STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435110	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain Springs Healthcare	**2000 WESLEYAN BLVD , RAPID CITY, South Dakota, 57702**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/11/26 through 2/12/26. Areas surveyed included quality of care and treatment related to a staff member's failure to use a mechanical lift during a resident transfer. Fountain Springs Healthcare was found to have past non-compliance at F689.	F0000		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, record review, and policy review, the provider failed to ensure the safety of a resident regarding the use of devices according to the care plan when one of one sampled resident (1) who needed to be transferred with a stand aid lift (a mechanical device used to assist from a seated to a standing position) while using a gait belt and pivot transfer (after assisting a resident to a standing position without a lift, the resident then turns their body to move to another surface). This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include:	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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
Kristine Harvey	Administrator	2/24/2026

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F0689 SS = D	Continued from page 1 1. Review of the provider's 1/15/25 submitted SD DOH FRI final report regarding resident 1 revealed: *On 1/15/26, the physical therapy (PT) staff reported to administrator A and director of nursing (DON) B that resident 1 reported that certified nurse assistant (CNA) C transferred her to the bed the night before on 1/14/26 without using the stand aid lift. Resident 1 complained of increased pain to her left knee due to that transfer. CNA C was suspended pending investigation of the event. *The resident's care sheet (a personalized document that addresses a resident's care needs) included transfer instructions that the staff were to use the sit-to-stand lift for transferring resident 1. *CNA C admitted to moving her from the commode seat to the bed with a gait belt and a pivot transfer instead of using the stand aid lift. Resident 1 complained of pain in her left knee after the transfer. CNA C notified the nurse who then provided resident 1 with pain medication. *CNA C received disciplinary action for not transferring a resident in the manner that was indicated on that resident's care sheet. CNA C completed individual education on following the resident care sheets regarding how a resident was to be transferred. She was then allowed to return to work. *The provider performed weekly audits on the staff when they transferred residents and provided education to the staff regarding following a resident's care sheet and how to use a stand aid lift. 2. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted to the facility on 12/9/25. Upon admission, she was able to transfer with the assistance of one staff and used her walker for ambulation (walking). *Resident 1 fell on 1/11/26. She reported to staff that she was trying to transfer herself into her recliner without staff assistance. She denied pain after the fall and had no signs or symptoms of an injury. *On 1/12/26 resident 1 complained of pain and rated it an 8 out of 10 (using the 10 point scale) to her left leg. She was transferred to the emergency room for	F0689		

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F0689 SS = D	Continued from page 2 evaluation after her provider and power of attorney (POA) were notified. She had an x-ray (a non-invasive form of medical imaging to check for bone injuries) that did not show any new injuries. *After returning to the facility, resident 1 was re-evaluated by a physical therapist on 1/13/26 who recommended using a stand aid lift for safe transfers. *Resident 1 was re-evaluated by her medical provider on 1/13/26 and started on a Lidocaine 5% patch [a pain-relieving patch] and Tramadol 25mg as needed up to three times daily [a pain medication] for increased pain to her right knee and leg. *Resident 1 was transferred the next day on 1/14/26 by CNA C without the use of the stand aid lift. *She was evaluated by her medical provider again on 1/15/26 with no new orders. She would continue with a Lidocaine 5% patch, Tramadol, and ice compresses for pain control. *Physical therapy evaluated her on 1/15/26 and updated her transfer status to a full body lift (a mechanical lift and sling used to lift a person's full body) due to pain in her left leg. 3. Interview on 2/12/26 at 9:27 a.m. with resident 1 revealed: *She occasionally had sharp pains in her left knee. *She did not remember the incident where CNA C transferred her to the bed without using the stand aid lift. *She felt safe with the staff. 4. Interview on 2/12/26 at 9:32 a.m. with resident 2 revealed: *She could not walk and relied on a wheelchair for mobility. *Staff used a total body lift (a mechanical lift and sling used to lift a person's full body) to get her out of her wheelchair. She stated that she never felt unsafe while the staff has used the total body lift to transfer her.	F0689		

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F0689 SS = D	Continued from page 3 5. Interview with registered nurse (RN) D on 2/12/26 at 8:58 a.m. revealed: *Staff used “care sheets” to keep track of the resident’s information. That information included how they needed to be transferred, their diet, incontinence status (involuntary urine or bowel leakage), oxygen use, fall risk status, and if the resident had any pressure ulcers (skin and/or underlying tissue injury from prolonged pressure). *The care sheets were updated daily by management. *The staff used the care sheets for four of the five hallways within the facility. The fifth hallway used a new system called a Kardex (a report of the resident’s care needs and interventions) that is generated from information entered into the resident’s care plan (personalized plan in the EMR that addresses a resident’s care needs, goals, and interventions). RN D stated that eventually the residents’ care needs would be communicated to the staff through the Kardex system instead of the care sheets. 6. Interview on 2/12/26 at 9:19 a.m. with CNA’s E and F revealed: *Residents were expected to be cared for based on the information on the resident’s care sheet. *The care sheets were updated by management daily. *If a resident’s conditions were to change, the staff would be responsible for notifying management so the resident’s care sheet could be updated. *When a new resident was admitted to the facility they were evaluated by DON B or nurse manager G, who would verbally communicate the resident’s needs to the staff, and then they would update the resident’s care sheet. The PT department would assess the residents the next day and make new recommendations to perform safe transfers if that was needed. 7. Interview on 2/12/26 at 10:16 a.m. with director of PT H revealed: *The PT department would get a physician’s order to evaluate a newly admitted resident. This evaluation would happen the day after the resident was admitted to the facility. The evaluation would include recommendations on how to safely transfer the resident.	F0689		

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F0689 SS = D	Continued from page 4 This information was communicated to DON B and nurse manager G, who would then communicate that information with the staff and update the resident's care sheet. *She remembered when resident 1 had her fall on 1/11/26 and when she had pain after her transfer on 1/14/26. She stated that resident 1 still had the ability to stand but they changed her to a lift due to anxiety about having pain after working with PT. 8. Interview on 2/12/26 at 10:25 a.m. with DON B revealed: *Staff were expected to follow instructions on the resident's care sheet for transfers. *She was aware that the care sheet was not a part of the resident's EMR. They were transitioning the staff to use the Kardex system as a reference for resident care information. 9. Review of the provider's March 2025 CNA job description revealed: *The CNAs were expected to perform duties for "caring for residents in the community, consistent with the plan of care and established long-term care standards and community policies and processes." 10. The provider was unable to provide a policy for following residents' care plans, using mechanical lifts, or transferring residents. 11. The provider's implemented actions to ensure the deficient practice does not recur was confirmed on 2/12/26 after observations and interviews revealed the facility had followed their quality assurance process and: *Counseled CNA C regarding ensuring all residents are transferred according to their care sheets. *An all staff meeting was conducted on 1/15/26 regarding the need to follow the resident's transfer status on the care sheet. If staff could not attend in person, they were expected to review the information and sign the education sheet. *Audits were performed from 1/14/26 through the time of survey of staff performing resident transfers.	F0689		

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F0689 SS = D	Continued from page 5 *Reporting to the quality assurance committee the above audit findings. Based on the above information, non-compliance at F689 occurred on 1/14/26, and based on the provider's implemented corrective actions on 1/15/26 and additional corrective action plans, for the deficient practice confirmed on 2/12/26, the non-compliance is considered past non-compliance.	F0689		