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 01/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN SPRINGS HEALTHCARE CENTER	2000 WESLEYAN BLVD RAPID CITY, SD 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
F 000	INITIAL COMMENTS A complaint facility-reported incident (FRI) investigation for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 1/2/24. The area surveyed was resident safety and potential neglect. Fountain Springs Healthcare Center was found to have past noncompliance at F689 for lack of appropriate and necessary resident supervision.	F 000		
F 689 SS=G	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 observation, interview, record review, review of the facility-reported incident (FRI), and policy review, the provider failed to maintain a secured environment for one of one sampled resident (1) with a history of wandering and severe cognitive impairment who had eloped on 12/25/23 outdoors and into a fenced courtyard approximately 100-150 feet from the door he had exited from. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted on 4/3/23 and currently resided at the facility. *His diagnoses included Alzheimer's dementia,	F 689	Past noncompliance: no plan of correction required.	

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

Kristine Harvey | Executive Director | 01/17/2024

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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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 1 psychosis, and a history of prostate cancer. *His 10/11/23 Brief Interview for Mental Status (BIMS) score was "3" indicating he had severe cognitive impairment. *He was able to ambulate independently. *He wore a Wanderguard (a system that alerts caregivers when a resident approaches and/or opens an alarmed door) on his wrist due to his history of wandering and exit-seeking behavior. *The Wanderguard was tested daily by staff in the morning and in the evening to ensure it was working properly. -That testing was documented on the resident's monthly Treatment Administration Record (TAR). Review of the FRI submitted by administrator A to the South Dakota Department of Health on 12/26/23 at 11:30 a.m. revealed: *"On 12/25/23 at roughly 12:00 a.m. resident [1] was found outside of the building." -He was seen by staff inside the facility no less than "5 to 8 minutes prior to the event" referred to above. *No door alarm had sounded when the resident exited the building. *The provider's 12/26/23 investigation of the incident revealed the following: -The door alarm battery "was noted to be depleted [not functioning]" when it was checked. -Door alarm checks had not been implemented on weekends or holidays and that was when the elopement occurred. -The speaker volume for the alarm activation system at the nurses' station was turned down. Review of the updated March 2018 Elopement/Wandering policy revealed for the use of door monitoring systems "2. The maintenance department or designee tests the monitoring	F 689		

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F 689	Continued From page 2 system [of alarmed doors] on a daily basis using the manufacturer supplied device [as applicable] and documents the test." Interviews on 1/2/24 at 11:30 a.m. and 12:05 p.m. with director of nursing A and director of maintenance B revealed non-compliance at F689 was considered past non-compliance. The provider implemented corrective actions for the deficient practice by completing the following steps: *Having the maintenance director assume responsibility for monitoring and documenting weekday door alarm testing effective 12/30/23. -Weekday door alarm checks were completed by nursing staff prior to 12/30/23. -Director of maintenance B asked nursing staff for the results of door alarm checks completed the previous day and documented the results in the "TELS" system (computerized health care maintenance system) without validating those results himself. *Having the Activity Department assume responsibility for monitoring and documenting weekend and holiday door alarm testing on the Daily Door Alarm Test Log. -Test Log documentation between 12/30/23 and 1/2/24 was reviewed and verified by the survey team. *Re-setting the speaker volume on the alarm activation system at the nurses' station and securing the system with a keypad lock accessible only by management staff. *After activating a door alarm the survey team confirmed the following had occurred: -Staff appropriately responded to the alarm. -The speaker volume of the activation system was acceptable.	F 689		

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F 689	Continued From page 3 The survey team determined there had been a deficient practice on 12/25/23 when resident 1 eloped. The survey team was able to verify the provider recognized the deficient practice, implemented corrective actions on 12/26/23 and was monitoring to ensure no re-occurrence of the previous deficient practice occurred.	F 689		