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	05/28/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, record review, and policy review, the provider failed to ensure that allegations of abuse for one of one resident (1) were promptly investigated and reported. Failure to promptly investigate and report the allegation may have put all residents at risk for potential abuse. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's 1/28/25 submitted SD DOH FRI final report regarding resident 1 revealed: *A progress note indicated that on 12/29/24 at 1:00 p.m., resident 1 reported to licensed practical nurse (LPN) E, who was not assigned to care for resident 1 that day, that: -Resident 1 had asked certified nurse aide (CNA) G to stay out of her room, but CNA G continued to stay in her room. -CNA G used inappropriate language and gestures towards the resident. -CNA G had used her phone to take pictures of and record the resident. *Another progress note from 12/29/24 indicated that: -Registered nurse (RN) D, who was assigned to care for resident 1 that day, was notified by CNA F that resident 1 told CNA F that CNA G had been disrespectful to her while providing personal care. -RN D went to resident 1 with two unidentified staff members to find out what concerns the resident had with CNA G or the care she provided. -Resident 1 said she had no concerns. -It also indicated that CNA F wrote a statement about the incident that resident 1 complained to her about. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*RN D and LPN E contacted the former assistant director of nursing (ADON) C, who was the manager on call, to notify her of the incident. -RN D reported to ADON C that resident 1 was having behaviors toward staff. -LPN E reported to ADON C that the resident had concerns about a CNA who had cared for her, but she did not provide specific details of what the resident had reported, only that resident 1 did not want that specific staff member in her room. -ADON C asked RN D and LPN E to document the interaction and not have that staff member provide care for resident 1. *On 12/30/24, the progress notes were reviewed by director of nursing (DON) B at the interdisciplinary team (IDT) meeting, and she asked social services director (SSD) H to speak with resident 1 to get more specific information. -SSD H spoke with resident 1, but no further information was elicited. *The incident was not reported to administrator A, law enforcement, or SD DOH, and no investigation was initiated at that time. *During a 1/21/25 discharge follow-up call by LPN I, resident 1 repeated the allegations of CNA G's use of inappropriate language and gestures towards her, and that CNA G had used their phone to take pictures and record her. -LPN I reported this information to administrator A, who initiated an investigation and reported the allegations to law enforcement and SD DOH in an initial report on 1/22/25. *That investigation validated the allegation of verbal abuse, and CNA G was terminated from working in the facility effective 1/24/25. Interview on 5/28/25 at 1:48 p.m. with CNA J revealed: *CNA J stated she would report any suspected abuse to a nurse, and if the nurse did not act on the allegation, she would report the information to the charge nurse and then the unit manager, if no action was taken. *She had recently received education on reporting potential abuse. *How to identify and report potential abuse was also discussed at a recent staff meeting. Interview on 5/28/25 at 4:37 p.m. with DON B revealed: *She confirmed that she failed to timely investigate and report the 12/29/24 incident that involved resident 1. *She felt that the staff was doing really well with the ongoing education that was being provided. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She stated she was much more diligent in investigating all potential concerns. Interview and record review on 5/28/25 at 3:15 p.m. with administrator A revealed the disciplinary action, education, interviews, and audits referenced in the provider's 1/28/25 submitted SD DOH FRI were completed and documented. The provider's implemented actions to ensure the deficient practice does not recur was confirmed onsite on 5/28/25 after record review revealed the facility had followed their quality assurance process and: *DON B received disciplinary action for failing to report and investigate in a timely manner. *DON B was assigned and completed education on abuse prevention on 1/22/25. *ADON C was educated to ask clarifying questions when staff called to report resident behaviors or resident requests to avoid specific caregivers being assigned to them. *LPN E was educated to report exactly what residents share with her, which could indicate potential abuse or neglect situations. *All nursing staff were educated to honor a resident's request to leave their room. *All nursing staff were educated to follow up with the administrator or DON if they reported an incident and had not received feedback from the administrator or DON regarding that incident. *All nursing staff completed a HIPAA confidentiality training course and reviewed the policy regarding video camera and phone use in the facility. *All nursing staff received education on the provider's Abuse Reporting and Response policy. *Audits were conducted by Administrator A for daily reviews of residents' progress notes over two weeks to ensure that all potential abuse or neglect events were reported and/or investigated in a timely manner. *Staff interview confirmed they understood the education provided. Based on the above information, non-compliance at F609 occurred on 12/29/24, and based on the provider's implemented corrective actions on 1/24/25, for the deficient practice confirmed on 5/28/25, the non-compliance is considered past non-compliance.