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Division of Healthcare Access & Quality and Health Protection
Health Protection
Licensure and Certification
Public Health Preparedness and Response.
Rural Health

TO: Hillary J. Schwab, Executive Director
Kathy Jensen, Finance Director
Compass Point
1809 Williams Street
PO Box 277
Sturgis, SD 57785

FROM: Chris Qualm, Administrator
Office of Health Care Facilities Licensure and Certification
600 East Capitol Avenue
Pierre, SD 57501

DATE: 5/7/2021

RE: Compliance Survey conducted April 28, 2021

BY: Cindy Koopman Viergets, REHS, Senior Health Facilities Surveyor

Survey Type: Environmental, Sanitation, Safety, Fire Prevention, Accessibility

Code Standards: Administrative Rules of South Dakota:
*46:04:20 — Inpatient Chemical Dependency
NFPA code 101 "LSC" 2009 Chapters 1-10 inclusive & Chapter 32
Americans with Disabilities Act Accessibilities Guidelines (ADAAG)

cc: Muriel J. Nelson
Division of Community Behavior Health Services Department of Social Services

## INTRODUCTION

Enclosed please find the list of deficiencies related to state rules identified as a result of the April 28, 2021 survey at your facilities located at:
* 1807 Williams Street, Sturgis (Inpatient Chemical Dependency and Alcohol and Drug).

CLASSIFICATION: Chemical Dependency Treatment Facility (Inpatient)

BED CAPACITY: 9, Census: 5

As a result of the survey areas were discovered that will require a plan of correction. For each deficiency listed below, state the completion date for the corrections, the corrective action you have taken, or the plan of correction that you intend to make, and the person's position title responsible for monitoring continued compliance. Please mail your plan of correction to our office no later than May 17.2021. (Please do not include individual staff names in your plan. You may use the sample format listed below or use one that includes the same reporting requirements.)

I toured with the chemical dependency technician (CDT), registered nurse (RN), maintenance person, and finance officer on 4/28/21 from 9: 10 a.m. to 10:30 am. The following findings were noted:

A. the provider failed to maintain yearly inspection records for the fire alarm system. Findings include:

I. Record review of the annual fire alarm inspections revealed the last inspection had been in 2016. Interview with the CDT at the time of the record review confirmed those findings. She stated she was not aware where the other annual inspections were located.

Interview on 4/11/18 at 4:45 p.m. with the nurse manager confirmed the annual fire alarm inspection for the 2017 year had not been completed.

**Corrective action taken or what plan is intended to make the correction:** The annual inspections were located in the business office. The findings informed me that ALL yearly fire alarm inspections have been completed. This includes years 2014-2020. The nurse manager was incorrect in her confirmation of the year 2017 not being completed, as the year 2017 is indeed included in the annual fire alarm inspections. I (Hillary Schwab- Director) have compiled these documents and have attached them for your review.

**Date when correction was or will be made:** I (Hillary Schwab) compiled the annual fire alarm inspections on 5/13/20

**Staff position responsible for monitoring this area:** Hillary Schwab (Director) and Marissa Merriman (Maintenance staff).

**How will this area be monitored in the future for continued compliance?** Hillary Schwab (myself) will monitor maintenance staff. I will ensure we receive an annual fire alarm inspection each year after the beginning the fiscal year (in June or July). We have planned a maintenance meeting for July 6th in order to address this issue, contact the contractor and set up an appointment for contractor to pay a visit to the agency.

B. The provider failed to maintain three of four corridors (west, east, and front) free and clear of obstructions. Findings include:

1. Two couches extended into the corridor by the living room which prevented a clear path of egress to the exit doors located at the end of the west and east corridor. Two bookcases and a coat tree were stored in the path of egress in the west corridor. A bookcase with videos and movies was stored in the path of egress to the front exit door.

Interview on that same day and time with the RN revealed they had just purchased new furniture and had to rearrange the living room.

**Corrective action taken or what plan is intended to make the correction:**

Couches were moved into the living room. The two bookcases were moved out of the hallway, as was the coatrack. The movie case was moved and the shelf was placed on the wall.

**Date when correction was or will be made:** 5/6/21

**Staff position responsible for monitoring this area:** Marissa Merriman, maintenance staff.

**How will this area be monitored in the future for continued compliance?** Marissa will do daily walk-throughs of the inpatient building.

C. The provider failed to follow proper procedure for sanitizing the kitchen tables and countertops in the kitchen. Findings include:

1.Review of the disinfectant used for the sanitizing of the kitchen table and countertops revealed it required a clear rinse to be used as a disinfectant. Interview with the RN and maintenance person revealed they were not aware it required a clear potable rinse after use.

**Corrective action taken or what plan is intended to make the correction:**

All inpatient technicians have been disinfecting the kitchen table and countertops. After disinfecting, the technicians have been rinsing the table and countertops with a clean wet rag with water.

**Date when correction was or will be made:** 6/2/21

**Staff position responsible for monitoring this area:** Nurse, maintenance staff and technicians.

**How will this area be monitored in the future for continued compliance?** A monitoring schedule was put into place. This schedule consists of a daily checklist with three slots for AM, afternoon and PM.

D. The provider failed to ensure resident bedding and facility linen was disinfected. Findings include:

1. Review of the posted directions for laundry revealed they used a color-safe bleach to disinfect resident bedding upon discharge. Interview with the CDT revealed they also used that same color-safe bleach to disinfect the facility laundry. Interview with the RN and maintenance person revealed they were not aware the color-safe bleach had no disinfection properties.

**Corrective action taken or what plan is intended to make the correction:** Maintenance staff alerted the business office, and we have purchased the suggested products for disinfecting the facility laundry.

**Date when correction was or will be made:** 5/10/21

**Staff position responsible for monitoring this area:** Maintenance staff, Marissa Merriman and the inpatient technicians.

**How will this area be monitored in the future for continued compliance?** The inpatient technicians will add these specific products to the weekly grocery list, and maintenance staff will ensure these products are being used when she does her daily walkthrough of the building.

E. The provider failed to provide a continuous supply of hot water on the west end of the facility. Findings include:

1. Testing of the handwashing sinks on the west end of the facility revealed no hot water was available for handwashing or hygiene. The temperature of the hot water was 70 degrees Fahrenheit.

**Corrective action taken or what plan is intended to make the correction:**

The faucet was not mixing the water correctly, and we turned the hot water heater up.

**Date when correction was or will be made:** 5/5/21

**Staff position responsible for monitoring this area:** Marissa Merriman, maintenance staff

**How will this area be monitored in the future for continued compliance?** Maintenance staff, Marissa Merriman will be notified and it will be fixed at that time. The hot water heater temp will be checked every month and initialed.

F. The provider failed to ensure combustible storage was not stored in the gas furnace room. Findings include:

I. The furnace room contained suitcases, backpacks, clothes, stuffed animals, and boxes of games. Interview with the PN revealed she was aware they could not use the furnace room as storage.

**Corrective action taken or what plan is intended to make the correction:** All of the combustible storage and the client storage was moved to the outpatient building.

**Date when correction was or will be made:** 5/12/21

**Staff position responsible for monitoring this area:** All staff

**How will this area be monitored in the future for continued compliance?** Maintenance will check monthly and it will be incorporated into the training and orientation of new staff.

G. The provider failed to ensure ready-to-eat food was not handled with bare hands by the residents. Findings include

1. Two unidentified clients entered the kitchen and used their bare hands to retrieve ice cubes from the freezer. Those same clients also grabbed handfuls of shelled nuts in a bowl that were available on a table in the kitchen. Interview with the RN revealed she was not aware a scoop should be provided for the ice cubes in the freezer. She was aware the shelled nuts in the bowl should not be available for all unless a scoop is provided or they are individually packaged.

**Corrective action taken or what plan is intended to make the correction:** All ice cubes are in a sealed container and tongs are used to retrieve the ice cubes. Food is no longer allowed to be grabbed out of bowls or plates with bare hands. All food is covered and tongs and/or scoops are used to retrieve them.

**Date when correction was or will be made:** 4/28/21

**Staff position responsible for monitoring this area:** Inpatient techs and the nurse

**How will this area be monitored in the future for continued compliance?** We have posted signs to remind people to use scoops/tongs. This rule will be incorporated into the new hire training and orientation.

H. The provider failed to maintain documentation for the fire drills that included all pertinent information. Findings include:

1. Interview with the CDT revealed they did not have documentation for each fire drill, but the reminders for a drill were on the CDT's calendar. The information for the fire drills was in the CDT's daily notes. That information stated the time of day the drill was held, and all residents evacuated. Interview with the RN revealed they did have a binder with fire drill documentation, but it may have been misplaced.

**Corrective action taken or what plan is intended to make the correction:** Technicians were notified that they need to fill out the log that is in the fire binder after a fire drill. We will be conducting a day and night drill per month.

**Date when correction was or will be made:** 6/2/21

**Staff position responsible for monitoring this area:** Nurse, techs and maintenance staff

**How will this area be monitored in the future for continued compliance?** Maintenance and tech supervisor will check at least once per week to make sure logs are filled out and drills are being done.

I. The provider failed to ensure the fire alarm system was inspected annually by an outside contractor.

1. Interview with the finance officer revealed she had copies of the last automatic sprinkler inspection report and health inspection report, but she did not have a copy of latest fire alarm inspection. Nor was she sure one had been completed in the year 2020.

**Corrective action taken or what plan is intended to make the correction:** All of the annual fire inspections are included.

**Date when correction was or will be made:** 5/13/21

**Staff position responsible for monitoring this area:** Maintenance staff, Marissa Merriman

**How will this area be monitored in the future for continued compliance?** Maintenance staff sets this up each year.

Hillary Schwab, Executive Director - LPC
7/29/21