To: Chief Deputy Willie Whelchel
Care Campus and LaCrosse Street Facility
321 Kansas City Str. STE 110
Rapid City, SD 57701

From: Chris Qualm, Administrator
Office of Health Care Facilities Licensure and Certification
615 East 4th St.
Pierre, SD 57501-1700

Re: Compliance Survey conducted 11/20/2018

By: Cindy Koopman Viergets, Sr. Health Facilities Surveyor/Sanitarian
Department of Health, Health Care Facilities Licensure & Certification

Classification: Alcohol and Drug Treatment Facility
Survey Type: Environmental Sanitation, Safety, Fire Prevention, and Accessibility

Code Standards: Administrative Rules of South Dakota (ARSD) 67:61
National Fire Protection Association Code 101 "Life Safety Code" (LSC) 2000 Edition, chapters 1-10 inclusive and chapter 33
Americans with Disabilities Act Accessibilities Guidelines (ADAAG)

Cc: Mary LeVee, Department of Social Services
Division of Behavioral Health Services

Facilities Reviewed:

Administration and Counseling:	321 Kansas City Str.
Safe Solutions and Detoxification:	321 Kansas City Str.
Crisis Care:	321 Kansas City Str.
LS Facility:	725 N. LaCrosse Str.

The purpose of this survey was to conduct an initial survey, evaluate the operation, and determine compliance with South Dakota Administrative Rules 67:61:09 & 67:61:10.

The following is a list of items that were found out of compliance with the above rules. Please provide a plan of correction, correction date, and quality assurance plan for the following noted deficiencies. We request that you provide this office with your plan of correction stating the completion date for the corrections, the corrective action you have taken, or the plan of correction that you intend to make. **The plan must be submitted to our office by January 12, 2019.** Please indicate staff position or titles, not personal names, in your plan of correction if/when you identify what staff position will be responsible for corrections or monitoring compliance. Please sign the plan of correction prior to returning. In lieu of mailing, you may scan and email your copy to the following: Mary.levee@state.sd.us Heidi.gravett@state.sd.us and cindy.koopmanviergets@state.sd.us.

If you have questions regarding the survey please do not hesitate to contact the Department of Health.

Administration and Counseling: 321 Kansas City St.

1. All fire extinguishers were not inspected monthly since the annual inspection on 2/28/18.
   Date of correction: 1-9-19

   Plan of correction:
   Staff Assistant IV contacted Buildings & Grounds to create regularly scheduled monthly inspections of fire extinguishers. On-site Building Tech I will was provided keys to monitor the fire extinguishers in the secured client areas of PCSO – Addiction Treatment Services Safe Solutions and Crisis Care. The on-site Building Tech I will report completion of this task to the Housing Director monthly. The overnight custodian will be responsible for completing the monthly inspection of the fire extinguishers in non-secured client and staff areas of PSCO – Addiction Treatment Services Administration and Counseling. The overnight custodian will report completion of this task to the Housing Director monthly.

2. The alarm was not sounded for all fire drills. A vocal notification was given to announce the fire drill.
   Date of correction: 1-17-19

   Plan of correction:
   The Housing Director and Buildings & Ground have established employee training on how to perform fire drill from the fire alarm panel. The Housing Director and Shift Supervisors will schedule drills - one fire drill per month on each shift or per requirements. Alarm test documents will be completed requiring signatures by employees performing the test, shift supervisor and housing director verification. Documents to be kept electronically and in the fire alarm binder.

3. The most current automatic sprinkler inspection was not available.
   Date of correction: 1-12-19

   Plan of correction: Staff Assistant IV submitted attachment with POC.

4. The most current fire alarm and smoke detection with sensitivity inspections were not available.
   Date of correction: 1-12-19

   Plan of correction: Staff Assistant IV submitted attachment with POC.

Safe Solutions and Detoxification: 321 Kansas City St.

1. Two of six dryers have foil/paper lined dryer ducts.
   Date of correction: 1-18-19

   Plan of correction:
   Staff Assistant IV contact Buildings & Grounds to replace the 2 east dryer ducts with semi-rigid ducts with a completion date of 1-18-19. Staff Assistant IV will follow-up on 1-18-19 and report to leadership that this is completed.

2. Four random smoke detectors still had their orange plastic covers in place.
   Date of correction: 12/31/18

   Plan of correction:
   Housing Director assigned Detox Tech to complete a walk-through of the facility and to remove any orange plastic covers still in place over smoke detectors. Completion of task was reported to the Housing Director.

3. Two of two janitor carts had toilet paper and paper towels stored on the bottom shelf next to the mop bucket.
   Date of correction: 12/31/18

   Plan of correction:
   Housing Director spoke with on-site Building Tech I about not storing paper products on the lower level of their cleaning carts. The Housing Director will follow-up in 30 days to verify compliance.

4. Fourteen of fourteen shower fixtures did not have suicide prevention/break away fixtures (shower heads, control knobs, and grab bars).
   Date of correction: 1-10-19

   Plan of correction:
   Correspondence from DOH inspector sites ARSD 67:61:18:01 as reference for this citation. ARSD 67:61:18:01 is criteria basis for 3.7 services. At our facility, we do not provide 3.7 services. We are not accredited for medically monitored inpatient programs (3.7) and are not required to meet this standard. The treatment level for this area is 3.2D, 3.1 and 2.5 service levels (ARSD 67:61:17:01, ARSD 67:61:16:01 and ARSD 67:61:15:01 respectively).

5. Shower shoes were not provided for clients.
   Date of correction: 1-9-10

   Plan of correction: The Housing Director is working towards a plan to implement shower shoes with an implementation date to be determined. The Housing director is working with the Tech Supervisors and Tech Training officers on developing the policy and procedure. Training points will include issuing, disinfecting and storage of reusable shower shoes. Monthly compliance checks will likely be completed by the Housing Director and Tech Supervisor.

6. No disinfectant or cleaning and disinfecting procedures were provided for clean-up of blood, vomit, fecal matter, or any bio-hazardous substance.
Date of correction: 1-10-19

Plan of correction:
The cleaning and disinfection procedure are as follows:
1. Put on appropriate clean-up equipment: Rubber gloves, rubber boots, mask, apron and eye protection.
2. Sprinkle absorbent powder on spill.
3. Wait about 2-3 minutes then, using the two scoops, scoop up semi-solid gel and put in red disposable biohazard bag.
4. Spray area with Quat 25 and 1:10 Bleach:Water solution (blood, fecal matter and vomit, TB, MRSA, VRE and CDiff). Contact time ten minutes. Then clean up with mop and rags. Bleach-Water solution for HIV and HBV also. CDC guideline 5: Cleaning and Disinfecting Environmental Surfaces in Healthcare Facilities.
5. Put everything that can be washed in one or two of the bio-washable bags (clear with red stripe). Place in dirty laundry cart or can. Items will be washed at sanitizing temperatures or with sanitizing chemicals. Items that will not be washed will be placed in red biohazard bag and disposed of with biohazard items through certified medical waste providers.
6. Take off equipment (gloves last), spray boots in mop sink with Quat 25 and 1:10 Bleach-Water solution, rinse then dry.
7. Place mask and rubber gloves and apron in red disposable bag. Both red disposable bags need to be put in bio-waste box.
8. When equipment is dry, put back in cabinet.

7. No disinfectant was used for those clients with tuberculosis (TB) disease, Clostridium difficile, methicillin-resistant Staphylococcus Aureus, vancomycin-resistant enterococcus or any other infections.
*Per interview with the detoxification supervisor, he stated they would keep a client in a private room if that client had TB. He was not aware if that private room was treated as an isolation room with negative air pressure.
Date of correction: 1-10-19

Plan of correction:
Private Isolation rooms are not equipped with negative air pressure systems.

If a client is suspect for TB, they are given a surgical mask, screened and taken to a hospital for an x-ray. If a client has known active TB, they are not admitted into our services. When working with a client that is suspected of TB, staff will wear a surgical mask and PPE during client contact and when cleaning the area where client has been contained.

If a client is known to have C-Diff, VRE or MRSA, they are admitted into an ISO room for the duration of their stay. Bleach is used to clean the room and staff wear personal protective equipment when cleaning and when contacting the client. Quat 25 and 1:10 Bleach-Water solution (TB, MRSA, VRE and CDiff). Let stand for ten minutes. Then clean up with mop and rags. Bleach-Water solution for HIV and HBV also. CDC guideline 5: Cleaning and Disinfecting Environmental Surfaces in Healthcare Facilities.

All medical equipment is disinfected with Micro-Kill disinfecting wipes with a contact time of 2 minutes.

8. All fire extinguishers were not inspected monthly since the annual inspection on 2/28/18.
   Date of correction: 1-9-19

   Plan of correction:
   Staff Assistant IV contacted Buildings & Grounds to create regularly scheduled monthly inspections of fire extinguishers. On-site Building Tech I will was provided keys to monitor the fire extinguishers in the secured client areas of PCSO – Addiction Treatment Services Safe Solutions and Crisis Care. The on-site Building Tech I will report completion of this task to the Housing Director monthly. The overnight custodian will be responsible for completing the monthly inspection of the fire extinguishers in non-secured, secured and non-client areas of PSCO – Addiction Treatment Services Administration and Counseling. The overnight custodian will report completion of this task to the Housing Director monthly.

9. The alarm was not sounded for all fire drills. A vocal notification was given to announce the fire drill.
   Date of correction: 1-17-19

   Plan of correction:
   The Housing Director and Buildings & Ground have established employee training on how to perform fire drill from the fire alarm panel. The Housing Director and Shift Supervisors will schedule drills - one fire drill per month on each shift or per requirements. Alarm test documents will be completed requiring signatures by employees performing the test, shift supervisor and housing director verification. Documents to be kept electronically and in the fire alarm binder.

10. There was no documentation that indicated fire drills had been completed.
    Date of correction: 1-10-19

    Plan of correction: The Housing Director and Shift Supervisors will schedule drills - one fire drill per month on each shift or per requirements. Alarm test documents will be completed requiring signatures by employees performing the test, shift supervisor and housing director verification. Documents to be kept electronically and in the fire alarm binder.

11. Two of six handwashing sinks were supplied with only cold water. They were used for drinking water.
    Date of correction: 02/28/19

    Plan of correction: Per email from Buildings & Grounds Project Manager, drinking fountains will be installed in the SAFE SOLUTIONS areas in Jan./Feb. 2019.

12. An extension cord was noted for the laptop at the intake station.
    Date of correction: 01/31/19

    Plan of correction: Staff Assistant IV purchased 10' surge protector to replace 4' surge protector and extension cord. Staff Assistant placed Buildings & Grounds ticket (4949) on 12/21/18 to have this installed as the previous cord was taped down and attached to the intake station. Staff Assistant IV will verify completion on 01-31-19 and report to the Leadership Team.

13. The most current automatic sprinkler inspection was not available.
    Date of correction: 01-12-19

    Plan of correction: Staff Assistant IV submitted attachment with POC.

14. The most current fire alarm and smoke detection with sensitivity inspections were not available.
    Date of correction: 01-12-19

    Plan of correction: Staff Assistant IV submitted attachment with POC.

Crisis Care: 321 Kansas St.

1. All fire extinguishers were not inspected monthly since the annual inspection on 2/28/18.
   Date of correction: 1-9-19

   Plan of correction: Staff Assistant IV contacted Buildings & Grounds to create regularly scheduled monthly inspections of fire extinguishers. On-site Building Tech I will was provided keys to monitor the fire extinguishers in the secured client areas of PCSO – Addiction Treatment Services Safe Solutions and Crisis Care. The on-site Building Tech I will report completion of this task to the Housing Director monthly. The overnight custodian will be responsible for completing the monthly inspection of the fire extinguishers in non-secured client and staff areas of PSCO – Addiction Treatment Services Administration and Counseling. The overnight custodian will report completion of this task to the Housing Director monthly.

2. Undated repackaged snacks (cookies, crackers, and bread) were noted in a basket by the kitchenette sink.
   Date of correction: 01-31-19

   Plan of correction:
   Food provided by Behavior Management Systems that is repackaged or to be repackaged, will be labeled with an expiration date.
   Food prepared by CBM and provided by PCSO – Addiction Treatment Services, will be kept in the detox prep kitchen until it is requested by the Crisis Care Tech Staff.
   All tech staff working in Crisis Care will perform daily inspection of food expiration dates and dispose as needed. Tech Supervisors will conduct weekly and monthly audits of the Crisis Care kitchenette and refrigerators and report to the Housing Director of any issues and non-compliance. Tech Training Officers and Housing Director will be responsible to educating both PCSO-Addiction Treatment Services employees and BMS staff with food labeling and disposal requirements.

3. Outdated sack lunches were noted in the refrigerator of the kitchenette.
   Date of correction: 01/31/18

   Plan of correction:
   Food provided by Behavior Management Systems that is repackaged or to be repackaged, will be labeled with an expiration date.
   Food prepared by CBM and provided by PCSO – Addiction Treatment Services, will be kept in the detox prep kitchen until it is requested by the Crisis Care Tech Staff.
   All tech staff working in Crisis Care will perform daily inspection of food expiration dates and dispose as needed. Tech Supervisors will conduct weekly and monthly audits of the Crisis Care kitchenette and refrigerators and report to the Housing Director of any issues and non-compliance. Tech Training Officers and Housing Director will be responsible to educating both PCSO-Addiction Treatment Services employees and BMS staff with food labeling and disposal requirements.

4. The alarm was not sounded for all fire drills. A vocal notification was given to announce the fire drill.
   Date of correction: 1-17-19

   Plan of correction:
   The Housing Director and Buildings & Ground have established employee training on how to perform fire drill from the fire alarm panel. The Housing Director and Shift Supervisors will schedule drills - one fire drill per month on each shift or per requirements. Alarm test documents will be completed requiring signatures by employees performing the test, shift supervisor and housing director verification. Documents to be kept electronically and in the fire alarm binder.

5. There was no documentation that indicated the crisis care clients participated in fire drills.
   Date of correction: 1-10-19

   Plan of correction:
   The Housing Director and Shift Supervisors will schedule drills - one fire drill per month on each shift or per requirements. Alarm test documents will be completed requiring signatures by employees performing the test, shift supervisor and housing director verification. Documents to be kept electronically and in the fire alarm binder.

6. No disinfectant or cleaning and disinfecting procedures were provided for clean-up of blood, vomit, fecal matter, or any bio-hazardous substance.
   Date of correction: 1-10-19

   Plan of correction:
   The cleaning and disinfection procedure are as follows:
   1. Put on appropriate clean-up equipment: Rubber gloves, rubber boots, mask, apron and eye protection.
   2. Sprinkle absorbent powder on spill.
   3. Wait about 2-3 minutes then, using the two scoops, scoop up semi-solid gel and put in red disposable biohazard bag.

4. Spray area with Quat 25 (blood, fecal matter and vomit) and 1:10 Bleach:Water solution (TB, MRSA, VRE and CDiff). Let stand for ten minutes. Then clean up with mop and rags. Bleach-Water solution for HIV and HBV also. CDC guideline 5: Cleaning and Disinfecting Environmental Surfaces in Healthcare Facilities.
5. Put everything that can be washed in one or two of the bio-washable bags (clear with red stripe). Place in dirty laundry cart or can. Items will be washed at sanitizing temperatures or with sanitizing chemicals. Items that will not be washed will be placed in red biohazard bag and disposed of with biohazard items through certified medical waste providers.
6. Take off equipment (gloves last), spray boots in mop sink with Quat 25, rinse then dry.
7. Place mask and rubber gloves and apron in red disposable bag. Both red disposable bags need to be put in bio-waste box.
8. When equipment is dry, put back in cabinet.

7. No disinfectant was used for those clients with TB, Clostridium difficile, methicillin-resistant Staphylococcus Aureus, vancomycin-resistant enterococcus or any other infections.
Date of correction: 1-10-19

Plan of correction:
Private Isolation rooms are not equipped with negative air pressure systems.
If a client is suspect for TB, they are given a surgical mask, screened and taken to a hospital for an x-ray. If a client has known active TB, they are not admitted into our services. When working with a client that is suspected of TB, staff will wear a surgical mask and PPE during client contact and when cleaning the area where client has been contained.
If a client is known to have C-Diff, VRE or MRSA, they are admitted into an ISO room for the duration of their stay. Bleach is used to clean the room and staff wear personal protective equipment when cleaning and when contacting the client. Quat 25 and 1:10 Bleach-Water solution (TB, MRSA, VRE and CDiff). Let stand for ten minutes. Then clean up with mop and rags. Bleach-Water solution for HIV and HBV also. CDC guideline 5. Cleaning and Disinfecting Environmental Surfaces in Healthcare Facilities.
All medical equipment is disinfected with Micro-Kill disinfecting wipes with a contact time of 2 minutes.

8. Shower shoes were not provided for all clients.
Date of correction: 1-9-19

Plan of correction: The Housing Director is working towards a plan to implement shower shoes with an implementation date to be determined. The Housing director is working with the Tech Supervisors and Tech Training officers on developing the policy and procedure. Training points will include issuing, disinfecting and storage of reusable shower shoes. Monthly compliance checks will likely be completed by the Housing Director and Tech Supervisor.

9. The most current automatic sprinkler inspection was not available.
Date of correction: 1-12-19

Plan of correction: Staff Assistant IV submitted attachment with POC.

10. The most current fire alarm and smoke detection with sensitivity inspections were not available.
Date of correction: 01-12-19

Plan of correction: Staff Assistant IV submitted attachment with POC.

11. Shower fixtures in male and female bathrooms did not have suicide prevention/break away fixtures (shower heads, control knobs, and grab bars).
Date of correction: 1-10-19

Plan of correction:
Correspondence from DOH inspector sites ARSD 67:61:18:01. ARSD 67:61:18:01 is criteria basis for 3.7 services. At our facility, we do not provide 3.7 services. We are not accredited for medically monitored inpatient programs and are not required to meet this standard. The treatment level for this area is 3.2D, 3.1 and 2.5 service levels (ARSD 67:61:17:01, ARSD 67:61:16:01 and ARSD 67:61:15:01 respectively).

LaCrosse Street Facility: 725 N LaCrosse St.

1. No paper towels were provided at the kitchen's handwashing sink
   Date of correction: 1-10-19

Plan of correction: Building Tech I will monitor 2x/wk and fill as needed. Housing Director will audit fixtures monthly to ensure compliance. Fixture supplies will be corrected as needed by providing tech staff with key to fixtures.

2. No disinfectant or cleaning and disinfecting procedures were provided for clean-up of blood, vomit, fecal matter, or any bio-hazardous substance.
   Date of correction: 1-10-19

   Plan of correction:
   The cleaning and disinfection procedure are as follows:
   1. Put on appropriate clean-up equipment: Rubber gloves, rubber boots, mask, apron and eye protection.
   2. Sprinkle absorbent powder on spill.
   3. Wait about 2-3 minutes then, using the two scoops, scoop up semi-solid gel and put in red disposable biohazard bag.
   4. Spray area with Quat 25 () and 1:10 Bleach:Water solution (blood, fecal matter and vomit, TB, MRSA, VRE and CDiff). Let stand for ten minutes. Then clean up with mop and rags. Bleach-Water solution for HIV and HBV also. CDC guideline 5: Cleaning and Disinfecting Environmental Surfaces in Healthcare Facilities.
   5. Put everything that can be washed in one or two of the bio-washable bags (clear with red stripe). Place in dirty laundry cart or can. Items will be washed at sanitizing temperatures or with sanitizing chemicals. Items that will not be washed will be placed in red biohazard bag and disposed of with biohazard items through certified medical waste providers.
   6. Take off equipment (gloves last), spray boots in mop sink with Quat 25, rinse then dry.
   7. Place mask and rubber gloves and apron in red disposable bag. Both red disposable bags need to be put in bio-waste box.
   8. When equipment is dry, put back in cabinet.

3. The male detoxification and male custodial bathrooms had:
   *Walls with peeling paint.
   *All toilets needed a deep cleaning around the bases.
   -Those toilets also appeared to be sagging into the floor.
   Date of correction: 1-31-19

Plan of correction: Buildings & Grounds Staff will complete tasks relating to the peeling paint and sagging toilets by 1-31-19. Building Tech I will complete deep cleaning in the bathrooms. Building Tech I will monitor cleanliness and resolve with regular cleaning.

Agency Signature: Will Wheeler

Date: 2-8-19