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 _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS HEALTHCARE CENTER	2000 WESLEYAN BLVD RAPID CITY, SD 57702

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F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 8/15/24. One Facility Reported Incident (FRI) was investigated. Fountain Springs Healthcare Center was found to have past non-compliance at F684. On 8/15/24 at 9:00 a.m., an Immediate Jeopardy was identified for a FRI related to the quality of resident care and treatment that occurred on 7/24/24. The investigation revealed verbal and written education initiated on 7/24/24 removed the immediacy. Substantial compliance was confirmed on 8/15/24 after review of the provider's Quality Assurance and Performance Improvement (QAPI)/Quality Assessment and Assurance (QAA) minutes, documented staff education, competencies and audit information, personnel files, observation of the main kitchen and dining room, and multiple staff interviews. The provider was found to have past non-compliance at F684 related to the provider's failure to ensure a physician-ordered resident diet order was followed and appropriate emergency medical intervention was initiated timely. On 8/27/24 at 2:15 p.m. the Immediate Jeopardy template was electronically mailed to administrator A for reference. Census: 83	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristine Harvey
TITLE: Executive Director
(X6) DATE: 8/28/2024

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.

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F 684	Continued From page 1 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on the South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, and policy review, the provider failed to ensure: *A physician-ordered diet order was followed for one of one sampled resident (1). *Appropriate and timely emergency medical intervention was initiated for one of one sampled resident (1) who choked during a meal service. On 8/15/24 at 9:00 a.m., an Immediate Jeopardy was identified for a FRI related to the quality of resident care and treatment that occurred on 7/24/24. The investigation revealed verbal and written education initiated on 7/24/24 removed the immediacy. Substantial compliance was confirmed on 8/15/24 after review of the provider's Quality Assurance and Performance Improvement (QAPI)/Quality Assessment and Assurance (QAA) minutes, documented staff education, competencies and audit information, personnel files, observation of the main kitchen and dining room, and multiple staff interviews. The provider was found to have past non-compliance at F684 related to the provider's failure to ensure a physician-ordered resident diet order was followed and appropriate emergency medical intervention was initiated timely. On 8/27/24 at 2:15 p.m. the Immediate Jeopardy template was electronically mailed to	F 684	Past noncompliance: no plan of correction required.	

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administrator A for reference.

Findings include:
1. Review of the SD DOH FRI regarding resident 1 revealed:
*She choked in the main dining room during a noon meal fed to her by her visiting sister on 7/24/24.
*Staff provided abdominal thrusts then administered cardiopulmonary resuscitation (CPR) after she became unresponsive.
-She passed away at the facility after emergency medical personnel arrived and took over the chest compressions until an emergency room physician ordered to cease CPR.

Review of resident 1's electronic medical record (EMR) revealed:
*She was 86 years old and her date of admission to the facility was 11/12/19.
*Her diagnoses included: spastic hemiplegic cerebral palsy, Parkinson's disease, atrial fibrillation, depression, and anxiety.
*A 3/22/23 physician's code status order to: DNR (do not resuscitate).
*A 5/9/23 physician's diet order for: "Regular texture, mildly-thick liquid consistency. Minced and moist meats and full supervision; NO straws. Add moisture to meats for diet."
*Her 6/28/24 quarterly Minimum Data Set (MDS) assessment indicated she had no broken or loosely fitting dentures. The resident held food in her mouth during and following meals. She coughed or choked during meals.
*Registered dietician E's 6/5/24 quarterly assessment indicated the resident required staff assistance to be fed. Her diet included mildly thick liquids and minced and moist meat.

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Interview, review of personnel files, and review of the certified nurse aide (CNA) job description on 8/15/24 at 10:20 a.m. with human resources (HR) manager C revealed:
*The licenses or certifications for a sample of staff identified in the FRI (registered nurse B, CNA/certified medication aide G, and CNA H) were current.
*Review of the updated March 2012 CNA job description revealed CPR certification was not a requirement of that position.
*HR manager C stated:
-Several CNAs became CPR-certified after the incident and another group of CNAs was scheduled to take a CPR course in September 2024. The facility's goal was to have all CNAs CPR-certified.
-Managers on duty were now expected to be CPR-certified.
-A facility RN planned to become a CPR instructor for the facility.

Interview on 8/15/24 at 10:44 a.m. with dietary manager (DM) D revealed:
*Cook F failed to correctly prepare and plate resident 1's meal and was terminated from employment on 7/24/24.
*Resident 1's tray card indicated her meat was to have been minced and moist in consistency.
-The breaded cod served to her on 7/24/24 was not put through the food processor and no moisture was added to it before it was served to resident 1.
*DM D had documentation to support on 12/20/23 cook F was able to satisfactorily read and interpret recipes and verbalize the variations in therapeutic diets, modified diets, and liquids.

Observation and continued interview with DM D in

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the kitchen revealed:
*Information related to the International Dysphagia Diet Standardization Initiative (IDDSI-used to describe texture modified foods and thickened liquids) was found in the food prep area.
-Various other modified diets and thickened liquid information was posted in other places in the kitchen.
*Review of a random unidentified resident's tray card who received a minced and moist meat diet revealed:
-A legible diet order was on one side of the card.
-On the other side of the card in capital letters was "MM" (minced and moist) beside the description of the main entrée for lunch that day (spaghetti).
*The kitchen had an adequate supply of pre-thickened beverage options and pre-measured thickening packets to be used to thicken beverages such as coffee.
-Any other beverage that required thickening was thickened by the dietary staff with other liquid thickening products.

Interview on 8/15/24 at 12:15 p.m. with CNA H revealed:
*She was assisting another resident at resident 1's table when the choking incident occurred.
*Resident 1's breaded cod was chopped into pieces when it was served.
-CNA H knew the resident received a modified diet but was not certain if the texture of the fish was correct or not. She had not asked another staff for clarification.
*Since the incident:
-All staff were re-trained on modified diet textures. CNA H now knew resident 1"s fish should have had a "more pureed type look" like "wet cat food"

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when it was served to her on 7/24/24.
-Thickener packets were removed from the beverage station and kitchen staff were expected to thicken resident beverages when indicated.
*The FRI report interview with CNA H indicated: "she [CNA H] went over and assessed [resident 1], and she thought resident 1 was blue so then she started yelling out."
-CNA H had not administered abdominal thrusts to resident 1 because she received mixed responses from other staff who were present as to whether or not she was allowed to perform that maneuver. Abdominal thrusts can and should have been initiated by her or any other CNA for a choking resident.
*She completed "a lot of on-line learning and trainings (in-house)" related to the FRI and verbalized an understanding of what she was expected to do moving forward.

Interview on 8/15/24 at 12:30 p.m. with certified medication aide (CMA)/CNA G revealed she:
*Was one of the first staff to arrive in the dining room after a call to help resident 1 was heard.
*Provided the resident a few back blows in the dining room, then was instructed to move the resident out of the dining room before performing the first abdominal thrusts the resident received. CMA/CNA G was expected to have immediately started abdominal thrusts in the dining room rather than waiting to move the resident to another location before starting them.
*Initiated chest compressions after resident 1 was moved to her room and after she was directed to do so by assistant director of nursing (ADON) I. CMA/CNA G was not CPR-certified at the time of the incident and should not have performed that intervention.
*Stated "A lot of refreshers [training] and

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education" was provided regarding how staff were to respond to a similar situation should it happen again.

Interviews on 8/15/24 at 11:15 a.m., 11:30 a.m., and 12:45 p.m. with director of nursing (DON) A regarding the FRI revealed:
*In addition to the cook, caregivers were also responsible for ensuring residents received the diets per their physician's order.
-Diet texture pictures are now posted at the kitchen serving window for caregivers to use to compare against the diet order on a resident's tray card.
*The use of the abdominal thrust maneuver was taught in the CNA training curriculum and expected to have been performed by CNAs when indicated.
*In most cases the execution of emergency medical interventions was not expected to have been interrupted or delayed by moving the resident to an alternate location(s) first.
*ADON I was suspended and then terminated on 7/31/24 for directing CMA/CNA G to start CPR on resident 1.
*A detailed plan of action was completed by the facility on 7/25/24 related to resident 1's choking incident. The plan was based on a Root Cause Analysis of the FRI and resulted in the development of multiple performance improvement plans.
-These plans included systemic changes and actions such as staff education and re-training, audits, checklists, competencies, and personnel changes to ensure the deficient practice does not reoccur. The changes and actions were confirmed on 8/15/24 through observation, interview, and review of the provider's Plan of Correction binder.

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F 684	Continued From page 7 Based on the above information, non-compliance at F684 occurred on 7/24/24. Based on the provider's implemented plan of correction for the deficient practice confirmed on 8/15/24, the non-compliance is considered past non-compliance.	F 684		