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	435109	A. BUILDING _____ B. WING _____	C 04/25/2025

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FIRESTEEL HEALTHCARE CENTER	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 4/22/25 through 4/25/25. Firesteel Healthcare Center was found not in compliance with the following requirements: F554, F584, F625, F656, F812, F847, F867, F880, and F925. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/22/25 through 4/25/25. Areas surveyed included foul odors, a norovirus outbreak, pressure ulcer prevention and treatment, incident investigation, accident hazards related to an elopement and a fall from a mechanical lift machine, lost or stolen resident items, bed hold notices, and change in condition notification. Firesteel Healthcare Center was found not in compliance with the following requirements: F584, F625, and F880.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (31 and 104) were assessed for the ability to safely self-administer medications delivered through nebulizer machines (device that converts liquid medication into an inhalable mist). Findings include:	F 554	1) On 4/24/2025 at 8:45 a.m., the CMA failed to stay in the room with resident 31 while administering nebulizer treatment. This resident did not have an order for self-administration of the nebulizer treatment. On 04/24/2025 at 9:44 AM , the CMA failed to stay in the room with resident 104 while administering a nebulizer treatment. This resident did not have an order for self-administration of the nebulizer treatment. Resident 104 was reviewed for ability to self-administer nebulizer treatments after set-up. An evaluation was completed, and an order was recieved to allow this resident to self-administer nebulizer treatments after set-up by CMA or LN. Resident 31 was reviewed for ability to self-administer nebulizer treatments after set up. After IDT review, it was decided that this resident is unable to safely self-administer nebulizer treatments after set-up by CMA or LN. Continued to next page.	5/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Petar Mirkovic
TITLE: Executive Director
(X6) DATE: 05/20/2025

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 554	Continued From page 1 1. Observation and interview on 4/23/25 at 8:45 a.m. with resident 31 revealed: *She confirmed the staff would: -Have set up the nebulizer (neb) medication (med) for her to administer on her own. -Not have stayed in the room to ensure she had taken all the medication. *She stated, "They come back and check on me to make sure I finished it." *The neb machine remained on the table stand with the tubing and the reservoir cup (medication chamber) disassembled. *The tubing and reservoir cup appeared to have been cleaned out. Observation and interview on 4/24/25 at 7:32 a.m. with certified medication aide (CMA) DD while administering a neb med to resident 31 revealed she: *Placed the med in the reservoir cup of the neb tube assembly. *Placed the neb machine on the table stand next to resident 31's recliner, turned it on, and handed the neb tube assembly to the resident. *Left the resident's room, went back to her medication cart and continued to pass meds to other residents. -The resident was not visible to her while she was back at her med cart. *Stated she would check back with the resident to ensure she had completed the treatment later. . Review of resident 31's electronic medical record (EMR) revealed: *She was admitted on 12/6/24. *She had a Brief Interview for Mental Status (BIMS) assessment score of 12, which indicated she was	F 554	2. All residents identified who desire to self-administer medications. All residents who desire to self-administer medications have been evaluated to determine ability.5/20 LL,DNS New orders for medication via nebulizer will be reviewed for the ability to self-administer after set-up. New orders will be identified during the daily clinical meeting. 3. DNS or designee will educate all LN and CMAs by 5/21/2025 (5/20 LL,DNS) on the following: - Self-administration of all types of medications 5/20 LL, DNS - Guidelines for Administration of Aerosolized Care 4. The DNS or designee will audit the administration of nebulizer treatments 3x weekly x 4 weeks; then weekly x 8 weeks. The DNS or designee will bring the results of the audits to the monthly QAPI meeting for further review and recommendation to cont-inue or discontinue the audit.	

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moderately cognitively impaired.
*A physician's order on 12/6/24 for budesonide (med to reduce inflammation) inhalation suspension 0.5mg [milligrams]/2ml [milliliters] to be given two times a day by neb for shortness of breath (SOB).
-There was no physician's order found to support she could have self-administered that neb med treatment.
-There was no assessment to support she had been assessed as capable of self-administering the budesonide.
*Her care plan did not include that she self-administered of any medications.

Interview and record review on 4/24/25 at 8:30 a.m. with staff development registered nurse (RN) F regarding resident 31 revealed:
*She had not been aware the staff had been leaving the resident to self-administer the budesonide neb treatment.
"They are supposed to have an order for the resident so she can self-administer her neb treatment."
*She confirmed there was no order found in resident 31's electronic medical record (EMR) to support she could have self-administered that med.
*She confirmed there was no assessment found in her EMR to support she had been capable of safely self-administering the budesonide neb treatment.

2. Observation and interview on 4/24/25 at 9:44 a.m. of resident 104 in his room revealed:
*He was inhaling a nebulizer treatment independently.
*There were no staff members with him.
*He indicated that a nurse sat with him when he

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was first prescribed the nebulizer treatments, educated him on how to complete the treatment, and reminded him to keep breathing.
-Since then, staff would set up the nebulizer machine, and they would leave so he could complete the treatment by himself.

Review of resident 104's EMR revealed:
*He admitted on 4/3/25.
*His 4/9/25 BIMS assessment score was 15, which indicated he was cognitively intact.
*He had a physician's order for "Ipratropium-Albuterol Solution 0.5-2.5 (3) MG [milligrams]/3ML [milliliters] 3 ml inhale orally via nebulizer three times a day ..." that started on 4/3/25.
*There were no physician's orders for his self-administration of the nebulizer medication.
*There were no assessments or evaluations indicating that he was safe to have self-administered that medication.
*His care plan did not include that he could safely self-administer the nebulizer medication.

3. Review of the provider's 9/2017 Self-Administration of Medication policy revealed:
1."If the resident desires to self-administer medications, the Self-Medication Evaluation is completed. This evaluation is completed before the resident is able to self-administer."
2."If it is determined the resident may self-administer medications, the nurse:"
a."Obtains a physician order for self-administration for the specific medication (s)."
b."Initiates the Self-Medication Administration Care Plan."
c."Determines whether medications will be stored at nursing station or resident's room."

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F 554	Continued From page 4 d."Initiates the Bedside Self-Medication Administration Record, if medications are stored at bedside." e."Obtain and initiate proper safety mechanisms if medications are stored at the bedside (i.e.lock box)." f."LN director of nursing (DON) has a key to any lock box or locked drawer holding medications." 3."If the resident is able to self-administer medications, the evaluation is reviewed quarterly or upon resident's change in condition." 4."If the resident is unable to self-administer medications, the interdisciplinary team (IDT) reviews the Self-Medication Evaluation and determines if there are other areas the resident can complete."	F 554		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584	1. Sewer odor, the corrective action taken to resolve the deficient practice is the following: a. On 04/28/25 the facility had Bender/Sewer complete an additional smoke test of the therapy gym/common area. This smoke test revealed smoke leaking from two heating units in the therapy gym. b. Krohmer Plumbing on 04/29/2025 came to the facility to inspect the two heating units and installed back check valves in each unit to prevent sewer gases coming back up from the 2 inch drainpipe. c. On 04/30/2025 camera viewed the drain piping in both heating units to verify that P-Traps existed and functioning properly. Upon completion no P-Traps were found in units. d. On 05/01/25 the maintenance department installed P-traps in heating units that reside in the therapy gym. e. On 05/09/2025 a sewer smell was noticed in the linen room that contains a sub-pump. Krohmer was called to facility again. Krohmer found a vent pipe that had a cracked fitting which was the reason for the smell. Krohmer replaced this cracked pipe and they stated that this should resolve any odors in linen room. f. On 05/10/2025, the maintenance department repainted the linen room to ensure no lingering smells were in the old paint. g. ED audited for a sewer smell on 05/10, 05/11, 05/12, with no sewer smell noted. h. On the mid morning of 5/12 facility staff noticed a sewer smell continuing to come from the linen room. i. Krohmer plumbing returned to facility on 05/14/2025 to inspect the linen room and found the heating unit in linen room had a pipe leaking sewer smell that had no P-trap. Continued on next page.	5/21/2025

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F 584	Continued From page 5 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure a homelike environment that was free from foul odors for: *The physical therapy gym, the nurse's desk outside the physical therapy gym, and near the rehab dining room. *The area around the nurse's station on the 200-hallway. Findings include: 1. Interview on 4/22/25 at 3:27 p.m. with therapy director R revealed: *There was a sewer odor coming from the linen closet near the therapy gym. *A contracted company recently performed a smoke test to determine areas of poor ventilation.	F 584	Krohmer plumbing installed a P-trap on this pipe found in the heating unit on 05/14/2025. Krohmer stated that this should be the last source of sewer odor and to call them 5/15 if we notice any other odor. 2. The facility held a resident council meeting on 05/09/2025 updating all residents on repairs completed to combat the sewer odor issue. All residents were informed that if they smell any foul odor to notify nursing staff, and nursing staff will notify leadership. 3. The facility maintenance staff will interview five staff per week and five residents per week asking if they have smelled any foul odor/sewer smell 1x weekly for 4 weeks, 1x monthly for 3 months. 4. The ED/designee will bring the audit results to monthly QAPI meetings for further review and to continue or discontinue the audits. 1. The room of resident 48 was deep cleaned on 5/15/25. The deep clean schedule was adjusted for resident 48 to include twice weekly cleaning. 2. The deep clean schedule was reviewed for all residents. All defiant practices were corrected. 3. The housekeeping staff was re-educated by housekeeping supervisor on the 5 step daily room cleaning and the deep clean check off list. 4. The ED/designee will audit the deep clean process 3x weekly for 4 weeks, then weekly x 8 weeks. The ED/designee will bring the audit results to monthly QAPI meetings for further review and to continue or discontinue the audits.	5/21/2025

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-Some fixes were made which helped decrease the sewer odor in one of the therapy gym rooms.
-There were still periods where a sewer odor was lingering and noticeable.
-The odor was worse in the morning, usually around 9:00 a.m.

Interview on 4/22/25 at 5:22 p.m. with resident 30 in her room revealed:
*She felt the sewer odor throughout the facility had been an issue for a long time.
*She said that she was able to smell the same sewer odor on her way to the therapy gym that morning.
*She had informed the administrator and other staff about the sewer odor on several different occasions.
-The administrator had told her that he solved the problem, but she could still smell the odor.

Interview on 4/22/25 at 5:56 p.m. with administrator A revealed:
*He confirmed he was aware of the sewer odor issue near the physical therapy gym.
*He confirmed a contracted plumbing company performed a smoke test to determine any areas of leaking ventilation.
-He showed photos of the smoke coming out from under the wall in the therapy gym.
-The drywall in that area was removed to find an uncovered pipe in the cinderblock wall.
-That uncovered pipe was potentially the source of the sewer odor.
-The pipe was fixed, and the wall was repaired.

Observation and interview on 4/23/25 at 9:40 a.m. with resident 30 in the therapy gym revealed:
*There was a distinct sewer odor near the entrance to the therapy gym. The odor grew

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stronger in the therapy gym.
*Resident 30 was utilizing a piece of gym equipment.
-She indicated that the odor had been there for years.
-Her room was near the rehab dining room, and she sometimes could smell the sewer odor near her room.

Review of the provider's online maintenance log revealed:
*There were seven different work orders provided for review regarding the sewer odor from January through March 2025 including:
-Work order #3609 titled "sewer smell" submitted on 1/30/25 read, "Heater units checked and put water in traps to ensure that no traps are empty. [Ran] water in sinks and in bathtub as well to ensure no sewer gases are coming back out of the plumbing."
-Work order #3689 titled "Sewer Smell" submitted on 2/27/25 read, "Sink with no water in p-trap allowing sewer [gases] to escape."
-Work order #3720 titled "sewer smell" submitted on 3/10/25 read, "checked Room and did not note any odd smells but will contact vendor to smoke test."
-Work order #3724 titled "sewer smell" submitted on 3/11/25 read, "Contacted [vendor] to smoke test vents on building but they cannot be out for another week as they are booked up. Drains checked, no problems noted, there is an odor but cannot smell sewer gases."
-Work order #3729 titled "sewer smell" submitted on 3/12/25 at 7:58 a.m. read, "Still waiting for vendor to come smoke test, will check drains."
The affected locations were documented as the "300 desk area [the nurse's desk outside the physical therapy gym], hallway into therapy,

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therapy, [staff member's] office, and OP [outpatient] therapy room."
-Work order #3731 titled "sewer smell" submitted on 3/12/25 at 9:34 a.m. read, "Still waiting for vendor. Checked room and smell is not as bad as it is being described. Will have Housekeeping spray rooms. Let staff know multiple times that we are waiting for the vendor."
-Work order #3776 titled "ceiling tile" submitted on 3/24/25 read, "ceiling tile was removed out of place in the OP room where the recent sewer gas/smoke test was completed."

Review of the provider's invoice from the contracted plumbing vendor revealed:
*The vendor conducted smoke tests on 3/19/25 and 4/7/25.
*They found a "1.5 [inch] pipe in the block wall was not capped off."

2. Observation and interview on 4/23/25 10:30 a.m. with resident 48 regarding his room located on the 200-hallway revealed:
*He was lying on his bed.
*There was a strong urine smell in his room.
*The gray sweatpants he was wearing appeared to be wet.
*He had an empty urinal that was hanging from a small garbage can next to the bed.
*He did not notice any odors in his room.

Interview on 4/23/25 at 9:48 a.m. with certified medication aide (CMA) O regarding the strong urine smell by the 200-hallway nurses' station revealed:
*Resident 48's room had a strong urine odor that was noticeable down the hall.
*Resident 48 tried to use his urinal and would sometimes spill or miss the urinal causing urine

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to go on the floor or other areas.
*The housekeepers have cleaned resident 48's room when he allows them to.

Interview on 4/23/25 at 10:19 am. with housekeeper P regarding the urine odor in the 200-hallway revealed:
*She stated they have had several strange smells throughout the building recently.
*They had issues with a radiator in a room and needed to call someone to fix it.
*Housekeepers have done a deep clean in rooms when residents were not in those rooms.
*The deep clean included mopping the floor with Ecolab Rapid Multi-surface Disinfectant Cleaner that addresses urine smells.
*If she was notified of an accident or someone urinating on the floor, she would clean it up and use that chemical.

Observation on 4/23/25 at 2:53 p.m. in the 200-hallway revealed:
*A strong urine odor was noticeable starting near the nurses' station.
*The odor became stronger and was very noticeable going down the hall, then lessened and lingered a few rooms down the hallway.

Interview on 4/24/25 at 9:55 a.m. with contracted housekeeping supervisor Q regarding the urine odors in the 200-hallway revealed:
*She was aware of the odors.
*They had daily task sheets that the housekeepers were to fill out for each room they cleaned.
*She kept those sheets for a month.
*Resident 48 did not like to let people change his sheets or deep clean his room which contributed to the odors.

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*They tried to coordinate room cleaning with his bath day.
*She did not feel housekeeping staff got a lot of help from nursing staff when trying to coordinate problem areas that needed to be cleaned to help reduce the odors.

Observation on 4/24/25 at 9:55 a.m. in the 200-hallway continued to show a strong urine smell was noticeable starting at the nurse's station that odor continued past room 205.

Observation and interview on 4/24/25 at 10:22 a.m. in the 200-hallway with administrator A revealed:
*He confirmed there was a strong urine odor between rooms 201 to 205.
*He thought one of those rooms was the source of the odor.
*He stated resident 48 had anxiety and exhibited behaviors when staff tried to clean his room.

Observation on 4/25/25 at 7:58 a.m. of resident 48's room after it had been deep cleaned revealed:
*It still had a strong urine smell.
*The urine odor was masked by the scent of an air freshener.

Review of the provider's undated 5-step Daily Room Cleaning policy revealed:
*"Purpose: To teach Environmental Services employees the proper cleaning method to sanitize a patient room or any area in a healthcare facility."
*"5. Damp mop
-Remember-The procedure is to 'damp mop'-not wet mop.
-The most important area of a patient's room to

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F 584	Continued From page 11 disinfect is the floor. This is where most airborne bacteria will settle and so it needs to be sanitized daily. -As with dust mopping, start in the far corner of the room, move all furniture necessary, and run the mop along the edges first. Never push the mop into a corner. That will only lead to build up."	F 584		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625	1. It was noted on 4/22/2025 that resident 52 had been transferred to the hospital on 4/4/2025. He was readmitted to the facility on 4/8/2025. No documentation indicated he had received the bed hold policy information. Resident 52 had a 5-day Medicaid bed hold that covered the cost of his room while hospitalized. It was noted on 4/22/2025 that resident 33 was hospitalized from 12/28/2025 through 1/2/2025. No documentation was noted that this resident was provided with bed hold policy information. This resident was not charged for a bed hold during hospitalization. It was noted on 4/22/2025 that resident 107 was hospitalized from 4/9/2025 through 4/15/2025. No documentation was noted that this resident was provided with bed hold policy information. Resident 107 had a 5-day Medicaid bed hold that covered the cost of her room for 5 days while hospitalized. Resident was not billed for her room for the remainder of her hospitalization. It was noted on 4/22/2025 that resident 66 was hospitalized on 2/17/2025. No documentation was noted that this resident was provided with bed hold policy information Resident 66 had a 5-day Medicaid bed hold that covered the cost of his room while hospitalized. 2. All recent transfers or leave of absences reviewed to ensure they were provided with bed hold information. (5/20 LL, DNS) 3. The Executive Director, Director of Nursing, and interdisciplinary team have reviewed the bed hold policy.Bed Hold Policy reviewed to ensure that the resident and/or representative is informed of the Bed Hold Policy in writing upon admission, transfer, or leave of absence. (5/20 LL, DNS) Continued on next page.	5/21/2025

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F 625	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to provide bed-hold notices to the resident or the resident's responsible party at the time of transfer to a hospital for four of four sampled residents (33, 52, 66, and 107) who had transferred to the hospital. Findings include: 1. Observation and interview on 4/22/25 at 5:06 p.m. with resident 52 in his room revealed: *He was sitting in his recliner. *He had a sling around his left arm and shoulder. *He stated he was in the hospital for four days earlier this month. Review of resident 52's electronic medical record (EMR) revealed: *He had a Brief Interview for Mental Status (BIMS) assessment score of 15, which meant he was cognitively intact. *He had a fall on 4/4/25 and was transferred to the emergency room (ER). *His emergency contact had been notified on 4/4/25 of the need for an emergency room evaluation. *He was readmitted to the facility on 4/8/25. *No documentation indicated he had received the bed hold policy information. 2. Review of resident 33's EMR revealed she was hospitalized from 12/28/24 through 1/2/25. Neither she nor her representative were provided with a bed hold notice to indicate if she wanted the facility to hold her bed during her hospital stay. 3. Review of resident 107's EMR revealed she	F 625	4. The DNS or designee will audit all discharges and transfers x4 weeks then 2 transfers or dicharges per week x 2 months. The DNS or designee will bring the results of the audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	

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F 625	Continued From page 13	F 625		

was hospitalized from 4/9/25 through 4/15/25. Neither she nor her family were provided with a bed hold notice to indicate if she wanted the facility to hold her bed during her hospital stay.

4. Review of resident 66's EMR revealed:
*He had a BIMS score of 15 which meant he was cognitively intact.
*He had been admitted on 12/26/24.
*Since his admission, he had been transferred to the hospital multiple times.
*He was hospitalized on 2/17/25.
*There was no documentation that a written Bed Hold policy or notice had been given to the resident or his representative at that time.

Interview on 4/24/25 at 9:12 a.m. with business office manager CC revealed:
*"When a resident was admitted to the facility the Bed Hold policy was given to the resident or their representative."
*When a resident transferred to the hospital they called the family about the Bed Hold policy.
-The nurse initiating the transfer of the resident was to initiate the bed hold paperwork.
-She was unaware if anyone documented that.

Interview on 4/25/25 at 9:55 a.m. with administrator A revealed:
*The Bed Hold policy was given at the time of admission to new residents.
*They had not issued bed hold notices for Medicaid residents who returned within five days because Medicaid pays for holding the resident's bed the first five days of a hospital stay.
*He was unaware that all residents needed a bed-hold signed when they were transferred to the hospital.

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F 625	Continued From page 14 5. Review of the provider's undated South Dakota Notice of Bed-Hold Policy revealed: "It is the policy of the Center to offer the resident and /or resident representative the option to hold the resident bed upon leave of absence, transfer, or discharge. If a bed hold is not in place, the Center may choose to pack resident belongings for safekeeping. The resident has the right to be re-admitted to the Center in the next available bed at the appropriate level of care if bed hold is not secured." *"Private Pay Residents: Bed hold is paid by private funds." *"Medicare Residents: Bed hold is paid by private funds." *"Medicaid Residents: -"https://dss.sd.gov/sdmedx/docs/providers/LongTermCareManual.pdf." 1."The recipient must be absent from the nursing facility due to an inpatient hospital stay in order to qualify for reserved bed days." 2."The state may pay for 5 reserved bed days." 3."The facility may be reimbursed for non-medical, therapeutic leave days, approved by a physician." *The form requested a signature indicating acknowledgement of receiving that notice.	F 625		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656	1. In review of resident 19's current comprehensive care plan, it was noted that her care plan did not reflect her diagnosis of post-traumatic stress disorder or interventions staff should utilize to address that diagnosis and avoid re-traumatizing. There was also no mention of the use of a foot cradle on her care plan. In review of resident 85's care plan, it was noted that the resident's care plan stated that he had an active surgical wound on his neck. Upon interview with staff, it was noted that the surgical wound had been resolved over a year ago. Resident 85's care plan was reviewed and revised to reflect acurate information. Continued on next page.	5/21/2025

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F 656	Continued From page 15 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 656	In review of resident 33's comprehensive care plan, it did not reflect the unique dietary needs of the resident. It also was noted that this resident's care plan reflected a wound that was no longer active. Resident 33's care plan was reviewed and revised to reflect accurate information. 2. The care plans of residents with devices, PTSD diagnosis, and skin conditions were reviewed and revised. (LL, DNS 5/20) 3. The Executive Director, Director of Nursing, and Interdisciplinary Team have reviewed the facility's Comprehensive Care Plan Policy; Baseline Care Plan Policy; Baseline Plan of Care Acknowledgment Policy. New and resolved care plan items will be identified during the daily clinical meeting. The facility will hold a monthly care plan meeting. 4. The DNS or designee will audit 4 resident care plans x 4 weeks; and then audit 2 comprehensive care plans weekly x 2 months. The DNS or designee will bring the audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	

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review, the provider failed to ensure resident care plans were updated to reflect the current needs of three of twenty-six sampled residents (19, 33, and 85), such as resident preferences, skin wound prevention, and PTSD re-traumatizing prevention.
Findings include:

1. Observation and interview on 4/23/25 at 2:28 p.m. with resident 19 in her room revealed:
*She was lying on her back in bed.
*There was a foot cradle over her feet, a device to lift the blankets away from a resident's feet.
*She was very soft-spoken and indicated that she normally stays in bed each day.
-She was terrified of falling.
-She had a fall about a year ago and has stayed in bed since then.
-She refuses to get out of bed.
-She had no current skin issues or pressure injuries.

Review of resident 19's current comprehensive care plan revealed:
*She was admitted on 5/5/22.
*Her diagnoses included major depressive disorder (a mood disorder), and post-traumatic stress disorder (PTSD).
*Her care plan included that she was a veteran and had access to psychiatric resources through the Veteran's Administration (VA).
-She was receiving telehealth counseling services.
*Her care plan did not include her diagnosis of PTSD or interventions staff should utilize to address that diagnosis and avoid re-traumatizing.
*There was no mention of the use of a foot cradle on her care plan.

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Interview on 4/24/25 at 1:33 p.m. with certified nurse aide/certified medication aide (CNA/CMA) BB about resident 19 revealed:
*She was a contracted travel staff member and had been working at the facility for four months.
*She was not aware that resident 19 had a diagnosis of PTSD or what strategies to use to address the resident's psychosocial wellbeing.
-She was not aware of possible trauma triggers for resident 19.
*She was aware that resident 19 frequently refused to get out of bed, and she had never seen resident 19 out of bed in her time working at that facility.

Interview on 4/24/25 at 1:47 p.m. with CNA EE about resident 19 revealed:
*She was not aware that resident 19 had a diagnosis of PTSD or any trauma triggers.
*She had access to resident care plans through the provider's "point of care" electronic program.
-The "point of care" electronic program allowed the nursing staff to review the resident's care plan and chart care items such as food and fluid intake, behavior symptoms, and bladder and bowel output.

Interview on 4/24/25 at 2:18 p.m. with Minimum Data Set (MDS) coordinator D revealed:
*As the MDS coordinator, she was the main person in charge of initiating and updating resident care plans.
*Other departments, such as social services and dietary, also participated in developing and updating the residents' comprehensive care plans.
-She indicated to talk to the social services department regarding resident 19's behavioral health needs.

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*She was not aware that resident 19 was using a foot cradle when she was in bed.
-She confirmed that she would have expected specialized equipment, like that foot cradle, to have been included on the resident's care plan.

Interview on 4/24/25 at 2:37 p.m. with social services director (SSD) E revealed:
*She confirmed that resident 19 was a veteran and had a history of trauma and mental health concerns.
-She exhibited paranoia at times.
-Her past trauma included her experience in the military and a car accident where she almost died.
*Care plans should have included the resident's trauma history and any trauma triggers so staff could avoid re-traumatizing the resident.
*Care plans should have also included a resident's personality and effective ways that staff should communicate with or approach residents.

Interview on 4/24/25 at 4:23 p.m. with MDS coordinator D revealed that resident 19's foot cradle was implemented a few months ago. The former wound care nurse implemented the device but had not updated the resident's care plan.

2. Interview on 4/25/25 at 8:43 a.m. with resident 33 revealed:
*She indicated that her normal eating habits included skipping breakfast. She said she never ate breakfast.
*While lying in bed, she utilized a hiking water bladder (a flexible container for holding liquids) with a straw that rested on her bedside table.
-She believed she did not have the strength to pick up the normal water bottle from her bedside table, so she had her daughter bring in the water

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bladder to use for fluid intake while she was in bed.

Review of resident 33's EMR revealed her current comprehensive care plan did not include her preference of skipping breakfast or her use of the water bladder.

Interview on 4/24/25 at 9:53 a.m. and 11:29 a.m. with registered nurse (RN) K revealed:
*She was aware that resident 33 usually skipped breakfast. The resident kept snacks in her room to consume as she wished.
*She was aware that the resident used the water bladder for fluid intake while in bed.
*She had the ability to add items to the resident's care plan, but the intake team (consisting of one of the resident care managers and the social worker) and the MDS coordinator usually managed the care plan.
*Normal dietary items to include on the care plan included the resident's diet order, preferences and allergies, and nutrition supplements.

3. Observation and interview on 4/23/25 at 3:47 p.m. of resident 85 with licensed practical nurse (LPN) N and RN K revealed:
*Both of resident 85's lower legs were wrapped with compression bandages.
*LPN N and RN K confirmed that resident 85 had venous stasis wounds (open sores that develop on the skin due to impaired blood circulation in the veins) on both of his lower legs and was to use "Unna boots" (compression bandages) for those wounds.

Review of resident 85's current comprehensive care plan revealed:
*His care plan included that he had "actual

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impairment to skin integrity of the neck r/t [related to] surgical wound."
*The care plan did not include that he had wounds on both of his lower legs or that he was to use the Unna boots.

Interview on 4/24/25 at 11:35 a.m. with RN K revealed:
*The Unna boots were specialized wound treatment compression wraps.
-That was a new treatment intervention for resident 85.
*The wraps stayed on his legs until the nurse supervisors changed them.
-She did not know how often the Unna boots were changed.

Continued interview on 4/24/25 at 11:42 a.m. with RN K and DNS B revealed:
*Resident 85 had venous stasis ulcers on both his lower legs. He was noncompliant with elevating his legs to reduce his edema (a buildup of fluid that causes swelling).
*His Unna boots were not actual boots, and they explained it was a system of wet wrapping.
-The inner wrappings were saturated with medicated ointment, then wrapped with compression wrappings over the top.
*The wrappings were changed twice per week.
*They confirmed that resident 85's surgical wound on his neck (that was included on his current comprehensive care plan) was no longer an issue and was resolved over a year ago.

4. Interview on 4/24/25 at 2:05 p.m. with MDS coordinator D revealed:
*The comprehensive care plan was built from the MDS assessment and the care area assessments that were triggered by the initial

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comprehensive MDS assessment question responses.
*The social worker was in charge of the social/emotional portion of the care plan.
*Other departments were responsible for other sections of the care plan, such as the activities and dietary departments.
*The care team discussed the residents daily during their "stand-up" meeting and made care plan changes as needed.
*They did not often go into detail with including wound treatments on the care plan as the treatment orders could change often.
-Rather, they would include a statement such as, "Resident has a skin impairment, see orders for current treatments."

5. Interview on 4/24/25 at 3:22 p.m. with resident care manager G and staff development RN F revealed:
*The care management team developed and updated resident care plans.
*The resident care managers were to complete the initial baseline care plan when a resident was admitted to the facility.
*Each department was to be involved in developing and updating a resident's comprehensive care plan and revising as needed.

6. Interview on 4/24/25 at 3:30 p.m. with director of nursing services (DNS) B revealed:
*She was new to her position as the DNS in that facility since the beginning of April 2025.
*Comprehensive care plans should include topics such as a resident's transfer status, mobility, psychosocial, behavioral, social services, relevant diagnoses, certain medications, skin issues, and nutritional status.
*She was not aware of resident 19's PTSD

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F 656	Continued From page 22 diagnosis and agreed that was an important topic to have included include on the resident's care plan. *She would have expected resident 33's unique dietary and drinking equipment preferences to have been included on her care plan. *She agreed that once a wound was healed and resolved, it should have been removed from the care plan. -The care plan should have been updated with current skin concerns like resident 85's venous ulcers. 7. A care plan policy was requested on 4/24/25 at around 12:18 p.m. A care plan policy was not provided by the end of the survey on 4/25/25 at 1:52 p.m.	F 656		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812	1. On 4/24/2025 CDM educated all dietary staff on the following below: a. How to thaw frozen foods, b. Safe refrigerator storage for all food, c. Potentially hazardous foods, d. Cooling cooked items and completing Chill down log. 2. All residents have potential to be affected by deficient practice. 3. a. The CDM will audit dietary cooks to ensure safe food handling. Will be conducted 4x weekly for 4 weeks; and then audit 1x weekly for 3 months. b. The CDM will audit walk in fridge to ensure safe food storage guidelines are followed. This audit will be conducted 4x weekly for 4 weeks; and then audit 1x weekly for 3 months. 4. The CDM will bring the results of the audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	5/21/25

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F 812	Continued From page 23 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to follow standard food safety practices to ensure: *Prepared foods were covered when stored in one of one walk-in cooler. *The food stored in the walk-in cooler was stored appropriately to prevent cross-contamination. *Potentially hazardous food was prepared, stored, and served at safe food temperatures for one of one observed meal service. Findings include: 1. Observation on 4/22/25 at 3:15 p.m. of the walk-in cooler in the kitchen revealed: *A tray of 21 individual servings of chocolate pudding in reusable dessert bowls on a tray rack that were not covered and were open to air. *A shelving unit that contained on its: -Top shelf a cardboard box containing a plastic package of sliced beef that was fully cooked and another cardboard box containing three plastic packages of sliced smoked fully-cooked ham. -Top shelf, a laminated sign zip tied which displayed "Safe Refrigerator Storage..." with a chart that directed to store: --"Ready-to Eat Foods" on the top shelf. --"Raw Fish and Seafood" on the second shelf. --"Raw Beef" on the third shelf. --"Raw Pork" on the fourth shelf. --"Raw Ground Beef or Pork" on the fifth shelf. --"Raw Poultry Raw Eggs" on the bottom shelf. -Second shelf a cardboard box of "Texas Smoked Brand Layflat Bacon" that contained strips of raw bacon. --The cardboard box was observed with a small amount of water on top of it.	F 812		

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F 812	Continued From page 24 --The box contained a label that stated "KEEP FROZEN". -Third shelf, a metal container of turkey slices covered with tin foil dated 4/22. -Bottom shelf, a plastic tub of lettuce mixed with shredded cheese covered with tin foil that was not labeled or dated. --That ready-to-eat salad was stored underneath the cardboard box of raw bacon strips, with water on top of the box, having the potential for cross-contamination. 2. Interview on 4/22/25 at 3:24 p.m. with an unidentified staff member who walked into the cooler regarding the container of salad that was stored on the bottom shelf revealed he replied, "I'm not a cook" and left the walk-in cooler. Observation and interview on 4/22/25 at 3:26 p.m. with food and nutrition services (FANS) cook S who walked into the cooler regarding the container of salad stored on the bottom shelf revealed she: *Lifted the tin foil covering, looked at the salad, and stated it had been made that day and would be served at the supper meal. *Had not moved the container of ready-to-eat salad stored on the bottom shelf underneath the cardboard box of raw bacon strips. Observation on 4/22/25 at 5:40 p.m. in the main dining room of the evening meal revealed the meals served to the residents included a lettuce salad. Observation on 4/23/25 at 9:03 a.m. of the walk-in cooler in the kitchen revealed the plastic tub of lettuce mixed with shredded cheese was not in cooler.	F 812		

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F 812	Continued From page 25 Interview on 4/23/25 at 9:04 a.m. with FANS cook T regarding yesterday's observations of the shelving unit in the walk-in cooler with the ready-to-eat salad stored below the cardboard box of raw bacon strip revealed he agreed that it created the potential for cross-contamination and was a problem. Interview on 4/23/25 at 9:09 a.m. with administrator A in the kitchen regarding the concern with the storage of ready-to-eat salad stored below the cardboard box of raw bacon strips in the walk-in cooler revealed he agreed with the concern for cross-contamination and stated, "We've been working on that a lot." Interview on 4/24/25 at 11:32 a.m. with regional dietitian I regarding the ready-to-eat salad stored below the cardboard box of raw bacon strips in the walk-in cooler revealed she agreed that had for potential cross-contamination and it would not have been stored according to the provider's Safe Refrigerator Storage reference. 3. Observation on 4/24/25 at 11:10 a.m. of the walk-in cooler revealed a tray cart was in the cooler with trays of: *Plated egg salad sandwiches covered with clear plastic wrap. *Bowls of egg salad covered with clear plastic wrap. Observation and interview on 4/24/25 during the noon meal service in the kitchen revealed: *FANS cook U was dishing the prepared food onto plates for the residents. *FANS cook V was placing the plates of prepared food onto individual serving trays.	F 812		

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*Regional dietitian I and FANS manager H were observing the process.
*At 11:49 a.m. FANS cook V pulled a plate with an egg salad sandwich covered with plastic wrap from the tray rack in the walk-in cooler to serve to a resident.
-Regional dietitian I used a food thermometer and took the surveyor 43021 requested temperature reading of the prepared egg salad sandwich, which was 53.4 degrees Fahrenheit (F).
-That temperature was requested as certain foods are considered more hazardous than others and are called potentially hazardous foods (PHF) or Time/Temperature Controlled for Safety (TCS) food.
--PHF/TCS foods include eggs.
--PHF/TCS foods must be maintained at or below 41 degrees F for food safety.
*FANS cook U stated:
-The egg salad mixture had been prepared the day before (4/23/25), using hard-boiled eggs and mayonnaise and then placed into the walk-in cooler overnight.
-She had made the sandwiches with that egg salad mixture that morning (4/24/25) at 10:00 a.m. and then had put those egg salad sandwiches into the walk-in cooler.
*Regional dietitian I took the food temperature at 51.6 degrees F for the egg salad in the bowls, which she stated was for the International Dysphasia Diet Standardization Initiative (IDDSI)'s level five "minced and moist" diet.
*At 11:52 a.m. FANS cook V pulled another plate with an egg salad sandwich covered with plastic wrap from the tray rack in the walk-in cooler to serve to a resident.
*At 11:57 a.m. FANS cook V requested an egg salad sandwich and regional dietitian I pulled a plate with an egg salad sandwich covered with

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F 812	Continued From page 27 plastic wrap from the tray rack in the walk-in cooler and gave it to FANS cook V who served it to a resident. *At 12:01 p.m. FANS cook V requested another egg salad sandwich and regional dietitian I pulled a plate with an egg salad sandwich covered with plastic wrap from the tray rack in the walk-in cooler and gave it to FANS cook V who served it to a resident. *At 12:02 p.m. regional dietitian I used a food thermometer and took the surveyor 43021 requested temperature reading of the prepared egg salad sandwiches which was: -50.4 degrees F for the egg salad in a bowl for the IDDSI's level five minced and moist diets. -50.7 degrees F for the prepared egg salad sandwiches. -FANS cook U confirmed: --The egg salad mixture had been prepared the day before (4/23/25), using hard-boiled eggs and mayonnaise and then placed into the walk-in cooler overnight. --She had made the sandwiches with that egg salad mixture that morning (4/24/25) at 10:00 a.m. and then had been put those egg salad sandwiches into the walk-in cooler. *There was no record of any food temperatures taken of the egg salad prior to the noon meal service to support the egg salad had been in the appropriate temperature range. *Both regional dietitian I and FANS manager H agreed that the egg salad: -Was a PHF/TCS food item. -Food temperature was not maintained at or below 41 degrees F. -Should not have been served at the noon meal to residents. Observation on 4/24/25 at 3:30 p.m. of the	F 812		

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F 812	Continued From page 28 walk-in cooler in the kitchen revealed several uncooked pizzas were on trays in a tray rack that were uncovered. Interview on 4/24/25 at 3:35 p.m. with FANS manager H revealed her expectation was for food that was stored in the walk-in cooler to be covered to prevent cross contamination. She agreed: *The individual servings of chocolate pudding in reusable dessert bowls should have been covered. *The uncooked pizzas should have been covered. Interview on 4/25/25 at 12:10 p.m. with FANS manager H regarding food storage in the walk-in cooler revealed she: *Agreed that the storage of the ready-to-eat salad below the cardboard box of raw bacon strips in the walk-in cooler had the potential for cross-contamination and was not stored safely. *Had posted the laminated sign in the walk-in cooler regarding "Safe Refrigerator Storage..." with a chart that displayed how to properly store ready-to-eat foods and raw meats. *Had received that "Safe Refrigerator Storage ..." from the regional dietitian and she expected the dietary staff would follow that chart. 4. Review of the provider's October 2017 Food Storage policy revealed "Raw eggs and thawing meats are stored in the refrigerator, preferably on the bottom shelf. Do not store them over ready to eat foods." Review of the provider's November 2018 Preparation and Service of Foods - Safety Precautions policy revealed:	F 812		

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F 812	Continued From page 29 *"Cooling and Cold Holding Methods": -"Potentially Hazardous/Time Temperature Control for safety foods (PHF/TCS) are cooled within 4 hours to 41°F or less if prepared from ingredients at room temperature." Review of the provider's October 2017 Food Temperature policy revealed: *"For potentially hazardous foods on the trayline, the temperature of the food is periodically monitored throughout the meal service to maintain proper hot or cold holding temperatures." *"Corrective action is taken for food temperatures outside of regulatory standards (hot foods should be 140°F or above, cold foods 41°F or less)."	F 812		
F 847 SS=E	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner	F 847	1. Facility along with corporate office reviewed/edited the arbitration agreement. The accept/decline box was removed from the agreement, signing the agreement states you agree to it and the additonal boxes were not needed. 2. On 5/09/2025 the facility held a resident council meeting explaning the arbitration agreement to residents and notifying the residents that they have the option to edit,revoke, and make any changes they wish to the document. Each resident in attendance was given a copy of the agreement to take with. Facility identified every single resident that had a signed arbitration agreement. Every single resident or family representative was contacted to re-explain the agreement and ask residents/representative if they would like to keep document signed or revoke. If they chose to revoke the new copy was scanned into PCC. 3.The Social Services Director/Designee will audit the arbitration process by ensuring all new admits receive a paper copy of the arbitration agreement with ample time to decide. Once facility receives back a signed copy, Social Services Director/ Designee will follow up with family a second time to ensure they completely understood document and wish to keep it signed, this will be audited x3 months.(PM, ED 5/20) Continued to next page.	5/21/25

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F 847	Continued From page 30 that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on record review, interview, resident admission packet review, and policy review, the provider failed to ensure residents or their representatives fully understood the binding arbitration agreement process for two of three sampled residents (66 and 89). Findings include: 1. Review of the provider's record of residents or	F 847	4. The SSD/Designee will bring the results of the audits to the monthly QAPI meeting for further re view and recommendation to continue or discotinue the audits. (PM, ED 5/20)	

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their representatives who had entered into a binding arbitration agreement revealed:
*Resident 66 admitted on 11/8/24 and signed the binding arbitration agreement that same day.
*Resident 89 admitted on 3/3/25 and his wife signed the binding arbitration agreement on 3/4/25. That form had an area to checkmark "I Accept" or "I Decline" and his wife had marked the box next to "I Accept."
*There was no checkmark for "I Accept" or "I Decline" on resident 66's binding arbitration agreement form.

2. Interview on 4/23/25 at 8:31 a.m. with social services director (SSD) E revealed the provider's parent company recently revised the binding arbitration agreement form to include the "I Accept" or "I Decline" options to make the form easier to understand for residents or their representatives.

3. Phone interview on 4/24/25 at 10:53 a.m. with resident 89's wife revealed:
*She went through the admission paperwork with facility staff on 3/4/25, the day after resident 89 was admitted.
*She could not remember what the binding arbitration agreement was or if anyone had explained the form to her.
*When asked if she was aware that by signing the agreement, she was giving up her right to legal litigation in a court of law, resident 89's wife indicated that she did not realize that.
*She seemed to have been quite upset about that on the phone.

Continued interview on 4/24/25 at 3:43 p.m. with resident 89's wife in-person revealed:
*During the admission process, she felt

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overwhelmed because there was "so much information all at once."
*SSD E sat with her through the admission process and explained the paperwork to her.
-She could not remember SSD E having explained the binding arbitration agreement that in-depth with her.
-She could not remember anyone explaining to her that by signing the binding arbitration agreement, she was giving up her right to pursue legal litigation in a court of law.
-"It felt more like a 'and sign here, and here, and here.'"
-If she would have known the implications of the binding arbitration agreement, she would not have agreed and signed it.
*She confirmed that she did not feel forced to sign the document to have her husband admitted to the facility.

4. Interview on 4/24/25 at 4:03 p.m. with resident 66 revealed:
*He thought he admitted to the facility a couple of months ago.
*He could not remember anything about the arbitration agreement from the admission process.
*He indicated his wife might know more about the admission process.
*When asked if he was aware that by signing the agreement, he was giving up his right to litigation in a court proceeding, resident 66 indicated that he did not realize that.
*He was verbally upset about having signed that document and threw his hands in the air in frustration.

The surveyor attempted to call resident 66's wife on 4/25/25 at 10:31 a.m. and left a voicemail

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requesting to call the surveyor back. The surveyor was unable to reach resident 66's wife by the end of the survey on 4/25/25 at 1:52 p.m. to discuss the binding arbitration agreement.

Review of resident 66's electronic medical record revealed:
*He had admission Minimum Data Set (MDS) records on 8/12/24, 11/8/24, 12/26/24, 2/21/25, and 3/5/25.
*The binding arbitration agreement provided to the survey team was from his 11/8/24 admission.
*His 11/14/24 admission MDS assessment indicated that he had a Brief Interview for Mental Status (BIMS) assessment score of 14, which indicated he was cognitively intact.
*His latest 3/11/25 quarterly MDS assessment BIMS assessment score was 13, which indicated he was cognitively intact.

5. Interview on 4/25/25 at 10:36 a.m. with SSD E and administrator A revealed:
*SSD E was the primary staff member to explain the binding arbitration agreement to newly admitted residents and their representatives during the admission meeting.
-She usually met with residents and their representatives for 45 to 60 minutes.
-She would explain that the binding arbitration agreement was optional.
-She would specifically review the bolded portions of the agreement.
*Some residents and their representatives would request a paper copy to review on their own and decide later to sign the agreement or not.
*If residents or their representatives wanted to rescind the binding arbitration agreement, they would contact their legal department for further direction.

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F 847	Continued From page 34 6. Review of the provider's September 2022 South Dakota Arbitration Agreement revealed: *In italics directly below the document title read, "Optional - Not Required" *The items in bold font included: -"This Arbitration Agreement will remain in effect for all care and services subsequently rendered at the Center, even if such care and services are rendered following the Resident's discharge and readmission to the Center." -"THE PARTIES UNDERSTAND AND AGREE THAT BY ENTERING INTO THIS ARBITRATION AGREEMENT THEY AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO HAVE ANY CLAIM DECIDED IN A COURT OF LAW BEFORE A JUDGE AND JURY." -"If someone other than the Resident signs this Arbitration Agreement, they represent to the Center by signing this Arbitration Agreement on the Resident's behalf that they are the legal agent for the Resident and have full power and authority to bind the Resident to this Arbitration Agreement." -"The Resident and Resident's agent further acknowledge that they have received a copy of this Arbitration Agreement, have had an opportunity to read it and ask questions about it, and that they have the right to seek legal counsel concerning this Arbitration Agreement. By signing below, Resident and Resident's agent acknowledge that they fully understand the terms contained in this Arbitration Agreement." -"The Resident and Resident's agent further acknowledge that they are voluntarily entering into this Arbitration Agreement and understand that it is not a condition of admission to the Center or a condition for receiving continued care."	F 847		

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F 847	Continued From page 35 -"IN WITNESS WHEREOF, the parties, intending to be legally bound, have signed this Agreement on the date written below." *There were two boxes to checkmark: one indicating "I Accept" and the other indicating "I Decline."	F 847		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.	F 867	1. Education provided to the IDT on QAPI process by 5/1/2025. ED/DNS assigned education on ED/DNS QAPI responsibility by 5/1/2025. QAPI prioritization tool completed noting all potential DOH annual survey deficiencies by 5/1/2025. QAPI document updated on 5/8/2025 to reflect past and current SD DOH citations. 2. DDCO at facility on 5/08/2025 to review POC with IDT and perform audits. On 5/09/2025 IDT meeting with DVP; DDCO; ED; DNS to review 2567 and POC. 3. IDT will understand and explain the QAPI process as evidence by the SNF Clinic(online education portal) (PM, ED 5/20) percentage at 100% by 5/9/2025. Appoint a QAPI Coordinator to manage and own the QAPI process and lead meetings by 5/2/25. IDT will complete monthly audits specific to their department and will be audited by DNS x 6 months. Goal is to have a successful QAPI plan, identifying areas of concern, implement plans to correct areas of concern, improve quality of care, improve survey outcomes and quality measures. 4. DDCO will attend QAPI meetings x 3 months via phone or in person to ensure facility is correctly completing QAPI plan and policy. DDCO will provide guidance needed at that time.	5/21/25

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F 867	Continued From page 36 §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health	F 867		

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outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§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 program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data

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F 867	Continued From page 38 resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to identify, implement, and document quality assurance and performance improvement (QAPI) plans of action to correct identified infection control deficiencies for three of three months reviewed (January through April 2025) related to hand hygiene and personal protective equipment (PPE) compliance benchmarks. Findings include: 1. Observations and interviews made throughout the survey from 4/22/25 through 4/25/25 revealed that there were issues regarding hand hygiene and PPE compliance, which potentially contributed to the outbreak of a gastrointestinal illness that affected several residents and staff. Refer to F880. 2. Interview and record review on 4/25/25 at 11:19 a.m. with administrator A regarding their quality assurance and performance improvement (QAPI) activities revealed: *Administrator A reviewed their QAPI data on an Excel spreadsheet with the surveyor. *Their QAPI committee met at least monthly to review data and quality measures. -During their meetings, they reviewed the previous month's audits and data. -For example, their January reports reflected data gathered in December. *They identified infection control as a performance measure to track monthly. -Data gathered included hand hygiene and PPE compliance.	F 867		

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F 867	Continued From page 39 -Audits were completed monthly to track performance. *Their plan of correction (POC) for those areas included continuing to educate staff about the importance of hand hygiene and following PPE guidelines. *It was identified that their POC did not include actions beyond educating staff, and their compliance percentages continued to fall below their identified benchmarks each month from January to April 2025 (that data would have reflected December 2024 through March 2025). *They had not tried any other documented methods to increase hand hygiene and PPE compliance to improve their identified infection control concerns. 3. Review of the provider's QAPI report records revealed: *Their compliance benchmark for both hand hygiene and PPE was set at 95% on one page of their QAPI report, but was set at 100% on a different page. *According to their 2025 data, their monthly compliance percentages were as follows: -For hand hygiene: 90% compliance for January, February, March, and April. -For PPE: 85% in January, February, and March, and 90% in April. *Notes from their January 2025 QAPI meeting included: -Hand hygiene: "Investigation: Hand [Hygiene] was at about 90% this month. At times, it was noted that staff did not use hand sanitizer after coming out of rooms each time. Plan of Correction: ICP [infection control program] continue to educate staff [of] the importance of hand [hygiene] and using hand sanitizer after each room. Use of soap and water after 3 times	F 867		

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of hand sanitizer usage."
--There was a section for "Outcome," but nothing was noted in that section.
-PPE compliance: "Investigation: PPE compliance was at about 85% this month. Staff would go into COVID rooms with surgical masks on and not N95 [a specialized face mask]. Gowns not being worn at all times during cares in EBP [enhanced barrier precautions] rooms. Plan of Correction: ICP continue to educate staff [of] the importance of the signs on the doors and wearing the correct PPE. List of COVID positive residents were placed at the [nurse's] station to make staff more aware of which residents required the special quarantine precautions. Outcome: Once staff were reminded on the importance of correct PPE usage, this improved."
*Notes from their February 2025 QAPI meeting included:
-The hand hygiene notes were identical to January's notes.
-PPE compliance: "Investigation: PPE compliance was at about 85% this month. Gowns not being worn at all times during cares in EBP rooms. Plan of Correction: ICP continue to educate staff [of] the importance of the signs on the doors and wearing the correct PPE."
--There was a section for "Outcome," but nothing was noted in that section.
*Notes from their March 2025 QAPI meeting included:
-The hand hygiene notes were identical to January's and February's notes.
-The PPE compliance notes were identical to February's notes.
-PPE Plan of Correction: "ICP continue to educate staff [of] the importance of the signs on the doors and wearing the correct PPE. Outcome: EBP rooms audited and precautions taken down

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F 867	Continued From page 41 if did not meet criteria to help with importance of PPE."	F 867		
F 880 SS=H	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880	1. Observation on 4/22/25 at 4:41 PM that resident 33's door had contact precautions noted on the door. Upon interview, it was noted that this resident no longer requires contact precautions. Contact precautions were discontinued, and signage was removed from resident 33's door on 4/22/25 as she had completed antibiotic treatment on 4/17/25. 2. All residents reviewed for criteria related to transmission-based precautions. Deficient findings were corrected. Facility Norovirus outbreak has resolved. 3. The Director of Nursing and Interdisciplinary team have reviewed the following policies: -Transmission based precautions -Hand washing -Donning and Doffing PPE -Hand hygiene for residents prior to meals Nursing staff will be educated on the above policies by 5/21/2025. (5/20 LL, DNS) All staff not in attendance will be education prior to their next working shift. DON and interdisciplinary team meeting held in collaboration with Dr. Timmer, facilty medical director, to review, revise, and create as necessary policies and/or procedures to ensure infection control practices related to hand hygiene, personal protective equipment, and preventing the spread of infections and communicable diseases are available and followed by staff. 4. The Director of Nursing or designee will audit transmission-based precautions, meal service, hand washing, hand hygiene for residents prior to meals, infection control compliance while staff provide resident care (5/20 LL, DNS) and donning and doffing PPE related to those infection control policies for the health and safety of the residents. Continue next page	5/21/25

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F 880	Continued From page 42 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint intake review, observation, interview, record review, and policy review, the provider failed to ensure proper infection control practices were followed regarding: *Hand hygiene practices by staff members BB, GG, and HH during two of two dining	F 880	The Director of Nursing or Designee will perform random staff interviews to determine if staff have full understanding of infection control policies and to determine if any barriers exist that would affect infection control compliance. (5/20 LL, DNS) These audits will be completed 3 times weekly x 4 weeks and weekly x 2 months. The Director of nursing or designee will bring the audit findings to the monthly QAPI committee for further review and recommendations on continuing or discontinuing the audits	

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observations in two of three dining rooms.
*Hand hygiene and personal protective equipment (PPE) use by three of three staff observed (L, M, and BB) during personal cares for one of one sampled resident (41), personal cares for one of one sampled resident (33) on contact precautions (which indicated staff should have worn gowns and gloves), and assisting with resident transportation for two of two sampled residents (33 and 85).

Failure to follow infection control practices potentially contributed to a norovirus [a highly contagious virus that causes nausea, vomiting, and diarrhea] outbreak in April 2025 which included three residents (18, 40, and 76) with confirmed norovirus infections and at least forty-two additional residents (1, 2, 3, 4, 12, 13, 14, 16, 22, 23, 24, 25, 29, 30, 31, 33, 34, 35, 36, 41, 42, 43, 45, 53, 58, 60, 64, 65, 67, 68, 69, 77, 78, 79, 80, 85, 93, 99, 100, 107, 258, and 259) with identified gastrointestinal (GI) symptoms.

Findings include:

1. Review of the 4/16/25 SD DOH complaint intake form revealed:
*An anonymous email reported a concern that the provider had a "severe outbreak of norovirus."
*The anonymous reporter was concerned the provider was not monitoring "hand washing, sanitation, [and] dishwashing."
*The writer was "fearful" for their family member that resided at the facility.

2. Review of a separate SD DOH complaint intake received on 4/16/25 revealed:
*The complainant reported that resident 107 was recently hospitalized and had to be admitted to

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F 880	Continued From page 44 the intensive care unit (ICU). Review of resident 107's electronic medical record (EMR) revealed: *On 4/9/25, she experienced vomiting, diarrhea, weakness, and confusion. She was unable to speak coherently. *On 4/9/25 around 4:45 p.m., she was sent to the local emergency room for evaluation. -She was then admitted to the ICU for a diagnosis of pneumonia. *She continued to experience diarrhea throughout her hospitalization. *She returned to the facility on 4/15/25. 3. Observation on 4/22/25 at 3:51 p.m. of certified nurse aide (CNA) M and CNA/certified medication aide (CMA) BB performing personal cares for resident 41 revealed: *Both CNAs performed proper hand hygiene before putting on clean pairs of gloves. *Resident 41 had been incontinent of bowel, and they cleaned her up and removed the soiled brief. *Without removing her gloves or performing hand hygiene, CNA/CMA BB walked over to resident 41's wardrobe and touched the door handles, rummaged around in the wardrobe, and grabbed a clean brief. *She continued to assist resident 41 with putting on the clean brief with those same soiled gloves on. *Both CNAs kept on their same pair of soiled gloves throughout the process of changing resident 41's brief, getting her cleaned up, and redressing resident 41. *Both CNAs then removed their gloves and did not perform hand hygiene. *With their unclean hands, they touched: -The resident's sling used for the full body lift.	F 880		

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-The full body lift.
-The resident's positioning pillow.
-The resident's wheelchair.
-The door handle to exit the room.
-CNA M also touched the resident's water cup, held the straw between her right index and middle fingers, and helped resident 41 take a drink of water.
*CNA/CMA BB wrapped up the trash and walked away with it down the hallway.
-After she came back, she brought the full body lift out into the hallway and cleaned it.
*Neither of them were observed to have performed hand hygiene after assisting the resident.

4. Interview on 4/22/25 at 4:10 p.m. with both CNA M and BB about the above observation revealed:
*Neither of them realized they had missed several opportunities for hand hygiene and changing their gloves.
*CNA M questioned how soon she should have performed hand hygiene after removing her gloves as she explained she "came out here [the hallway] to do that, is that not soon enough?"
-The surveyor explained that she touched the resident's water cup and drinking straw after removing her gloves and had not yet performed hand hygiene after assisting the resident with personal care. Her contaminated hands potentially increased the risk of spreading infection.
-She agreed she had done that and promptly walked away from the conversation.

5. Observation on 4/22/25 at 4:41 p.m. of CNAs L and M in resident 33's shared room revealed:
*There was a sign on the door for "Contact

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Precautions" which explained what PPE each person entering the room was required to wear.
-PPE was available and hanging on the door.
*CNA M came out of resident 33's side of the room with no evidence that she had worn PPE while interacting with the resident.
*CNA L came out of resident 33's side of the room with the full body lift and parked it in the hallway. She was not wearing any PPE.
-She did not clean the lift.
*She did not put on any PPE and then went back into resident 33's side of the room.
*She came back out of the resident's room, wearing one glove on her left hand and was holding a small bag of trash. There did not appear to be any PPE in the small trash bag.
*She was holding the bag of trash while she was pushing resident 33 in her wheelchair down the hallway.
-She was touching the left wheelchair handle with the same hand that she was holding the trash with.
*She wheeled the resident all the way down the 400-hallway and turned towards the rehab dining room.
*By 4:56 p.m., no staff had come back to clean the lift.

6. Interview on 4/22/25 at 4:58 p.m. with licensed practical nurse (LPN) N revealed:
*She confirmed that resident 33 had an order for contact precautions, but she was not sure why the resident was on contact precautions.
-She wondered if it was from the gastrointestinal (GI) "bug" that went through the building for the past several weeks.
-When reviewing resident 33's record, she confirmed that the resident had diarrhea and vomiting the previous week.

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F 880	Continued From page 47 *She explained that contact precautions were implemented for residents "known or suspected to be infected with infectious agents transmitted [from] person-to-person." *For contact precautions, she expected staff to wear at least a gown and gloves when providing care to the resident, even for transferring. -If staff were physically touching the resident, she expected staff to wear PPE for infection control purposes. *She indicated that the contact precautions for resident 33 were no longer necessary since her GI symptoms had subsided several days ago. -She discontinued that order for contact precautions in resident 33's electronic medical record (EMR). *She did not know exactly why the contact precautions sign and the PPE were still on resident 33's door and guessed that someone may have forgotten to discontinue the precautions after she was symptom-free. *She expected staff to have followed the contact precautions signage and use the proper PPE or contact a nurse if there were any questions. 7. Interview on 4/22/25 at 5:05 p.m. with CNA L revealed: *She could not remember how long she had been working at that facility. *When asked if she knew which resident in the shared room from the above observation was on contact precautions, she indicated that she did not know how to tell which resident in that room was on contact precautions. *She confirmed that neither she nor CNA M wore gowns while interacting with resident 33, they only wore gloves. *When asked if she knew what contact precautions meant, she said that they were	F 880		

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supposed to wear gowns, gloves, and sometimes a face shield when interacting with the resident.
*She said she also caught the GI bug that was going around the facility recently.
*When asked why she did not follow the contact precautions as posted on the door and in the resident's orders, she said, "I don't know, that's what I was trained to do, to just follow the other CNA."
*When asked how often she was to clean the lift, she indicated that it was supposed to have been cleaned after each resident's use.
-She still did not clean the lift after being informed that she had not cleaned the lift after taking it out of the resident's room.

8. Observation on 4/22/25 at 5:11 p.m. revealed LPN N was removing the contact precautions sign and PPE off resident 33's door.

9. Observation on 4/22/25 from 5:34 p.m. to 5:40 p.m. in the rehab dining room revealed:
*CNA/CMA BB was sitting between two residents (41 and 56) to help them eat supper.
*With her bare hands, she touched her hair braids to push them back behind her shoulders.
*Without performing hand hygiene, she continued to help the two residents eat their meals.
-She was taking straws out of their wrappers and placing the straws into the residents' beverages, touching the resident's silverware handles, squeezing condiments out of packets, and wiping the residents' mouths with their napkins.

10. Observation on 4/22/25 at 5:49 p.m. of the evening meal on the memory care unit (MCU) revealed:
*Residents were not assisted with cleaning their hands before their meal.

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F 880	Continued From page 49 *CNA HH did not sanitize her hands before she passed the residents' meal trays. *She was observed coughing into her hand, she did not sanitize her hands after coughing, then she delivered the resident's meal tray. *There was a potentially contaminated rehabilitation cone device on the table. -A resident grabbed the cone and appeared to have been trying to take a drink from the cone as he picked it up and brought it to his mouth. -CNA HH noticed this and gently removed the potentially contaminated cone from his hands. She continued serving meal trays without performing hand hygiene. *She served nine residents their meal trays and did not sanitize her hands. 11. Observation on 4/23/25 at 9:29 a.m. of the morning meal service on MCU revealed: *Some residents were sitting at the table prior to meal service. *CNA GG did not perform hand hygiene before assisting residents with eating. *CNA GG was observed assisting a resident to eat after the resident had coughed. -The resident was not offered hand sanitizer or a hand wipe. *CNA GG then moved to another table without sanitizing her hands and assisted a different resident with eating. 12. Observation on 4/23/25 at 10:09 a.m. near the 400-hallway nurse's station revealed: *CNA M had a glove on her right hand and was holding a bag of trash. *At the same time, she was touching resident 85's wheelchair handle as she pushed him down the hallway.	F 880		

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13. Interview on 4/24/25 at 8:43 a.m. with resident 33 revealed:
*She confirmed:
-She had the GI bug earlier that month.
-Staff did not put on gowns when they helped her with personal cares.
*She was no longer experiencing GI symptoms like vomiting or diarrhea.

Review of resident 33's electronic medical record revealed:
*Her quarterly Minimum Data Set (MDS) assessment completed on 4/4/25 revealed a Brief Interview for Mental Status assessment score of 14, which indicated she was cognitively intact.
*A nursing progress note from 4/8/25 that read, "Contact precautions and isolation to room implemented per protocol for GI illness."
*She experienced diarrhea on 4/8/25, 4/9/25, 4/10/25, and 4/11/25.
*A physician's order started on 4/8/25 for "Contact precautions as recommended for residents known or suspected to be infected with infectious agents transmitted person to person via the direct/indirect contact route (e.g. VRE [Vancomycin-resistant Enterococcus], Clostridium Difficile, MRSA [Methicillin-resistant Staphylococcus aureus] etc.)."

14. Interview on 4/24/25 at 11:32 a.m. with LPN FF regarding resident and staff hand hygiene during meal service revealed:
*There was usually hand sanitizer on the tables for residents to use before meals.
*Residents were given a hand wipe to clean their hands with their meals.
*It was her expectation that staff assisting residents with eating would sanitize their hands before assisting a resident, and before assisting

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F 880	Continued From page 51 the next resident. 15. Interview on 4/24/25 at 1:50 p.m. with CMA II revealed: *She was aware of a GI outbreak in the facility the past couple weeks. *She reported the outbreak was facility-wide and included many residents and staff members. *She reported if she were assisting residents to eat, she would sanitize her hands before assisting residents, then after assisting them before she assisted another resident. 16. Interview on 4/25/25 at 10:15 a.m. with resident care manager registered nurse (RN) G revealed: *She was a the provider's infection preventionist. *There was an outbreak of norovirus in the facility during April 2025. *They tested three residents, each from different wings of the facility, all were positive for norovirus. *After that initial testing, all residents with GI symptoms (nausea, vomiting, diarrhea) were assumed to have norovirus and were tracked for infection control purposes. *Residents with symptoms were placed on contact precautions to prevent further spread of the virus. *Residents remained on contact precautions for 24 hours after symptoms stopped. 17. Interview on 4/25/25 at 10:51 a.m. with director of nursing services (DNS) B and division director of clinical services (DDCO) C revealed: *DNS B recently started her position at the facility on 4/7/25. *Since the resident GI symptoms started on 4/8/25, she was fully aware of the GI outbreak.	F 880		

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F 880	Continued From page 52 -In her time at that facility, she noted concerns in infection control such as hand hygiene. *On 4/8/25, residents who were experiencing diarrhea and vomiting were placed on contact precautions. *The staff collected and sent stool cultures to the laboratory for testing from three residents that had GI symptoms (residents 18, 40, and 76). Those residents resided in different areas of the facility. On 4/12/25, those stool culture results came back positive for norovirus. *Both DNS B and DDCO C appeared disappointed when they were informed about the above observations. -They expected staff to have followed the provider's policies on hand hygiene, glove use, and contact precautions. *A total of 45 residents were affected. -The census at the time of the survey was 104. 18. Review of the provider's "Line listings for infections by resident" tracking sheet revealed: *Between 4/6/25 and 4/14/25, a total of 45 residents (1, 2, 3, 4, 12, 13, 14, 16, 18, 22, 23, 24, 25, 29, 30, 31, 33, 34, 35, 36, 40, 41, 42, 43, 45, 53, 58, 60, 64, 65, 67, 68, 69, 76, 77, 78, 79, 80, 85, 93, 99, 100, 107, 258, and 259) had been identified to have GI symptoms. 19. Review of the provider's March 2018 handwashing/hand hygiene policy revealed: *"Policy statement: This Center considers hand hygiene the primary means to prevent the spread of infections." *"Procedure: -1. Personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.	F 880		

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-2. Personnel follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors."

20. Review of the provider's May 2015 Initiating Transmission-Based Precautions policy revealed:
*Policy Statement: "Transmission-Based Precautions are initiated when there is reason to believe that a resident has a communicable infectious disease.
-Transmission-Based Precautions may include Contact Precautions, Droplet Precautions, or Airborne Precautions."
*Procedure:
-"1. If a resident is suspected of, or identified as, having a communicable infectious disease, the Charge Nurse or Nursing Supervisor notified the Infection Preventionist and the resident's Attending Physician for appropriate Transmission-Based Precautions."
-" ...4. Transmission-Based Precautions remain in effect until the Attending Physician or Infection Preventionist discontinues them, which occur after pertinent criteria for discontinuation are met."
-"5. When Transmission-Based Precautions are implemented, the Infection Preventionist or designee:
--a. Validates protective equipment (i.e., gloves, gowns, masks, etc.) is maintained near the resident's room so that everyone entering the room can access what they need;
--b. Posts the appropriate notice on the room entrance door and on the front of the resident's chart so that all personnel will be aware of precautions, or be aware that they must first see a nurse to obtain additional information about the situation before entering the room. This Center's

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F 880	Continued From page 54 process for notification is signage ..." -"6. In an emergency, the Infection Preventionist, [Executive Director], and/or Medical Director have the administrative authority, accountability, and responsibility to: --a. Institute actions necessary to control or prevent infections within the Center; --b. Notify the health department of reportable diseases, as appropriate; --c. Initiate isolation precautions; --d. Obtain laboratory specimens; --e. Restrict or ban admissions; --f. Restrict or ban visitations; --g. Implement other measures as necessary to prevent and control infections within the Center." 21. Review of the provider's March 2025 Transmission-Based Precautions (Isolation) policy revealed: *"Policy Statement: Transmission-Based Precautions (previously referred to as isolation precautions) are implemented for residents known to be, or suspected of being, infected with infectious agents." *"Procedure: -1. Use Transmission-Based Precautions in addition to Standard Precautions. -2. The four types of Transmission-Based Precautions may be used alone, or in combination for diseases that have multiple routes of transmission. Determination of use is based on how the infectious agent is transmitted. --Contact precautions. --Droplet precautions. --Airborne precautions. --Enhanced barrier precautions. -3. The need to implement Transmission-Based Precautions is determined by the [facility's] Infection Preventionist (IP), Director of Nursing	F 880	1	

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and/or consultation with the local health department. Precautions are based on CDC [Centers for Disease Control and Prevention] guidelines. Precautions are the least restrictive possible for the resident.
-4. The facility documents in the resident's medical record the rationale for the type of transmission-based precautions selected as well as the length of time the precautions is maintained.
-5. Communication of Transmission-Based Precautions is accomplished with the pertinent signage and verbal reports to personnel and visitors.
-6. Residents on TBP [Transmission-Based Precautions], apart from EBP [Enhanced Barrier Precautions], should remain in their room for the duration of precautions, except for medically necessary care or resident choice.
-7. Indirect transmission of infectious agents can occur through contact with resident care equipment. Whenever possible, personal care items such as thermometers, stethoscopes, blood pressure cuffs and gait belts will be dedicated for use by the resident needing contact, droplet, or airborne precautions. All reusable items, including glucometers and other point-of-care devices are cleaned using appropriate disinfectant after using the devices with individual residents."
*"Contact Isolation Precautions:
-Contact, or touch, is the most common and most significant mode of transmission of infectious agents. Contact transmission can occur by directly touching the resident, through contact with the resident's environment, or by using contaminated gloves or equipment.
-Personnel having contact with the infected resident should wear gloves and a gown.

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F 880	Continued From page 56 -Prior to leaving the resident's room, gown and gloves are removed and hand hygiene performed. -Options for residents on contact precautions may include a private room, cohorting with another infected or colonized resident or sharing a room with a resident with limited risk factors (no immunosuppression, IVs, indwelling catheters or open skin lesions). -Residents with wound drainage, fecal incontinence, or diarrhea, that cannot be contained, should be placed on contact precautions until a specific organism for the origin of the medical issue is identified."	F 880		
F 925 SS=G	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, record review, and policy review, the provider failed to ensure effective pest control for flying ants for one of twenty-six sampled residents (91) who complained of flying ants in his room and ant bites on his back. Findings include: 1. Interview and observation on 4/23/25 at 10:56 a.m. with resident 91 in his room revealed he stated: *He was having a problem with flying ants in his room. *The problem was daily and he had "killed 30 to 40 of the flying ants every day." *The "maintenance guy thinks they are coming in	F 925	1. On 4/29/2025 maintenance department did a facility sweep of all rooms for any signs of pests/ants. 6 rooms were noted to have signs ants in the room, these were all located on 500 wing. On 4/29/2025 all rooms noted above were deep cleaned and ant bait posted in rooms. On 5/01/2025 monthly service was performed by premier pest to spray for ants in facility. On 05/08/2025 premier pest sprayed all of 500 wing, they stated no ants were visible. Premier pest used a spray to kill colony of ants instead of simply ants. All halls and rooms were sprayed on same date. On 05/09/2025 maintenance supervisor checked outside perimeter of 500 wing to ensure no ant hills or visible sign of ants present next to exterior walls. Maintenance supervisor used a commercial spray and sprayed exterior 500 wing 5 feet away from exterior walls and 5 feet above exterior walls. On 05/09/25 Premier pest also sprayed entire exterior of building. On 5/10/2025 ED sprayed all window borders of 500 wing, sprayed beneath windows where heating unit is located on exterior wall, sprayed all concrete joints that lead to wall of 500 wing. On 5/12/2025 activities director conducted a sweep of all resident rooms to ensure any snacks or food were stored properly. On 5/12/2025 premier pest sprayed facility wide every room with spray that targets colony ants. Facility sweep of all rooms conducted on 5/16/2025, no ants present.	5/21/25

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F 925	Continued From page 57 from behind [the] heater" that was located on the wall below the window in his room. *Every morning his bedside table was covered with them and four to five of the flying ants were in his bed. -He had bites all over his back from the flying ants. -Resident 91 lifted the back of his shirt and showed his back which appeared to have several small red marks on his mid back. *Resident 91 stated he had been having problems with the flying ants for several weeks. -He stated "I can feel them [flying ants] when they bite, they grab your attention." *He stated that yesterday (4/22/25), staff had asked him if he would like to move to another room, but he liked his current room. -He was asked to vacate his room for a couple of hours, and said that three staff members had been in his room. -When he woke up this morning (4/23/25), there were around 40 flying ants on his nightstand. *There were three dead flying ants on his nightstand which he stated he had killed with a tissue. *Maintenance assistant X was outside the resident's window with a spray bottle which he used to spray at the area below the window. *A round container of ant bait was on the floor by the window next to the heater on the wall. *A liquid ant bait was on the floor by the wall at the head of resident 91's bed. 2. Observation on 4/23/25 at 11:22 a.m. revealed resident 91 walked into the hallway with his walker and stated he had "a bug" on his window screen. Upon entering his room, an active flying ant was observed on the window screen in his room.	F 925	2. At resident council on 5/09/2025 all residents in attendance were educated on the measures facility has taken to resolve the pest/ant concern. Residents were all notified if they saw any ants in rooms to notify staff immediately. 3. All staff have read and acknowledged the facility pest control policy, ensuring that it is every staff members responsibility to report a concern of a pest or ant in a residents room. If any resident room is noted with ants a skin check will be performed by LN to assess for abnormal findings. ED and interdisciplinary team in collaboration with Dr. Timmer, facility medical director reviewed, revised and created as necessary policies to ensure all residents are free from concerns with pests. 4. The facility will monitor performance of plan above by completing facility wide pest control audits. These audits will be completed 2x weekly x 4 weeks and weekly x 3 months. The maintenance director will bring the audit findings to the monthly QAPI committee for further review and recommendations on continuing or discontinuing the audits.	

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F 925	Continued From page 58 3. Observation and interview on the morning of 4/24/25 with resident 91 and staff in his room revealed: *At 7:55 a.m. the resident was in his room eating his breakfast and he: -Stated that social services director (SSD) E had brought in his breakfast that morning. -Pointed to seven dead flying ants on his nightstand, and stated he had used a paper napkin to kill them. -Stated five flying ants were in his bed that morning. *At 7:58 a.m. maintenance supervisor (MS) W and SSD E entered his room and asked him about moving to another room. -SSD E offered to move him to another room so they could deal more effectively with the flying ant problem. -SSD E escorted the resident out of the room to show him the other room. -MS W stated they had been working on the flying ant problem for a few weeks: --They had offered to move the resident multiple times. --He had a bug control contractor in to service resident 91's room and he would provide those invoices. *At 8:06 a.m. SSD E stated the resident had agreed to move to the other room that day. 4. Interview on 4/24/25 at 8:15 a.m. with restorative aide Y regarding the problem with flying ants revealed she had seen flying ants in a room on the 500 hallway and a room on the 400 hallway: *In the 400 hallway's room, she had seen flying ants "about a week ago, but not since then in that room."	F 925		

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(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 925	Continued From page 59 *She felt the flying ant problem in the 400 hallway's room had been taken care of. 5. Interview on 4/24/25 at 9:30 a.m. with administrator A regarding the flying ants revealed he had: *A pest control company come into the facility to service the affected room, and after several treatments, the pest control company had told him they could not do anything more regarding the flying ants. *Staff deep cleaned resident 91's room on Tuesday, 4/22/25, as they felt the snacks resident 91 kept in his room had attracted the flying ants. *They had also set out bait traps to help with the flying ants. 6. Interview on 4/24/25 at 4:33 p.m. with resident 91 in his new room revealed: *He stated he was moved into the room by 10:30 a.m. that morning. *The staff had moved his bed and recliner from his other room. *He had not seen any flying ants in his current room yet. 7. Observation on the afternoon of 4/24/25 of resident 91's previous room revealed: *At 4:39 p.m. the room was empty except for one dining room chair and an overbed table. -Two live and active flying ants were noted on the window screen in the room. -There was a sticky strip hanging from the ceiling by the window. -There were three (Product name) liquid ant baits noted on the floor by the base board. -An ant bait was by the heater unit on the floor below the window. *At 4:46 p.m. certified medication	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435109	A. BUILDING _____ B. WING _____	C 04/25/2025

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

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F 925	Continued From page 60 assistant/certified nursing assistant (CMA/CNA) BB entered the room and confirmed there were two flying ants on the window screen. 8. Interview on 4/25/25 at 11:00 a.m. with resident 91 in his new room revealed he stated: *He "hasn't seen a bug yet" and was in a good mood. *Had a good night's sleep and had slept for ten hours. 9. Interview on 4/25/25 at 11:03 a.m. with SSD E revealed she had become aware of the issue with the flying ants yesterday, 4/24/25. When she had delivered resident 91's breakfast tray into his room he had stated he was having a problem with the flying ants in his room. 10. Interview on 4/25/25 at 11:21 a.m. with MS W revealed: *He had reviewed his records. He had become aware of the flying ants in resident 91's room on 4/11/25 when a work order was entered into their electronic maintenance software system called Technology-Enabled Life Safety (TELS). *In response, they had done the following in resident 91's room: -Deep cleaned resident 91's room as they felt the snacks resident 91 kept in his room had attracted the flying ants. -Placed containers of ant bait on the floor in resident 91's room. -Sprayed ant killer on the outside of the facility by resident 91's room. *He had requested the pest control company provide treatment for the flying ants. *He confirmed the flying ants had continued to be a problem as of 4/23/25, when resident 91 had reported the problem to the surveyor.	F 925		

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F 925	Continued From page 61 11. Interview on 4/25/25 at 12:15 p.m. with administrator A revealed he had become aware of the flying ants problem at "about the same time" as MS W had on 4/11/25. 12. Review of the provider's invoices from the contracted pest control company revealed invoices for monthly contract services detailing: *"Target: Spiders, Ants, Roaches." *"Location: Interior Baseboards, Kitchen." *On the following dates: -1/8/25. -2/3/25. -3/5/25. -4/1/25. *There was no documentation of the pest-control company having an additional visit or involvement after 4/1/25. Review of an e-mail communication from the provider's contracted pest control company revealed a message on 4/24/25 at 8:34 a.m. stated "We were there for monthly scheduled service on March 4th and April 1. We did an extra call on March 21st to spray for ants..." Interview on 4/24/25 at 4:55 p.m. with administrator A revealed the provider had no invoice from the contracted pest control company for 3/21/25, but he verified they had provided service at the facility on that date. Review of the requested provider's TELS Work Orders regarding the flying ants revealed: *Work Order #3833 created on 4/11/25 at 3:43 p.m. by licensed practical nurse (LPN) Z regarding resident 91's room indicated: -"Comments: Resident states that he has flying	F 925		

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	435109	A. BUILDING _____ B. WING _____	C 04/25/2025

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F 925	Continued From page 62 ants coming in his room by his window." -Updated Status: 4/14/25 at 10:48 a.m. "Set to Completed" by maintenance assistant X. --"Notes: Housekeeping deep cleaned area, Maintenance checked area and posted Ant traps, resident offered to move and declined." *Work Order #3847 created on 4/17/25 at 7:42 a.m. by CMA AA regarding resident 91's room indicated: -"Notes: Resident stated he killed about 15-20 bugs located in his bed and inside of his dresser. Resident states that the strips in the windows do not serve a purpose." -Updated Status: 4/18/25 at 2:54 p.m. "Set to Completed" by maintenance assistant X. -"Notes: [Maintenance assistant X] 04/18 [4/18/25] Traps have been placed, sprayed for bugs, housekeeping has been notified to deep clean [that room] regularly." *Work Order #3858 created 4/22/25 at 6:55 a.m. by LPN N regarding Room 500. -Updated Status: 4/22/25 at 7:36 a.m. "Set to Completed" by MS W. -"Notes: House keeping deep cleaned residents [resident's] room, found many food particles all over [the] ground. Maintenance silicone sealed flooring and pest control had recently been out to spray. Also Ant traps placed." Review of the provider's May 2015 Pest Control policy revealed: *"Purpose: To provide an environment free of pests." *Procedure: The Center has a pest contract that provides frequent treatment of the environment for pests. It allows for additional visits when a problem is detected." -"Monitoring of the environment is done by the	F 925		

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F 925	Continued From page 63 Center's staff. Pest control problems are reported promptly."	F 925		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10653 S	A. BUILDING: _____ B. WING _____	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESTEEL HEALTHCARE CENTER	1120 E 7TH AVE MITCHELL, SD 57301

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 4/22/25 through 4/25/25. Firesteel Healthcare Center was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/22/25 through 4/25/25. Firesteel Healthcare Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Petar Mirkovic

TITLE: Executive Director

(X6) DATE: 05/17/2025