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	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain Springs Healthcare	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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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.

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review the provider failed to complete a baseline care plan for one of one recently admitted sampled resident (38) within 48 hours of her admission to the facility.Findings include:1. Review of the 8/9/25 SD DOH FRI regarding resident 38 revealed:*On 8/8/25 resident 38's daughter had called the facility to report resident 38 had told her that on the evening of 8/7/25 a staff member was rough with resident 38 while performing cares.*Resident 38 was admitted on [DATE] after a repair of her right tibia (a bone in the lower leg) fracture.*Resident 38 was to be transferred with the use of a full body mechanical lift (a mechanical lift and sling used to lift a person's full body) according to her care plan.*On 8/7/25 at approximately 8:00 p.m. certified nursing assistant (CNA) N and CNA O were getting her ready for bed.*CNA N assisted resident 38 to transfer from her wheelchair to bed with the use of a slide board (a sturdy, smooth-surfaced transfer board as a bridge to move a person from one surface to another).*Resident 38 stated CNA N rushed her and was rough when she assisted resident 38 to lift her legs into her bed.*Resident 38 was not injured but stated the transfer was painful and she did not want CNA N to care for her.*Interview with CNA N revealed she had used the slide board to transfer resident 38 to bed at resident 38's request.*CNA N did not feel she was rough or had rushed resident 38.*CNA O stated she did not think CNA N had been rough but stated the transfer did not go well due to utilizing the slide board instead of the full body mechanical lift.2. Review of resident 38's electronic medical record revealed:*She was admitted on [DATE] and discharged on 9/12/25. *The admission progress note stated, staff assist of 2 with total body lift/ medium divided leg sling and medium toilet sling for transfers.*Resident 38 was non-weight baring on her right leg.*Resident 38's baseline care plan was initiated on 8/5/25 but was not completed until 8/8/25.*The intervention related to resident 38's weight baring restrictions, RLE NWB [right lower extremity nonweight baring] was initiated into the baseline care plan on 8/12/25.*The intervention related to how resident 38 transferred by Mechanical lift was initiated into the baseline care plan on 8/12/25. That intervention was not initiated until seven days after her admission.*On 8/5/25 the admission progress note, written by resident care manager (RCM)/ registered nurse (RN) I stated resident 38 and her daughter declined review of resident 38's care plan.3. Interview on 9/18/25 at 10:50 a.m. with licensed practical nurse (LPN) J revealed:*She referenced the residents' care plans to determine what care a resident required.*If she needed to determine how a resident transferred, she would reference the resident's care plan or the daily care sheet (a sheet printed daily that identified the cares and needs of each resident according to the resident's care plan).*She stated the care sheets were updated daily.4. Interview on 9/18/25 at 11:55 a.m. with RCM/RN I revealed:*She had completed resident 38's admission and baseline care plan.*The baseline care plan was developed within the admission Nursing Evaluation in the resident's EMR during the admission process.*RCM/RN I verified resident 38's baseline care plan had not been completed within 48 hours after admission to the facility.*She stated she reviewed the resident's care plan with new residents and the resident's representative during the admission process and then offered them a copy.*She stated most resident's and resident's representative refused a copy. She would document that it was offered in her admission progress note.*She verified resident 38's baseline care plan was not completed at the time she offered it to resident 38 and resident 38's daughter.*She would have completed it immediately and printed a copy for them at that time if they would have wanted a copy.*When asked how the staff would know what cares to provide a newly admitted resident if there was no baseline care plan to outline the resident's plan of care, she stated there was a care sheet for staff to reference that was updated daily.*She stated she was the primary person responsible for updating the daily care sheets but there were other management staff who were also able to update them.*Review of the 8/7/25 care sheet for resident 38 revealed she was non-weight-bearing to her right lower extremity, had a fall prior to admission to the facility which resulted in a fracture of her right tibia, and she was a Hoyer lift (full body mechanical lift) for transfers.5. Interview on 9/18/25 at 3:52 p.m. with director of nursing (DON) B revealed:*She expected a resident's baseline care plan to be completed within 48 hours after admission, and staff to follow the resident's care plan when they provided resident cares.*She verified resident 38's care plan was not completed within 48 hours after admission to the facility.*After review of resident 38's 8/5/25 admission Nursing Evaluation with DON B she verified within the Ambulation, Mobility, and Transfers portion of the evaluation it indicated resident 38's needs were:- Ambulation Assist: 1 Person-Mobility Device: Gait

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI), interview, and record review, the provider failed to ensure:*One of one sampled resident's (77) Wander Guard was not removed by one of one licensed practical nurse (LPN) R.*The presence and function of one of one sampled resident's (77) Wander Guard was accurately documented by two of two LPNs (M and R) and one of one registered nurse (RN) (Q).*Transport driver P securely fastened the four safety hooks to the resident's (60) wheelchair in one of three facility-operated buses before the transport driver started transporting the resident to another location. Failure to ensure the safety hooks were securely fastened potentially placed the resident at risk for harm or injury.This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incidents.Findings include: 1. Review of the provider's 6/30/25 submitted SD DOH FRI final report regarding resident 77 revealed: Her diagnoses included dementia, and her cognition was severely impaired. She was at risk for wandering behavior and elopement. The resident wore a Wander Guard (a wearable door alarming device) on her wrist and on her wheelchair. This device sounded if she attempted to open a secured and alarmed door. On 6/25/25 at approximately 5:45 p.m., a staff member opened the entrance door for a visitor to exit the facility. From behind the reception desk, staff were able to allow the door to open without activating the alarm. The visitor went out the door to his car in the parking lot. Resident 77 was sitting by the front door at that same time. When the visitor returned to the facility from his vehicle, he noticed resident 77 was now outside the facility. It was presumed she had gotten out of the door before the door had fully closed behind the visitor. The visitor notified a staff member after he was let back inside the facility that the resident was outdoors. The root cause of the elopement was that the resident's Wander Guard was removed about 5:30 a.m. on 6/25/25 by an overnight shift nurse before the resident was sent out of the facility for medical treatment. The nurse had not documented the removal of the Wander Guard, and she was not certain if she had communicated that information to the day shift nurse. The resident returned to the facility at 8:30 a.m. that same day. Her Wander Guard was not replaced at that time. Nursing staff had documented on resident 77's Treatment Administration Record (TAR) that her Wander Guard was on her wrist and working the day shift on 6/25/25, the overnight shift on 6/25/25 to 6/26/25, and the day shift on 6/26/25, even though she was not wearing the Wander Guard. Review on 9/22/25 at 11:30 a.m. of the provider's FRI binder revealed the process changes, disciplinary action, education, performance improvement plan (PIP), and audits referenced in the provider's 6/30/25 submitted SD DOH FRI final report had been documented and completed. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 9/22/25 after record review revealed the facility had followed their quality assurance process and: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Elopement binder at the nurses' station was updated to reflect resident 77's need for Wander Guards on both her wrist and wheelchair. Appropriate nursing staff were educated regarding the provider's expectations regarding the removal of and documentation of a resident's Wander Guard use. Caregiver education was completed on 6/27/25 regarding the expectations for Wander Guard use. A Wander Guard Performance Improvement Plan (PIP) was initiated on June 26, 2025, and monthly audits associated with that PIP have continued. Signage was posted on the main entrance doors regarding steps to mitigate the risk of resident elopement. Daily Wander Guard checks were added to the certified nurse aide (CNA) task list. Based on the above information, non-compliance at F689 occurred on 6/26/25, and based on the provider's implemented corrective actions on 6/27/25, for the deficient practice confirmed on 9/22/25, the non-compliance is considered past non-compliance. 2. Review of the provider's 7/31/25 submitted SD DOH FRI regarding resident 60 revealed: *On 7/30/25 at 4:30 p.m., resident 60 was being transported from the facility to an appointment. -During the transport, transport driver P made a turn, and resident 60's wheelchair tipped to her right side, where she hit her right arm against the lift. -Transport driver P pulled the transport bus over to the side of the road and went to the back of the bus, assessed the situation, and resident 60 told transport driver P that her right arm hurt, and she had a small scrape on her right elbow from the lift. -Transport driver P had acknowledged that she did not secure resident 60's wheelchair with the floor straps and immediately secured resident 60's wheelchair with the floor straps before continuing to resident 60's appointment. -When returning to the facility, transport driver P notified a nurse of the incident with resident 60. *Transport driver P was suspended 7/30/25 pending the outcome of the investigation. 3. Review of transport driver P's personnel records revealed she had completed her competence for loading wheelchair passengers on 5/18/25. 4. Review on 9/22/25 at 1:13 p.m. of the provider's FRI binder revealed: *Suspended transport driver P effective 7/30/25 pending the investigation. *Safety checks were completed on all facility-operated buses on 7/31/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*TELS (internal communication system) updated to include safety checks on all three facility-operated buses weekly for four weeks, then monthly indefinitely. *All transport drivers completed loading wheelchair passenger, unloading wheelchair passenger, and safe driving competencies on all three facility-operated buses, or will complete before next time driving a facility-operated bus. *All transport drivers are assigned to [NAME] Ability Four Point Wheelchair restraint and will be completed before the next time driving a facility-operated bus. *Order obtained for {local counseling provider} for resident 60. Daily 1:1 social worker visit to continue until {local counseling provider} was available to have an initial visit. *Disciplinary action was completed with transport driver P on 8/1/25 and reinstated. *Audits were completed three times per week with four residents to ensure the two front and two rear tie downs are secured to the wheelchair, the resident is secured using the lap seatbelt and/or shoulder strap if applicable, and the seat belts and tie downs are in good working condition. *Each transport bus was now equipped with a reminder sign that displays a reminder to verify all safety straps are secured to the wheelchairs, seatbelts are in place, and the lift is raised. 5. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed after record review revealed the facility had followed their quality assurance process, education was provided to all transport drivers regarding loading and unloading wheelchair passengers, [NAME] Ability Four Point Wheelchair restraint, and safe driving competencies had been completed. Audits were completed with no negative findings and discussed in QAPI. Based on the above information, non-compliance at F689 occurred on 7/30/25, and based on the provider's implemented corrective action on 8/7/25, for the deficient practice confirmed on 9/22/25, the non-compliance is considered past non-compliance.