

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/27/2016
NAME OF PROVIDER OR SUPPLIER FOUNTAIN SPRINGS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p><i>*Addendums noted with initial comments in asterisk per 6/6/16 per telephone with facility administrator and DON: NS/SDDAH/EL</i></p> <p>Surveyor: 23059 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/25/16 through 4/27/16. Fountain Springs Healthcare was found not in compliance with the following requirements: F253, F281, F371, F431, and F441.</p> <p>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/25/16 through 4/27/16. Areas surveyed included quality of care, environmental services, and dietary services. Fountain Springs Healthcare was found not in compliance with the following requirement: F253.</p>	F 000	<p>Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.</p>	
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059</p> <p>Surveyor: 26632 Based on observation, interview, and policy review, the provider failed to ensure a clean and sanitary environment had been maintained for the following: *Numerous randomly observed doors and door jambs (framework that surrounds the doors) with missing paint present in four of five halls (Dunn,</p>	F 253	<p>F253</p> <p>1. The door jambs have been painted; The sink alcoves have been repaired so no gypsum board is visible; All bathroom vents have been cleaned; Resident belongings and storage have been removed from bathroom and the floor cleaned; Storage items have been removed from the clean linen room; The vertical blinds in the dining room have been</p>	6-10-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Emergency Permit Holder* (X6) DATE *5-16-16*

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 253	<p>Continued From page 1 Watson, Miller, and Garman). *Numerous randomly observed resident room sink alcoves had gypsum board visible on the corners in four of five halls (Dunn, Watson, Miller, and Garman). *Approximately eighty percent of the resident room bathroom vents had a build-up of dust in four of five halls (Dunn, Watson, Miller, and Garman). *Storage of resident belongings in resident bathroom shower areas in four of five halls (Dunn, Watson, Miller, and Garman). *Storage of clean linens and resident care supplies in three of five halls (Watson, Miller, and Garman). *Broken vertical shades in the Miller dining room. *Broken ceiling tiles in the Miller dining room. *Wooden chair rail pulled away from the wall at the head of the bed in room 100. *Preventative maintenance and housekeeping logs. Findings include:</p> <p>1. Random observation from 4/25/16 through 4/27/16 revealed:</p> <p>a. Missing paint down to the bare metal for numerous resident room door jambs and bathroom door jambs in Dunn, Watson, Miller, and Garman halls.</p> <p>b. Randomly observed resident room sink alcoves with the lower corners of the walls gouged down to the gypsum board in Dunn, Watson, Miller, and Garman halls.</p> <p>c. Numerous observed shared resident and private resident bathroom showers with resident belongings being stored. Those items included wheelchairs, walkers, plastic storage containers, and miscellaneous resident belongings. The floors of the showers in those bathrooms had an</p>	F 253	<p>replaced; The ceiling tiles have been replaced; The chair rail in room 100 has been repaired; A preventative maintenance program has been initiated; Resident 1's room has been dusted.</p> <p>2. All residents are at risk.</p> <p>3. The Administrator will educate all staff no later than 5-24-16 on the maintaining a clean and clutter-free environment. The Administrator and Maintenance supervisor will devise a preventative maintenance checklist no later than 5-24-16. The Administrator will conduct walking rounds with housekeeping weekly to check for room cleanliness. Those not in attendance at education session will be educated prior to their first shift worked.</p> <p>4. The Administrator or designee will conduct weekly facility rounds to check to ensure the following: Rooms are clean and dusted; Ceiling tiles are in good repair; clean storage supply rooms are free from other storage items; Resident bathrooms are free from storage items and the floors are clean; vertical blinds are in good repair. Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the Administrator in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations of continuation/discontinuation of audit.</p> <p><i>*A reporting system is in place for staff to notify maintenance of any items in need of repair. NS/DP/DA/EL</i></p>	

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F 253	<p>Continued From page 2</p> <p>accumulation of dust and dirt build-up. Those rooms were located in Dunn, Watson, Miller, and Garman halls.</p> <p>d. Observation of the Watson, Miller, and Garman clean linen rooms and clean storage rooms revealed emergency power extension cords were stored with clean linen and resident care supplies.</p> <p>e. Two of two sets of windows in the Miller dining room had missing vertical blinds. Those blinds were laying on the window ledges.</p> <p>f. The ceiling tiles in the entry area of the Miller dining room were cracked with areas of missing tile present in the corners.</p> <p>g. The wooden chair rail in room 100 was pulled away from the wall and hanging partially attached. That was above the head of the bed.</p> <p>h. There was no preventative maintenance program in place to ensure an ongoing repair of resident areas was completed. Interview on 4/26/15 at 11:00 a.m. with the maintenance supervisor and review of the preventative maintenance program revealed general building upkeep was not part of that program.</p> <p>i. Testing of the ledge and bedside stand in resident 1's room revealed a large accumulation of dust had collected on the surveyor's finger after one swipe. Interview with resident 1's wife who was also a resident revealed she stated the housekeeping staff did not dust very often in their room. She stated "I know I have a lot of stuff, but they could still dust from time to time." She stated she was unhappy with the dusting provided by the housekeeping staff.</p> <p>2. Review of the provider's Room Deep Clean Schedule revealed the list had been started on 8/3/15 and three to five rooms were to have been deep cleaned each day Monday through Friday.</p>	F 253			

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F 253	<p>Continued From page 3</p> <p>The documentation was only present for August 2015. There was no documentation on that list the rooms had been cleaned. The current room cleaning schedule was for four days each week with the same amount of rooms present. There were no dates for that schedule or when the rooms had been cleaned.</p> <p>Review of the provider's undated Housekeeping policy revealed: **Resident rooms: -Complete unit cleaning if a resident was discharged or moved to a different room. -Bedrails, over-the-bed tables, night stands, chairs, wastebaskets, light fixtures, telephone cords, call light cords, window ledges, doors, sink vanities, mirrors, paper towel holders, toilet stool, tank, and base. Shower stalls, being observant of soiled or torn privacy curtains, drapes, and shower curtains. -Dust mop and wet mop floors as needed. *Miller dining room: Dust mop and wet mop the entire floor. Check walls, chairs and tables legs. Empty garbage. *Nutrition room: Counter, sink, check outside/inside of refrigerator for spills. *EZ Stands must be cleaned daily."</p> <p>Interview on 4/26/16 at 2:00 p.m. with the housekeeping supervisor revealed he had made the cleaning schedules up in response to resident complaints of dirty rooms. He revealed he had not kept any documentation that the rooms were cleaned as scheduled. He did not do any audits to ensure the cleanliness of the rooms or any other areas housekeeping was responsible for cleaning.</p> <p>Interview on 4/27/16 at 2:00 p.m. with the interim</p>	F 253			

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F 253	Continued From page 4 administrator revealed: *He had been there approximately one month. *He had not been aware of the housekeeping and maintenance problems. *He agreed the general preventative maintenance of the building had not been kept up. *The new construction of the therapy wing had kept the maintenance supervisor very busy.	F 253		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, and record review, the provider failed to establish and maintain communication for one of one resident (12) with peritoneal dialysis (PD) to ensure professional standards were followed. Findings include: 1. Interview on 4/26/16 at 10:30 a.m. with resident 12 regarding her peritoneal dialysis revealed: *She had dialysis four times daily. *She had started doing it twice daily on 4/20/16 in her room. On 4/22/16 she had graduated from training and she had done it four times daily in room since then. *Staff had made her a sign to hang on her door so no one would come in while she was doing her dialysis. *Staff were aware she was doing dialysis in her room, but she did it independently.	F 281	F281 1. No corrective action was taken for Resident 12 as she was discharged to home during the survey on 4/27/16. 2. All residents receiving dialysis services are at risk. 3. The DON will educate the nurses no later than 5-24-16 on ensuring any resident on dialysis or peritoneal dialysis have communication with the dialysis center and such is reflected in their plan of care. The Administrator will ensure a contract with the dialysis center is in place before any dialysis patients are admitted. Those not in attendance at education session will be educated prior to their first shift worked. 4. [redacted] DON or designee will audit all residents on dialysis each week to ensure there is communication with the dialysis center and the care plans are up to date. Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the DON at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.	6-10-16

**We currently do not have any dialysis. At which time we do, we will do it.*

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F 281	<p>Continued From page 5</p> <p>Observation 4/26/16 at 11:15 a.m. revealed resident 12's door was shut. There was a sign on the door saying not to enter, and therapy was in progress.</p> <p>Interview on 4/26/16 at 11:21 a.m. with staff I revealed: *She thought the resident was only practicing in her room and had not done dialysis on her own. *She knocked on the door, and the resident stated she could not come in as she was in the middle of dialysis.</p> <p>Interview on 4/26/16 at 12:00 p.m. with the director of nursing revealed they did not have a peritoneal dialysis contract with the dialysis provider.</p> <p>Interview on 4/27/16 at 10:15 a.m. with the dialysis nurse at the dialysis unit revealed she had: *Not contacted the nursing home to tell them resident 12 was going to begin to independently doing her dialysis in her room on Wednesday, 4/20/16. *Not sent orders to the provider to discontinue fluid restriction. *Sent home all needed supplies for the resident to continue PD in her room.</p> <p>Interview on 4/27/16 at 3:20 p.m. with staff F revealed dialysis information and communication records would be kept for the resident in a binder at the nurses station marked "Dialysis Binder". *That binder did not have any information in it on resident 12.</p> <p>Review of resident 12's nurses notes revealed: *On 4/12/16 at 11:55 p.m. staff H noted daily</p>	F 281			

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F 281	Continued From page 6 weights were ordered and to call the physician if weight increased three or more pounds in 36 hours. -Her weights were omitted on the treatment administration record on 4/13/16, and 4/16/16 through 4/26/16. *On 4/20/16 at 9:33 p.m. staff G noted the first time the resident had done dialysis by herself. She had reported she did everything without any difficulty. *On 4/21/16 at 7:50 p.m. staff G noted resident 12 had self-administered peritoneal dialysis without any difficulty. Review of the resident's 4/7/16 care plan revealed: *There was no mention of when dialysis was to take place. *There was no mention of where dialysis was to be done. Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, page 437 regarding nurse communication revealed: "In carrying out any plan of care, nurses need to use communication techniques that are appropriate for the client's individual needs."	F 281			
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	F 371	F371 1. No immediate correction could be taken for the handwashing or food temperatures. Staff were educated at time of survey. The bananas were moved and stored properly; Food is covered and dated when stored in the refrigerator; Water pitchers were removed from under the sink; The microwave and refrigerator was cleaned; Mineral build up in the sink and ice/water dispenser has been removed; and the cabinets in the nutrition room have been cleaned.	6-10-16	

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F 371	Continued From page 7 This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, and policy review, the provider failed to ensure: *Handwashing was done before using the ice machine scoop to fill containers for drinks at meal time. *Temperature of foods were taken and within safe limits before serving. *Bananas in boxes were stored at least six inches off of the kitchen floor. *Handwashing while serving food was maintained. *The Miller wing dining room refrigerator was clean. *Food in the Miller wing dining room refrigerator was covered and dated. *The microwave and refrigerator in one of one nutrition room was kept clean. *Water pitchers were not stored under the sink drain line in one of one nutrition room. *The sink and ice/water dispenser was kept free from buildup of minerals in one of one nutrition room. *The cabinets in the Miller dining room and the nutrition room were kept in a clean condition. Findings include: 1. Observation on 4/25/16 at 4:30 p.m. through 4/27/16 at 1:00 p.m. revealed a box of bananas were on the cement floor in kitchen area. Interview on 4/27/16 at 2:15 p.m. with the certified dietary manager (CDM) revealed: *The box of bananas was to be returned to food	F 371	2. All residents are at risk. 3. The Administrator, DON, Dietary Manager and RD have reviewed the policy on kitchen sanitation, food temperatures and use of thermometers, food storage, and handwashing and glove use, as well as reviewed the cited deficiency. The DON will educate all nursing, dietary staff, and housekeeping staff on the above no later than 5-24-16. Those not in attendance at education session will be educated prior to their first shift worked. 4. The DON or designee will audit to ensure the following: Handwashing and glove use is appropriate; Food is covered and dated when stored; Food is stored at least 6 inches from floor; Food temp logs are maintained and food is temped per policy; Microwaves, refrigerators and cabinets are clean; There are no mineral deposits on sink faucet or ice machine. Audits will be weekly for four weeks and then monthly for three months. Audits will be discussed by the DON at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.	

*dietary Services NS/SDDO/HEL

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F 371	<p>Continued From page 8 delivery service. *Staff were not aware the bananas were to be returned.</p> <p>Review of the provider's undated General Food Service Sanitation policy revealed: *Food items would be stored on shelves. *Food was to have been stored at a minimum of six inches above the floor. *Perishable food such as fruit must have been refrigerated immediately.</p> <p>2. Observation on 4/26/16 at 11:45 a.m. revealed a pan of chicken breasts: *The temperature of those chicken breasts was 120 degrees Fahrenheit (F) after it was taken out of the oven. *One pan of chicken breasts had already been taken to the another dining room. -The temperature of those chicken breasts recorded on the tracking sheet was 180 degrees F.</p> <p>Interview on 4/26/16 at 11:50 a.m. with staff J revealed she had only taken the temperature of one of the pans of chicken. *That pan had been sent to the other dining room. *She did not know why there was a discrepancy in the temperature of the pans.</p> <p>Observation on 4/26/16 at 5:18 p.m. during the supper meal revealed: *The temperature of sandwiches was 50 degrees F. *One sandwich had already been served. *Staff K stated "Do we take the temperature of the sandwiches?" *Staff K stated the sandwiches had been placed in the cooler about an hour ago.</p>	F 371		

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F 371	<p>Continued From page 9</p> <p>Review of the provider's undated Handling Cold Foods for Trayline policy revealed: *Cold food items for meal service were to have been placed in the refrigerator at least three to four hours before serving. *Cold temperatures would be taken before food service and halfway through service to assure foods were not more than 41 degrees F.</p> <p>3. Observation on 4/26/16 at 4:35 p.m. and again at 4:50 p.m. revealed an unidentified staff filled containers with ice for the dining room drinks. He did not wash his hands prior to scooping ice from ice machine.</p> <p>4. Observation on 4/26/16 at 4:58 p.m. and 5:15 p.m. with staff K revealed she had been serving food in the tray line. She put her hand in her pocket to get a pen out. She did not wash her hands before returning to the tray line.</p> <p>Interview on 4/27/16 at 2:15 p.m. with the CDM revealed her expectations would have been for staff: *To wash their hands before scooping ice for containers due to possible contamination of ice that is used in residents' glasses. *To take temperatures of all foods hot and cold before serving to make sure the food was the right temperature. *In the tray line to wash hands whenever leaving the tray line. That included after putting their hands in their pocket.</p> <p>Surveyor: 26632 5. Observation on 4/26/16 of the Miller dining room revealed: *The refrigerator was soiled on the inside with</p>	F 371		

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F 371	Continued From page 10 food particles and dried spilled liquids. *There was a container of what appeared to be pudding, a glass of juice, and multiple single serve butter pats that were unlabeled and undated. Observation on 4/26/16 of the nutrition room revealed: *The microwave and refrigerator in the nutrition room were soiled inside with food particles from spills. The outsides had a layer of dust on them. *The sink and water/ice dispenser in the nutrition room had a build-up of minerals on the surfaces and in the drain pan of the dispenser. *There were four trays of water pitchers stored under the sink drain line in the nutrition room. Interview on 4/27/16 at 1:30 p.m. with the CDM revealed: *Housekeeping was responsible for cleaning the inside and outside of the refrigerators and microwaves. *She agreed the water pitchers were at risk for contamination when stored under a drain line. The drain line could leak. *All food and drink left in the refrigerators were to have been labeled and dated. *The cabinets in the Miller dining room were in bad shape and needed replacing. She agreed they were unclean and in an uncleanable condition. *She agreed the nutrition room cabinets required a thorough cleaning inside and out.	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431	F431 1. The narcotic medication stored in the medication cart awaiting destruction has been destroyed.	6-10-16	

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F 431	<p>Continued From page 11</p> <p>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, interview, and policy review, the provider failed to ensure narcotic medication awaiting for destruction had been accounted for in two of three observed</p>	F 431	<p>2. All residents are at risk.</p> <p>3. The DON will educate nurses no later than 5-24-16 on ensuring discontinued schedule II, III and IV medications are accounted for until they are destroyed. Those not in attendance at the education session will be educated prior to their first shift worked.</p> <p>4. The DON or designee will audit each medication cart each week to ensure all schedule II, III, and IV medications are accounted for while in the medication cart. Audits will be weekly for four weeks and then monthly for three months. Results of the audits will be discussed by the DON at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.</p>		

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F 431	<p>Continued From page 12</p> <p>medication carts (Dunn and Miller). Findings include:</p> <p>1. Observation on 4/27/16 at 1:30 p.m. with licensed practical nurse (LPN) A of the Dunn medication cart revealed two medication cards in the narcotic box that were laying beside the standing cards. Those cards contained: *Twenty-nine one-half tablets of hydrocodone-acetaminophen 5/325 milligrams (mg) (strong pain pill). *Twenty-eight tablets of lorazepam 0.5 mg (for anxiousness).</p> <p>Interview with LPN A at that time revealed the cards laying down were medications no longer in use and were going to be destroyed. She stated: *They did not count those medications with the change-of-shift narcotic medication count. *The director of nursing (DON) came and picked them up. *She had been unsure how often the DON picked up those medications.</p> <p>2. Observation on 4/27/16 at 1:42 p.m. of the Miller medication cart with LPN C revealed three medication cards that contained narcotics. Those cards were laying down beside the standing cards. Those cards contained: *Hydrocodone-acetaminophen 5/325 mg, ten tablets. *Oxycodone 5-325 mg (for pain), twenty-eight tablets. *Hydrocodone-acetaminophen 10-325 mg, twelve tablets.</p> <p>Interview with LPN C during the above observation revealed those medications were no longer being used and were waiting to be</p>	F 431			

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F 431	Continued From page 13 destroyed. She stated they did not count those medications as part of the change-of-shift narcotic medication count. She said the DON came and picked up those medications, she was unsure how often that happened. Interview on 3/27/16 at 2:10 p.m. with the director of clinical services confirmed the narcotics waiting to be destroyed in the Dunn and Miller medications carts had not been accounted for. She stated they did not have a policy for the accountability of the narcotics waiting to be destroyed.	F 431			
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	F 441	F441 1. No immediate corrective action could be taken for Resident 11's dressing change. Staff member was educated at the time of survey. Resident 11's dressing change is being done per policy. The EZ stand lifts have been cleaned; The wall in the Miller Dining room has been repainted; The documentation kiosks have been cleaned; Cupboards in the Miller Dining room have been cleaned; All oxygen concentrator filters have been cleaned, including those in rooms 466, 469, 468, 221 and 460. The torn fall prevention mats have been discarded. 2. All residents are at risk. 3. The Administrator, DON and IDT have reviewed the policies and procedures on infection control which include: hand washing and glove use; cleaning and maintenance of walls, kiosks, EZ lifts, fall	6-10-16	

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F 441	<p>Continued From page 14</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which 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: 29162 Based on observation, record review, interview, and policy review, the provider failed to ensure: *One of one sampled resident's (11) dressing change had been completed in a clean manner. *One of two nurse's handwashing had been completed in an effective manner. *All EZ lifts were cleaned on a regular basis. *The wall by the microwave in the nutrition room was kept in a cleanable condition. *The wall by the documentation kiosk in the Miller dining room was kept in a cleanable condition. *All documentation kiosk screens were cleaned after being soiled with visible finger prints and debris. *Three of three fall prevention mattresses were kept clean and in a cleanable condition. *Cupboards in the Miller dining room were kept in a cleanable condition. *Five of five resident rooms (466, 469, 468, 221, and 460) had oxygen concentrators that were kept clean.</p>	F 441	<p>prevention mattresses and oxygen filters and have reviewed the deficiencies cited in this area. The DON will educate staff no later than 5-24-16 on the above and maintaining a cleanable surface. Those not in attendance at education session will be educated prior to their first shift worked.</p> <p>4. The DON or designee will audit two dressing changes each week to ensure that the dressing change, including hand washing, is performed per policy and will do walking rounds each week to ensure resident equipment is clean and serviceable. Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the DON at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.</p> <p><i>*including resident 11 until his wound has healed.</i> <i>NS/SDDOH/EL</i></p>	

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F 441	<p>Continued From page 15</p> <p>Findings include:</p> <p>1. Observation on 4/26/16 at 10:50 a.m. of registered nurse (RN) D and licensed practical nurse (LPN) E while they completed a dressing change for resident 11 revealed:</p> <p>*LPN E:</p> <ul style="list-style-type: none"> -Set up the supplies for the resident's treatment on his bedside table. She did not clean the table or place a clean barrier on it. -Dropped the clean scissors for RN D to use directly onto the resident's bedspread. -Washed her hands three times during the treatment. She did not wash her hands for more than six seconds during any of the handwashing she completed. <p>*RN D:</p> <ul style="list-style-type: none"> -Used the scissors that had been laying directly on the resident's bedspread to remove his dressing. -Took a wash cloth, added soap from the hand soap dispenser and ran a small amount of water onto it from the sink. She then wiped the resident toes with that washcloth. -Took dry 4X4 gauze that had been laying on the resident's bedside table (no barrier) and placed them directly on his toes. -Used tape from the same uncleaned bedside table to secure resident 11's dressing. <p>Interview on 4/27/16 at 2:15 p.m. with the director of nursing and director of clinical services revealed:</p> <ul style="list-style-type: none"> *The bedside table should have been cleaned or had a clean barrier put down before clean supplies had been laid on it. *The scissors should not have been laid on the resident's bedspread. *The resident's toes had not been washed 	F 441			

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F 441	<p>Continued From page 16 thoroughly.</p> <p>*LPN E had not washed her hands in an effective manner.</p> <p>*They agreed the cleansing technique used on the resident's toes had resulted in them not being washed in an accurate manner.</p> <p>Review of the provider's April 2014 Dressings Clean/Aseptic policy revealed the bedside stand was to have been cleaned or had a barrier of a towel laid down to establish a clean field.</p> <p>Review of the provider's May 2014 Hand Hygiene in the Health Care Setting Guidelines revealed handwashing was to have been completed for at least twenty seconds.</p> <p>Surveyor: 26632</p> <p>2. Random observations on 4/25/16 from 4:00 p.m. through 5:00 p.m., 4/26/16 from 7:30 a.m. through 5:00 p.m., and on 4/27/16 from 7:30 a.m. through 4:00 p.m. revealed:</p> <p>a. All EZ lifts had a large build-up of debris on the standing base. Residents were transferred from wheelchairs, beds, bathtubs, and toilets with the EZ lifts, and at times had bare feet. The soiled bases could have transferred infectious materials from one resident to another.</p> <p>b. The wall by the microwave in the nutrition room and by the kiosk in the Miller dining room had missing paint which exposed the gypsum board making them uncleanable surfaces.</p> <p>c. All documentation kiosks throughout the building had varying degrees of finger prints and debris. That could be a source of infectious organisms.</p> <p>d. Three of three fall mattresses observed were soiled with dirt and unidentifiable stains. There was also multiple tears in the surface of those</p>	F 441			

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F 441	<p>Continued From page 17</p> <p>mattresses. Those tears made the surfaces uncleanable.</p> <p>e. The cupboards in the Miller dining room were sticky to touch and the doors and drawers were difficult to open. This made them a source for infectious material to collect, along with debris.</p> <p>f. Oxygen concentrators in rooms 466, 469, 468, 221, and 460 had dirty filters. Those filters ensured a resident had clean oxygen.</p> <p>Review of the provider's undated Housekeeping policy revealed: *Miller dining room: Dust mop and wet mop the entire floor. Check walls, chairs and tables legs. Empty garbage. *Nutrition room: Counter, sink, check outside/inside of refrigerator for spills. *EZ Stands must be cleaned daily.</p> <p>Review of the revised April 2014 Oxygen Concentrator Use policy revealed to clean the filter on a regular basis. There was no indication how often a regular basis would have been.</p> <p>Interview on 4/26/16 at 2:00 p.m. with the housekeeping supervisor revealed he had made the cleaning schedules up in response to resident complaints of dirty rooms. He revealed he had not kept any documentation that the rooms were cleaned as scheduled. He did not do any audits to ensure the cleanliness of the rooms or any other areas housekeeping was responsible for cleaning.</p> <p>Interview on 4/27/16 at 2:00 p.m. with the interim administrator revealed: *He had been there approximately one month. *He had not been aware of the housekeeping and maintenance problems.</p>	F 441			

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F 441	Continued From page 18 *He agreed the general preventative maintenance of the building had not been kept up. *The new construction of the therapy wing had kept the maintenance supervisor very busy.	F 441		

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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 4/27/16. 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 K038, K062, K069, and K072 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to ensure exit access was maintained in one randomly observed location at the cross-corridor doors in the south part of the Simpson wing (500 wing). Findings include: 1. Observation at 1:30 p.m. on 4/27/16 revealed a set of cross-corridor doors in the Simpson wing. The east leaf of those doors was temporarily out of service for residents and staff. It was only used to enter the construction area. The west leaf was held open by a magnetic hold open device tied to the building fire alarm system. That door provided access to resident rooms 501 and 503 as well as the beauty shop.	K 038	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance K038 1. The door hardware was replaced at the time of survey. 2. All residents are at risk. 3. The Maintenance Supervisor will educate all staff on reporting any	6-10-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Emergency Permit Holder - 5-16-16

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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K 038	Continued From page 1 Testing of that door at the time of the observation revealed that door would close with the self-closing device and latch into its frame with the positive latching hardware. The door handle to release the latching hardware was not functioning and could not be reopened from the south side. That left the potential for occupants in the south side of that door to be locked in the building. The door could be opened from the north side through use of panic bar door hardware. Interview with the maintenance supervisor at the time of the above observation and testing revealed he was unaware the door could not be opened from the south side due to a non-functioning door handle. He indicated that door had recently been removed to allow for construction activity. He indicated the door hardware might have been altered when the contractors reinstalled the door. The door hardware was fixed upon finding this deficiency.	K 038	inoperable doors to Maintenance immediately. Education will occur no later than 5-24-16. Those not in attendance at education session will be educated prior to their first shift worked. 4. The Maintenance Director or designee will audit four door fixtures each week to ensure they are operational. Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the Maintenance Director at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.	
K 062 SS=C	This deficiency has the potential to affect one of nine smoke compartments. NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to ensure the automatic sprinkler system was maintained in accordance with National Fire Protection Association (NFPA) 25.	K 062	K062 1. Western States Fire Protection has been contacted and will be scheduled to test the sprinkler system backflow prevention device. 2. All residents are at risk. 3. The Maintenance Supervisor was educated on the requirement to test the sprinkler system backflow prevention	6-10-16

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NAME OF PROVIDER OR SUPPLIER FOUNTAIN SPRINGS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 WESLEYAN BLVD RAPID CITY, SD 57702	
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K 062	Continued From page 2 Annual backflow testing was not being performed on the sprinkler system. Findings include: 1. Document review of the fire sprinkler inspection reports prepared by Western States Fire Protection revealed no indication the annual testing of the sprinkler system backflow prevention device was being conducted as required by NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Interview with the maintenance supervisor at 11:30 a.m. on 4/27/16 revealed he was not aware of the above testing requirement. He indicated he believed Western States Fire Protection Inc. was conducting all the required testing. This deficiency has the potential to affect nine of nine smoke compartments.	K 062	device annually at the time of survey and Western States Fire Protection has been notified of this and have added testing to our inspections. 4. The Maintenance Director has added this to the annual inspection requirements and will ensure this test is performed annually going forward. Any problems will be discussed by the Maintenance Director at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure the commercial kitchen hood was maintained in compliance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations for one of one commercial kitchen hood. Findings include: 1. Observation at 12:45 p.m. on 4/27/16 revealed a commercial cooking hood in the kitchen. The gas stove appliance being protected by the fire	K 069	K069 1. The stove was moved so that is was inside the exhaust hood perimeter at the time of survey 2. All residents are at risk. 3. The Maintenance Supervisor will educate kitchen staff on ensuring the stove is not moved outside of the exhaust hood perimeter. Education will occur no later than 5-24-16. Those not in attendance at education session will be educated prior to their first shift worked.	6-16-16

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435110	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2016
NAME OF PROVIDER OR SUPPLIER FOUNTAIN SPRINGS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 069	Continued From page 3 suppression system and kitchen hood exhaust system was located under that commercial kitchen hood. That stove was also located outside the clearance of the hood approximately six inches. That stove appliance should have been located inside the exhaust hood perimeter a minimum of six inches. This clearance is required to aid in proper removal of smoke, heat, and grease laden vapors up through the exhaust system and not into the kitchen. Interview with the maintenance supervisor at the time of the above observation confirmed that condition. He indicated he was not aware of the required six inches of inside perimeter clearance. He also indicated that the appliance was probably moved by the commercial kitchen hood cleaning company when they last came through in January.	K 069	4. The Maintenance Director or designee will audit the stove location two times weekly to ensure it is within the exhaust hood perimeter. Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the Maintenance Director at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.	
K 072 SS=D	This deficiency has the potential to affect one of nine smoke compartments. NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10, 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure means of egress were continuously maintained free of obstructions in one randomly observed location (exit access into the sunroom in the Miller wing). Findings include:	K 072	K072 1. The therapy equipment was moved at the time of survey. The sign on the door was replaced with an "Emergency Exit Only" sign at the time of survey. 2. All residents are at risk. 3. The Maintenance Supervisor will educate all staff on ensuring equipment is not blocking the egress to any doors and that signs cannot state "Not An Exit".. Education will occur no later than 5-24-16. Those not in attendance at education session will be educated prior to their first shift worked.	6-10-16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435110	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2016	
NAME OF PROVIDER OR SUPPLIER FOUNTAIN SPRINGS HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 072	<p>Continued From page 4</p> <p>1. Observation at 1:45 p.m. on 4/27/16 revealed an exit access corridor leading to the sunroom in the Miller wing (200 wing). That access was obstructed with physical therapy equipment. That equipment has the potential to impede egress through the exit in the event of an emergency.</p> <p>2. Further observation at the above time revealed a sign had been posted on that same exit access door into the sun room indicating "not an exit." The maintenance supervisor indicated that sign was placed on the door to reduce the opening of the door by residents and visitors and creating nuisance alarms. That sign had the potential to confuse occupants into thinking that door was not a means of egress from the building. Proper signage to provide occupants knowledge of the use of that door shall be "emergency use only."</p> <p>Interview with the maintenance supervisor at the time of the above observations revealed he was aware of the issues. He indicated he had communicated with physical therapy staff of the requirement to keep corridors and the exit access clear.</p> <p>This deficiency has the potential to affect one of nine smoke compartments.</p>	K 072	<p>4. The Maintenance Director or designee will audit four door areas each week to ensure the egress is not blocked and that any signage on the door reads "Emergency Exit Only". Audits will continue for four weeks and then monthly for three months. Audits will be discussed by the Maintenance Director at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.</p>	

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10723	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2016
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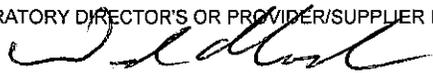
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S 000	Compliance/Noncompliance Statement Surveyor: 23059 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/25/16 through 4/27/16. Fountain Springs Healthcare was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 23059 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 4/25/16 through 4/27/16. Fountain Springs Healthcare was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Emergency Permit Holder*

5-16-16

STATE FORM

6899

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If continuation sheet 1 of 1

