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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435110	A. BUILDING _____ B. WING _____	01/06/2022

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

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F 000	INITIAL COMMENTS Surveyor: 41895 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 1/4/22 through 1/6/22. Fountain Springs Healthcare Center was found not in compliance with the following requirements: F838, F880, and F886.	F 000		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;	F 838	1. Unable to correct deficient practice noted during survey. All residents have the potential to be affected. 2. The ED or designee will update/complete the facility assessment to include a comprehensive review of the current resident population, resources needed to care for the residents, staffing requirements, services provided, equipment, supply inventories, maintenance, and activity logs, health information managing and sharing,facility and community based risk assessment, utilizing an all-hazards based approach and educate all staff on the facility assessment by 2/2/2022. The ED or designee will educate all staff not in attendance prior to their next working shift. 3. The ED or designee will review the facility assessment every six months and as needed to ensure the needs/resources of the center are accurately reflected in the assessment. The ED or designee will bring the results of the review to the QAPI committee to review whether the center needs to update the facility assessment.	2/2/2022

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

Kristine Harvey | Executive Director | 1/26/22

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.

JAN 28 2021

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F 838	Continued From page 1 (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, and facility assessment review, the provider failed to ensure a facility-wide assessment had: *Been updated annually.	F 838		

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F 838	Continued From page 2 *Included -A comprehensive review of the current resident population. -Resources needed to care for the residents. -Staffing requirements. -Services provided. -Equipment, supply inventories, maintenance, and activity logs. -Health information managing and sharing. -Facility and community based risk assessment, utilizing an all-hazards based approach. Findings included: Review of the provider's undated facility assessment revealed: *The assessment was twenty-two pages long. *It had included an overview of the provider's population from 11/13/18 through 11/12/19. *It had not addressed: -The care requirements of the resident population. --How the acuity, diseases, conditions, and treatments would have impacted their care needs such as how much assistance the residents would have potentially required from the staff. --How the cognitive, mental, and behavioral care requirements would have impacted their care needs such as how much assistance the residents would have potentially required from the staff. -Cultural food and nutrition diets for all the residents. -Types of accommodations needed to address cultural, ethnic, and religious factors in the resident population. -Equipment, supply inventories, maintenance, and activity logs. -Services provided, such as pharmacy and rehabilitation services.	F 838		

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F 838	Continued From page 3 -How many staff were needed to care for the residents or how they would have been scheduled/assigned. -Services provided by contract with a plan for annual reviews of them. -Health information managing and sharing. -Facility and community based risk assessment, utilizing an all hazards based approach. Interview and facility assessment review on 1/6/22 at 1:40 p.m. with administrator B regarding the facility assessment revealed: *She used a computer program provided by her corporate office to complete the facility assessment. *The facility assessment had not been updated since 2019. *It was her responsibility to complete the facility assessment. *She agreed it was not complete and many of the portions of the assessment had not been completed. *When asked if her assessment addressed what was needed to care for the residents she stated it addressed "about half" of what was required to be included in the facility assessment.	F 838		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880	See next page.	

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F 880	Continued From page 4 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880	**Directed Plan of Correction** **Fountain Springs Healthcare Center** **F880 and F886** **Corrective Action:** 1.For the identification of lack of: *Appropriate use of personal protective equipment (PPE) and hand hygiene between transitions of care. *Availability of disinfectant supplies. *Appropriate handling of wound care supplies during treatment. *Appropriate use of PPE or other communication alternatives when communicating with resident(s) with hearing impairment. *Appropriate specimen collection Technique when conducting COVID-19 Testing per BinaxNOW device. (F886) The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above (see next page)	2/2/2022

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F 880	Continued From page 5 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation, interview, record review, and policy review, the provider failed to ensure infection prevention and control practices were maintained for: *Appropriate personal protective equipment (PPE) use by one of one certified nurse aide (CNA) (H) between transitions of care for three of three residents (51, 130, and 277). *Availability of disinfectant supplies in one of two observed PPE carts outside of two of two residents' rooms who were on droplet precautions. *Handling of wound care supplies by one of one licensed practical nurse (LPN) G during one of one observed resident's (127) wound care treatment. *Appropriate use of PPE or other communication alernative(s) by staff when communicating with one of one resident (25) with a hearing impairment.	F 880	cares and services will be educated/re-educated by ED or designee by 2/2/2022. **Identification of Others:** 1. ALL residents and staff have the potential to be affected if lack of: *appropriate use of PPE and Hand hygiene between transitions of care. *availability of disinfectant supplies. *appropriate handling of wound care supplies during treatment. *appropriate use of PPE or other communication alternatives when communicating with resident(s) with hearing impairment. *appropriate specimen collection technique when conducting COVID-19 testing per Binax NOW device. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by DNS or designee by 2/2/2022. (See next page)	

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F 880	Continued From page 6 Findings include: 1. Observation on 1/5/21 at 11:10 a.m. of LPN G preparing to perform a wound care treatment for resident 127 revealed: *She performed hand hygiene, gathered her wound care supplies (4X4 inch gauze, bordered gauze, normal saline ampules, skin prep wipes, and collagen) from the medication cart, entered his room, and set those supplies directly on top of his uncleaned bedside table. *After the resident stated he needed his undergarment changed LPN G gathered those same wound care supplies from the uncleaned bedside table and placed them back inside her medication cart. Observation and interview on 1/5/21 at 11:50 a.m. with LPN G returning to perform resident 127's wound care treatment revealed she: *Re-gathered supplies needed for his wound care treatment from the medication cart, re-entered his room, and set those supplies on a towel on top of the bedside table and performed his dressing change. *Agreed those dressing supplies should not initially have been placed on an unclean surface. *Agreed those dressing supplies should have remained in the resident's room until she returned to perform the wound care treatment to avoid possible cross-contamination of other supplies with those supplies. Interview on 1/6/21 at 11:30 a.m. with assistant director of nursing/infection control nurse D regarding the above wound care treatment revealed she would have expected wound care supplies had been laid on a clean barrier and kept inside of that resident's room until after that	F 880	**System Changes:** 1. Root cause analysis conducted answered the 5 Whys: Breakdown in communication WHY? Lack of education and competency WHY? Time during COVID and new staff WHY? Feel like staff are trained and ready to work on floor WHY? Sense of security of education without acknowledgment all come from different training backgrounds and most of education comes after training. OUTCOME: Facility will create updated auditing and surveillance program around communication and education. Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/ training with demonstrated competency and documentation. Divisional Director of Clinical Operations contacted the South Dakota Quality Improvement Organization (QIN) on 1/24/22 a call was held with QIO, ED, DNS and DDCO in regards to the root cause analysis and other tools were reviewed on the call as well.(see next page)	

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F 880	Continued From page 7 wound care had been performed. 2. Observation and interview on 1/5/22 at 3:30 p.m. of CNA H revealed: *She exited resident 130's room wearing a face shield and an N95 mask after performing hand hygiene. -Signage on that room door indicated that resident was on droplet precautions. *Wearing that same N95 mask and face shield that had not been disinfected she walked down the hall to resident 277's room. -Signage on that room door indicated that resident was also on droplet precautions. *She put on a gown and gloves outside of that room then entered. -She exited that room not discarding her N95 mask or disinfecting her face shield. *She walked down the hall to resident 51's room, but was stopped by the surveyor before entering. -There was no infection precaution signage on that door. *She had thought residents 130 and 277 were on droplet precautions because they were new admissions. -The nurse had not "filled her in" on the details of those residents' infection prevention and control needs. *She was expected to discard her N95 mask and disinfect her face shield after all encounters with any resident on infection control precautions, but was so busy she had forgotten to do that. *Had not realized the risk of exposing the residents referred to above with new infections related to improper personal protective equipment use. Review of resident 130's medical record revealed she:	F 880	**Monitoring:** 1. Administrator, DON, and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined ap-proaches to ensure effective implementation and ongoing sustainment. The results of these audits will be taken by the ED or designee to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	

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F 880	Continued From page 8 *Admitted 1/4/22. *Required droplet precautions related to methicillin-resistant staphylococcus aureus (MRSA)pneumonia and influenza A. Review of resident 277's medical record revealed she: *Admitted 12/22/21. *Required droplet precautions related to being unvaccinated for COVID-19. 3. Observation on 1/5/22 at 3:40 p.m. of the PPE cart outside of resident 130's revealed: *No accessible product available for staff to disinfectant their face shield upon exiting that room. -Resident 130 was on droplet precautions. Interview on 1/5/22 at 3:45 p.m. with director of clinical operations A and director of nursing (DON) C regarding the observations above revealed they: *Confirmed CNA H had not appropriately discarded and disinfected PPE potentially exposing residents 130, 277, and 51 to new infection. *Expected PPE carts had been kept adequately stocked with PPE and products to disinfect PPE. *Communication logbooks at the nurses' station and communication sheets updated daily for each residential living unit and provided to caregivers kept them up to date on pertinent resident information such as needed infection control precautions and measure. Review of the undated How To Safely Remove Personal Protective Equipment signage outside of resident 130 and 277s' door revealed: *Paragraph 1:	F 880		

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F 880	Continued From page 9 -"Remove the respirator after leaving the patient room and closing the door." *2. Goggles or Face Shield: -"Outside of goggles or face shield are contaminated!" -"If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container." Surveyor: 41895 4. Observation and interview on 1/4/22 at 3:00 p.m. with resident 25 revealed she: *Had been unable to hear this surveyor and stated staff usually just pull down their mask so she could read their lips. *Stated she knew I could not remove my mask. *Did not have a notebook or anything to write on in her room for communicating. *Had dug through a pile of mail on her bed, handed this surveyor an envelope, a pen, and asked the surveyor to write on the envelope. *Was able to read well and when the envelope had been completely used the surveyor used the surveyors' tablet to complete the interview. *Was able to read very quickly and understood. *Had not been offered a notebook other option to help her communicate with staff. *Did understand when the staff pulled down their mask it would have put her at potential risk for exposure to COVID-19. Review of resident 25's revised 7/27/21 care plan revealed: *She had a hearing deficit. *Understood best by reading lips or written communication. *"Staff may pull down face mask when communicating with me."	F 880		

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F 880	Continued From page 10 Interview on 1/4/22 at 3:45 p.m. LPN J regarding communication with resident 25 revealed staff had been told to leave on their face shield and pull their masks down to communicate with her. Interview on 1/5/22 at 2:58 p.m. with CNA I regarding communication with resident 25 revealed: *Sometimes resident 25 could hear staff and at other times could not. *The resident would ask her to pull her mask down so she could read her lips. *She had been told and it was on the resident care sheet she could pull down her mask. *Had communicated by writing with resident at times. *Agreed resident 25 did not have a notebook or anything for staff to write on to communicate with her. Interview on 1/5/22 3:25 p.m. with DON C regarding communication with resident 25 revealed: *She had agreed pulling down mask to communicate with resident 25 "could" be an infection control risk. *Resident 25 would ask her to pull her mask down when communicating with her. -It made her uncomfortable but because the resident asked she did pull down her mask. *She was not sure if the resident had been educated on the risks of having staff pull down their masks. *Did not know if other options had been tried for communicating with resident 25, such as a white board, notebook, or clear masks. *Referred this surveyor to unit coordinator E with further questions.	F 880		

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F 880	Continued From page 11 Interview on 1/6/22 at 8:38 a.m. with RN/unit coordinator E regarding communication with resident 25 revealed: *She agreed pulling down mask to communicate with resident 25 was an infection control risk. *She had not thought about trying a different form of communication with her. *She did not know there were clear masks. *She agreed there were alternative methods of communication such as a notebook, white board, or using the resident's iPad. -In the past, the iPad had been set up by activities so, staff could talk to it and it would write the words out for her. -She did not know if the resident still had an iPad. On 1/6/22 at 9:50 a.m. a policy had been requested for what personal protective equipment was to be worn by staff during resident care and when in resident care areas. *A copy of an email was provided by director of clinical operations A which revealed: -It had a date of 12/29/21 at 5:48 p.m. -Subject of the email was "COVID Update Call Notes 12/29/21". -All staff should be wearing eye protection and an N95 mask.	F 880		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:	F 886		

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F 886	Continued From page 12 §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the	F 886	**Directed Plan of Correction** **Fountain Springs Healthcare Center** **F880 and F886** **Corrective Action:** 1.For the identification of lack of: *Appropriate use of personal protective equipment (PPE) and hand hygiene between transitions of care. *Availability of disinfectant supplies. *Appropriate handling of wound care supplies during treatment. *Appropriate use of PPE or other communication alternatives when communicating with resident(s) with hearing impairment. *Appropriate specimen collection Technique when conducting COVID-19 Testing per BinaxNOW device. (F886) The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above (see next page)	2/2/2022

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F 886	Continued From page 13 transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation, interview, review of COVID-19 testing competency reviews, review of the Abbott BinaxNOW COVID-19 Ag (antigen) product insert instructions, and policy review, the provider failed to ensure: *One of one registered nurse (RN)/unit coordinator (F) had conducted COVID-19 testing in a manner consistent with their policy and according to manufacturer's recommendations. *One of one RN/unit coordinator (F) and one of one director of nursing (DON) (C) had completed a BinaxNOW COVID-19 testing competency prior to administering COVID-19 testing. Findings include: 1. Observation and interview on 1/4/22 at 10:24 a.m. with RN/unit coordinator F revealed she: *Tested an unidentified resident for COVID-19 using the BinaxNOW COVID-19 Ag test. -Inserted the specimen swab greater than one inch inside one nostril. -After rotating that swab inside one nostril, removed it, and immediately inserted that swab	F 886	cares and services will be educated/re-educated by ED or designee by 2/1/2022. Identification of Others: 1. ALL residents and staff have the potential to be affected if lack of: *appropriate use of PPE and Hand hygiene between transitions of care. *availability of disinfectant supplies. *appropriate handling of wound care supplies during treatment. *appropriate use of PPE or other communication alternatives when communicating with resident(s) with hearing impairment. *appropriate specimen collection technique when conducting COVID-19 testing per Binax NOW device. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by DNS or designee by 2/1/2022. (See next page)	

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F 886	Continued From page 14 into the prepared test card for processing. *Stated that process was used for all residents and staff she tested using that COVID-19 test. *Had no resource to support that testing process she used. *Was unaware that process was not consistent with the provider's policy or manufacturer's recommendations. Interviews on 1/4/22 at 10:40 a.m. with RN/unit coordinator E and 10:52 a.m. with DON C regarding COVID-19 testing revealed they: *Used the same process described by RN/unit coordinator F when they administered the BinaxNOW COVID-19 test. -Were unaware that process was not consistent with the provider's policy or manufacturer's recommendations. Interview on 1/6/21 at 11:30 a.m. with assistant director of nurse/infection control nurse D regarding COVID-19 testing revealed: *She confirmed RN/unit coordinator F had incorrectly administered that BinaxNOW test. *Staff who had been expected to administer that test were evaluated on their ability to competently perform that task before performing it. Interview and review of COVID-19 BinaxNOW competencies and COVID-19 testing on 1/6/21 at 1:30 p.m. with director of clinical operations A revealed: *RN/unit coordinator F had not administered that COVID-19 test according to the provider's policy or manufacturer's recommendation, but should have. -She had completed her BinaxNOW COVID-19 competency on 9/24/21. *DON and RN/unit coordinator E had not	F 886	System Changes: 1. Root cause analysis conducted answered the 5 Whys: Breakdown in communication WHY? Lack of education and competency WHY? Time during COVID and new staff WHY? Feel like staff are trained and ready to work on floor WHY? Sense of security of education without acknowledgment all come from different training backgrounds and most of education comes after training. OUTCOME: Facility will create updated auditing and surveillance program around communication and education. Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/ training with demonstrated competency and documentation. Divisional Director of Clinical Operations contacted the South Dakota Quality Improvement Organization (QIN)on 1/24/22 a call was held with QIO, ED, DNS and DDCO in regards to the root cause analysis and other tools were reviewed on the call as well. (see next page)	

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F 886	Continued From page 15 completed their competencies. *All staff who administered COVID-19 tests had been expected to have a competency completed. Review of the 9/25/20 COVID-19 ABBOTT BINAXNOW POC [point of care] DEVICE Competency revealed: *Procedure Step: -"5. Insert the nasal swab less than 1 inch into the nostril of the exhibiting the most drainage or congestion. Rotate the swab 5 times or more against the nasal wall. -6. Using the same swab, repeat this process for the other nostril to ensure than an adequate sample is collected from both nasal cavities." Review of page 2 of the BinaxNOW COVID-19 Ag Product Insert revealed: *Nasal Swab: -"To collect a nasal swab sample, carefully insert the swab into the nostril exhibiting the most visible drainage, or the nostril that is most congested if drainage is not visible. Using gentle rotation, push the swab until resistance is met at the level of the turbinates (less than one inch into the nostril). Rotate the swab 5 times or more against the nasal wall then slowly remove from the nostril. Using the same swab, repeat sample collection in the other nostril."	F 886	Monitoring: 1. Administrator, DON, and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and on-going sustainment. The results of these audits will be taken by the ED or designee to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	

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

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E 000	Initial Comments Surveyor: 41895 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 1/4/22 through 1/6/22. Fountain Springs Healthcare Center was found not in compliance with the following requirement: E004 and E039.	E 000		
E 004 SS=E	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must	E 004	1. All residents have the potential to be affected. 2. The Executive Director will review/revise the EP to ensure functionality to meet the needs of the center in the event of an emergency by 2/2/2022. 3. The Executive Director will bring the EP plan to the QAPI committee semi-anually and as needed for review and recommendation for any changes necessary to the plan.	2/2/2022

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

Kristine Harvey | Executive Director | 1/26/2022

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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E 004	Continued From page 1 develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Surveyor: 44928 Based on interview and document review, the provider failed to evaluate at least annually and maintain a comprehensive emergency preparedness program. Findings include: 1. Review of the most current copy of the provider's emergency preparedness (EP) policy and procedure manual revealed last reviewed date was 10/2019. Interview on 1/5/22 at 10:45 a.m. with administrator B revealed 10/2019 was last review of the EP policy and procedure manual.	E 004		
E 039 SS=E	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2),	E 039		

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E 039	Continued From page 2 §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements,	E 039	1. All residents have the potential to be affected. 2. The ED will coordinate an emergency preparedness drill with community resources for the month of May 2022. The ED or designee will conduct a mock disaster drill in the facility by 2/2/2022. The drills will be documented in the plan. 3. The results of the drill will be brought to the QAPI committee by the ED for further review and recommendations.	2/2/2022

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E 039	Continued From page 3 directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions	E 039		

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E 039	Continued From page 4 designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must	E 039		

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E 039	Continued From page 5 conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the	E 039		

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E 039	Continued From page 6 following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility,	E 039		

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E 039	Continued From page 7 ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,	E 039		

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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
E 039	Continued From page 8 facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435110	A. BUILDING _____ B. WING _____	01/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 9 engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435110	A. BUILDING _____ B. WING _____	01/06/2022

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

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E 039	Continued From page 10 the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Surveyor: 44928 Based on interview and emergency preparedness manual review, the provider failed to document two desktop exercises, and failed to conduct a full-scale exercise. The findings include: 1. Interview on 1/5/22 at 10:45 a.m. with administrator B revealed the provider failed to complete a full-scale exercise. The provider did complete two emergency preparedness tests during 2021, but failed to document those tests, including: *Participation with local and county response partners during a hailstorm in 2021.	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435110	A. BUILDING _____ B. WING _____	01/06/2022

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FOUNTAIN SPRINGS HEALTHCARE CENTER	2000 WESLEYAN BLVD RAPID CITY, SD 57702

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E 039	Continued From page 11 *A drill they performed during a fire taking place across the interstate from the facility. The administrator reviewed the emergency preparedness binder where documentation would have been included if it had been documented. -No documentation was in the binder.	E 039		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435110	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/05/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/5/21. Fountain Springs Healthcare Center 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 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K300, K321, and K918 in conjunction with the providers commitment to continued compliance with the fire safety standards.	K 000		
K 300 SS=C	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the required smoketight characteristics of the ceiling at three locations (core area, Watson Way resident wing, and activities room). Findings include:	K 300	1. The connecting duct work in the following locations, 1) core area infront of the boiler room access door, 2) Watson Way wing by resident room 350, and 3) Activities room by the office will be re connected to the return grille. This will be done no later than 2/2/2022. 2. All residents potentially at risk. 3. All HVAC units will be audited for proper ducting to include grille to HVAC unit. 4. The Maintenance Director and Maintenance Assistant will be educated on proper ducting of HVAC units to ensure 100% smoketight compartments.This will be done no later than 2/3/2022 or prior to their first shift worked thereafter. 5. The Maintenance Director or Designee will conduct audits on 4 HVAC units to ensure proper ducting. Audits will be done weekly x4 and monthly x3. Audits will be discussed by the Maintenance Director or Designee during monthly QAPI for review and recommendations of continued/discontinuation of audits.	2/2/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristine Harvey	Executive Director	01/26/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435110	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/05/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 300	Continued From page 1 1. Observations on 1/5/22 beginning at 10:15 a.m. revealed the lay-in ceiling had open grilles that were not connected to ductwork at the following locations: *Core area in front of the boiler room access door *Watson Way wing by resident room 350 *Activities room by the activities director office. Interview with the maintenance supervisor at the time of the observations confirmed those findings. He stated he was not sure how long the transfer grilles had been in place in the ceiling grid. Further discussion with the maintenance manager revealed he was unaware the ceiling opening was not allowed. He was unaware the opening would negatively affect the operation of the smoke detection system and the automatic fire sprinkler system. The opening would allow heat and smoke to rise and pass into the plenum space where there was no smoke detection or sprinkler coverage. The surveyor explained to the maintenance worker and the maintenance supervisor that plenum return air was not allowed in a healthcare facility. An emphasis was also placed on the need for the smoketight ceiling characteristic to facilitate proper function of the smoke detectors and automatic fire sprinklers. The deficiency affected requirements for ventilation ductwork installation and had the potential to affect 100% of the occupants of the smoke compartments.	K 300		
K 321 SS=C	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321	1. On 1/20/2022 both doors on the Miller hall dining/ day room were equipped with self closing hardware.	2/2/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435110	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/05/2022**

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FOUNTAIN SPRINGS HEALTHCARE CENTER	**2000 WESLEYAN BLVD** **RAPID CITY, SD 57702**

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K 321	Continued From page 2 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain one hazardous areas (Miller Hall dayroom) as required. Findings include: 1. Observation on 1/5/21 at 11:00 a.m. revealed the Miller Hall dayroom was over 100 square feet and had large amounts of combustibles stored in it. Boxes of personal protective equipment	K 321	2. All residents potentially at risk. 3. All staff will be educated to report any doors that are not equipped with self closing hardware that lead to a storage room into the Maintenance Work Book. This will be done no later than 2/2/2022 or prior to their first shift worked thereafter. 4.The Maintenance Director or designee will conduct weekly audits of 4 doors to ensure proper closing. Audits will be conducted weekly x4 and monthly x3. Audits will be discussed by the Maintenance Director or designee during monthly QAPI for review and recommendations of continued/ discontinuation of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435110	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/05/2022**

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K 321	Continued From page 3 (gowns and masks) were kept in the room. The door was equipped with three spring hinges, but the door would not self-close. Interview with the maintenance supervisor at the time of the observation confirmed those findings. He stated the springs had been removed from the hinges to prevent the doors from self-closing. The deficiency affected requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment.	K 321		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435110	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING	DATE SURVEY COMPLETE: **1/5/2022**
NAME OF PROVIDER OR SUPPLIER **FOUNTAIN SPRINGS HEALTHCARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **2000 WESLEYAN BLVD RAPID CITY, SD**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 918	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to document generator battery conductivity monthly for 2021. Findings include: 1. Record review and interview on 1/5/22 at 9:15 p.m. with the maintenance supervisor revealed: *There was no documentation of the battery conductivity in the monthly maintenance logs for the generator for calendar year 2021. *He confirmed the generator maintenance-free battery could not be tested for specific gravity (the older battery testing requirement). *He was unaware of the monthly battery conductivity documentation requirement. The deficiency affected 100% of the building occupants.

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

The above isolated deficiencies pose no actual harm to the residents

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10723	A. BUILDING: _____ B. WING _____	01/06/2022

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S 000	Compliance/Noncompliance Statement Surveyor: 41895 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/4/22 through 1/6/22. Fountain Springs Healthcare Center was found in compliance.	S 000		

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

Kristine Harvey

TITLE

Executive Director

(X6) DATE

01/20/2022