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

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 11/10/2022

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 health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 11/8/22 through 11/10/22. Areas surveyed included quality of care and resident neglect. Fountain Springs Healthcare Center was found not in compliance with the following regulations: F585, F835, and F868.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy	F 585	1. All residents have the potential to be affected. All grievances year to date have been tracked, trended and analyzed through the QAPI process. 2. ED and EDIT (Executive Director in Training) have been educated on the grievance policy by the DDCO (Divisional Director of Clinical Operations) by 11/29/22. 3. The ED or designee will bring the results of grievances from resident council to the monthly resident council to review their findings and resolution to the residents concerns. The DNS or designee will audit the grievance log and QAPI minutes monthly for the tracking, trending and analyzing of grievances. Monthly times 3 months and quarterly times 3 quarters. The DNS or designee will bring the results of the audit to QAPI for further review and recommendation to continue or discontinue the audits.	12/9/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristine Harvey
TITLE: Executive Director
(X6) DATE: 11/30/2022

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 585	Continued From page 1 to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by	F 585		

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F 585	Continued From page 2 anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on review of a South Dakota Department of Health complaint intake, grievance forms, resident council minutes, interview, and policy review, the provider failed to: *Follow their process for resolving, tracking, and trending grievances. *Investigate and report back to the resident council findings for call light response time and staffing concerns they voiced during two of two resident council meetings. Findings include:	F 585		

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F 585	Continued From page 3 1. Review of the August-October 2022 grievance forms revealed: *Five reports of long call light response times in August, two in September, and four in October. *Administrator-in-training (AIT) B had investigated those reports. *Action taken in response to those grievances included: -Comparing the reported call light response time against a call light alarm report which showed the time a call light was activated and the time it was turned off. -Educating staff regarding expected call light response time (15 minutes), appropriate placement of the call light, asking for assistance if needed to respond to a call light, reminding staff not to turn a call light off before the resident's need was met, and having night shift carry a walkie talkie when working on an identified living unit where the automated system that identifies what room a call light has been activated cannot be heard. -Encouraging staff to ask residents following meals if they had any needs after dinner since that was a difficult time to be able to answer call lights promptly. Interview on 11/10/22 at 9:20 a.m. with AIT B regarding the grievances referred to above revealed he: *Was hired in May 2022 and his training on the grievance process had been "a continuous education process with executive director (ED) A." -Worked together with her initially to learn the process and expectations, began completing them on his own after he gained sufficient experience, and continued to confer with her on an as needed basis.	F 585		

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F 585	Continued From page 4 *Had not known if his grievance actions referred to above had any effect in decreasing the frequency of call light response time or reducing the time in which call lights had been responded to. *Had made the following observations regarding the call light grievances: -Residents admitted for short term rehabilitation seemed to use their call lights more frequently than long term care residents. -Residents who refused to leave their rooms for meals had a higher rate of reporting long call light wait times at mealtimes. -Call lights were often activated at shift changes, 6:00 a.m., 2:00 p.m., and 10:00 p.m. -The automated system that announced what room a call light had been activated cannot consistently be heard on the short term rehabilitation living unit. *Discussed grievances during the weekday morning stand-up meeting, but there was not a formal process for identifying a root cause for those grievances, developing an action plan to address those grievances, collecting and reviewing data to determine if an action plan had been effective. Interview on 11/9/22 at 5:15 p.m. and on 11/10/22 at 9:45 a.m. with ED A regarding the grievance process revealed: *Her current oversight of the grievance process was ensuring grievance forms were discussed during weekday morning "stand-up" meetings with department managers and identifying the most appropriate staff person to investigate that grievance. *There were two binders in a canvas bag on the floor of her office that held grievance tracking and trending reports.	F 585		

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F 585	Continued From page 5 *Trending information was expected to be addressed through the Quality Assurance and Assessment (QAA) committee. -The QAA committee had not met since February 2022. Interview on 11/10/22 at 8:21 a.m. with social services director D regarding the grievance process revealed: *She was responsible for counting the total number of grievances each month, reviewing and identifying any trends or patterns related to them. *ED A e-mailed her each month for a report of her findings that were expected to be discussed during the QAA committee meeting. -ED A had last e-mailed her the beginning of August 2022 for her July 2022 grievance report. *There had not been a QAA meeting since about February 2022. Interview on 11/9/22 at 5:30 p.m. and on 11/10/22 at 9:20 a.m. with ED A regarding the grievance process revealed she: *Was responsible for ensuring administrator-in-training B and all department managers understood their departmental expectations regarding quality performance. *Was responsible for effectively overseeing the QAA committee and grievance processes, but that had not occurred. -She had made other responsibilities a priority. 2. Review of the August-October 2022 resident council minutes revealed: *New business for the 8/18/22 meeting included: "Nursing care for the weekend is short handed at times." *Old business for the 9/15/22 meeting included: -No mention of follow-up regarding the weekend	F 585		

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F 585	Continued From page 6 staffing concern identified at the 8/18/22 meeting. -"Call lights-waiting a long time to answer-continues to still be a concern for the committee-new grievance form completed." *New business for the 9/15/22 meeting included: "Call light times need to be attended to in a more timely manner." *Old business for the 10/18/22 meeting included no mention of follow-up regarding call light response time discussed at the 9/15/22 meeting or the weekend staffing concern identified at the 8/18/22 meeting. *ED A had signed off on, but not dated the August 2022 meeting minutes, signed and dated the September 2022 minutes on 10/20/22, and not signed off on the October 2022 resident council minutes. Interview on 11/10/22 at 11:20 a.m. with an unidentified resident revealed: *She tried to attend resident council meetings when she could. *She had not known if concerns expressed at those meetings by residents were followed-up on. -Call light response times still seemed "too long" at times. -Sometimes she heard staff complain "they were short staffed." Interview on 11/10/22 at 1:00 p.m. with activity director C and ED A regarding resident council revealed: *Activity director C was responsible for coordinating and overseeing resident council meetings including: -Documenting concerns expressed by council members on grievance forms, investigating those concerns with the assistance of other interdisciplinary team members, and reporting	F 585		

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F 585	Continued From page 7 back to resident council the outcome of those investigations. -Discussing resident council grievances during QAA committee meetings in order to identify opportunities for process improvements. *She had not completed the grievance form referred to above in old business from the 9/15/22 meeting nor had she completed any new grievances voiced by council members during the August 2022 and September 2022 meetings she facilitated. -That was her responsibility and it had not occurred. *She confirmed resident council minutes had not reflected if the council had been updated on actions taken regarding grievances expressed during the previous month's council meeting, but should have. *She was hired in July 2022 and stated "it had been a learning process" understanding the responsibilities of her role as the activity director. *ED A confirmed it was her responsibility to hold activity director C accountable for her departmental quality performance including the documentation, follow-up of resident council grievances, and sharing grievance follow-up with council members, but that had not occurred. 3. Review of the revised November 2016 Grievance policy revealed: *"2. The Executive Director (ED), Social Services/designee oversees the grievance procedure and coordinates the Center system for collecting, tracking, and responding to grievances." *"12. The ED reviews the Grievance Log at the Daily Stand-Up Meeting for needed resolution and/or follow-up. If a Grievance is not resolved in two business days, the ED reviews the Grievance	F 585		

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F 585	Continued From page 8 daily at the meeting until resolution obtained." *"13. Social Services/designee analyzes grievances monthly for tracking and trending. Identifiable trends are addressed through the QAPI Committee." Review of the revised January 2017 Resident Council policy revealed: *"5. Concerns brought forth by the Council are resolved via the Center grievance policy." *"7. The Center communicates a response and/or decisions to the Resident Council by the next meeting."	F 585		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, review of a South Dakota Department of Health complaint intake, grievance binder, resident council minutes, job description review, and policy review, the provider failed to ensure the facility was operated and administered by executive director (ED) A to ensure quality management and improvement processes had been implemented for all seventy-four residents in the facility. Findings include: 1. Interview on 11/9/22 at 5:15 p.m. and on 11/10/22 at 9:45 a.m. with ED A regarding the grievance process revealed: *Her current oversight of the grievance process	F 835		

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F 835	Continued From page 9 was ensuring grievance forms were discussed during weekday morning "stand-up" meetings with department managers and identifying the most appropriate staff person to investigate that grievance. *There were two binders in a canvas bag on the floor of her office that held grievance tracking and trending reports. *That trending information was expected to be discussed during monthly Quality Assessment and Assurance (QAA) committee meetings. -The QAA committee had not met since February 2022. *Performance Improvement Projects (PIPs) were expected to be identified by the QAA committee for things that had driven quality of care and services like grievances. *There were informal PIPs for things like the use of lidocaine patches, medication administration, and skin care. -There was no formal process for determining if any changes made as a result of those PIP had been effective or sustained. 2. Review of the revised November 2016 Grievance policy revealed: *"2. The Executive Director (ED), Social Services/designee oversees the grievance procedure and coordinates the Center system for collecting, tracking, and responding to grievances." *"12. The ED reviews the Grievance Log at the Daily Stand-Up Meeting for needed resolution and/or follow-up. If a Grievance is not resolved in two business days, the ED reviews the Grievance daily at the meeting until resolution obtained." *"13. Social Services/designee analyzes grievances monthly for tracking and trending. Identifiable trends are addressed through the	F 835	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey. 2. The ED job description was reviewed with the ED by the DDCO. 3. The DDCO will provide oversight to ensure the grievance policy and QAPI policy are followed.	12/9/2022

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F 835	Continued From page 10 QAPI [Quality Assessment and Performance Improvement] Committee." Review of the revised October 2018 QAPI plan policy revealed: *Governance and Leadership: -"1. The Executive Director is responsible and accountable to the corporation to ensure QAPI is effectively implemented and integrated throughout the center. They are responsible for managing QAPI activities so they remain continuous, without lapses or interruptions. Also they are accountable to the governing body for requested documentation to be complete and submitted timely." *"6. Leadership and Management Supported: -QAPI meetings are held on a monthly basis."	F 835		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI	F 868	See next page.	

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F 868	Continued From page 11 program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on review of a South Dakota Department of Health complaint intake narrative, call light alarm reports, grievance binder, interview, and policy review, the provider failed to ensure: *Quality Assessment and Assurance (QAA) committee meetings had occurred on a monthly basis according to their policy. *A Quality Assessment and Performance Improvement (QAPI) program had been implemented to identify and address concerns related to residents' quality of care within the facility. Findings include: 1. Interview on 11/10/22 at 9:45 a.m. with executive director A regarding QAA and QAPI revealed: *She was responsible for overseeing the facility's quality management program including QAA committee meetings and QAPI projects. *QAA was expected to meet monthly, but it had	F 868	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey. A QAPI meeting was held on 11/29/22 with appropriate tracking and trending noted. 2. The ED and EDIT were re-educated on the QAPI policy and the importance of having a QAPI program that has been implemented to identify and address concerns related to the residents quality of care within the facility by the DDCO by 11/29/2022. 3. The DNS or designee will audit that the monthly QAPI meeting has occurred and that all resident concerns were reviewed and addressed monthly times 6 months. The results of the audits will be brought to the QAPI meeting for further review and recommendation to continue or discontinue the audits.	12/9/2022

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F 868	Continued From page 12 not met since February 2022. -Other responsibilities had taken priority over those meetings. *Grievances had been discussed during weekday morning interdisciplinary "Stand-Up" meetings. -Trends were verbally discussed among staff who attended those meetings, but there was no documentation of any corrective action that was taken in response to those trends and no data collection or analysis to determine if any corrective actions had been effective or not. *Performance Improvement Projects (PIPs) were expected to be identified by the QAA committee for things that had driven quality of care and services like grievances. *There were informal PIPs for things like the use of lidocaine patches, medication administration, and skin care. -There was no formal process for determining if any changes made as a result of those PIP had been effective or sustained. 2. Review of the revised October 2018 QAPI plan policy revealed: *Governance and Leadership: -"1. The Executive Director is responsible and accountable to the corporation to ensure QAPI is effectively implemented and integrated throughout the center. They are responsible for managing QAPI activities so they remain continuous, without lapses or interruptions. Also they are accountable to the governing body for requested documentation to be complete and submitted timely." *"6. Leadership and Management Supported: -QAPI meetings are held on a monthly basis." Refer to F585 and F835.	F 868		