STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435110	A. BUILDING _____ B. WING _____	**10/21/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, and policy review, the provider failed to ensure infection control practices and facility policies and procedures were followed for the current coronavirus 2019 (COVID-19) pandemic for: *Hand hygiene by one of one observed unlicensed assistive personnel (UAP) (C) who had taken five of five residents' (1, 2, 3, 4, and 5) vital signs. *Disinfection and storage of a blood pressure wrist cuff and pulse oximeter finger probe used by one of one UAP (C). *Disinfection of a portable cart that held a blood pressure cuff and pulse oximeter finger probe used by one of one UAP (C). Findings include: 1. Observation on 10/21/20 between 2:45 p.m. and 3:00 p.m. of UAP C taking residents' vital signs revealed: *Without performing hand hygiene, she entered resident 1's room, removed a pulse oximeter finger probe from her smock pocket, and placed it on the resident's finger. -She removed a blood pressure cuff from her pocket and placed it on the resident's wrist. -She removed the finger probe and cuff then returned them to her pocket after she was unable to get accurate readings. -She left the room, returned with a portable cart, used the blood pressure cuff and pulse oximeter finger probe from that cart to take the resident's vital signs again. -She placed the used blood pressure cuff and pulse oximeter back into that cart and pushed the cart into the hallway without cleaning and disinfecting any of those items. *Without performing hand hygiene she immediately entered the shared room of residents 2 and 3. -She removed the uncleaned blood pressure cuff from her pocket, took resident 2's blood pressure, and returned the cuff to her pocket. -Without performing hand hygiene she removed the uncleaned pulse oximeter probe from her pocket, took resident 3's oxygen saturation reading, and returned the uncleaned probe to her pocket. *Without performing hand hygiene she immediately entered the shared room of residents 4 and 5. -She removed the uncleaned pulse oximeter probe from her pocket and took resident 5's oxygen saturation reading. -Without performing hand hygiene she used that uncleaned pulse oximeter probe and took resident 4's oxygen saturation reading. *She left the room and had not performed hand hygiene. Interview on 10/21/20 at 3:00 p.m. with UAP C regarding taking residents' vital signs and disinfection and storage of reusable medical equipment revealed: *She stated she was unaware she needed to clean and disinfect reusable medical equipment. *She agreed hand hygiene should have been completed before, after, and between resident care. *She was unaware storing reusable medical equipment in her smock pocket had posed an infection control risk. Interview on 10/22/20 at 12:40 p.m. with director of nursing B regarding the above observations revealed: *UAP C had been an employee for over fifteen years. *It was her expectation that reusable medical equipment was cleaned and disinfected after it was used. *Storage of reusable medical equipment inside clothing pockets was not an acceptable practice. *Consistent hand hygiene prior to, during (if necessary), after, and between resident care was expected. Review of the provider's March 2018 updated Handwashing/Hand Hygiene policy revealed: *7. Use an alcohol-based hand rub or soap and water for the following situations: -b. Before and after direct contact with residents; -i. After contact with a resident's intact skin; -l. After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; . Review of the provider's May 2015 Cleaning and Disinfecting Resident Care Items and Equipment policy revealed: *c. Non-critical items are those that come in contact with intact skin but not mucous membranes. -ii. Most non-critical reusable items can be decontaminated where they are used. *d. Reusable items are cleaned and disinfected or sterilized between residents.

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

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.