

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Fountain Springs Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>42558</p> <p>Based on a facility reported incident (FRI) review, observation, interview, record review, and manufacture operator's instruction review, past noncompliance was confirmed for an incident occurring on 4/29/24. Findings include:</p> <p>1. Review of the provider's 4/29/24 SD DOH FRI revealed:</p> <p>*On 4/29/24 certified nursing assistant (CNA) E did not use a standing frame mechanical lift as directed in the manufacturer's instructions and resident 2's care plan when she released the safety buckle while the resident was in the lift, and he fell .</p> <p>-Resident 1 was not injured.</p> <p>2. The provider's implementation of systemic changes to ensure the deficient practice does not recur was confirmed after: record review revealed the facility had followed their quality assurance process, education was provided to all direct care staff regarding mechanical lift safety and following resident's care plan/care sheets, observations and interviews revealed staff understood how to correctly operate mechanical lifts according to each resident's individualized care plan/care sheet, a new device evaluation was completed regarding resident safety utilizing a standing frame lift, review of the appropriate sling sizes for each resident's mechanical lift needs, review of staff schedules confirmed staffing levels met resident assistance needs, and verifying certified nurse aide (CNA) competencies and audits were being performed.</p> <p>Based on the above information, non-compliance at F689 occurred on 4/29/24, and based on the provider's implemented corrective actions for the deficient practice confirmed on 5/22/24, the non-compliance is considered past non-compliance.</p>

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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