Surveyor: 28057 Review of the provider's July 31, 2013 Ice Machine policy revealed it had not addressed how often or who had been responsible to have cleaned it.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	F 441  *1. Resident #9 was admitted with a closed wound to the heel in a leg that was being considered for amputation due to circulation problems. The area was not open or draining, so she was not affected by this practice. All residents who have wound care would have the potential to be affected by this practice. LPN B was educated on 4-30-14 by the DON regarding appropriate wound technique.  2. CNA F was verbally counselled on 4-30-14 by the ADON regarding the infection control policies in relation to the handling of catheters and linen.  3. The medication refrigerators were defrosted by the ADON on 5-19-14.	6-19-14

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F 441	<p>Continued From page 19 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, and policy review, the provider failed to ensure: *Wound care for one of one observed resident (9) with a wound was completed in a sanitary manner by one of one observed licensed practical nurse (LPN) (B). *Catheter care for one of one observed resident (2) with a catheter was completed in a sanitary manner by one of one observed certified nursing assistant (CNA) F. *Soiled linen was handled in a sanitary manner by one of one CNA (F) in resident 2's room. *Medication refrigerators, residents' personal care items, resident care equipment, and resident living environment had been maintained in a clean and sanitary manner to prevent contamination in numerous areas. Findings include:</p> <p>1. Observation on 4/30/14 at 9:15 a.m. revealed LPN B entered resident 9's room. He put gloves on without washing his hands. He then swabbed the resident's pressure ulcer (an injury to skin and underlying tissue in a localized area caused by pressure usually over a bony area) on her heel with a Betadine swab. He verbalized as he</p>	F 441	<p>They were placed on a monthly check schedule.</p> <p>4. -The Administrator ordered storage shelves for each resident's toiletries on 5-6-14.</p> <p>-The plunger was moved to the utility room on 4-30-14 by the Housekeeping Supervisor.</p> <p>-The television was moved to the basement by the Social Services Asst. on 5-1-14.</p> <p>-The kiosks were cleaned per manufacturer's directions by the housekeeping staff on before 5-20-14.</p> <p>-The miller dining room items which were stored were moved on 4-30-14. The walls were cleaned on 5-1-14. The cabinets will be sanded and refinished by 6-19-14.</p> <p>-The Dunn shower room items were stored in a locked file cabinet during the construction from 4-30-14 to 5-2-14. The nail files and clippers were thrown away on 4-30-14. Each</p>		

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F 441	<p>Continued From page 20</p> <p>swabbed it that he would swab from the outside of the ulcer to the inside of the ulcer. He confirmed that had been his usual technique.</p> <p>Interview on 4/30/14 at 1:55 p.m. with the director of nursing (DON ) confirmed she would have expected a wound to have been swabbed from the inside to the outside. She had also expected hands to have been washed before putting clean gloves on to perform resident care.</p> <p>A policy had been requested for wound care on 4/30/14 at 11:30 a.m. from the DON. None had been received from the DON by exit that same day at 7:15 p.m.</p> <p>2. Observation and interview on 4/30/14 from 7:40 a.m. through 8:10 a.m. revealed CNA F entered resident 2's room. She proceeded to provide morning care to the resident. She had laid the resident's catheter bag on the floor to drain the tube of urine before she had emptied the catheter bag. She had not placed a barrier between the bag and the floor. During that same time she had removed the resident's soiled gown. She had placed the soiled gown directly on the floor even though she had placed some soiled linens in a plastic bag. The CNA had confirmed she had known the catheter bag should not have been placed directly on the floor. She agreed the gown should have been placed in the bag, not on the floor.</p> <p>Interview on 4/30/14 at 1:55 p.m. with the director of nursing (DON) confirmed the catheter bag should never be placed on the floor. She also agreed soiled linen should be placed in a bag, not on the floor.</p>	F 441	<p>resident will be issued their own clippers. The Administrator ordered new locked chemical cabinets for both bath areas on 5-6-14.</p> <p>The Housekeeping Supervisor cleaned all of the EZ stands on 5-1-14. They will be checked daily by the hall's housekeeper.</p> <p>*All staff will be in-serviced by the ADON or designee regarding the above mentioned items on or before 5-28-14. <i>** random K/SDDDH/MF</i></p> <p>*Written audits will be completed by the Dept. Supervisors or designees weekly x4 and monthly x2. They will report to the Administrator monthly x3. The Administrator will report to the QA Committee quarterly. The QA Committee will determine when monitoring is to cease.</p> <p><i>* for the above listed areas to include catheter care for resident 2. K/SDDDH/MF</i></p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435110</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/30/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FOUNTAIN SPRINGS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2000 WESLEYAN BLVD RAPID CITY, SD 57702</b>	
(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 441	<p>Continued From page 21 .</p> <p>Review of the provider's undated Foley Catheter policy revealed the catheter bag was not to drag on the floor.</p> <p>Review of the January 14, 2014 provider's Laundry and Linen policy revealed soiled linen was to never be placed on the floor. Soiled linen was to have been bagged.</p> <p>Surveyor: 32572</p> <p>3. Observation on 4/30/14 at 10:00 a.m. of two of two medication refrigerators in the medication room revealed approximately two inches of ice build-up in the freezer sections in two of two small medication refrigerators.</p> <p>Interview at that time with the assistant director of nursing (ADON) confirmed there had been an excessive amount of ice build-up on the two small refrigerators in the medication room. She confirmed there had been no cleaning schedule in place for the medication refrigerators.</p> <p>Interview on 4/30/14 at 2:08 p.m. with the DON confirmed there had not been a cleaning schedule in place. She confirmed the ice build-up was not acceptable for the medication refrigerators.</p> <p>Surveyor: 32333</p> <p>4. Random observations on 4/29/14 and 4/30/14 throughout the facility revealed: *In multiple resident room shared bathrooms including residents' rooms 101, 102, 107, and 227: -Multiple residents' care items on the back of the toilets including personal care items such as skin protectant cream, Aloe touch wipes, baby</p>	F 441		

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F 441	<p>Continued From page 22</p> <p>powder, and foaming no-rinse cleanser (photo 9). -Room 107 had a plunger wrapped in a grabage bag on the floor (photo 10). -Room 102 had a television stored on the bathroom floor. *The kiosks (computer charting station) on Garman hallway, Watson Way hallway, Dunn Wing hallway, and the Miller Place dining room had been visibly soiled (photo 11). *The Miller Place dining room had the following: -Visibly soiled walls. -Worn wood cabinets potentially creating an uncleanable surface. -Therapy ice packs stored in the freezer with resident food items. -The upper cabinets had a shelf with sani-wipes and hot cocoa stored together. Another shelf had a brush, comb, syrup, honey, and hand sanitizer stored together. *The Dunn Wing shower room had the following: -Multiple resident use items had been stored underneath the sink including cleaning chemicals, Turbo-clean disinfectant, shaving cream, lotion, body wash, a sharps container, dirty nail clippers, and nail files(photo 12). -The cabinet on the wall contained Glybet surface and air disinfectant cleaner stored on the same shelf with resident use incontinent briefs. -On the back of the toilet there had been a box of vinyl examining gloves and Aloe touch wipes. *The Dunn and Watson whirlpool tub room had a clean linen closet that had disinfectant cleaner stored on the same shelf as clean resident-use towels. *The Hoyer storage room on the Dunn Wing hall had an EZ stand lift that had visible debris on it.</p> <p>A walk-through and interview on 4/30/14 at 3:15 p.m. with the administrator regarding the above</p>	F 441		

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F 441	Continued From page 23 listed items revealed she agreed they needed improvement.	F 441			

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NAME OF PROVIDER OR SUPPLIER  <b>FOUNTAIN SPRINGS HEALTHCARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2000 WESLEYAN BLVD RAPID CITY, SD 57702</b>
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K 000	INITIAL COMMENTS  Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/29/14. Fountain Springs Healthcare was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K029, K062 and K141 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 029 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to maintain proper separation in one randomly checked hazardous area (soiled utility room in Dunn wing). Findings include:	K 029	*The Dunn soiled utility room door was removed and adjusted on 5-5-14, so it would not catch on the newly installed carpet. No residents were affected by this practice. All residents have the potential to be affected by this practice.  *The Maintenance Supervisor added weekly door checks to the TELS computer prompting system and also to his fire inspection notebook.  *The maintenance assistant will check the doors weekly x12 weeks. The Maintenance Supervisor will report to the Administrator monthly x3. The Administrator will report to the QA Committee quarterly. The QA Committee will determine when monitoring is to cease.	6-19-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>5-21-14</b>
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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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435110</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/29/2014</b>
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K 029	Continued From page 1	K 029		
K 062 SS=F	<p>1. Observation at 1:00 p.m. on 4/29/14 revealed a soiled utility room in the Dunn wing. Testing of the door to that room revealed the bottom of that door would catch on the newly installed carpet and hold the door open. Interview with the maintenance supervisor at the time of the observation and testing confirmed that finding. This deficiency affected one of eight smoke compartments.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review, observation and interview, the provider failed to ensure the automatic sprinkler system was continuously maintained in reliable operating condition and inspected and tested periodically. Findings include:</p> <p>1. Review of the provider's automatic sprinkler system inspection reports revealed quarterly flow testing documentation was not available. Interview with the maintenance supervisor at the time of the record review indicated he was unaware of the quarterly flow testing requirements.</p> <p>2. Review of the provider's automatic sprinkler</p>	K 062	<p>K 062</p> <p>*1. Quarterly flow testing is scheduled for 5-29-14.</p> <p>2. A three year full trip test is scheduled for 6-4-14.</p> <p>3. A five year internal obstruction investigation will be done on 5-29-14.</p> <p>4. The laundry sprinkler heads were cleaned on 4-30-14 by the Maintenance Supervisor.</p> <p>5. The sprinkler head in the dish room was replaced on 4-29-14 by Western States Fire Protection. The new sprinkler head is Teflon coated so it will resist corrosion.</p>	6-19-14

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K 062	<p>Continued From page 2</p> <p>system inspection reports revealed no documentation for when the last 3 year full trip test for the dry system had been conducted. Interview with the maintenance supervisor at the time of the record review indicated he was unaware of the full trip test flow testing requirements.</p> <p>3. Review of the provider's automatic sprinkler system inspection reports revealed no documentation for when the last 5 year internal obstruction investigation had been conducted. Interview with the maintenance supervisor at the time of the record review indicated he was unaware of the 5 year internal obstruction investigation testing requirements.</p> <p>4. Observation at 11:30 a.m. on 4/29/14 revealed a laundry room in the partial basement. Further observation revealed lint loading on randomly observed sprinkler heads in that room. Interview with the maintenance supervisor at the time of the observation revealed he was unaware the sprinkler heads needed to be maintained free from corrosion, foreign materials, paint and physical damage.</p> <p>5. Observation at 2:45 p.m. on 4/29/14 revealed a dishwasher room in the kitchen. Further observation revealed heavy corrosion on one randomly observed sprinkler head in that room. Interview with the maintenance supervisor at the time of the observation revealed he was unaware the sprinkler heads needed to be maintained free from corrosion, foreign materials, paint and physical damage. This deficiency affected eight of eight smoke compartments.</p>	K 062	<p>No residents were affected by this practice. All residents have the potential to be affected by this practice.</p> <p>*The Maintenance Supervisor added sprinkler head checks to his weekly check lists and also entered them into the TELS computer prompt system.</p> <p>*The maintenance assistant will check the sprinkler heads weekly x12 weeks. The Maintenance Supervisor will report to the Administrator monthly x 3 months. The Administrator will report to the QA Committee quarterly. The QA Committee will determine when monitoring is to cease.</p>	

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K 141 K 141 SS=D	Continued From page 3 NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2.  This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure the storage requirements were followed for one of one liquid oxygen storage room (Oxygen transfilling room in the Garman wing). Findings include:  1. Observation at 2:10 p.m. on 4/29/14 revealed a liquid oxygen (less than 3000 cubic feet) storage room used transfilling. Doors to liquid oxygen storage rooms shall be secured to prevent unauthorized entry. Door hardware installed on that door did not have locking capabilities and would allow unauthorized entry. Interview with the maintenance supervisor at the time of observation revealed he was unaware of that requirement. This deficiency affected one of eight smoke compartments.	K 141 K 141	K 141  *A push button combination lock was installed on the liquid oxygen door on 5-5-14. No residents were affected by this practice. All residents have the potential to be affected.  *Nursing staff were inserviced on 5-5-14 regarding the importance of limiting access to the liquid oxygen via use of the new combination lock. The Maintenance Supervisor added a lock to his weekly checklists and added the lock to the TELS computer prompting system.  *The maintenance assistant will check the weekly x 3 months. The Maintenance Supervisor will report the Administrator monthly x3. The Administrator will report to the QA Committee quarterly. The QA Committee will determine when monitoring should cease.	6-19-14

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SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10723</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/30/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FOUNTAIN SPRINGS HEALTHCARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2000 WESLEYAN BLVD RAPID CITY, SD 57702</b>
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S 000	Initial Comments  Surveyor: 32572 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/29/14 through 4/30/14. Fountain Springs Healthcare was found not in compliance with the following requirement: S236.	S 000		
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS  Tuberculin screening requirements for healthcare workers or residents are as follows:  (1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;  This Rule is not met as evidenced by: Surveyor: 28057 Based on record review, interview, and policy review, the provider failed to ensure 1 of 5 sampled employees (E) and 1 of 14 sampled residents (9) received a two-step tuberculin (TB)	S 236	S 236  *Employee E's 4-23-14 second step of the two step TB test was negative. Resident #9s medication record shows she was admitted on 1-31-14. She received a Tb test on 2-3-14 and on 2-10-14. She had Tb tests read on 2-6-14 and 2-13-14. Since the medication record can't accept late entries, it is possible the surveyor and DON overlooked one page of the record (page one of eight). No residents were affected by this practice. All residents have the potential to be affected by this practice.  *The facility's policy was changed to require the second Tb test to be done within 14 days. The nurses were	6-19-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*May B. Sateran*

TITLE: *Adm. Staff*

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SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 236	Continued From Page 1  screening in the fourteen day timeframe. Findings include:  1. Review of dietary aide E's employee file revealed she had been hired on 3/28/14. She had received her second step of the two-step TB screening on 4/23/14. That had exceeded the fourteen day timeframe.  Review of resident 9's medical record revealed she had been admitted on 1/31/14. Review of her February 2014 medication administration record revealed she had received a tuberculin screening on 2/13/14. No other tuberculin screening had been documented in her record.  Interview on 4/30/14 at 4:35 p.m. with the director of nursing confirmed a two-step had not been completed in the two week time frame for employee E or resident 9.  Review of the provider's December 27, 2013 Tuberculin Skin Test Administration and Interpretation policy revealed the second step could be given up to three weeks after the first step. It could also be administered up to three months if needed but should not be a routine practice.	S 236	in-serviced on this requirement on 5-19-14 and 5-21-14.  *The Business Manager will track the employee and resident TB testing using a new tracking form. She will do this with each new hire and resident admission for one quarter. The Administrator will report to the QA Committee quarterly. The QA Committee will review progress quarterly and determine when monitoring may cease.	