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

ORIGINAL

PRINTED: 04/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435109		04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESTEEL HEALTHCARE COMMUNITY	1120 EAST 7TH AVENUE MITCHELL, SD 57301

(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 recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/30/15 through 4/2/15. Firesteel Healthcare Community was found not in compliance with the following requirements: F153, F280, F281, F431, F441, and F520.	F 000	Addendums noted with an asterisk per 5/5/15 telephone to facility DON. SD/SDDOH/MF	
F 153 SS=D	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to allow access to the medical record for 1 of 21 sampled resident's (20) power of attorney (POA) (legal representative) in a timely manner. Findings include: 1. Interview on 4/1/15 at 1:45 p.m. with resident 20's POA revealed he had: *Requested medical records regarding her recent falls. *Asked for the records on 3/30/15. *Been told he would have needed to sign a form to allow the provider to release the records.	F 153	F153 1. Resident #1's POA has received the requested medical records. Resident has since discharged home. 2. All residents are potentially at risk. 3. a. Facility Administrator or designee will in-service by 4/29/2015 all staff responsible for allowing medical record access and copies to residents or their legal representatives on a timely basis per regulations. b. Administrator or designee will complete written audits weekly x 4, then monthly x 2 on ensuring proper access and copies of medical records. Audit selection is random with a maximum of four. Audits can only be done if requests are made. The following areas will be audited. 1. Proper access to records within 24 hours 2. Copies to be given within 2 business days of request. 4. Administrator or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	5/18/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carey Brenner
TITLE: Administrator
(X6) DATE: 5/18/15

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 153	Continued From page 1 *Not received that form to have signed. Review of resident 20's medical record reviewed: *She had been admitted on 2/25/15. *Her diagnoses had included cancer, malaise (a feeling of discomfort), fatigue (tiredness), muscle weakness, and epilepsy (a brain disorder). *An attorney had prepared POA papers that had been signed by her on 12/8/10. *She had appointed her spouse as POA and he was her legal representative. Review of resident 20's 3/4/15 Minimum Data Set (MDS) assessment revealed: *She had a Brief Interview for Mental Status (BIMS) (a type of thinking assessment) that had a score of three. *A range of zero to seven was severely impaired. Interview on 4/1/15 at 2:25 p.m. with the director of nursing (DON) regarding resident 20's medical records revealed: *He was the POA for resident 20, and he was to have had access to her medical records. *He was at the facility "most of the time." *Social services was to have given him the form to have signed to release the medical records to him. Interview on 4/1/15 at 2:45 p.m. with the licensed social worker regarding resident 20's medical records revealed: *The husband was the POA for resident 20, and he was to have had access to her medical records. *He had asked her for the form for him to have signed it that morning. -That above form was an Authorization for the Release of Health Information.	F 153		

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F 153	Continued From page 2 *She had been unable to complete his request at the above time. *She would have him sign the form today. *The signed form would need to have been received by the medical records staff. -That staff person in medical records would then be responsible for obtaining the requested information for him. *He would then receive the requested medical record information by the end of the day or tomorrow morning (4/2/15). Interview on 4/1/15 at 3:00 p.m. with registered nursing unit manager B regarding resident 20's medical records revealed: *Her POA had asked her on 3/30/15 between 2:00 p.m. and 3:00 p.m. for her medical records regarding her recent falls. *She stated she had reviewed her recent falls with him. *He had wanted copies of her recent falls reports. *She stated that information was on internal documents that could not be released to him. *That information would have been found in the nurses' notes, and that could have been released to him. Interview on 4/1/15 at 3:55 p.m. with medical records staff person S regarding resident 20's medical records revealed: *When she received the signed release form from the POA she would have been able to copy those requested records. *She was able to generate from the provider's electronic records a copy of the nurses' notes. Interview on 4/1/15 at 3:55 p.m. with the administrator revealed: *The resident or his or her legal representative	F 153		

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F 153	Continued From page 3 had the right to access all records pertaining to himself or herself. *That was to have been as soon as possible or within twenty-four to forty-eight hours of having been requested. Interview on 4/2/15 at 8:58 a.m. with the DON and director of clinical services for South Dakota facilities regarding resident 20's medical records revealed they agreed: *Her POA's access to her medical records needed to have been completed in a more timely fashion. *He should have had access to her medical records within twenty-four hours. Review of the provider's undated Procedure for Releasing and Copying Medical Records revealed: *If a person requesting copies of medical records was not the resident then that individual needed to have had legal authority to act on the behalf of that resident. *There needed to have been a Health Insurance Portability and Accountability Act (HIPAA) (privacy rule) release signed. *All cases that involved requests for medical records needed to have obtained a copy of the document that had given the requesting individual the authority to have received a resident's medical records. *Once authority to have received a resident's medical records had been verified: -The provider was to have notified their privacy officer, vice president of operations, general counsel, and risk manager of the record request via email. -That notification was to have included the record request form and the document authorizing the	F 153		

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F 153	Continued From page 4 requester to receive the medical records to the general counsel and the risk manager. *The provider required that access to and copies of the medical records would be provided to the requester within specified periods of time. Review of the provider's September 2012 Long Term Care Facilities Resident's Bill of Rights in the admission's packet provided to each resident upon admission revealed: *Residents had a right to their records. *The provider was to have provided the photocopies of the records within two working days after the request.	F 153		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 1. Residents #1, 10, 11 care plans were changed to reflect their changes of condition and # 13 care plan was changed to add the special precautions needed to care for her infectious disease. 2. All residents are potentially at risk. 3. a. All interdisciplinary team members will be educated on the care planning process to ensure the care plan is updated and revised as necessary. Education will be by the facility Director of Nursing or designee by 4/29/2015.	5/18/15

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F 280	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to update and revise the care plan for: *One of three residents (13) with infectious disease processes. *Three of twenty-one sampled residents (1, 10, and 11) with changes to their current level of care. Findings include: 1. Observation on 3/30/15 at 5:00 p.m. of resident 13's room revealed signage on her door notifying visitors to check with staff prior to entering her room. Review of resident 13's medical record revealed: *She had been diagnosed with a bladder infection that contained the bacteria Extended Spectrum Beta-Lactamase (ESBL) on March 26, 2015. *That bacteria was resistant to many common antibiotics and required staff and visitors to use contact precautions (the use of gloves and a gown when entering the resident's room to prevent the spread of infection). Review of resident 13's current care plan revealed: *There was no mention of the special precautions staff would need to provide for her care. *It had not been updated or revised since the 3/26/15 infection noted above. Refer to F441, finding 1. 2. Interview on 3/31/15 at 10:30 a.m. with resident	F 280	* [redacted] 5/15/2014 MF b. DON or designee will complete written audits of updating/revising care plans weekly x 4, then monthly x 2. Audit selection is random with a maximum of four. The following areas will be audited 1. Care plans are updated/revised to reflect the current needs and changes of the resident. 4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	

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F 280	Continued From page 6 1 revealed he had: *Been admitted on 10/27/14. *Been a diabetic for many years. *Counted how many carbohydrates he ate each meal in the past to determine how much insulin he needed. *Not counted his carbohydrates at each meal since he had been in this facility. Review of resident 1's 10/27/14 admission physician's orders revealed no orders for the resident to count carbohydrates to determine how much insulin he was to receive. Review of resident 1's 10/31/14 care plan revealed: *"The resident was to count the carbohydrates he had at each meal to determine his insulin dosage, and his diabetes was to be managed as effectively as possible." *Dietary staff were to provide diabetic diet with carbohydrate counting sheets to nursing staff. Interview on 4/1/15 at 2:30 p.m. with the director of nursing regarding resident 1 revealed she: *Was unable to locate a physician's order for the resident to count carbohydrates at meals. *Was not sure if he had ever counted carbohydrates at meals to determine his insulin dose. *The nurses administered insulin according to what his blood sugars were when they were checked before meals and at bedtime according to the 10/27/14 physician's orders. 3. Observation and interview on 3/31/15 at 11:15 a.m. of registered nurse (RN) G regarding resident 10 revealed she: *Changed the colostomy (bag on the outside of	F 280		

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F 280	Continued From page 7 the abdomen to collect stool) protective dressing (wafer) on the resident. *Was unsure how often the wafer was changed, but she thought as needed (PRN). *Did not document anywhere she had changed the wafer. *They usually documented on the resident's treatment administration record (TAR) when the colostomy wafers were changed, but the orders had not been placed on his TAR. Review of resident 10's 3/31/15 care plan revealed: *"Staff to change colostomy bag PRN and nurse to change wafer PRN." *"Staff to monitor and chart bowel movements and bag and wafer changes." Review of the provider's undated Ostomy (colostomy) Care policy revealed "Document the procedure in the resident's TAR." 4. Review of resident 11's medical record revealed she had diagnoses of: *Urine retention (unable to empty the bladder completely). *Diabetes type II (affects the way the body processes blood sugar). *Muscle weakness. *Difficulty walking. *History of falls. *Hypertension (high blood pressure). *Dementia (impaired thinking/memory). *Pressure ulcer (sore over a bony area from being in the same position for an extended period of time) stage three (the depth extends into the fat/tissue under the skin). *Communication deficit. Review of resident 11's care plan dated 3/9/15	F 280		

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F 280	Continued From page 8 revealed: *She was to have pudding thickness type liquids. *The staff were to follow the provider's clostridium difficile (c-diff [infection that causes diarrhea]) protocol for the resident. Review of resident 11's physician's orders dated 1/27/15 revealed: *There was no pudding thickness type liquids ordered. *She had no orders for treatment of C-diff. Interview on 4/1/15 at 10:25 a.m. with the director of nursing revealed she agreed the resident's care plan had not been updated to reflect she no longer had C-diff and was no longer receiving pudding thickness type liquids. 5. Review of the provider's undated care plan policy revealed: *"Care plans must set realistic, specific and achievable goals that are individualized for each resident. The care plan must be updated as there are changes in the resident's condition. Changes maybe health related, mood and behavior related, activities of daily living [everyday routine cares] functioning related, activities related, dietary related, medication related etc. In addition, interventions related to resident falls, skin integrity, resident to resident altercations, or new MD orders must be added to the care plan as the event occurs." *"Changes may be due to a decline or improvement in the resident's condition."	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281	F281 *(375) SB/SDDOH/MF 1. The resident was assessed upon discovery of the deficient practice. 2. All residents are potentially at risk.	5/18/15

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F 281	Continued From page 9 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to appropriately assess one randomly observed resident (25), with a change in condition, for 1 of 25 sampled residents. Findings include: 1. Observation on 3/31/15 at 11:10 a.m. of registered nurse (RN) D checking the blood sugar level on resident 25 revealed: *Physical therapy had reported to the RN minutes earlier the resident was not feeling well and requested her blood sugar be checked. *While she was checking her blood sugar the resident complained of chest heaviness and also having been lightheaded. *RN D found the resident's blood sugar to be within her normal limits at 103 and advised her she would not need any insulin or food at that time. *She had not followed-up on the residents complaints by performing a thorough assessment regarding the above complaints. Interview immediately following the above observation with RN D revealed she: *Had performed an assessment one half to an hour earlier on the resident. *Thought her chest heaviness might have been related to a slight cough the resident had experienced earlier that morning. *Would normally wait another half hour to an hour before completing another assessment for new symptoms or complaints. *Was not aware of any heart problems in the	F 281	3. a. Education to all professional nursing staff completed by the DON or designee on or before 4/29/15 on ensuring professional standards are being followed, including assessment of any change of condition. b. Director of Nursing or designee will complete 4 random written audits weekly x 4, then monthly x 2 on professional standards. The sample selection is random. The following will be audited. 1. Monitor for change in condition, appropriately assess, monitor, intervene, and document changes. 4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	

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F 281	Continued From page 10 resident's health history. *Agreed she should have performed a thorough assessment to find out what had been causing her new complaints and to identify if there had been a change in her condition. Interview on 4/1/15 at 4:30 p.m. with the director of nursing (DON) regarding the above observation revealed she agreed RN D should have performed an assessment on resident 25. Review of the provider's April 2013 Change of Condition policy revealed: *The resident's condition should have been thoroughly assessed when a resident had new complaints or symptoms to determine if there had been a significant change in health. *If there had been a significant change, the residents family and physician should have been notified of a change.	F 281		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	*All medication rooms and carts were checked for the issues identified. SB/DDH/MF F431 1. The medication was taken to the Central Nurses Station for disposal. 2. All residents are potentially at risk. 3. a. Education to all licensed nursing staff by the Director of Nursing or designee on or before 4/29/15 on timely and proper medication destruction, including disposal of medications that inadvertently become loose from the medication blister pack.	5/18/15

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F 431	Continued From page 11 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *Timely destruction and an accurate count of one randomly observed controlled medication in one of three medication rooms that was located on the rehab/west hall. *Three tablets of a controlled medication found in one of two medication carts that was located at the central hall nurse's station was disposed of properly. Findings include: 1. Observation and interview on 4/1/15 at 2:30 p.m. with registered nurse (RN) D of the rehab/west hall medication room revealed: *The top locked cupboard contained a 30 milliliter (ml) bottle of liquid Ativan (anti-anxiety controlled medication) for a resident who had passed away.	F 431	b. Director of Nursing or designee will complete written audits of timely and proper destruction of medications weekly x 4, then monthly x 2. Audit selection is random with a maximum of four. The following areas will be audited 1. Timely medication destruction 2. Proper medication destruction 4. Director of Nursing or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	[redacted] SB/SDDH/MF

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F 431	Continued From page 12 *It had been opened and was almost full. *It had a pharmacy date of 12/19/14. *There was no reconciliation (count) sheet for that medication. *It had not been counted regularly to know how much medication should have remained. *She would check the resident's medical record to see if the reconciliation count sheet they used had been put in his chart. Interview on 4/1/15 at 5:45 p.m. with RN unit coordinator B regarding the above medication revealed: *She could not find the reconciliation count sheet in the resident's chart. *Their policy was to take medication awaiting destruction to the central hall nurses station medication room and place it in the top locked cupboard. *Nursing staff should have removed the medication and taken it to the central hall nurses station placing it in the top cupboard. *It was to have been destroyed with the pharmacist at her next visit to the facility. *The pharmacist would not routinely go to the rehab unit to inspect their medication room or destroy any medications that were discontinued or no longer used when she was there. Interview on 4/2/15 at 9:21 a.m. by phone with consulting pharmacist Q and her regional manager R revealed: *They were unaware of the Ativan having been left unaccounted for in the rehab/west hall medication room. *Consulting pharmacist Q "must have missed it." *She routinely checked that medication room when she was at the facility every month. *The regional manager R's expectation was that	F 431		

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F 431	Continued From page 13 medications were stored and destroyed per facility policy. 2. Observation and interview on 4/1/15 at 1:47 p.m. with medication aide E while auditing the central hall's medication carts revealed: *One blister pack card (individual card of medication doses) of Tramadol (narcotic pain medication) had eighteen doses punched out. *On the back of the card tape had been put on three of those punched out doses. *Of those three doses one tablet had been placed back in with tape on the back and the front had been circled with permanent marker. *During reconciliation of the medications, it was discovered that a tablet had fallen into the medication cart and was found. *That was reported to be the dose that had been missing. *There was no documentation as to why the two empty blisters had been taped. *She stated it was not their policy to tape a medication back into the blister pack. *It should have been appropriately destroyed. Review of the 12/2/14 Controlled Medication Record/Count for the above Tramadol blister pack card revealed the following: *On 12/10/14 there had been documentation by two staff of: -"Count off by one- punched on 8th." -"Missing count justified/reconciled." Interview on 4/1/15 at 4:40 p.m. with RN unit coordinator C regarding the above Tramadol blister pack card revealed: *She had been aware the reconciliation of the medication had been off by a count of one. *The missing medication had been found in the	F 431		

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F 431	Continued From page 14 bottom of the medication cart drawer, had been taped back into the blister pack, and had been circled with a permanent marker. *Staff should not have taped the medication back into the card and should have wasted it appropriately according to the facility policy. Review of the provider's 5/1/10 Disposal/Destruction of Expired or Discontinued Medication policy revealed: *"Wasted medications are defined as medications contaminated or refused that require disposal. Facility should not place wasted medications back in their original containers."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	F441 1.Residents #13, #14 and #17 rooms are being cleaned according to proper infection control protocol, Residents #13, #14 and #17 have appropriate PPE's stored outside of their room and Residents #14 and #17 have appropriate signage on their door. 2. All residents are potentially at risk.	5/18/15

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F 441	Continued From page 15 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, manufacturer's guidelines, and policy review, the provider failed to: *Use appropriate environmental infection control techniques when cleaning three of three residents' (13, 14, and 17) rooms who had an infectious disease that required strict cleaning techniques. *Ensure appropriate personal protective equipment (PPE) was available outside the room for staff/visitors to put on prior to entering three of three residents' (13,14, and 17) rooms who had an infectious disease that required specific PPE use. *Have appropriate signage on the door of two of three residents (14 and 17) with a known or suspected infectious disease. Findings include: Surveyor: 32331 1. Observation on 3/30/15 from 5:12 p.m. through	F 441	3. a. Director of Nursing or designee will complete written audits on the following areas: Appropriate PPE availability outside of resident rooms doors for residents with infectious diseases and appropriate signage is present on door of residents with infectious diseases. Administrator or designee will complete a written audit on the following area: Appropriate cleaning techniques are used for cleaning of rooms with residents with infectious diseases. Audits will completed weekly x 4, then monthly x 2 and will contain 4 samples per area.	X [redacted] 5/5/2015 MF

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F 441	Continued From page 16 6:00 p.m. on the central wing revealed: *Resident 16's room door had the following signage: "Please see nurse before entering room." *Outside that room there was a plastic container with three pull-out drawers that contained gloves, masks, and gowns. *During the above time on the central wing resident 17's room revealed: *No signage as the above for resident 16 on his room door. -He had a roommate in his room. *There was no plastic container or any type of dispenser that contained gloves, masks, and gowns outside his room. *That resident was later discovered in the survey process that: -He was to have had the appropriate signage on his door. -That would have alerted staff and visitors regarding his current infectious process. Surveyor 33488 2. Observation on 3/30/15 at 5:15 p.m. of resident 13's room revealed: *A sign had been posted outside her room advising staff or visitors to see the nurse before entering. *An isolation cart with PPE was inside the room next to the divider curtain that separated the the resident and her room mate. Interview on 3/30/15 at 5:30 p.m. with registered nurse (RN) V regarding resident 13 revealed: *She had been diagnosed with bacteria in her urine called extended spectrum beta-lactamase (ESBL) on 3/26/15. That bacteria was found resistant to numerous antibiotics and required contact precautions (additional precautions used	F 441	b. The Administrator, DON, Medical Director and Interdisciplinary Team have reviewed the findings in this deficiency and policies and procedures about infection prevention and control to ensure policies reflect: -Identification, tracking and trending of infections - Appropriate communication of ALL staff, residents and family of infection - Appropriate use of personal protective equipment - Appropriate cleaning and sanitation of environment and equipment - Appropriate hand hygiene and glove use for assigned task Additionally, the Administrator or designee will educate all housekeeping staff on room cleaning techniques and DON or designee will complete education to all staff on appropriate signage and PPE availability for residents with infectious diseases on or before 4/29/2015 regarding the above stated infection control practices. 4. Administrator or designee and DON or designee will report the results of the audits to the facility QAPI committee for review and recommendation monthly x 3 then quarterly x 2. SB/SDDOH/MF	

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F 441	Continued From page 17 when contact with highly infectious bacteria was likely). *She was being actively treated with antibiotics for her infection. Review of resident 13's current careplan revealed her : *Made no mention of her current isolation/contact precautions. *There was no interventions listed for staff to know how to perform her cares while she had that infection. Interview on 3/31/15 at 9:55 a.m. with RN D regarding resident 13's contact precautions revealed staff only needed to gown and glove when handling urine, soiled linens, or providing personal care. Interview on 3/31/15 at 3:02 p.m. with RN unit coordinator B regarding care for resident 13 revealed: *Her expectations were: -Staff would only gown and glove when dealing with urine soiled items. *They [the facility] no longer moved residents or their roommates when contact precautions were required if the infected resident had a roommate. *It was felt removing the infected resident from their roommate would cause social isolation, and therefore they no longer used that practice. Interviews on 3/31/15 at 4:35 p.m. through 4:50 p.m. with certified nursing assistants (CNA) T and U regarding how they cared for resident 13 and special precautions they would use revealed: *CNA T would only gown and glove when providing personal care. *CNA U administered medications to the resident	F 441		

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F 441	Continued From page 18 and would not normally put on PPE upon entering her room. -She would use hand sanitizer before entering and leaving the room. -Her understanding was she would not have to put on PPE as long as she had not provided personal care to the resident. 3. Random observations from 3/31/15 through 4/1/15 of resident 17's room revealed: *He had no signage on the door that would notify staff/visitors to check with the nurses prior to entering. *His isolation cart with the PPE was stored behind the door to his room. *His roommate was also present during observations. Review of the medical record for resident 17 revealed: *He was diagnosed with Clostridium difficile (C-diff) (highly contagious bacteria found in stool on 3/24/15). *His current careplan documentation showed he was to have used a commode instead of the bathroom due to his C-diff. *He was known to have been occasionally incontinent (unable to hold bowel and bladder). *He was mentally alert but physically had been unable to clean himself after an episode of incontinence. Interview on 4/1/15 at 10:35 a.m. with the environmental services (housekeeping and laundry) supervisor and her assistant housekeeper F who were cleaning the room across the hall from resident 17 revealed: *She (the above supervisor) had been unaware resident 17 required contact precautions.	F 441		

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F 441	Continued From page 19 *She reported there should have been signage on the door alerting visitors and staff to check with the nurse before entering. *During daily stand-up meetings with the department leaders resident health status changes were to be discussed and passed along to staff who would care for the resident. *She would hand her staff the report with the expectation they would read it. *She had never verified if that occurred or if staff were knowledgeable on how to appropriately clean a room and resident items for a resident with that infection. *When staff had cleaned the room they had not used appropriate cleansers that were necessary to kill the above bacteria. *Bleach solution (bleach and water) was to have been used at a one to ten ratio. *Her bleach container: -Was fully concentrated. -Was not mixed to the appropriate ratio. -Had been used to spray the floor or equipment surface only if stool had been seen. *Staff would only use bleach once per week as it made the floors "sticky." *Assistant housekeeper F revealed: -They were not told what specific precautions they needed to take while cleaning an isolation room or what cleaners to use. -The isolation carts filled with PPE was often not sufficiently or frequently re-stocked by staff. Interview on 4/1/15 at 10:50 a.m. with housekeeper W regarding the cleaning and sanitation of resident rooms and equipment who are require contact isolation precautions revealed: *She used the fully concentrated bleach spray for all residents on precautions regardless of the type	F 441		

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F 441	Continued From page 20 or infection. *She was not aware of the manufacturers' guidelines that required the bleach product to be diluted to a 1:10 ratio and not sprayed on in full concentrated form. *She agreed she should have followed manufactures guidelines for appropriate dilution and cleaning. Interview on 4/1/15 at 11:00 a.m. with medication aide E regarding resident 17 revealed: *She was unsure why he had not had signage on his door alerting staff and visitors to check with the nurse before entering. *She was unaware of the location of policies and procedures to refer to about contact isolation requirements. *"No one has told us what precautions are to be used. We have nothing to reference." Interview on 4/1/15 at 11:10 a.m. with RN central unit coordinator C regarding resident 17 revealed: *She was responsible for posting any signage related to any isolation precautions outside of residents' rooms. *She had not placed any signage on resident 17's door alerting staff/visitors to check with the nurse before entering. *In her opinion it would not be confidential to post a sign outside his door. *She had no explanation why there had been signage posted for another resident down the same hall under the similar contact isolation precautions if it was not confidential to do so. *He had been "mostly continent" that she was aware of. *They (the facility) no longer isolated residents away from roommates. *If the residents shared a room they would not	F 441		

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F 441	Continued From page 21 share the bathroom while one resident was under strict precautions. *It was her expectation the resident and any of his equipment/supplies were not infectious as long as they were not touching the resident's stool. *When asked how she ensured the safety of the residents, visitors, and staff she replied "There is no risk unless they touch stool." Interview on 4/1/15 at 3:50 p.m. with resident 17 revealed: *He was alert and oriented. *He had seen staff clean his room many times. *They had never used bleach on his floor except when they had seen a spot of stool. *"They bring in a broom from their cart and sweep my floor. *Once they are finished sweeping, they take the broom back out and place it on their cart. *Their mop is already moistened before they bring it in the room." *He had seen them "spritz" his bedside table with bleach before. *He was familiar with the smell of bleach and when they mopped he had not smelled any bleach products being used on his floor. 4. Review of the 2012 Cleaning and Disinfecting Resident's Room policy found in the central nurses station cupboard revealed disinfection of a diluted bleach solution of one to ten ratio would be used for routine environmental disinfection. Review of the provider's May 2014 Contact Precautions policy revealed: *Gloves were to be worn when entering the room. *A gown should have been put on prior to entering the resident's room.	F 441		

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F 441	Continued From page 22 Review of the provider's May 2014 C-diff policy revealed: *Contact precautions would be used for residents with active or recurring infections. *Bleach should have been used per manufacture's guidelines and cleaned daily or more often if they became contaminated. *Residents should have been placed in private rooms or with residents also to have been known to be infected with C-diff. Review of the provider's May 2014 ESBL policy revealed: *Infected residents should have been placed in private rooms or with another resident with ESBL. *Use of a bleach solution at a one to ten ratio should have been used for disinfection and manufacturer's guidelines followed. Review of the provider's May 2014 Infection Prevention and Control Plan revealed: *An infection prevention plan should have included: -Assessment of risk. -Strategies to decrease risk. -Evaluation of effectiveness of strategies. -Surveillance plan based on analysis of previous date. *The goals of the infection control prevention program included: -Decreasing the risk of infections. -Prevent onset and spread when possible. -Monitor for occurrence and control outbreaks. -Monitor for occurrences and implement appropriate control measures. -Identify and correct problems relating to practices. -Maintain compliance with state and federal regulations and standards of practice.	F 441		

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F 441	Continued From page 23 *Compliance with infection control was monitored and documented by staff evaluation and observations of practices. 5. Observation and interview with registered nurse (RN) O on 3/30/15 at 6:00 p.m. of resident 14's room revealed: *She was not in her room during the observation. *She had a room mate. *The staff had noticed a firm red area on her right buttock on 3/28/15. *The staff found blisters on that same area on 3/30/15. *Her physician had been notified of the blisters and given orders for Acyclovir (a medication for Shingles [a viral disease that presents with blisters and pain, and could have been transferred to other residents by touching drainage from a blister]). *The physician had suspected Shingles and wanted to begin treatment until he could visit the resident and make a diagnosis. *There was no signage on her door indicating family or visitors should have talked to the nurse prior to entering the resident's room. *RN O stated the staff were waiting for the physician to visit to decide if she required contact precautions (precautions used to prevent the virus from spreading to other residents and staff). Observation and review on 3/31/15 of resident 14's progress notes revealed: *At 8:46 a.m. RN O documented her physician had stated he would stop that day to see her. *Interview at 2:40 p.m. with RN supervisor H revealed contact precautions had not been instituted, but staff were to perform good handwashing.	F 441		

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F 441	Continued From page 24 *Resident 14 had been out of her room for breakfast and lunch meals, and for a bath. *At 3:00 p.m. RN O documented her physician had been called and reported he would see her today. *At 4:45 p.m. an isolation cart (used to store protective equipment for staff to use to protect themselves from infectious diseases) had been placed outside her door, and signage on her door indicated family and visitors should talk to the nurse prior to entering her room. *RN O documented at 5:30 p.m. the physician had assessed resident 14 and diagnosed her with Shingles. Review of resident 14's progress notes revealed on 4/1/15 at 7:00 a.m., "Resident on precautions for Shingles. Only c/o [complains of] Shingle pain when area is touched or moved. Staff educated precautions." Interview on 3/31/15 at 5:00 p.m. with certified nursing assistant (CNA) P revealed: *She worked all units in the building and worked wherever she was needed. *Most of the CNAs floated to whatever unit needed the most help. *The uncertified nursing assistants remained on the unit they were hired on until they became certified. *CNAs knew how to care for the residents by getting an oral report from the nurse, or by reading information in the CNA book at the desk. Interview on 3/31/15 at 5:10 p.m. with RN C revealed: *The day shift did not get a full report on the residents. *They could read a written report from the night	F 441		

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F 441	Continued From page 25 shift and read through the notes. Review of the CNA book on 3/31/15 at 5:20 p.m. of the east/east wing revealed no information regarding resident 14 or precautions regarding Shingles. Interview on 4/1/15 at 6:15 p.m. with the director of nursing revealed she agreed the staff had not followed their policy for contact precautions for resident 14. Review of the provider's May 2014 Contact Precautions policy revealed: *The provider would use contact precautions for residents with known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment. *The resident might be placed in a private room, or with a resident who had an active infection with the same organism but with no other infection. *All residents with precautions would be identified with a sign on their door that stated "See nurse before entering room". *The staff would be alerted as to the type of precautions they were to follow for each resident identified. *Gloves and gowns were to have been worn when entering the room and providing care. *After removal of gloves and gowns, hands and clothing should not touch potentially contaminated environmental surfaces.	F 441		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520	F520 1. No specific residents were cited. 2. All residents are potentially at risk.	5/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435109		04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESTEEL HEALTHCARE COMMUNITY	1120 EAST 7TH AVENUE MITCHELL, SD 57301

(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 520	Continued From page 26 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to implement and follow through to resolution identified deficiencies related to infection control and to develop and implement corrective actions. Findings include: 1. Interview on 4/1/15 at 11:10 a.m. with the director of nursing (DON) and the director of clinical services from South Dakota facilities regarding the provider's quality assurance (QA) program: *The QA committee met monthly on the following	F 520	3. a. The Administrator, DON, Medical Director and Interdisciplinary Team have reviewed the findings in this deficiency and policies and procedures about quality assurance and process improvement program. Education to all staff to be completed by the DON or designee on or before 4/29/15 to include. 1. QAPI Policies and procedures 2. Representation of "frontline" associates✓ b. Director of Nursing or designee will complete 4 random audits weekly x 4, then monthly x 2 on proper QAPI policies/procedures/frontline associate representation. Audits will include the following. 1. Proper QAPI policies and procedures are being followed 2. Representation from "frontline" associates on the committee* 4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3. *including the director of housekeeping. SB/SDDOH/MF with input and participation in infection control. SB/SDDOH/MF	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435109		04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESTEEL HEALTHCARE COMMUNITY	1120 EAST 7TH AVENUE MITCHELL, SD 57301

(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 520	Continued From page 27 dates: 6/24/14, 7/29/14, 8/26/14, 10/28/14, 11/25/14, 12/30/14, 1/27/15, 2/24/15, and 3/30/15. *QA activities were identified from observations in the facility, daily stand-up meetings with staff in each of the four wings (central, west, south, and east) Mondays through Fridays, clinical "walk arounds", customer satisfaction services, care conferences, observations, audits, interviews, and weekly leadership meetings. *They used root-cause analysis (tool used to identify the most basic cause of a problem) analysis for identifying problem areas. *They were currently doing tracking and trending with infection control in the facility. *There were no current audits on infection control. Review of QA attendance records from 6/24/14 through 3/30/15 revealed: *Staff who attended had been the administrator, DON, all the department managers, the medical director, and the pharmacist. *The environmental services supervisor F was not in attendance for seven of the nine meetings. Review of the provider's undated QA Performance Improvement (QAPI) policy revealed: *Develops and implements appropriate plans of action to correct identified quality deficiencies. *The QAPI program was led by the facility administrator with assistance from the DON. *QAPI meetings occurred at least monthly. Refer to F441, findings 1 through 3. Surveyor 33488 Review of the provider's May 2014 Infection	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 28 Prevention and Control Plan revealed: *An infection prevention plan should have included: -Assessment of risk. -Strategies to decrease risk. -Evaluation of effectiveness of strategies. -Surveillance plan based on analysis of previous date. *The goals of the infection control prevention program included: -Decreasing the risk of infections. -Prevent onset and spread when possible. -Monitor for occurrence and control outbreaks. -Monitor for occurrences and implement appropriate control measures. -Identify and correct problems relating to practices. -Maintain compliance with state and federal regulations and standards of practice. *Compliance with infection control was monitored and documented by staff evaluation and observations of practices.	F 520		

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

ORIGINAL

PRINTED: 04/14/2015
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	435109		03/31/2015

NAME OF PROVIDER OR SUPPLIER
FIRESTEEL HEALTHCARE COMMUNITY

STREET ADDRESS, CITY, STATE, ZIP CODE
1120 EAST 7TH AVENUE
MITCHELL, SD 57301

(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
K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/31/15. Firesteel Healthcare Community (Building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K018, K029, K066, and K076 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K18 1. No residents cited in the deficiency. 2. All residents are potentially at risk. 3. a. Education to be provided to all therapy staff on proper corridor separation by Administrator or designee by 04/29/2015. b. Administrator or designee will complete written audits weekly x 4, then monthly x 2 on proper corridor separation. Audit selection is random with a maximum of four. The following areas will be audited. 1. Proper corridor separation is maintained. 4. Administrator or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	5/18/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carey Brenner
TITLE: Administrator
(X6) DATE: 4/22/15

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	435109		03/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESTEEL HEALTHCARE COMMUNITY	1120 EAST 7TH AVENUE MITCHELL, SD 57301

(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
K 018	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain corridor separation from use areas with doors capable of resisting the passage of smoke at one randomly observed door (rehabilitation gym). Findings include: 1. Observation at 1:30 p.m. on 3/31/15 revealed the rehabilitation gym corridor door had an exercise leg weight on the floor holding the corridor door open. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He indicated the door had a magnet holder installed in 2014 to allow the door to remain open. He stated that hooks on the inside face of the door were used to hang coats. The weight of the coats was sometimes stronger than the magnet. The deficiency affected a single location of numerous locations required to be equipped with a smoketight corridor door.	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	K29 1. No residents cited in the deficiency. 2. All residents are potentially at risk. 3. a. Education to be provided to all maintenance staff on proper separation procedures by Administrator or designee by 04/29/2015.	5/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	435109		03/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESTEEL HEALTHCARE COMMUNITY	1120 EAST 7TH AVENUE MITCHELL, SD 57301

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K 029	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain proper separation of one of nine hazardous areas (kitchen pantry). Findings include: 1. Observation beginning at 12:30 p.m. on 3/31/15 revealed the kitchen pantry storage room was over 100 square feet in area. The corridor door was not equipped with a self-closing device. Interview with the maintenance supervisor at the time of the observation confirmed that finding. Doors to hazardous areas were required to be self-closing. The deficiency affected requirements for providing separation of hazardous areas.	K 029	b. Administrator or designee will complete written audits weekly x 4, then monthly x 2 on proper separation procedures. Audit selection is random with a maximum of four. The following areas will be audited. 1. Proper separation procedures are maintained. 4. Administrator or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.	K 066	K66 1. No residents cited in the deficiency. 2. All residents are potentially at risk. 3. a. Smoking policy will be changed by 4/29/15 to list the proper type of ashtray and storage container for ashtrays to empty into once they are full.	5/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
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FIRESTEEL HEALTHCARE COMMUNITY	1120 EAST 7TH AVENUE MITCHELL, SD 57301

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K 066	Continued From page 3 (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on document review, observation, and interview, the provider failed to adopt smoking regulations as required. Findings include: 1. Document review beginning at 2:00 p.m. on 3/31/15 revealed the smoking policy did not require: *Ashtrays of noncombustible material and safe design provided in all areas where smoking was permitted. *Metal containers with self-closing cover devices that ashtrays could be emptied into that were readily available to all areas where smoking was permitted. Observation at 3:00 p.m. on 3/31/15 revealed the smoking area at the front entrance did not have a metal container with a self-closing lid available. Observation at 3:30 on 3/31/15 revealed the smoking area outside the employee break room (former office) used open coffee cans for ashtrays. There was not a safe design type of ashtray or metal container with a self-closing lid	K 066	b. Education to be provided to maintenance staff on proper equipment to have in place in the designated smoking areas by Administrator or designee by 04/29/2015. c. Administrator or designee will complete written audits weekly x 4, then monthly x 2 on proper smoking regulations. Audit selection is random with a maximum of four. The following areas will be audited. 1. Proper equipment in place in smoking areas. 4. Administrator or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	435109		03/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESTEEL HEALTHCARE COMMUNITY	1120 EAST 7TH AVENUE MITCHELL, SD 57301

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K 066	Continued From page 4 available at that smoking location. Interview with the administrator at 4:15 p.m. confirmed the above findings. Failure to adopt and implement smoking regulations as required increases the risk of death or injury due to fire.	K 066		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to provide oxygen cylinders in a one-hour fire-rated enclosure (storage room in the east dining room). Findings include: 1. Observation at 2:45 p.m. on 3/31/15 revealed forty 80 cubic feet (cylinder size) and ten 20 cubic feet (cylinder size) oxygen cylinders (approximately 3600 cubic feet total) were kept in an interior storage room within the east dining room. The room had two windows: a fixed single pane window, a sliding glass window into the	K 076	K76 1. No residents cited in the deficiency. 2. All residents are potentially at risk. 3. a. Oxygen will be moved to an area that meets the on-hour fire-rate enclosure by 4/29/2015. b. Education to be provided to all maintenance staff on proper oxygen storage by Administrator or designee by 04/29/2015. b. Administrator or designee will complete written audits weekly x 4, then monthly x 2 on proper oxygen storage. Audit selection is random with a maximum of four. The following areas will be audited. 1. Proper oxygen storage. 4. Administrator or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	5/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
	435109		**03/31/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESTEEL HEALTHCARE COMMUNITY	**1120 EAST 7TH AVENUE** **MITCHELL, SD 57301**

(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
K 076	Continued From page 5 main room, and did not meet the rated wall requirements. Interview with the maintenance supervisor at the time of the observation confirmed the above findings. The deficiency affected requirements for storage of oxygen cylinders.	K 076		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED
	435109		03/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESTEEL HEALTHCARE COMMUNITY	1120 EAST 7TH AVENUE MITCHELL, SD 57301

(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
K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/31/15. Firesteel Healthcare Community (Building 02) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiency identified at K066 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is	K 066	K66 1. No residents cited in the deficiency. 2. All residents are potentially at risk. 3. a. Smoking policy will be changed by 4/29/15 to list the proper type of ashtray and storage container for ashtrays to empty into once they are full. b. Education to be provided to maintenance staff on proper equipment to have in place in the designated smoking areas by Administrator or designee by 04/29/2015.	5/18/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carey Brenner
TITLE: Administrator
(X6) DATE: 4/22/15

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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	435109		03/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESTEEL HEALTHCARE COMMUNITY	1120 EAST 7TH AVENUE MITCHELL, SD 57301

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K 066	Continued From page 1 permitted. 19.7.4 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on document review, observation, and interview, the provider failed to adopt smoking regulations as required. Findings include: 1. Document review beginning at 2:00 p.m. on 3/31/15 revealed the smoking policy did not require: *Ashtrays of noncombustible material and safe design provided in all areas where smoking was permitted. *Metal containers with self-closing cover devices that ashtrays could be emptied into that were readily available to all areas where smoking was permitted. Observation at 3:00 p.m. on 3/31/15 revealed the smoking area at the front entrance did not have a metal container with a self-closing lid available. Observation at 3:30 on 3/31/15 revealed the smoking area outside the employee break room (former office) used open coffee cans for ashtrays. There was not a safe design type of ashtray or metal container with a self-closing lid available at that smoking location. Interview with the administrator at 4:15 p.m. confirmed the above findings. Failure to adopt and implement smoking regulations as required increases the risk of death or injury due to fire.	K 066	c. Administrator or designee will complete written audits weekly x 4, then monthly x 2 on proper smoking regulations. Audit selection is random with a maximum of four. The following areas will be audited. 1. Proper equipment in place in smoking areas. 4. Administrator or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	10653 S		04/02/2015

NAME OF PROVIDER OR SUPPLIER: FIRESTEEL HEALTHCARE COMMUNITY

STREET ADDRESS, CITY, STATE, ZIP CODE: 1120 E 7TH AVE, MITCHELL, SD 57301

(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) COMPLETE DATE
S 000	Initial Comments Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 3/30/15 through 4/02/15. Firesteel Healthcare Community was found not in compliance with the following requirements: S130, S288, and S360.	S 000		
S 130	44:04:02:06 FOOD SERVICE Food service must be provided by a licensed facility or food establishment that is inspected by a local, state, or federal agency. The facility must meet the safety and sanitation procedures for food service in chapters 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive, the Food Service Code. In addition, a mechanical dishwasher must be provided in all facilities of 20 beds or more. The facility must have the space, equipment, supplies, and mechanical systems for efficient, safe, and sanitary food preparation if any part of the food service is provided by the facility. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained for the wiping cloths used in the dishroom area of the kitchen. Findings include: 1. Random observations from 3/30/15 at 4:45 p.m. through 4/1/15 at 11:30 a.m. in the dishroom	S 130	S130 1. The wiping clothes were removed and stored properly upon discovery of deficient practice. 2. All residents are potentially at risk. 3. a. Education to be provided to all dietary staff on proper use and storage of wiping cloths used in the dish room area of the kitchen by CDM or designee by 04/29/2015. b. CDM or designee will complete written audits weekly x 4, then monthly x 2 on proper use and storage of wiping cloths. Audit selection is random with a maximum of four. The following areas will be audited. 1. Proper storage of wiping cloths. 4. CDM or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	5/18/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carey Breaser

TITLE: Administrator

(X6) DATE: 4/22/15

STATE FORM 6899 VC2H11 If continuation sheet 1 of 1

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	10653 S		04/02/2015

NAME OF PROVIDER OR SUPPLIER: FIRESTEEL HEALTHCARE COMMUNITY

STREET ADDRESS, CITY, STATE, ZIP CODE: 1120 E 7TH AVE, MITCHELL, SD 57301

(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) COMPLETE DATE
S 130	Continued From page 1 in the kitchen revealed wet cloths laying on the following: *The counter of the three-compartment sink. *The edge of the sink between two of the three-compartments on the three-compartment sink. *The dishmachine counter next to dishes on the dirty end of the dishmachine. *On top of a three-tiered cart. *Those cloths were not being stored in a sanitizing solution. Interview on 4/1/15 at 11:30 a.m. with the certified dietary manager revealed: *She agreed the wiping cloths used in the dishroom needed to have been properly sanitized between uses. *She stated the wiping cloths were to have been placed in the three-compartment sink or in a sanitizing bucket with EcoLab Oasis 146 Multi-Quat (quaternary) Sanitizer. *She confirmed those wiping cloths were not being properly sanitized when they were left out of the above solution. Review of the provider's undated Product Specification Document of the EcoLab Oasis 146 Multi-Quat Sanitizer revealed it: *Could be used to sanitize hard, non-porous food contact surfaces such as tables, counters, and food processing equipment. *Was an effective sanitizer on food contact surfaces when used at 150 to 400 per parts per million active quat mixture. *Was to have been exposed to surfaces as a sanitizing solution for a period of not less than one minute. Review of the provider's undated Kitchen Cloths policy revealed:	S 130		

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S 130	Continued From page 2 *Kitchen cloths were to have been clean and available as needed. *They were to have been properly stored in the sanitizing solution between uses. *Cloths were to have been rinsed after each use and stored in sanitizing solution. *That sanitizing solution would have been changed throughout the day to ensure its effectiveness. *Cloths used for cleaning purposes would have been stored in sanitizing solution between uses.	S 130		
S 288	44:04:07:02.02 NUTRITIONAL ADEQUACY The dietetic service must ensure that food prepared is nutritionally adequate in accordance with the Recommended Dietary Allowances and is chosen from each of the five basic food groups listed in the Food Guide Pyramid, 1996 or 2005, Center for Nutrition Policy and Promotion, U.S. Department of Agriculture, in accordance with consideration for individual needs and reasonable preferences. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on observation, interview, record review, and policy review, the provider failed to ensure the menus were written to provide the correct portions and adequate amounts of daily bread servings for all residents on oral diets. Findings include: 1. Observation of the noon meal on 3/31/15 at 11:55 a.m. revealed:	S 288	S288 1. No immediate correction could be made. Residents are receiving meals as described on the menu. 2. All residents are potentially at risk. 3. a. RD will review and revise as needed by 4/29/2015 the daily menus to ensure six or more bread servings are provided each day. a. Education to dietary staff to be completed by the CDM or designee on or before 4/29/15 on proper serving of six or more bread servings. b. CDM or designee will complete written audits weekly x 4, then monthly x 2 on proper serving of six or more bread servings per day. Audit selection is random with a maximum of four. The following areas will be audited. 1. Menus are properly written to ensure six bread servings are given each day. 2. Six bread servings are provided each day.	5/18/15

South Dakota Department of Health

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S 288	Continued From page 3 *The written base menu items were served consisting of: -Two to three ounces (oz) of roast beef. -One slice of bread. -One-half cup of mashed potatoes. -Three oz of gravy. -One-third cup of peas. -One, two inch by two inch serving of pie with a graham cracker crust. *The written base menu was for two slices of bread. Interview at the above time with dietary assistant N revealed she did not serve anyone two slices of bread as written on the menu "except for a few big eaters on large portions." Review of the written base menu for 3/31/15 revealed the following bread servings: *At breakfast: -One-half cup oatmeal or three-fourth cup cold cereal. -One slice toast. *At the noon meal: -Two slices bread. -Graham cracker crust on the cool EZ (easy) pie. *At the evening meal: -One-half slice bread. *The above menu provided five servings of bread per day. Review of the 1996 Food Guide Pyramid revealed the basic menu pattern had been established for six or more bread servings per day. A bread serving consisted of: *One-half cup oatmeal or three-fourth cup cold cereal. *One slice bread or toast. *Three graham cracker squares.	S 288	4. CDM or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	

South Dakota Department of Health

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S 288	Continued From page 4 Interview on 4/1/15 at 11:30 a.m. with the certified dietary manager regarding the written base menu and the bread servings confirmed: *The bread servings per the written menu on 3/31/15 were less than the required six or more bread servings per day. *The total bread servings served on 3/31/15 were four servings and less than the required six or more bread servings per day. *The menu needed to have included the minimum number of bread servings per day. Review of the provider's undated Meal Planning policy revealed: *Nutritional needs of individuals would have been provided in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. *Menus were to have been written to provide adequate amounts at each meal to have satisfied recommended daily allowances.	S 288		
S 360	44:04:13:01 Application of chapter This chapter applies to all new facilities and to renovations, additions, and changes in space use of currently approved existing facilities. Accessible and usable accommodations must be available to the public, staff, and...residents with disabilities. Minimum requirements, except as noted in this chapter are those in "ADA Accessibility Guidelines for Buildings and Facilities." 28 C.F.R., Part 36, Appendix A, as published in 56 Fed. Reg. 35605 to 35690, inclusive (July 26, 1991), http://www.usdoj.gov/crt/ada/req3a.html#Anchor-Appendix-52467.	S 360	S360 1. No specific residents were cited. 2. All residents are potentially at risk. 3. a. Maintenance Supervisor will remove the incorrect signage on toilet rooms by 4/29/2015. a. Education to maintenance staff to be completed by the Administrator or designee on or before 4/29/15 on proper labeling of toilet rooms. b. Administrator or designee will	5/18/15

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S 360	Continued From page 5 Facilities must comply with NFPA 101 Life Safety Code, 2000 edition. Facilities must also comply with the building construction standards of the International Building Code, 2000 edition. Facilities providing off-site services must comply with "Business Occupancy standards or other occupancies standards as applicable for the use of the facility from "NFPA 101 Life Safety Code, 2000 edition, and construction standards of the International Building Code, 2000 edition for the buildings where these services are offered. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation, record review, and interview, the provider failed to maintain accessible toilet rooms for resident use for two randomly observed common area toilet rooms (west wing of building 01 and in building 02). Findings include: 1. Random observation beginning at 12:45 p.m. on 3/31/15 revealed the toilet room next to the charge nurse's office in the west wing of building 01 was labeled with a sign indicating it was an accessible toilet room. The room did not meet grab bar or turning radius requirements. Interview with the maintenance supervisor at the time of the observation confirmed that finding. Review of the technical assistance for the previous survey dated 5/06/14 revealed advice had been given to remove the incorrect signage. 2. Random observation at 2:00 p.m. on 3/31/15 revealed the toilet room next to the nurses' station in building 02 was labeled with a sign	S 360	complete written audits weekly x 4, then monthly x 2 on proper labeling of toilet rooms. Audit selection is random with a maximum of four. The following areas will be audited. 1. Toilet rooms will be labeled appropriately. 4. Administrator or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.	

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S 360	Continued From page 6 indicating it was an accessible toilet room. The room did not meet grab bar or turning radius requirements. Interview with the maintenance supervisor at the time of the observation confirmed that finding. Review of the technical assistance for the previous survey dated 5/06/14 revealed advice had been given to remove the incorrect signage.	S 360		