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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435109	A. BUILDING B. WING	07/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESTEEL HEALTHCARE CENTER	1120 EAST 7TH AVENUE , MITCHELL, South Dakota, 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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/28/26 through 7/30/26. Firesteel Healthcare Center was found not in compliance with the following requirements: F561, F565, F644, F684, F689, F695, F732, F812, F880, and F883. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/28/26 through7/30/26. The area surveyed was abuse and neglect related to a fall from a bath chair. Firesteel Healthcare Center was found not in compliance with the following requirement: F689.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: A. Based on observation, interview, and record review, the provider failed to ensure an environment free from accident hazards for seventeen of seventeen sampled residents (3, 22, 23, 24,29, 43, 48, 70, 74, 78, 83, 84, 86, 92, 102, 106, and 110) who resided within a memory care unit (an area where specialized care is provided in a structured, safe and supportive environment to meet the unique needs of residents with significant memory and cognitive decline, that is secured to minimize unsafe wandering) and had access to the memory care unit exit door key.	F0689	1. Corrective Action The unsecured access badge located on top of the Memory Care refrigerator was removed immediately on 7/28/26. All staff were re-educated regarding security of access badges and the requirement that badges remain on the employee's person at all times was completed 8/3/26. Residents residing in the Memory Care Unit were assessed for any adverse outcomes related to potential exit access. No adverse outcomes were identified.	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Veronnica J. Smith	Administrator	8/21/26

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F0689 SS = G	Continued from page 1 Findings include: 1. Observation on 7/28/26 at 11:57 a.m. in the memory care unit kitchenette revealed resident 86 and her visitor were standing by the refrigerator, which was located by the exit door of the memory care unit. That door exited into one of the main hallways in the facility. Resident 86's visitor stated to resident 86, "it's still up here." Resident 86's visitor grabbed a staff member's badge from the top of the refrigerator, touched the badge to the badge reader on the memory car unit's exit door and unlocked the door. Resident 86's visitor placed the badge back on top of the refrigerator, said "goodbye" to resident 86, and exited the unit. There were no staff members present. 2. Observation on 7/28/26 at 12:10 p.m. revealed that medical memory care unit director W grabbed the badge from the top of the refrigerator and put it on her shirt. 3. Interview on 7/28/26 at 2:31 p.m. with resident 86 revealed that she did not have concerns about being able to leave the unit. She said "I just need the key the staff wear." 4. Observation on 7/28/26 at 4:32 p.m. revealed that certified medication aide (CMA) X's badge was sitting on top of the refrigerator and there were no staff members in that area. 5. Interview on 7/29/26 at 2:21 p.m. with memory care unit director W revealed that if there was a visitor who visited a resident in the memory care unit often, the staff would give the visitor a badge to unlock the memory care unit door and instruct them to place it on top of the refrigerator so they could leave the unit and not have to wait for the staff to let them out. She left her badge on top of the refrigerator on 7/28/26 so resident 86's visitor could leave the unit without waiting for her . She was not supposed to do that because a memory care resident could get out of the unit without the staff knowing. 6. Interview on 7/30/26 at 10:42 a.m. with administrator A revealed that all the residents who resided in the memory care unit had a physician's order to be on a locked unit for their safety. The	F0689	2. Other Residents at Risk All residents residing in the Memory Care Unit had the potential to be affected. The Administrator and Director of Nursing conducted a review of Memory Care security practices and verified badges were secured and inaccessible to residents. Information posted for family to request assistance for entrance/exit. 3. Systemic Changes Staff, including agency personnel, received education regarding: prior to next shift VJS Secure handling of access badges Resident elopement prevention Memory Care Unit visitor access procedures Visitors will no longer be provided unattended badge access. 4. Monitoring The Administrator/designee will complete audits of badge security and Memory Care exit practices ~~randomly~~ weekly VJS weekly for 3 weeks, then monthly for 3 months. Results will be reported to QAPI for review and further action as indicated. 8/20/26 by Administrator or designee VJS	

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F0689 SS = G	Continued from page 2 residents who resided in that unit were either at risk for elopement or had behaviors related to their cognitive impairment. She expected that the staff members would not leave their badges on top of the refrigerator because the residents could access them, and leave the unit. The facility did not have a policy related to the memory care or the locked doors. 7. Review of resident 86's electronic medical record (EMR) revealed that she admitted to the facility on 2/10/26. Her 5/11/26 Brief Interview for Mental Status (BIMS) assessment score was 5, which indicated her cognition was severely impaired. She had diagnoses of psychotic disorder with hallucinations (a mental health condition where a person loses touch with reality and experiences things through their senses that are not actually there), severe major depressive disorder with psychotic symptoms (a mental health condition where a person has extreme, debilitating sadness alongside a total loss of touch with reality), dementia with behavioral disturbance (a brain condition causing memory loss paired with extreme, unexpected shifts in mood and actions like agitation, wandering, and aggression), and anxiety disorder (a mental health condition defined by persistent worry, extreme fear, and physical tension that do not go away and interfere with daily life). Her 3/6/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated she was in the memory care unit, walked around the unit as desired, and would wander, looking for a family member. B. Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, observation, and policy review, the provider failed to ensure the staff provided accident prevention interventions and device use according to the manufacturer guidelines for one of one sampled resident (96) who needed to be secured into the whirlpool bath chair (a special seat used to lower and support a person during a whirlpool bath safely), by a safety belt, and sustained a laceration (cut or torn skin) above his left eye when he fell from the whirlpool bath chair onto the floor after certified nursing assistant (CNA) (Z) gave him a whirlpool bath without the safety belt on. The resident was subsequently transferred to the emergency room for evaluation and laceration repair with sutures. This citation is considered past non-compliance based on	F0689		

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F0689 SS = G	Continued from page 3 a review of the provider's corrective actions immediately following the incident. Findings include: 1. Review of the provider's 6/26/26 SD DOH FRI revealed that on 6/26/26 at 3:26 p.m., resident 96 was transferred from the whirlpool tub via the whirlpool bath chair. CNA Z moved the whirlpool bath chair backwards, the resident grabbed onto the side of the tub and fell forward onto the floor. CNA Z reported that resident 96 had put his hands out to try to catch himself; however, he hit his face on the floor. CNA Z then called for help from licensed practical nurse (LPN) I and certified medication aide (CMA) V. LPN I completed a head-to-toe assessment (an assessment she completed that looked over his body to see if he had any open areas or redness, checked his range of motion in his extremities, checked neurological vitals, and checked for signs of hip fractures) on resident 96. She identified one bruise on his left knee and left side of his face, with a bleeding laceration above his left eye. There was swelling and bruising to the left side of his face and eye. Resident 96 was able to move all his extremities as per his usual movement. He was alert and oriented to person, place, time, and event. He had no complaints of pain at that time. His neurological evaluation (assessment of nerve function, reflexes, coordination, motor skills, sensation, and mental status) (neuros) was within normal limits. Resident 96 was assisted off the floor by LPN I, CMA V, and CNA Z, who used the total body lift (a mechanical lift and sling used to lift a person's full body) to transfer him into his wheelchair. His emergency contact was notified of his fall and transfer to the emergency department (ED). Resident 96 had a Computed Tomography (CT) scan of his head and facial bones, with no fractures. He received four sutures to the laceration above his left eye. Upon his return to the facility, he denied having pain. The nursing staff completed neurological evaluations per the facility's protocol. CNA Z was suspended from working at the facility pending the investigation of the incident and disciplinary action. Prior to her return to the facility, she was provided education on the use of the safety belt when assisting a resident in the bath. 2. Review of resident 96's electronic medical record (EMR) revealed he admitted to the facility on	F0689		

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F0689 SS = G	Continued from page 4 7/25/25. His 6/30/26 Brief Interview for Mental Status (BIMS) assessment score was 6, which indicated his cognition was severely impaired. His diagnoses included unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities) and frontotemporal neurocognitive disorder (a brain condition where the front and side parts of the brain slowly break down, causing early changes in behavior, personality, or language rather than memory). His 7/25/26 Morse Fall Scale (a nurse-administered tool used to assess a patient's risk of falling based on history of falling, diagnoses, use of ambulatory aids, presence of intravenous [into or within a vein] equipment, gait quality [the way a person walks], and mental status) assessment score was 40, which indicated he had a moderate risk for falling. His undated care plan indicated he had an activities of daily living (ADL) self-care performance deficit due to his dementia, hemiplegia (a condition in which a person experiences paralysis on one side of the body), and limited mobility. He transferred with the assistance of two staff members and a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position). He was assisted by one staff member when in the bathtub. His 6/26/26 ED notes indicated that there was a facial laceration with mild bleeding, and mild blurry vision during the ED examination. Radiology read the head and facial bone CT, and there were no fractures. Resident 96's vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) remained stable. His mental status did not change, and he was awake and alert. His left upper eyelid was repaired with four sutures. 3. Review of the provider's whirlpool bathing education revealed that the four bath aides received direct education regarding the use of the whirlpool bath chair and the safety belt. 4. Interview on 7/28/26 at 2:44 p.m. with resident 96 revealed he thought he fell out of a tractor scoop and that is how he received the purple and red bruising and swelling to the left side of his cheek. There was no longer a laceration present above his left eye. He was unable to recall the fall at the facility. 5. Interview on 7/28/26 at 4:37 p.m. with resident 96's family member revealed they were informed about his fall from the whirlpool bath chair and had no concerns.	F0689		

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F0689 SS = G	Continued from page 5 6. Observations from 7/28/26 through 7/30/26 of four of four tub rooms revealed they had the "Penner Bath System Bed to Bath Transfer Procedures" posted for the staff to use during resident baths. This procedure included when staff were to apply the safety belt and remove the safety belt from the resident. 7. Review of the 6/26/26 Quality Assurance and Performance Improvement (QAPI) meeting minutes regarding resident 96's fall revealed the interdisciplinary team evaluated the resident after his fall, interviewed the staff members involved, and an initial audit was completed. The facility's correction actions for the deficient practice (not using the safety belt in the whirlpool bath) included providing education to the bath aides and then demonstrating the placement and use of the safety belt, and providing education to all staff who have the potential to use the bath chair before they assist a resident with a bath. Audits were to be completed by the director of nursing (DON) or designee daily, with three to five observations each day for one week. Then weekly for three weeks. Then monthly for 2 months. The QAPI meeting determined this will be a performance improvement plan (PIP) and would be ongoing with a goal of 100% compliance. 8. Review of the whirlpool tub daily audits completed from 6/29/26 through 7/3/26 revealed that each tub room was audited and in compliance with the safety belt being used when a resident was in the tub chair. There were nineteen individual audits completed of residents with the safety belt on. 9. Review of the whirlpool tub weekly audits completed from 7/6/26 through 7/24/26 revealed that sixteen individual audits were completed and in compliance with the safety belt being used when a resident was in the tub chair. 10. Interview on 7/30/26 at 10:58 a.m. with CNA Z regarding resident 96's fall revealed that resident 96 fell as he grabbed onto the side of the whirlpool tub as she pulled the whirlpool bath chair backward. She immediately opened the tub room doors and hollered for help. CMA V and LPN I came to assist the resident. After LPN I said it was safe to get him off the floor, the three staff members used the total body lift and transferred him into his wheelchair. They then took him to his room to get him dressed before taking him to the ED. CNA Z was suspended pending the facility's investigation until further notice. She was given verbal education on how to use the whirlpool bath chair and the safety belt after	F0689		

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F0689 SS = G	Continued from page 6 resident 96's fall. CNA Z said, "This was 100% my fault. I was rushing and trying to get as many baths done as possible, and I missed that step. I have learned to be extra cautious. Now I take my time, and everyone gets the [safety] belt in the whirlpool [bath] chair." 11. Interview on 7/30/26 at 11:09 a.m. with LPN I regarding resident 96's fall revealed that she was alerted to the tub room by CNA Z because resident 96 was on the bathroom floor. He was bleeding from the left side of his face, so she put a cloth over it to help clean it up. After it was cleaned up, we placed ice over the bleeding area. She completed her head-to-toe assessment and then helped transfer him into his wheelchair with a total body lift. She notified contracted travel LPN J, who was the assigned nurse for resident 96 that day. 12. Interview on 7/30/26 at 11:56 a.m. with contracted travel LPN J revealed that she was the nurse for resident 96 on 6/26/26. She assessed the resident, notified the director of nursing (DON) B, called the resident's physician, and received an order to send the resident to the ED for further evaluation. When he returned, she continued his neurological checks. 13. DON B was unavailable during the survey and could not be interviewed. 14. Review of the Penner Bathtub System Preparation manufacturer's instructions manual revealed, "9. All residents must always be securely safety belted at the waist when using any of the Penner Lift Systems. Ensure that the safety belt is routed through the loose buckle end." 15. Based on the above information, non-compliance at F689 occurred on 6/26/26, and based on the provider's corrective action plans that were initiated on 6/26/26 and implemented for the deficient practice, the non-compliance is considered past non-compliance.	F0689		
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of	F0565		

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F0565 SS = E	Continued from page 7 upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interview, document review, and policy review, the provider failed to ensure that the resident's grievances were addressed, and documentation reflecting the staff's efforts to resolve those grievances was communicated to the residents and approved as effective resolutions for eight of eight sampled residents (16, 30, 31, 63, 79, 81, 108, and 109) who attended the resident council meeting on 7/29/26 that reported concerns in grievance resolution. Findings include: 1. Interview with residents 16, 30, 31, 63, 79, 81, 108, and 109 during the resident council meeting on 7/29/26 revealed that they have not had grievances resolved, and the staff had not come to discuss with the council or any members the resolution of grievances brought from the resident council.	F0565	1. Corrective Action grievances voiced at the 7/15/26 Resident's Council will be reviewed/followed up at the next Resident Council on 8/19/26. 2. Other Residents at Risk all residents had the potential to be affected. Administrator conducted a review of the grievance policy/procedure. 3. Systemic Changes Administrator was educated to complete the grievance form thoroughly with documentation and notification of resolution. 4. Monitoring SS Director or designee will audit grievances that follow up was completed and form is fully completed weekly x3 and monthly x 3. Administrator or designee will report to ~~QI Committee monthly~~ QAPI monthly VJS	8/20/26

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F0565 SS = E	Continued from page 8 2. Review of resident 16's electronic medical record (EMR) indicated she admitted to the facility on 3/21/25. Her 6/4/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. 3. Review of resident 30's EMR indicated she admitted to the facility on 11/7/23. Her 6/29/26 BIMS assessment score was 11, which indicated her cognition was moderately impaired. 4. Review of resident 31's EMR indicated she admitted to the facility on 10/4/24. Her 7/17/26 BIMS assessment score was 15, which indicated her cognition was intact. 5. Review of resident 63's EMR indicated he admitted to the facility on 1/30/23. His 7/7/26 BIMS assessment score was 14, which indicated his cognition was intact. 6. Review of resident 79's EMR indicated he admitted to the facility on 2/13/26. His 6/5/26 BIMS assessment score was 15, which indicated his cognition was intact. 7. Review of resident 81's EMR indicated she admitted to the facility on 7/6/22. Her 7/28/26 BIMS assessment score was 13, which indicated her cognition was intact. 8. Review of resident 108's EMR indicated she admitted to the facility on 1/10/24. Her 7/10/26 BIMS assessment score was 15, which indicated her cognition was intact. 9. Review of resident 109's EMR indicated she admitted to the facility on 3/22/19. Her 4/3/26 BIMS assessment score was 15, which indicated her cognition was intact. 10. Review of grievances from May 2026 through July 2026 revealed 37 of 77 grievances have not had the grievance resolution documented, with the complainant notified and by what method they were communicated with. 11. Interview on 7/30/26 at 12:45 p.m. with Administrator A revealed that she was the grievance official in charge of reviewing and ensuring the completion of the grievances. She expected the grievances to be resolved, completed, and followed up with the complainant in 5 days. The grievance resolution, person notified, date and time of notification, and method of communication she	F0565		

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F0565 SS = E	Continued from page 9 would expect to have filled in with the appropriate information. 12. Review of the provider's updated March 2025 Grievance Procedure Policy revealed "The administrator oversees the grievance procedure and coordinates the center system for collecting, tracking, and responding to grievances. The administrator is designated as the Grievance Official for the center. Their contact information is posted with the policy in prominent areas throughout the center. The Administrator/designees routes the Grievance Form to the appropriate department manager, who reviews the grievance, responds within five business days, and returns the Grievance Form to the Administrator. The person with the grievance has the right to a written decision regarding his/her grievance."	F0565		
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and policy review, the provider failed to ensure the staff responded promptly to four of five sampled residents (31, 46, 105, and 108) who reported concerns about extended call light times. Findings include: 1. Interview on 7/28/26 at 9:06 a.m. with resident 46 revealed he had waited a long time, up to two hours, for the staff to answer his call lights. He said that if he had to go to the bathroom, it "really hurt" waiting, and that he was incontinent (involuntary urine or bowel leakage) if he had to wait too long. 2. Review of resident 46's EMR indicated he admitted to the facility on 4/19/24. His 6/10/26 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated his cognition was moderately impaired. His diagnoses included	F0684	1. Corrective Action No additional corrective action taken for Resident #105 as she is no longer in the facility. Call light reports were run for Resident #31, #46 and #108 for 8/10-13 and incidents in the "needs improvement" category investigated. 2. Other Residents at Risk all residents had the potential to be affected. Verified that call lights were operational and working. 3. Systemic Changes Department Directors are being assigned call light smart phone to help monitor call light response times and will be assigned to go follow up when a call a triggers "needs improvement" ~~and are assigned to go address~~ with floor staff VSS. Additional stand aide was obtained for 200 hall to reduce waiting times for residents.	

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F0684 SS = E	Continued from page 10 myelodysplastic syndrome (a type of blood and bone marrow disorder where the bone marrow produces too few healthy blood cells and some abnormal cells), type 2 diabetes mellitus (a condition involving disruptions in how the body regulates blood sugar), benign prostatic hyperplasia (an enlargement of the prostate gland) without lower urinary tract symptoms, and dorsopathy (disorders of the spine or back). His 6/10/26 MDS assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs), section GG, indicated he required partial/moderate assistance with oral hygiene, toileting hygiene, dressing his upper body, personal hygiene, and transfers between surfaces. He required substantial/maximum assistance with dressing his lower body and putting on and taking off his footwear. He was dependent on the staff for showering/bathing. 3. Review of resident 46's call light log (a structured record used in healthcare settings to track patient call button usage and staff responses) from 7/1/26 to 7/29/26 revealed that there were sixteen call light wait times longer than 15 minutes, eight call light wait times longer than 30 minutes, seven call light wait times longer than 40 minutes, and one call light wait time was 1 hour and 6 minutes. 4. Interview on 7/28/26 at 10:31 a.m. with resident 31 revealed that she had to wait up to 45 minutes for the staff to assist her to the commode (a portable chair with a built-in toilet seat and removable bucket, used for toileting). She felt like she had lost her independence because she was incontinent of bowel while waiting for the staff. 5. Review of resident 31's EMR indicated she admitted to the facility on 10/4/24. Her 7/17/26 BIMS assessment score was 15, which indicated her cognition was intact. Her diagnoses included parkinson's disease without dyskinesia (a progressive disorder of the nervous system that gradually damages dopamine-producing cells in the brain, leading to symptoms like tremors (shaking), muscle stiffness, slowed movement, and balance problems), rheumatoid arthritis (an autoimmune, chronic disease where the body's immune system attacks the lining of the joints), neuromuscular dysfunction of the bladder (a condition where nerve or muscle issues disrupt the signals between the bladder and the brain/spinal cord), type 2 diabetes, major depressive disorder, morbid (severe) obesity (excessive weight that significantly impacts health	F0684	4. Monitoring Call light reports will be run by the Administrator or designee to identify response times triggering in the "needs improvement" 3x weekly for 3 weeks, weekly x 3 months and will interview any resident in the "needs improvement" if needs were met and then reported to QI ~~Committee~~ QAPI VJS monthly and decide if audits need to continue. The Administrator or designee will report to QI Committee monthly.	8/20/26

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F0684 SS = E	Continued from page 11 and well-being), and anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). Her undated care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated she was dependent on one to two staff members when repositioning in bed and getting dressed. She transferred using a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) with two staff members. She used the sit-to-stand to get into her wheelchair, bathe, and use the restroom. 6. Review of resident 31's call light log from 7/1/26 to 7/28/26 revealed that there were fifteen call light wait times longer than 15 minutes, and one call light wait time of 33 minutes. 7. Interview on 7/28/26 at 3:54 p.m. with resident 105 revealed she was incontinent when she had to wait 15-20 minutes for the staff to assist her to the bathroom. That made her feel humiliated. She knew when she had to use the restroom but could not get there on time because she had to wait for the staff. 8. Review of resident 105's electronic medical record (EMR) revealed she admitted to the facility on 6/20/26. Her 7/9/26 BIMS assessment score was 15, which indicated her cognition was intact. Her diagnoses included anxiety disorder, and depression. Her undated care plan revealed she had an activities of daily living (ADL) self-care performance deficit due to an impaired balance, limited mobility, and limited range of motion. The 7/15/26 added interventions for her bathing/showering indicated she was to have two baths per week and as needed (prn). 9. Review of resident 105's call light log from 7/1/26 to 7/29/26 revealed there were seven call light wait times longer than 15 minutes, four call light wait times longer than 30 minutes, one call light wait time longer than 40 minutes, and two call light wait times longer than 50 minutes. 10. Interview on 7/28/26 at 9:25 a.m. with resident 108 revealed that she has had her call light on for up to one hour. That made her mad because the staff knew she had put the call light on because she needed their help. 11. Review of resident 108's EMR indicated she	F0684		

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F0684 SS = E	Continued from page 12 admitted to the facility on 1/10/24. Her 7/10/26 BIMS assessment score was 15, which indicated her cognition was intact. Her diagnoses included chronic kidney disease stage 3b (a moderate to severe decline in kidney function) and major depressive disorder. Her undated care plan indicated resident 108 is at risk for falls related to gait (walking) and balance problems. The interventions added on 4/10/25 indicated anticipating and meeting the resident's needs. Ensure the call light is within reach, and the staff was to encourage the resident to use it for assistance when needed. The resident needed prompt response to all requests for assistance. 12. Review of resident 108's call light log from 7/1/26 to 7/28/26 revealed there were twenty-one call light wait times longer than 15 minutes, and one call light wait time of 33 minutes. 13. Interview on 7/30/26 at 7:55 a.m. with contracted travel licensed practical nurse (LPN) K revealed that the residents should not wait more than 5 minutes for their call light to be answered. Any nurse or certified nursing assistant (CNA) can answer a call light to assist the resident. She said they know the call lights are alarming by using a phone that the facility provided. She had a facility phone with her at the time of the interview. 14. Interview on 7/30/26 at 8:00 a.m. with contracted travel CNA AA revealed the resident's call lights should be answered within 15 minutes. She did not have a phone device on her to indicate who had a call light on at the time of the interview. 15. Interview on 7/30/26 at 1:15 p.m. with staff development registered nurse (RN) D revealed the facility had a phone system that alerted the staff visually and auditorily when a resident's call light was activated. Each nurse's station had a screen that would show the call lights in each area. She expected each staff member to have a phone with them during their scheduled shift to answer the call lights. She expected the staff to answer the call lights within 15 minutes. 16. Review of the provider's 6/1/26 Call Light Education and Expectations revealed "although anyone can answer a call light, the care staff assigned to the residents are responsible for ensuring call lights are available, answered, and addressed promptly. The call light system is arranged to notify us as the call light escalates through Excellent, acceptable, needs improvement.	F0684		

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F0684 SS = E	Continued from page 13 Excellent is call answered in less than 10 minutes. Acceptable is call answered in less than 10-15 minutes. Needs improvement is call answered in over 15 minutes."	F0684		
F0812 SS = E	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 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 ensure sanitizer solutions were tested and documented for one of one main kitchen. Findings include: 1. Observation, interview, and July sanitizer log review on 7/28/26 at 9:37 a.m. in the main kitchen with dietary aide EE revealed a bucket of sanitizer solution with a wash rag inside of it was on one of the food prep tables. Dietary aide EE used the rag to wipe down the food prep table after she put cookies into Ziplock bags for snacks. She confirmed the sanitizer solution was changed three times a day or if the water was dirty. the July sanitizer log was hanging on a wall in the kitchen next to the dish room, and dietary aide EE confirmed that was where the dietary staff documented the sanitizer tests for the bucket of sanitizer solution. The July sanitizer log was missing 4 of 28 sanitizer test results for	F0812	1. Corrective Action Food service staff re-educated on the need to document temperature and sanitization logs on 7/30/26. 2. Other Residents at Risk All residents have the potential to be affected. Audited logs for freezer and facility refrigerators and identified pattern of missing temps 3. Systemic Changes Food service staff re-educated on documenting sanitizer logs, refrigerator and freezer logs day and night shifts 8/3/26. 4. Monitoring Administrator or designee will audit logs. Audits will then be weekly x 3 and then monthly x 3. Food Service Manager will report results to ~~Or~~ QAPI ~~Committee~~ monthly. VJS testing and VJS temperature and sanitation levels VJS	8/20/26

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F0812 SS = E	Continued from page 14 breakfast, 4 of 28 sanitizer test results for lunch, and 26 of 28 sanitizer test results for dinner. 2. Interview and April sanitizer log review on 7/29/26 at 4:30 p.m. with registered dietitian L, dietary supervisor M, senior certified dietary manager (CDM) GG, and senior CDM HH revealed they expected the dietary staff to test the sanitizer solution three times a day at each meal time. They agreed that was not being completed. Review of the April sanitizer log revealed 11 of the 30 breakfast sanitizer test results were missing, and 11 of the 30 lunch sanitizer test results were missing. Dietary supervisor M was unable to locate the sanitizer logs for May and June. 3. Interview on 7/30/26 at 1:43 p.m. with administrator A revealed she expected the dietary staff to follow the provider's policy for testing the sanitizer in the kitchen. She agreed that was not being done. 4. Review of the provider's updated November 2020 Sanitizer Solution policy revealed that, "Policy Statement: A sanitizing solution is used in the Dietary Department for sanitizing work surfaces. " "2. New solution is tested three times daily for proper concentration by using Sink and Sanitizer cleaner test strips or the visual compliance indicator test strips."	F0812		
F0883 SS = E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F0883	1. Corrective Action Resident #35, #56 and #60 were offered the pneumovax and administration or refusal documented. VJS 2. Other Residents at Risk A complete audit of all residents' pneumovax was completed. All residents who were identified as needing the updated pneumovax were offered and vaccine given to those who wanted it by 8/20/26. Administration or refusals were documented. VJS	

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F0883 SS = E	Continued from page 15 documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to minimize the risk of residents acquiring and transmitting pneumococcal disease by ensuring that three of five sampled residents (35, 56, and 60) were offered the pneumococcal vaccination. Findings include: 1. Review of resident 35's electronic medical record	F0883	3. Systemic Changes 100% of residents will be offered upon admission and then per CDC vaccine schedule. The admission checklist was updated to include offering the most recent required vaccines per CDC vaccine schedule. Admission Coordinator and admission team members were educated on the importance of offering required vaccines on admission. The ICP Nurse will continue to track any vaccine schedule changes and update the admission team as needed. 4. Monitoring DNS or designee will audit admissions that pneumovax was offered weekly x 3 and then monthly x 3. DNS or designee will report to ~~QI Council~~ monthly QAPI VJS and are responsible for offering and documenting administration or refusals VJS	8/20/26

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F0883 SS = E	Continued from page 16 (EMR) revealed that he admitted to the facility on 10/17/24. He had received the PCV 13 (an immunization that protects against thirteen types of streptococcus pneumoniae bacteria) vaccination on 8/21/20. There was no documentation that he was offered and received or declined the additional recommended pneumococcal vaccine. 2. Review of resident 56's EMR revealed that he admitted to the facility on 8/25/25. He had received the PCV 13 vaccination on 11/21/19. There was no documentation that he was offered and received or declined the additional recommended pneumococcal vaccine. 3. Review of resident 60's EMR revealed that he admitted to the facility on 5/26/26. He received the PPV 23 (a vaccine that protects against 23 types of streptococcus pneumoniae bacteria) vaccine on 11/12/10. There was no documentation that he was offered and received or declined the additional recommended pneumococcal vaccine. 4. Interview on 7/30/26 at 1:06 p.m. with registered nurse (RN) unit manager/infection preventionist (IP) C revealed she started using a new computer system on 6/1/26 for monitoring resident immunizations. When a resident admitted to the facility, they were offered immunizations that were needed according to the new computer system and the state immunization records. She stated, "It's a work in progress." She agreed that resident's 35, 56, and 60 were not offered the recommended pneumococcal vaccines, and that they did not decline or refuse the vaccines. She expected new admit immunization records to be reviewed on admission, and that residents were offered the needed immunizations after admission. 5. Review of the updated 6/19/25 Pneumococcal Vaccination of Residents policy revealed "The facility offers the Pneumococcal vaccination to facility residents among facility residents in accordance with Centers for Disease Control (CDC) recommendations and Federal requirements. Each resident's pneumococcal immunization status is determined upon admission or soon afterwords and is documented in the resident's EHR [electronic health record] medical record."	F0883		
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination.	F0561		

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F0561 SS = D	Continued from page 17 The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure resident bathing choices were being followed for one of one sampled residents (105). Findings include: 1. Interview on 7/28/26 at 3:54 p.m. with resident 105 revealed that she requested two baths per week since her admission to the facility. That request was not fulfilled. She then requested her physician to write an order for two baths per week. She said she felt uncomfortable and unclean, not being able to shower two times per week. 2. Review of resident 105's electronic medical record (EMR) revealed she admitted to the facility on 6/20/26. Her 7/9/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnoses included anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability),	F0561	1. Corrective Action No additional action taken for Resident #105 as she is no longer in the facility. 2. Other Residents at Risk all residents had the potential to be affected. Audited bathing orders for remaining residents to ensure that orders are properly care planned and bath sheets updated accordingly and resident bathing preferences VJS 3. Systemic Changes Audit of all residents receiving baths completed to ensure all baths are per CMS guidelines or resident preference. Third bath aide added 3x weekly and will evaluate the need for increased hours based on audits and resident preference. Every resident care plan will be reviewed on admission, re-admission and with each scheduled care conference to ensure they are up to date with resident preference. Admission Coordinator and admission team educated to ensure care plan updated with each admission and re-admission 4. Monitoring DON or designed will audit bath weekly x 4 then monthly x 3 (or until QAPI determines compliance), to ensure that each resident receives a bath per CMS guidelines or individual resident care-planned preference. VJS	8/20/26

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F0561 SS = D	Continued from page 18 and depression. Her undated care plan (personalized plan that addresses a resident's care needs, goals, and interventions) revealed she had an activities of daily living (ADL) self-care performance deficit due to an impaired balance, limited mobility, and limited range of motion. The 7/15/26 added interventions for her bathing/showering indicated she was to have two baths per week and as needed (prn). Her 6/26/26 Minimum Data Set (MDS) assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) section GG functional abilities and goals indicated that resident 105's self-care assessment for bathing was that she needed partial staff assistance. Her physician's order dated 7/14/26 indicated she was to have two baths weekly. 3. Review of the 400 hallway daily bath schedule revealed resident 105's bath was scheduled on Monday. There was not a second bath day scheduled for resident 105 that week. 4. Interview and 400 hallway daily bath schedule review on 7/30/26 at 1:15 p.m. with staff development registered nursing (RN) D revealed the staff had daily bath sheets that identified who was to get a bath each day. The bath sheets were kept in the tub rooms. These sheets were updated weekly by medical records S. If she was not available, then director of nursing (DON) B updated them. Staff development RN D expected that if there was a doctor's order for a resident to receive two baths weekly, the facility would follow that order. Staff development RN D reviewed resident 105's bath schedule and confirmed the resident was scheduled to receive a bath on Mondays, despite her physician's order for two baths per week. 5. Interview on 7/30/26 at 1:35 p.m. with medical records S revealed that she updated the bath schedule two times per week. She received updates on the physician's orders from staff development RN D or DON B and would follow those physician's orders if they regarded the resident's bath schedule. She said that RN D just fixed a bath schedule for resident 105 earlier after she found a physician's order. Medical records S was not aware of the order for resident 105. 6. The survey team requested the bathing policy on	F0561		

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

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F0561 SS = D	Continued from page 19 7/29/26 at 9:49 a.m. 7. The facility did not provide a bathing policy. When administrator A returned the requested documents to the team, she said the facility follows the Resident Assessment Instrument (RAI) (an official guide published by the Centers for Medicare & Medicaid Services (CMS) that provides instructions for the Resident Assessment Instrument) for bathing guidelines. 8. Review of the provider's updated April 2024 Physician Order Recaps policy revealed "the licensed nursing staff is responsible for inputting admission, telephone, and verbal physician's orders into the EHR [a digital electronic health record of a medical chart that stores health information] immediately upon receipt from the provider. The Director of Nursing establishes the licensed clinician responsible for recap and reconciliation of New, Discontinued, or Completed orders in the EHR daily and initiates corrections daily."	F0561		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure that two of five sampled residents (65 and 73) had a Preadmission Screening and Resident Review (PASRR) level II (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the	F0644	1. Corrective Action For resident #65 and #73 SS assessed residents under current rules/guidelines, would quality and submitted for PSARR II 2. Other Residents at Risk Social Services audited residents under current rules/guidelines and submitted identified for PSARR review. 3. Systemic Changes When doing a new MDS will review each resident for new diagnosis that may trigger a new PSARR. 4. Monitoring MDS Coordinator or designee will complete weekly audit of admissions and significant diagnosis changes for 3 months and report to ~~QI Committee~~ QAPI WIS monthly.	8/20/26

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F0644 SS = D	Continued from page 20 resident's care needs) completed. Findings Include: 1.Review of resident 65's EMR revealed she admitted to the facility on 5/25/23 and had diagnoses that included depressive disorder, hallucinations, and hoarding disorder. She had a 5/25/23 PASRR Level 1 completed. Her 9/11/23 PASRR Level II screening form determined resident 65 was exempt from a Level II review as the diagnosis of a mental illness was unsubstantiated. On 9/5/24, resident 65 received a new diagnosis of delusional disorders. Social Services director (SSD) N's notes documented on 10/24/24 indicated that the "PASRR is appropriate-we do monitor to update. Resident currently has a psychiatric diagnosis. PASRR II screen is not indicated." Resident 65's 11/8/24 quarterly Minimum Data Set (MDS) assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) completed by SSD N did not identify delusions. The 5/8/26 MDS assessment completed by SSD N did not identify delusions. Resident 65's November 2024 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated "Resident is exhibiting delusion thoughts." Her 6/2/25 care plan identified she had behaviors including: delusions, hallucinations, hoarding, and neglecting the doctor's orders. SSD N indicated in a 1/24/25 progress note that "Resident thought process and decisions are based on her perceived perceptions and beliefs. These are not always realistic and can often be delusional in nature. These do get in the way of her thinking and ability to manage her own needs. Resident does like to take her time with things so that she can sort the details out. These details turn from real to some delusional. Safety awareness is poor at times." Diagnoses were major depressive disorder, single episode, mild and delusional disorders. "Continue to see thoughts on delusional side. We have seen resident not making good decisions surrounding her healthcare choices. She has certain beliefs that she follows regardless if they are true or not." 2. Interview and EMR review on 7/29/26 at 4:14 p.m, with SSD N regarding the Level 1 and Level II PASRR provided by the facility for resident 65 revealed that the PASRRs provided by the facility	F0644		

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F0644 SS = D	Continued from page 21 were from 2023. SSD N stated there were no additional PASRRs completed on resident 65. She expected a PASRR to be done if there was a new diagnosis of delusional disorders present. She confirmed in resident 65's EMR that the diagnosis of delusional disorders was added during her stay at the facility and that no PASRR was completed. 3. Review of resident 73's EMR revealed he admitted to the facility on 10/27/23. His 6/16/26 Brief Interview for Mental Status (BIMS) assessment score was 0, which indicated his cognition was severely impaired. His diagnoses included unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities) and unspecified psychosis (a diagnostic category used when a person experiences clear psychotic symptoms) not due to a substance or known physiological condition, diagnosed on 8/27/24. A PASRR level 1 screen was completed on 10/26/23 with Maximus (a clinical service that evaluates individuals applying for or residing in Medicaid-certified nursing facilities). The level I screen indicated that resident 73 "did not show that you have a serious mental illness or an intellectual/developmental disability (IDD). You do not need more screening unless you have or may have a serious mental illness or an IDD and experience a significant change in treatment needs." His 9/11/2025 pharmacy medication review had a signed order acknowledging he was prescribed the antipsychotic medication Olanzapine 2.5 milligrams (mg) twice a day (BID) for the treatment of unspecified psychosis since July 2024. 4. Interview and EMR review on 7/30/26 at 10:35 a.m. with SSD N revealed that she would submit a PASRR level II for a resident who had a serious mental illness diagnosis. She reviewed resident 73's EMR and confirmed he had a serious mental illness. SSD N was not notified if a resident received a new diagnosis. No additional mental health authorities were notified of resident 73's psychosis diagnosis. 5. Review of the provider's revised 1/1/25 PASRR Process Policy and Procedure revealed "4. If there is a significant change of condition that affects their diagnosed need for a PASRR 2, staff refer for a NEW PASRR Level 2. a. The Level 2 evaluator determines if the resident's current care needs are able to be met at the NF [nursing facility]. b. If the resident	F0644		

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F0644 SS = D	Continued from page 22 remains appropriate for the nursing facility (NF), there may be new recommendations to be placed on the care plan. c. If the resident is no longer deemed appropriate for the NF setting, the evaluator will discuss with the Administrator and/or the social services Director. B. Follow up as needed per federal PASRR rules."	F0644		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one portable oxygen cylinder (a pressurized container that stores and transports compressed or liquid oxygen) was securely transported. Findings include: 1. Observation on 7/30/26 at 10:23 a.m. in hallway 400, outside the nurse's station, revealed contracted travel licensed practical nurse (LPN) K removed an oxygen cylinder from the back of a resident's wheelchair and carried it down the hallway towards the 100 hallway. 2. Observation on 7/30/26 at 10:28 a.m. revealed contracted travel LPN K carried an oxygen cylinder from the direction of the 100 hallway to the 400 hallway, outside the nurse's station and placed the oxygen cylinder on the back of the same resident's wheelchair as the observation above. 3. Observation on 7/30/26 at 11:28 a.m. of the oxygen storage room revealed there were five wheeled carts available to transport oxygen tanks. Three of those wheeled carts had oxygen cylinders in them. There was an orange sign posted on the wall in the oxygen storage room, which stated "Do not leave oxygen tanks standing alone! They must be in a holder at all times!"	F0695	1. Corrective Action Education was completed on safe oxygen handling and transport when utilizing oxygen cylinders 7/30/26 and again via directed Inservice. 2. Other Residents at Risk all residents could be affected. 3. Systemic Changes : transport carts available in oxygen room as well as in clean utility rooms on each hall to ensure they are available when needed to transport oxygen cylinders. 4. Monitoring DNS or designee will randomly audit transport of O2 canisters weekly x3 and monthly x 3. DNS or designee will report to ~~QI Committee~~ QAPI VIS monthly.	8/20/26

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F0695 SS = D	Continued from page 23 4. Interview on 7/30/26 at 10:25 a.m. with registered nurse (RN) medication nurse H, who witnessed LPN K remove and replace the resident's oxygen cylinder, revealed that the oxygen cylinder should have been in a wheeled cart for both the empty and full oxygen cylinders during transport. 5. Interview on 7/30/26 at 10:32 a.m. with contracted travel LPN K, regarding the oxygen cylinders revealed the oxygen cylinder she removed from the resident's wheelchair was empty and that she retrieved a full oxygen cylinder from the oxygen storage room. She carried the full oxygen cylinder down the hallway and placed it on the resident's wheelchair. She confirmed there were wheeled carts available in the oxygen room for transport, but "they are way down the hallway so I just carry them." She would normally carry the oxygen cylinders back and forth from the oxygen storage room when she needed to change out a resident's empty oxygen cylinder. 6. Interview on 7/30/26 at 11:40 a.m. with RN unit manager/infection preventionist C and staff development RN D revealed, staff development RN D would get a wheeled cart from the oxygen storage room or bring the resident to the oxygen storage room to switch out the oxygen cylinders. RN unit manager/infection preventionist C agreed with that process. Staff development RN D stated she had told the staff to put the oxygen cylinders in a cart and wheel them down to the resident; however, she did not provide specific education on switching out the oxygen cylinders. 7. Interview on 7/30/26 at 12:14 p.m. with contracted travel certified nursing assistant (CNA) CC revealed she had seen someone drop an oxygen cylinder before and it "made a big hole in the wall." She changed out oxygen cylinders by bringing the residents to their room and using a wheeled cart to transport the oxygen cylinders. She has seen other staff members carrying the oxygen cylinders instead of using the wheeled carts for transportation. 8. Interview on 7/30/26 at 12:21 p.m. with RN medication nurse G revealed, she used the "oxygen cart" to transport the empty and full oxygen cylinders back and forth from the oxygen storage room. She identified the oxygen carts as the	F0695		

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F0695 SS = D	Continued from page 24 wheeled carts located in the oxygen storage room. 9. Interview and staff education review on 7/30/26 at 2:28 p.m. with staff development RN D revealed she provided the staff members with a five-minute video regarding oxygen use and safety and had them take a test. She confirmed that the printed content of the video identified that the oxygen cylinders should always be kept upright and be in a carrier. She stated that she does not do training with the contracted travel staff as they have their competencies through their agency. 10. Review of LPN K's employee file revealed she was provided, fire safety training through Relias (the provider's education training system) on 6/13/25; however, nothing specific related to oxygen safety. 11. Review of the provider's December 2017 Respiratory Care policy revealed "Safety precautions and care of oxygen delivery equipment are performed according to State and Federal regulation and manufacturer guidance. The Center observes precautions to prevent explosions, fire, etc. that are associated with oxygen use and storage. All oxygen tanks are secured in appropriate storage containers/stands or secured to a wall with a chain or heavy cable. Center personnel receive training regarding oxygen administration and safety.	F0695		
F0732 SS = D	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.	F0732	1. Corrective Action Licensed nurses were educated that daily census/staffing posting must be updated before the start of each shift. 2. Other Residents at Risk All residents have the potential to be impacted due to staffing. Licensed nurses were educated that daily census/staffing posting must be updated before the start of each shift.	

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F0732 SS = D	Continued from page 25 (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, document review, and interview, the provider failed to ensure the daily posted nurse staffing information reflected the actual resident census and hours worked by registered nurses (RNs), licensed practical nurses (LPNs), certified medication aides (CMAs), and certified nursing assistants (CNAs) per shift, and was posted in a location visible and accessible to the residents, staff, and visitors. Findings include: 1. Observation on 7/28/26 at 8:30 a.m. revealed the	F0732	3. Systemic Changes . Licensed nurses were educated that daily census/staffing posting must be updated before the start of each shift. 4. Monitoring Administrator or designee will audit that daily postings are updated prior to each shift weekly x 3 and then monthly x3. Administrator will report to ~~QI Committee~~ monthly GAPI VJS	8/20/26

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F0732 SS = D	Continued from page 26 facility resident census and daily nurse staffing information was posted in the window of the facility's main entrance. The information included the date, resident census, and the number of nursing personnel and their total hours scheduled to work for that day. 2. Review of the provider's nursing staff schedule for July 2026 revealed that no registered nurse was scheduled for 7/14/26 and 7/22/26. 3. Review of the provider's daily posted nurse staffing information for 7/14/26 and 7/22/26 revealed that on both days, one registered nurse was scheduled for a 12-hour day shift and one registered nurse was scheduled for a 12-hour night shift. 4. Interview on 7/30/26 at 9:00 a.m. with RN medication nurse H revealed that when the staff called in or missed their scheduled shift, the nurse on duty provided a call-in sheet to director of nursing (DON) B, staff development RN D, or administrator A. RN medication nurse H expected the call-in information to be relayed to receptionist U, who posted the daily nurse staffing information in the window of the main entrance. RN medication nurse H was not involved with completing the daily nurse staffing information and did not know if the posted information was updated throughout the day. 5. Interview on 7/30/26 at 9:15 a.m. with receptionist U revealed that she prepared and posted the daily resident census and nurse staffing information when she arrived at work each morning. She referenced the nursing schedule to obtain the number of CNAs and CMAs scheduled on each shift, but she did not know which nurses were RNs or LPNs. When she was hired in December 2025, receptionist T trained her to always write that one RN and two LPNs were scheduled for the day and night shifts. She did not post updates throughout the day as the census or nursing schedule changed. She agreed the posted information did not reflect the actual resident census or hours worked in each staffing category. 6. Interview on 7/30/26 at 9:48 a.m. with staff development RN D revealed that DON B and staffing coordinator P coordinated shift coverage to ensure that enough nursing staff were working to meet the residents' needs. Staff development RN D said three	F0732		

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F0732 SS = D	Continued from page 27 or four nurses were scheduled per shift, along with five CMAs and five CNAs for the day and evening shifts and four to six CNAs for the night shift. If staff called in for their scheduled shift, five nurse managers were expected to help cover the shift vacancies. The two scheduled bath aides and non-licensed staff activities and restorative therapy staff were also pulled to help where needed. "We all just pitch in where we can." 7. Interview on 7/30/26 at 10:32 a.m. with administrator A revealed that she did not update the Facility Assessment since she was hired in November 2025. She expected to see at least three nurses working the day shift and three nurses working the night shift. The nurse managers primarily worked in their offices and were not included in the hours reflected in the Facility Assessment, but she expected them to cover vacant nursing shifts and help the direct care staff as needed. She said that a registered nurse is scheduled to work at least eight hours a day, and if an RN was not on the schedule for 7/14/26 and 7/22/26, then the nurse managers were considered the RN for that day. Administrator A was not aware that the daily posted nurse staffing information should reflect the resident census and the nurse staffing updates throughout the day. She said none of the nurses completed the daily resident census and nurse staffing information, just the receptionists. She expected that receptionists T and U would accurately list the number of LPNs and RNs working each day. 8. The provider did not have a policy on posting the daily resident census and the nurse staffing posting information. 9. Review of the provider's 7/11/25 Facility Assessment, Staffing Plan, revealed that the staffing was evaluated and adjusted based on the resident census and residents' care needs. For a census of 125 residents, the Facility Assessment indicated that each day would include direct care hours performed by RNs (three or more per shift), LPNs (one or more per shift), and CNAs (three or more per shift).	F0732		

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F0880 SS = D	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; (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	F0880	1. Corrective Action Re-educated employee #BB regarding the enhanced barrier instructions on the resident door before her next shift, 8/5/26. 2. Other Residents at Risk All residents had the potential to be affected. Re-educated all staff via on-line training on EBP on 8/3/26. 3. Systemic Changes Re-educated all staff via on-line training on EBP on 8/3/26. 4. Monitoring DNS or designee will randomly audit cares in rooms with EBP weekly x 3 and then monthly x 3. DNS or designee will report results to ~~QI~~ QAPI ~~Committee~~ monthly.	VIS 8/20/26

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F0880 SS = D	Continued from page 29 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 observation, interview, record review, and policy review, the provider failed to ensure the staff followed standard infection prevention practices regarding enhanced barrier precautions (EBP) (gown and glove use when providing contact care) by one of one contracted travel certified nursing assistant (CNA) (BB) while she changed bed linens for one of one sampled resident (28) who required EBP. Findings include: 1. Observation on 7/28/26 at 11:04 a.m. revealed that contracted travel CNA BB made resident 28's bed. Resident 28 had a sign on his door indicating he required EBP. Contracted travel CNA BB was not wearing gloves or a gown, and the soiled bed sheet was lying on resident 28's floor. Contracted travel CNA BB picked up the soiled bed sheet with her bare hands, put it in a garbage bag, put that garbage bag on the floor, washed her hands in the resident's sink, picked up the garbage and linen bag, and brought them to the soiled utility room. 2. Review of resident 28's electronic medical record (EMR) revealed he admitted to the facility on 6/3/26. He had diagnoses of end stage renal disease (permanent kidney failure where the kidneys no longer clean waste or remove extra fluid from the blood). His July 2026 treatment administration record	F0880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESTEEL HEALTHCARE CENTER	1120 EAST 7TH AVENUE , MITCHELL, South Dakota, 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
F0880 SS = D	Continued from page 30 (TAR) indicated he had a dialysis tunneled catheter (a device used for a treatment that removes waste products and excess fluid from the blood when the kidneys are unable to), to right chest. On 7/29/26, his TAR indicated he had a wound to both of his shins and his right foot that the nurse completed treatments for. 3. Interview on 7/28/26 at 11:08 a.m. with contracted travel CNA BB revealed that she removed resident 28's soiled bed sheet and made his bed without wearing a gown. She verified he was on EBP. She did not need to wear a gown when changing or making his bed, but she would have worn a gown if she was providing personal care to resident 28 or if he was in the room when she changed his bedding. 4. Interview on 7/30/26 at 11:07 a.m. with contracted travel licensed practical nurse (LPN) K revealed that resident 28 required EBP because he had a dialysis tunneled catheter and his legs sometimes were severely swollen that they wept (body fluid oozes directly through the skin), and he had open areas on his legs. When a resident required EBP, the staff were to wear a gown and gloves when changing the resident's bed linen because of the possibility of infectious material being on the sheets. 5. Interview and EBP policy review on 7/30/26 at 11:12 a.m. with registered nurse (RN)/unit manager/infection preventionist C revealed that if a resident required EBP, she expected the staff to wear a gown and gloves when handling the residents bedding. She had educated the staff regarding EBP and had educated contracted travel CNA BB regarding EBP before. 6. Review of the providers 3/26/24 EBP policy revealed that if a resident required EBP, the staff were to follow EBP when changing the resident's linens.	F0880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESTEEL HEALTHCARE CENTER	1120 EAST 7TH AVENUE , MITCHELL, South Dakota, 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
E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 7/28/26. Firesteel Healthcare Center was found in compliance.	E0000		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Veronica J Smith	Administrator	8/21/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435109	A. BUILDING 01 - MAIN BUILD... B. WING	07/28/2026

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 7/28/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Firesteel Healthcare Center was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K211, K321, K353, K355, K363 and K761 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)	K0321	1. Corrective Action kick down was removed from maintenance office/storage room door Adjusted the door in 500 wing mechanical storage room so that door latched Cans of paint removed so that door was no longer propped open. Door to the boiler room was adjusted so that door wou d latch. 2. Other Residents at Risk Maintenance staff did a walk through of facility and tested each door for kick stops and door stops removed, and doors that did not latch were adjusted. 3. Systemic Changes Maintenance Director or designee will audit each door monthly to ensure that doors latch properly and are not propped open. All staff educated to report doors observed not to latch via TELs.	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Veronica J Smith	Administrator	8/21/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 07/28/2026

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FIRESTEEL HEALTHCARE CENTER	1120 EAST 7TH AVENUE , MITCHELL, South Dakota, 57301

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K0321 SS = E Bldg. 01	Continued from page 1 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to maintain two separate hazardous areas (maintenance office and 500 wing mechanical room) as required. Findings include: 1. Observation and testing on 7/28/26 at 11:15 a.m. revealed the maintenance office/storage room was over 100 square feet and contained combustible items. The corridor door to that room was equipped with a kick down device which was holding the door open. That kick-down prevented that door from automatically closing and latching under the operation of the door closer. Interview with the maintenance manager at the time of the observation confirmed that finding. 2. Observation and testing on 7/28/26 at 12:21 p.m. revealed the 500-wing mechanical/storage room was provided with a one-hour fire rated door. That door was being propped open by several cans of paint. That hazardous area had an anteroom between it and the corridor, however the door to that room was not latching into its frame. Interview with the maintenance manager at the time of the observation confirmed that finding. 3. Observation and testing on 7/28/26 at 4:18 p.m. revealed the door to the boiler room in the service wing would not close and latch into the door frame. That door would strike the frame when closing preventing it from closing and latching under the power of its automatic door closer. Interview with the maintenance manager at the time	K0321	4. Monitoring Maintenance Director or designee will audit each door monthly to ensure that doors latch properly and are not propped open and report to QI Committee monthly	8/20/26

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K0321 SS = E Bldg. 01	Continued from page 2 of the observation confirmed that finding. He stated he had recently started his position and was not yet fully trained on all the requirements for hazardous areas.	K0321		
K0355 SS = E Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to perform monthly checks of fire extinguishers in accordance with NFPA 10 for four randomly checked fire extinguishers (by the400-wing exit, service wing, front smoking area, and the boiler room exit). Findings include: 1. Observation on 7/28/26 at 1:12 p.m. revealed the fire extinguisher on the outside of the building (at the 400-wing exit) did not have any monthly maintenance checks written on the fire extinguisher tag since the annual inspection on 1/16/26. Interview with the maintenance manager at the time of the observation confirmed that finding. He stated he had recently started his position and was still learning about the building. He further revealed he was unaware there was a fire extinguisher in that location. 2. Observation on 7/28/26 at 3:21 p.m. revealed the fire extinguisher in the corridor in the service wing (by the janitors room) did not have monthly maintenance checks written on the fire extinguisher tag since March 2026. Interview with the maintenance manager at the time of the observation revealed he was unaware of that condition. He stated they must have missed that device during the monthly checks since that time. 3. Observation on 7/28/26 at 3:45 p.m. revealed the	K0355	1. Corrective Action Extinguishers outside the 400 wing, near the janitor's room, outside near the smoking area and exterior exit by boiler room were tagged and dated. 2. Other Residents at Risk Maintenance completed a building walk through to identify if any others had been missed. No other concerns identified. 3. Systemic Changes Maintenance team will inventory and put extinguishers on a map for better tracking. Checking for dates has been added to quarterly safety/infection control rounding which will review for compliance and place a TELs if any are out of compliance. 4. Monitoring Maintenance will audit all fire extinguishers for monthly checks and dating of tag monthly and ongoing. Maintenance Director will report to the QI Committee monthly	8/20/26

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K0355 SS = E Bldg. 01	Continued from page 3 fire extinguisher on the outside of the building near the front door (for the front smoking area) did not have monthly maintenance checks written on the fire extinguisher tag since the annual inspection on 1/16/26. Interview with the maintenance manager at the time of the observation Confirmed that finding. He went on to state he was unaware there was a fire extinguisher in that location. 4. Observation on 7/28/26 at 3:49 p.m. revealed the fire extinguisher at the exterior exit of the boiler room did not have monthly maintenance checks written on the fire extinguisher tag since the annual inspection on 1/16/26. Interview with the maintenance manager at the time of the observation Confirmed that finding. He stated he was also unaware there was a fire extinguisher in that location.	K0355		
K0211 SS = D Bldg. 01	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to provide egress doors free of all obstructions to full use as required at one randomly observed exit door location (east 400 wing). Findings include: 1. Observation and testing on 7/28/26 at 12:53 p.m. revealed the south leaf of the east facing double doors for the 400-wing exit (near the rehab dining room) was unable to be easily opened. Testing of that door revealed it would not open without applying greater than fifty pounds of force in the direction of the path of egress. Further observation at that same time revealed a metal backed door seal	K0211	1. Corrective Action seal removed from 400 exit and door tested for proper opening. 2. Other Residents at Risk no other risks identified 3. Systemic Changes Maintenance Director or designee will audit each exit door monthly to ensure that doors open properly. 4. Monitoring Maintenance Director or designee will audit each door monthly to ensure that doors open and report to QI Committee monthly	8/20/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 07/28/2026

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K0211 SS = D Bldg. 01	Continued from page 4 along the vertical edge of the south leaf would strike the north leaf preventing it from opening. Interview with the maintenance manager at the time of the observation confirmed that finding. He stated he was unaware that door was unable to be opened. He also believed the door seal which was striking the other door leaf could be moved to the exterior of that door leaf and it would no longer prevent that leaf from opening.	K0211		
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, measurement, and interview, the provider failed to maintain the required minimum of 18 inches of unobstructed space under sprinkler head deflectors for two randomly observed locations (electrical closet and therapy room). Findings include: 1. Observation and measurement on 7/28/26 at 11:52 a.m. revealed a sprinkler head in the electrical closet (adjacent to the cross-corridor doors just southwest of the therapy wing) was obstructed by an amplifier for the public addressing (PA) system on a	K0353	1. Corrective Action amplifier was moved in the electrical closet as were the closets in the therapy room. 2. Other Residents at Risk no other risks identified 3. Systemic Changes All staff educated that no items can be within 18 inches of ceiling/sprinkler system. 4. Monitoring All shelves/closets will be monitored weekly x 3 then monthly x three for compliance Quarterly audits will be completed with safety/infection control audits.	8/20/26

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	435109	A. BUILDING 01 - MAIN BUILD... B. WING	07/28/2026

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K0353 SS = D Bldg. 01	Continued from page 5 shelf. That PA amplifier was approximately only 8 inches below the bottom of the sprinkler head deflector. That shelf and that amplifier would interrupt the proper discharge and operation of the sprinkler head. Interview with the maintenance manager at the time of the observation revealed he was not aware of that obstructed sprinkler head. He went on to state he had recently started his position and was still learning about the building. 2. Observation and measurement on 7/28/26 at 11:58 a.m. revealed two sprinkler heads along the northwest wall in the therapy rooms were both obstructed by a set of large wardrobe closets. Those wardrobes were 11 inches below the bottom of the sprinkler head deflectors. Those wardrobes would interrupt the proper discharge and operation of those sprinkler heads. Interview with the maintenance manager at the time of the observation revealed he was not aware of those obstructed sprinkler heads. He went on to state he had recently started his position and was still learning about the building.	K0353		
K0363 SS = D Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting	K0363	1. Corrective Action corridor door to small storage room and to soiled utility room were adjusted so they will latch into its door frame 2. Other Residents at Risk no additional doors were identified. 3. Systemic Changes All staff educated to report to Maintenance when observing doors not latching. Maintenance Director or designee will audit each fire door monthly to ensure that doors latch properly. 4. Monitoring Maintenance Director or designee will audit each door monthly to ensure that doors latch properly. Maintenance Director will report to QI Committee monthly.	8/20/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 07/28/2026

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K0363 SS = D Bldg. 01	Continued from page 6 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to ensure corridor doors would resist the passage of smoke for one randomly observed location (500 wing storage room and soiled utility room). Findings include: 1. Observation and testing on 7/28/26 at 12:22 p.m. revealed the corridor door to the small storage room at the southeast end of the 500-wing did not close and latch into its door frame. To maintain a smoke tight rating to the egress corridor that door is required to latch. Interview with the maintenance manager at the time of the observation confirmed that finding. The deficiency had the potential to affect 100% of the occupants of that smoke compartment. 2. Observation and testing on 7/28/26 at 12:53 p.m. revealed the corridor door to the 500-wing soiled utility room (did not close and latch into its door frame. To maintain a smoke tight rating to the egress corridor that door is required to be latching. Interview with the maintenance manager at the time of the observation confirmed that finding. He stated he had recently started his position and was not yet fully trained on all the requirements for corridor doors. The deficiency had the potential to affect 100% of the occupants of that smoke compartment.	K0363		

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K0761 SS = D Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to maintain fire doors to ensure proper operation for two randomly observed locations (outside room 113 and the beauty shop). Findings include: 1. Observation and testing on 7/28/26 at 2:28 p.m. revealed the north leaf of the fire-rated cross-corridor doors outside room 113 did not automatically close and latch when released from the magnetic hold-open device. Fire-rated cross-corridor doors must automatically close and latch to maintain their fire rating. Interview with the maintenance manager at the time of the observation confirmed that finding. The deficiency had the potential to affect 100% of the occupants of that smoke compartment. 2. Observation and testing on 7/28/26 at 3:16 p.m. revealed the 90-min fire-rated door to the beauty shop would not automatically close and latch when released from the magnetic hold-open device. Fire-rated doors must automatically close and latch to maintain their fire rating.	K0761	1. Corrective Action fire door outside 113 and beauty shop were adjusted so they will latch into its door frame 2. Other Residents at Risk no additional doors were identified. 3. Systemic Changes Maintenance Director or designee will audit each fire door monthly to ensure that doors latch properly. 4. Monitoring Maintenance Director or designee will audit each door monthly to ensure that doors latch properly. Maintenance Director will report to QI Committee monthly.	

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FIRESTEEL HEALTHCARE CENTER	**1120 EAST 7TH AVENUE , MITCHELL, South Dakota, 57301**

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K0761 SS = D Bldg. 01	Continued from page 8 Interview with the maintenance manager at the time of the observation confirmed that finding. He stated he had recently started his position and was not yet fully trained on all the requirements for corridor doors. The deficiency had the potential to affect 100% of the occupants of that smoke compartment.	K0761		

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 _____	07/30/2026

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 44:73, Nursing Facilities, was conducted from 7/28/26 through 7/30/26. Firesteel Healthcare Center was found not in compliance with the following requirements: S157, S206, and S301.	S 000		
S 157	44:73:02:13 Ventilation A facility shall provide electrically powered exhaust ventilation in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation for the east half of the one-hundred corridor (whirlpool room, 114, 116, 118, and 120). Findings include: 1. Observation and testing on 7/28/26 at 2:35 p.m. revealed the exhaust ventilation in the 100 wing whirlpool room was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the maintenance manager at the time of the above observation confirmed that finding. He revealed he was unaware why the exhaust ventilation was not working at that location. He had recently started his position and was not yet fully familiar with the building's exhaust systems.	S 157	1. Corrective Action Exhaust for 100 hall has been fixed. 2. Other Residents at Risk : Other wings were audited and found to be in working order on 7/30/26. 3. Systemic Changes: Checking exhaust has been added TELS to be checked monthly and as needed. 4. Monitoring: Audits will be completed monthly that exhausts are checked and working by the Director of Maintenance or designee. Results will be reported monthly to QI Council by the Director of Maintenance.	8/20/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Veronica J Smith — TITLE: Administrator — (X6) DATE: 8/21/26

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S 157	Continued From page 1 2. Observation and testing on 7/28/26 at 2:39 p.m. revealed the exhaust ventilation in the bathroom shared by resident rooms 118 and 120 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the maintenance manager at the time of the above observation confirmed that finding. He revealed he was unaware why the exhaust ventilation was not working at that location. 3. Observation and testing on 7/28/26 at 2:40 p.m. revealed the exhaust ventilation in the bathroom shared by resident rooms 114 and 116 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the maintenance manager at the time of the above observation confirmed that finding. He was unaware why the exhaust ventilation was not working at that location. He believed the entire east side of the 100 wing was not functioning correctly.	S 157		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response;	S 206		

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S 206	Continued From page 2 (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure one of six employees reviewed (F) had completed the required annual personnel trainings regarding dining assistance, nutrition risks, and hydration. Findings include: 1. Review of employee F's personnel record revealed she was hired on 6/8/09 as a registered nurse (RN) medication nurse. She did not receive ongoing annual training on dining assistance, nutrition risks, and hydration. 2. Interview on 7/29/26 at 3:28 p.m. with staff development RN D revealed that initial staff	S 206	1. Corrective Action Employee F completed annual training on dining assistance, nutrition risks and hydration 7/29/26 2. Other Residents at Risk there were no additional staff out of compliance. 3. Systemic Changes Staff will be assigned/expected to complete the required training within their first 30 days of employment and then annually thereafter. 4. Monitoring: Administrator will utilize the worksheet from survey and audit each employee that is due for evaluation that each topic has been covered in the last year Audit will be completed monthly x 3. For new employees, HR Director will audit all new hires that they have completed all required topics within 30 days monthly x 3. Administrator and HR Director will report results to the QI Committee monthly.	8/20/26

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S 206	Continued From page 3 orientation training was assigned in SNF (Skilled Nursing Facility) Clinic, the facility's education portal. She provided ongoing annual training at monthly staff meetings and then assigned the education topics in the SNF Clinic to the staff who missed the meetings. She said the SNF Clinic assignments were expected to be completed within their assigned due date, generally 30 days. RN D stated that RN med nurse F did not complete her ongoing annual education regarding dining assistance, nutritional risks, and hydration. 3. Interview on 7/29/26 at 3:20 p.m. with administrator A revealed she expected the staff to complete their required training within their first 30 days of being hired at the facility and annually thereafter.	S 206		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements.	S 301	1. Corrective Action: Employee EE completed annual education on food handling and preparation techniques, serving and distribution procedures, time and temperature controls for food prep and service, nutrition and hydration and sanitation requirements	

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S 301	Continued From page 4 This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure one of two dietary employees (EE) reviewed had completed the required dietary trainings on food handling and preparation techniques, serving and distribution procedures, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements annually. Findings include: 1. Review of the employee EE's personnel records revealed that she was hired on 1/21/25 as a dietary aide (DA). She did not receive ongoing annual training on food handling and preparation techniques, serving and distribution procedures, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. 2. Interview on 7/29/26 at 3:28 p.m. with staff development registered nurse (RN) D revealed that initial staff orientation training was assigned in the SNF (Skilled Nursing Facility) Clinic, the facility's education portal. Dietary supervisor (DS) M was responsible for providing ongoing annual training for the dietary staff. 3. Interview on 7/30/26 at 1:24 p.m. with DS M and senior certified dietary manager (CDM) HH revealed that DS M began working as the supervisor in April 2026 and was still training with senior CDM HH. Neither of them was aware that DA EE did not complete her required ongoing annual education. DS M expected the staff to complete their training by the deadline specified in the SNF Clinic, which was typically 30 days	S 301	2. Other Residents at Risk completed annual education on food handling and preparation techniques, serving and distribution procedures, time and temperature controls for food prep and service, nutrition and hydration and sanitation requirements. 3. Systemic Changes annual inservice topics will be assigned so that all topics are addressed within 30 days of hire and then annually. 4. Monitoring Administrator or designee will audit each employee that is due for evaluation that each topic has been covered in the last year. Audit will be completed monthly x 3. For new employees, HR Director will audit all new hires that they have completed all required topics within 30 days monthly x 3. Administrator and HR Director will report results to the QI Committee monthly.	

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S 301	Continued From page 5 after the education was assigned. 3. Interview on 7/29/26 at 3:20 p.m. with administrator A revealed that DS M and registered dietitian L conducted monthly staff meetings to provide the dietary staff education to satisfy the ongoing annual training requirements. All dietary staff received "make-up review packets" that covered the required topics. She expected the staff to complete their required training within their first 30 days of being hired at the facility and annually thereafter.	S 301		