STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435109	A. BUILDING _____ B. WING _____	C 01/02/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/30/24 through 12/31/24, and on 1/2/25. Areas surveyed included quality of care, nursing services, dietary services, and accident hazards. Firesteel Healthcare Center was found not in compliance with the following requirements: F658, F689, and F803, and past non-compliance at F583.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		

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

Petar Mirkovic | Executive Director | 2/13/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 583	Continued From page 1 of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, record review, and policy review, the provider failed to protect a residents right to privacy for one of one resident (2) who had a photo taken of her head injury without permission by one of one certified nursing assistant (CNA) (J). This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's submitted 12/17/24 SD DOH FRI regarding resident 2 revealed: *She had fallen on 12/11/24. *She was found lying in her bathroom doorway with a lump and an abrasion (layer of skin broken) on the back of her head and an abrasion on her upper lip. *Registered nurse (RN) I had completed a full skin assessment, vitals, a post fall neurological evaluation, cleaned the wounds, and manually lifted resident 2 off the floor by himself. *As part of the providers final investigation they found that CNA J had taken a picture of the head wound because she was concerned RN I should have sent resident 2 to the hospital. *There were no identifying marks of resident 2 in the photo.	F 583	Past noncompliance: no plan of correction required.	

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F 583	Continued From page 2	F 583		

*CNA J had not shared the photo with anyone.
*CNA J was agency staff.
*CNA J was suspended pending an investigation due to a privacy violation of resident 2.

2. Review of resident 2's electronic medical record (EMR) revealed:
*She was admitted on 12/11/24
*She had a Brief Interview for Mental Status (BIMS) assessment score of 0, which indicated she was severely cognitively impaired.
*Her daughter was her POA.
*Her diagnoses included moderate protein-calorie malnutrition, anxiety disorder, and major depressive disorder.
*She had been admitted to hospice for end-of-life care.
*She needed two staff assistance for transfers between surfaces.
*She had a urinary tract infection.

3. Interview on 12/31/24 at 4:36 p.m. with director of nursing (DON) B revealed:
*CNA J had signed the Health Insurance Portability and Accountability Act (HIPAA) corporate training on 9/3/24.
*She received education regarding violating residents' privacy on 12/18/24.
*She received disciplinary action by written warning and probation on 12/18/24.
*CNA J's agency contract was completed on 12/21/24 and she was no longer employed at the facility.
*All staff have been educated regarding protecting resident's privacy and confidentiality since the incident.

4. Review of the 12/17/24 staff inservice revealed:

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F 583	Continued From page 3 *Education regarding the providers HIPAA policy was provided to staff. *Staff signed the inservice indicating they read and understood the education. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 12/18/24 after record and policy review revealed the facility had followed their quality assurance process, education was provided to all nursing care staff regarding protecting residents' privacy and confidentiality, and disciplinary action was taken on appropriate staff. Based on the above information, non-compliance at F583 occurred on 12/11/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 12/18/24, the non-compliance is considered past non-compliance.	F 583		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to adequately monitor five of five sampled residents (2, 3, 4, 5, and 6) for neurological changes after they had fallen. Findings include:	F 658		

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F 658	Continued From page 4 1. Review of the provider's submitted 12/17/24 SD DOH FRI regarding resident 2 revealed: *She had an unwitnessed fall on 12/11/24. *She was found lying in her bathroom doorway with a lump and an abrasion (layer of skin broken) on the back of her head and an abrasion on her upper lip. *Registered nurse (RN) I had completed a full skin assessment, vitals, a post fall neurological evaluation, cleaned her wounds, and he manually lifted resident 2 off the floor by himself. Review of resident 2's electronic medical record (EMR) revealed: *She was admitted on 12/11/24 *She had a Brief Interview for Mental Status (BIMS) assessment score of 0, which indicated she was severely cognitively impaired. *Her diagnoses included moderate protein-calorie malnutrition, anxiety disorder, and major depressive disorder. *She had been admitted to hospice for end-of-life care. *She needed the assistance of two staff for transfers between surfaces. *Her neurological evaluation was not completed at the designated times by RN I following her fall on 12/11/24. 2. Review of the provider's submitted 12/17/24 SD DOH FRI regarding resident 3 revealed: *He had fallen on 12/11/24 in the hallway heading back to his room from supper. *RN I had taken vitals and completed a full skin evaluation. *RN I did not find any injuries on resident 3 and stated he felt comfortable lifting the resident off of the floor without a full body mechanical lift.	F 658	1. Unable to correct deficient practice noted for residents 2,3,4,5 and 6. All residents have the potential to be affected. 2. The ED, DNS and interdisciplinary team reviewed the fall management and neurological check policy (updated January 2025) by 1/25/2025. The DNS or designee educated all licensed nurses on the fall management and neurological check policy and expectations for documentation by 1/30/2025. All staff not in attendance will be educated prior to their next working shift. 3. The DNS or designee will audit 8 falls weekly times four weeks and monthly times two months to ensure neuros were completed per the policy. The DNS or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	1/30/2025

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F 658	Continued From page 5	F 658		

Review of resident 3's EMR revealed:
*He was admitted on 2/27/24.
*He had a BIMS assessment score of 14, which indicated he was cognitively intact.
*His diagnoses included atrial fibrillation (irregular heartbeat), presence of cardiac pacemaker, and nonrheumatic aortic (valve) stenosis (a narrowing in the aortic valve).
*He walked independently to and from the dining room with his wheelchair.
*His neurological evaluation was not completed at the designated times by RN I following his fall on 12/11/24.

3. Review of residents 4, 5, and 6 EMR's following their falls indicated by the facility matrix revealed:
*Resident 4's neurological evaluation was not completed at the designated times by nursing staff following his fall on 11/5/24.
*Resident 5's neurological evaluation was not completed at the designated times by nursing staff following her fall on 12/24/24.
*Resident 6's neurological evaluation was not completed at the designated times by nursing staff following his fall on 11/11/24.

4. Interview on 12/31/24 at 4:36 p.m. with director of nursing (DON) B revealed:
*RN I was hired on 11/4/24
*She stated she felt he had enough education and training after ten completed training shifts and could work on his own.
*A day shift nurse had reported that RN I had not completed his neurological evaluation on resident 2 on 12/12/24.
*She was informed by RN I that he did not perform the neurological evaluation due to resident 2 being on hospice and sleeping.

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F 658	Continued From page 6 *She confirmed she educated RN I on the facility's policy regarding neurological evaluations before his next shift that evening on 12/12/24. *She had educated all staff regarding neurological evaluations on 10/29/24 and had not provided any new education on that topic since then. *She stated she had not evaluated any other residents' neurological evaluations for completion other than resident 2. 5. Review of the providers 9/2014 Neurological Evaluation policy revealed: *"In the event that a resident has an unwitnessed fall and/or it is suspected or known that the resident has bumped/hit his/her head, initiate neurological evaluations and continue for 72 hours." *"The nurse completes the Neurological Evaluation Log according to the following time frames: -a. Every 15 minutes (X8) [8 times] for 2 hours. (If stable and within normal limits for the resident, continue.) THEN -b. Every 30 (X4) [4 times] minutes for 2 hours. (If stable and within normal limits for the resident, continue.) THEN -c. Every 1 hour (X4) for 4 hours after the fall. (If stable and within normal limits for the resident continue.) Then -d. Every 8 hours (X8) for the remaining 64 hours after fall."	F 658		
F 689 SS=D	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	F 689		

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F 689	Continued From page 7 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, policy review, and interview the provider failed to ensure resident safety by not completing a hot liquid assessment at the time of admission. One of one sampled resident (11) had spilled coffee on herself without injury. Findings include: 1. Review of provider's 12/18/24 DOH FRI of resident 11 revealed: *On 12/18/24 at 12:30 p.m. resident 11 spilled her coffee on herself. -Resident 11 was interviewed by staff and stated, "Spilled my coffee right here (pointed at left arm and left outer thigh)." -Her clothing had been changed, the area was assessed by director of nursing (DON) B and registered nurse (RN) M and no redness was noted to her skin in that area. -Her family and primary care provider (PCP) was notified of the incident without injury. -Orders were received from PCP. 2. Review of resident 11's electronic medical record (EMR) revealed: *A Hot Liquid Assessment had not been completed at the time of admission. *Resident's baseline care plan had indicated the resident has impaired cognitive function and thought process related to Alzheimer's/Dementia. *Her 7/15/21 Brief Interview for Mental Status	F 689	1. Resident 11 had hot beverage assessment completed on 12/18/2024. All residents have hot beverage evaluations completed.All residents who trigger on the hot beverage eval will be asked to use a lid and care-planned according to choice. Hot beverage evaluations will be completed on admit and with any significant change in condition. All residents have the potential to be affected. 2. The ED, DNS and IDT reviewed the hot beverage policy by 1/25/2025. The DNS or designee will educate all staff on the hot beverage policy by 1/30/2025. All staff not in attendance will be educated prior to their next working shift. 2. The ED or designee will audit 8 random residents weekly times four weeks and monthly times two months to ensure a lid is in place if warranted per hot beverage evaluation. The ED or designee will audit temperature logs in all areas with a coffee pot weekly times four weeks and monthly times two months to ensure logs are completed accurately. The ED or designee will bring the results of these audits to the monthly QAPI for further review and recommendation to continue or discontinue the audits.	1/30/2025

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F 689	Continued From page 8	F 689		

(BIMS) assessment score was 12, which indicated she was moderately cognitively impaired.
*On 6/24/24 her MDS BIMS score was 5, which indicated she was severely cognitively impaired.
*On 9/11/24 her MDS BIMS score was 3, which indicated she was severely cognitively impaired.
*Her PCP ordered to monitor resident 11's left forearm and left thigh for signs and symptoms of burn, every shift for 1 week.
*Her 12/19/24 Hot Beverage Safety Evaluation score was a 3, which indicated that nursing was to evaluate the need for an individualized care plan addressing safe hot beverage consumption.
*Her care plan was updated on 12/31/24 to include she was to have a lid on a cup, for all hot beverages.

3. Interview on 12/31/24 at 2:37 p.m. with DON B revealed:
*The facility did not complete a hot liquid assessment with new admissions.
*She had indicated that if problems were to arise such as a resident spilling hot liquids, they would then complete a hot liquid assessment.

4. Interview on 1/2/25 at 12:00 p.m. with RN M revealed:
*She was the nurse on duty at the time of resident 11's coffee spill.
-She stated, she observed a medication aide (med aide) who had brought resident 11 back to her room after she had spilled the coffee on herself in the dining room. The nurse was not aware of the name of the med aide.
-She stated, the med aide had changed resident 11's clothing, as it was wet and soiled.
-Resident 11's skin was assessed with no redness or injury noted.

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F 689	Continued From page 9	F 689		

5. Observation on 12/31/24 of all coffee makers in the facility excluding the one in the main kitchen area revealed there were no temperature log sheets located near those coffee makers that indicated temperature checks were being completed on those hot liquids.

6. Review of the provider's temperature log sheets that were requested and received provided by executive director (ED) A on 12/30/24 revealed:
*The log sheets included temperature checks for the days of 12/18/24 through 12/30/24.
-Temperature checks listed on the log sheet included coffee and hot water to have been checked at breakfast, lunch, and supper.
-On 12/23/24 at breakfast, a coffee temperature check of 151 fahrenheit and on 12/28/24 at breakfast, a hot water temperature check of 155 fahrenheit was logged and no indication that there was a follow up temperature (temp) check completed.
*An additional request was made on 12/31/24 for temp log sheets that included the entire month of November and December. Those were received from ED A.
-Those temperature logs had conflicting logged temperatures, that differed from the above initially provided log sheet that only included the days of 12/18/24 through 12/30/24.

7. Observation on 12/31/24 at 11:30 a.m. in a dining hall revealed:
*Residents were seated around the tables waiting for the meal to be served.
*Dietary staff member had gone into a kitchenette area just behind the dining hall to get a resident a cup of hot chocolate per the president's request.

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F 689	Continued From page 10	F 689		

-She had indicated that she got the hot water from the coffee maker to make the hot chocolate.
-She said she thought the hot water on the coffee maker had been temp checked earlier in the day and she had received that information by word of mouth from other staff.
-No temperature log sheet was found near that coffee maker to verify if the temperature had been checked.

8. Interview on 12/31/24 at 11:45 a.m. with DON B revealed:
*The only hot water or coffee that was to be served to the residents, was to come from the prefilled thermal containers that were placed on the food carts in the dining hall.
-She indicated that those have been temp checked, since they are filled from the coffee maker located in the main serving area.

9. Interview on 12/31/24 at 12:40 a.m. with ED A revealed:
*The only coffee pot that was temp checked daily, was the one located in the main serving area.
*He had indicated that "All the water that goes to the coffee pots in the building come from the same pipe, therefore we do not check the water on the other coffee pots."

10. Interview on 1/2/25 at 12:10 p.m. with DON B and ED A revealed:
*On 1/1/25 the facility had implemented a process, that all hot liquids taken from any coffee maker in the facility, must be temp checked daily prior to serving residents during breakfast, lunch, and dinner.
*There would be a sheet placed on the side of the coffee maker displaying the temperatures.
-If the temperature was not in range, staff must

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F 689	Continued From page 11 notify dietary manager and rechecked prior to serving to the residents. *The coffee makers distributor would be notified if temperatures are out of range. *Coffee makers will have notes placed on them indicating that the machine is out of order and should not be used if needed. 11. Review of the provider's Hot Beverages policy published July 2010 and updated December 2014 revealed: *"Dietary staff checks and documents on a temperature log the hot beverage temperature per meal just prior to the hot beverages leaving the kitchen." *"The temperature of the hot beverage at resident contact should NOT exceed 150-degree Fahrenheit." *"If it is necessary to reheat or prepare a hot beverage, staff must perform this task and take the temperature of the beverage to validate service to the resident at equal to or less than 150-degree Fahrenheit." *"Coffee makers with electric heated burners are not present in any resident accessible areas." *"Only thermal containers are used to hold hot beverages in resident areas."	F 689		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance;	F 803		

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F 803	Continued From page 12 §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on the South Dakota Department of Health (SD DOH) complaint intake form, observation, interview, and document review, the provider failed to follow the planned menu for the renal and cardiac therapeutic diets, which had the potential to affect all residents who were prescribed those diets. Findings include: 1. Review of the 12/19/24 SD DOH complaint intake form revealed: *Resident 1 was prescribed a renal diet (a therapeutic diet to aid in the treatment of kidney diseases) due to her receiving dialysis treatments. *She was not receiving the correct foods for that diet. 2. Review of resident 1's electronic medical	F 803	1. Resident 1 unable to correct deficient practice noted during survey. All residents have the potential to be affected. 2. The dietician will educate the dietary manager on therapeutic diets by 1/27/2025. The ED/Dietary Manager will educate all dietary staff on serving the proper therapeutic diet and having proper diets readily available to serve per the menu by 1/27/2025. All staff not in attendance will be educated prior to their next working shift. 3. The ED or designee will audit 4 residents with therapeutic diets to ensure appropriate diets were served weekly times four and monthly times two months. The ED or designee will bring the results of these audits to the monthly QAPI for further review and recommendation to continue or discontinue the audits.	1/30/2025

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	435109	A. BUILDING _____ B. WING _____	C 01/02/2025

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record (EMR) revealed:
*She was admitted on 12/16/24 with a renal diet ordered by her primary physician.
*She was readmitted to the hospital on 12/23/34 due to infection complications.
*She came back to the nursing facility on 12/31/24 with an order to receive a renal diet.

3. Observation during supper service on 12/31/24 at 5:37 p.m. in the main kitchen revealed:
*Cook F prepared supper that day and was plating the residents' meals.
*The menu included a BBQ pulled pork sandwich, potato wedges, peas, and fruit fluff.
*When asked how he knew what foods residents with therapeutic diets were to be served, he pulled out the menu extension spreadsheet binder and showed the different diets.
*Every resident received the same meal despite there being different menu items for therapeutic diets such as the cardiac (foods that promote heart health) and renal diets.
*When asked if there were production sheets to help him estimate the amount of food to prepare for all the diets, he pointed to the "Diet Order Tally Record" on the bulletin board.
-Those tally sheets included how many of each diet type was currently in the building.
-The last time it was updated was on 12/16/24.

4. Review of the provider's menu extension spreadsheet binder at that time revealed:
*The supper menu for 12/31/24 included the following items:
-2 ounces of "BBQ Pork Platter" on a hamburger bun.
-A half cup of potato wedges.
-A half cup of green beans with onions.
-A half cup of fruit fluff.

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*Those residents on the renal diet were to receive a "Pork Roast" rather than a BBQ pulled pork sandwich, and "Rice/Noodles" rather than the potato wedges.
*Those residents on the cardiac diet were to receive a "Pork Roast" rather than a BBQ pulled pork sandwich, and a wheat dinner roll rather than the hamburger bun.

5. Continued interview on 12/31/24 at 6:06 p.m. with cook F revealed:
*He did not prepare the plain pork roast.
*There were no wheat dinner rolls.
*When asked why he did not prepare the alternate foods for the therapeutic diets, he said he "overlooked" the therapeutic diet spreadsheets and made the same food for everyone.
*He said he had been working at that facility for approximately six to seven months.
-He indicated his training was not the best. On his second day of working, the cook he was supposed to train with called in sick and there was no one else to cover.
-He had to learn everything by himself very quickly due to a lack of support.

6. Review of the "Diet Type Report" generated by the provider's EMR system revealed:
*The following residents were prescribed a renal diet:
-Resident 1.
-Resident 9.
-Resident 10.
*The following residents were prescribed a cardiac diet:
-Resident 8.
-Resident 7.

7. Interview on 1/2/25 at 8:32 a.m. with

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administrator A and food and nutrition services (FANS) director D revealed:
*They were not aware that the renal and cardiac therapeutic diets had not been followed to prepare and serve residents for supper on 12/31/24.
*They would have expected the diet orders to have been followed.
*Administrator A mentioned that several residents who were prescribed a therapeutic diet signed a "risk/benefit" form to decline the therapeutic diet.
*New dietary staff were to be paired with a seasoned staff member to train with them for two weeks.
*FANS director D said she printed a new "Diet Order Tally Report" sheet every day.
-When it was pointed out that the last time the reports were updated was on 12/16/24, she indicated that there had not been any changes in residents' diet orders, and she also got back from vacation that day, so she had not had the chance to update the reports.

8. Review of resident EMRs revealed:
*Residents 7 and 10 had signed the risk/benefit form.
*Residents 1, 9, and 8 did not have signed risk/benefit forms on file.

9. Review of the provider's 7/08 Therapeutic Diets policy revealed:
*Policy statement: "Therapeutic diets are prescribed by the attending physician."
*Procedure:
-"1. A therapeutic diet is prescribed by the resident's attending physician.
-2. Prescribed therapeutic diets are reviewed regularly along with other orders.
-3. Routine therapeutic menus are approved by

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F 803	Continued From page 16 the Dietitian; however, unusual or complex therapeutic diets are planned in writing by the Dietitian. -4. A tray card system is used to confirm each resident received the diet as ordered. -5. The Registered Dietitian and/or Dietary Manager record in the resident's medical record significant information relating to the resident's response to the therapeutic diet. -6. The Diet Order Terminology sheet explains routine diets available."	F 803		