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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435109	A. BUILDING _____ B. WING _____	C 02/10/2022

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 Surveyor: 40788 An extended complaint survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/8/22 through 2/10/22. Areas surveyed included quality of resident care, quality of resident treatment, and environmental services. Firesteel Healthcare Center was found not in compliance with the following requirements: F550 and F684. A COVID-19 Focused Infection Control survey was conducted by the South Dakota Department of Health Office of Licensure and Certification on 2/8/22 through 2/10/22. Firesteel Healthcare Center was found not in compliance with 42 CFR Part 483.80 infection control regulation: F880. Firesteel Healthcare Center was found in compliance with 42 CFR Part 483.10 resident rights and 42 CFR Part 483.80 infection control regulations: F550, F562, F563, F583, F882, F883, F885, F886, and F887. Firesteel Healthcare Center was found in compliance with 42 CFR Part 483.73 related to E-0024(b)(6). Total residents: 84	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550	See next page.	

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

Petar Mirkovic | Executive Director | 3/1/2022

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

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Surveyor: 43021 Based on observation, interview, care plan review, and policy review, the provider failed to ensure privacy was maintained for one of one	F 550	1. All residents have the potential to be affected. Unable to correct deficient practice identified during survey for resident 2. 2. Executive Director or designee will educate all staff on ensuring dignity and privacy are maintained for all residents. Education will be provided by 3/8/2022. All staff not in attendance will be educated prior to their next working shift. 3. Audits on ensuring dignity and privacy are maintained will be conducted weekly times four and monthly times two months by ED or designee. The ED or designee results of these audits will be taken to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	3/10/2022

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F 550	Continued From page 2 observed resident (2) by one of one unlicensed assistive personnel (UAP) (Q) and one of one restorative aide (E) during dressing and while in her bed. Findings include: 1. Observation on 2/8/22 at 8:07 a.m. and 8:10 a.m. of resident 2 in her room revealed: *The resident was clearly visible from the hallway through the open doorway. *She was lying on her bed with no clothing from waist down. *Her hips, thigh, and legs were exposed. *UAP Q was at the medication cart facing the inside of the room. -Had neither pulled the privacy curtain or closed the resident's room door to preserve her dignity. Surveyor: 40788 Observation on 2/9/22 at 9:00 a.m. of resident 2 in her room revealed she: *Laid on her bed on her side facing the open doorway wearing a shirt, incontinence brief, and socks. *Restorative aide E entered that room, removed a breakfast tray and exited that room. Interview at that same time with restorative aide E revealed she: *"Had not even noticed" resident 2 had no covering on her lower extremities. -Would have offered her a blanket to cover her legs if she had noticed. Interview on 2/9/22 at 9:30 a.m. with director of nursing B regarding the above observations revealed: *Restorative aide E should have offered to cover the resident's lower extremities, pulled the privacy curtain or asked to close her door to maintain her	F 550		

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F 550	Continued From page 3 dignity. *An increased level of awareness was expected of all staff to notice dignity issues and respond to them. Review of resident 2's care plan last updated on 10/21/21 revealed no indication she would have refused staff assistance to ensure her privacy and dignity. Review of the November 2016 Notice of Resident Rights Under Federal Law policy revealed: *Rights Related to Dignity and Grievances: -"15. The Resident has the right to be treated with respect and dignity."	F 550		
F 684 SS=F	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: Surveyor: 40788 Based on observation, interview, record review, review of Resident Council minutes, review of the Centers for Medicare and Medicaid Services (CMS) COVID-19 guidance, and policy review, the provider failed to ensure: *Sixty-nine of eighty-four residents had the choice to participate in communal dining in two of three resident dining rooms (central dining room and	F 684	1. All residents have the potential to be affected. Communal dining and activities were restarted on 2/10/2022. Resident 5 medication times were changes to accommodate appointments on 2/9/2022. Resident 11 was re-offered a room change with better temperature, resident refused. Plastic was placed on window and a center is pursuing quote on window replacement. Resident 11 was weighed on 2/10/2022 and has not experienced weight loss. Resident 11 will not agree to a weekly weight and chooses to exercise the right regarding refusal or treatment. At this time resident has agreed to a monthly weight. A physician order was obtained for a monthly weight. Resident also has signed a risk benefit waiver to refuse weights. Center policy for weights states "guidelines for residents who may need to be weighed weekly (not all inclusive): Residents with Stage II, III or IV pressure injuries. 2. All staff educated by ED, DNS or designee on CDC/CMS guidance regarding Covid and communal activities and dining, proper administration of medication, weight policy and maintaining comfortable room temperature for residents and their role and responsibilities regarding these areas by 3/8/2022. All staff not in attendance will be educated prior to their next working shift. See next page.	3/10/2022

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F 684	Continued From page 4 400 hall dining room). *Sixty-nine of eighty-four residents had the choice to participate in communal activities. *One of one resident (5) received medications as scheduled per nursing standards of practice and the facility's medication administration policy. *One of one resident's (11) preference for room temperature had been accommodated. *One of one resident (11) who required weight monitoring had been weighed weekly. Findings include: 1. Entrance conference interview on 2/8/22 at 8:15 a.m. with administrator A revealed: *The COVID-19 vaccination rate for residents was 92%. -Sixty staff had been vaccinated, thirty staff had vaccination exemptions, and nine staff had not been vaccinated yet. *There were no residents who had COVID-19. *There was one staff person who had COVID-19 and was not working. -Twice weekly COVID-19 testing for residents and staff was occurring. *Facility census was eighty-four. Observation on 2/8/22 at 11:35 a.m. of the central dining room revealed: *Five unidentified residents were eating in that dining room. -That dining room provided meal service for residents on the 100 hall, 200 hall, and four rooms on the 300 hall. Interview on 2/8/22 at 11:50 a.m. with medical records staff member P in the central dining room revealed: *Only residents who required staff assistance to eat participated in communal dining in either the	F 684	3. The ED, DNS or designee will conduct an audit for resident choice of communal activities and dining, resident room temperature, accuracy/timeliness of weights, and medication administered timely and adjusted if necessary on a random sample of 4 residents weekly times four weeks and monthly times two months. The ED, DNS or designee will take the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	

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F 684	Continued From page 5	F 684		

central dining room or the 400 hall dining room.
*Fifteen residents in the memory care unit (MCU) were able to communally eat in their own dining area on that unit.

Observation on 2/8/22 at 12:05 p.m. of the 400 hall dining room revealed:
*Five unidentified residents were eating in that dining room.
-That dining room provided meal service for the 400 hall and the 500 hall residents.

Review of the Resident Council minutes revealed:
*Residents had discussed the lack of communal dining at the 10/5/21 meeting.
-Administrator A stated it had not occurred due to "COVID concerns" related to the Delta variant.
*Residents asked about going to the dining room for meals at the 11/15/21 meeting.
-Administrator A explained "this is still being work on."
*Resident Council meetings had been suspended after that meeting.

Interview on 2/8/22 at 3:10 p.m. with director of nursing (DON) B regarding communal dining revealed:
*Fourteen days had to pass with no new COVID-19 positive residents or staff for communal dining to resume.
-There was currently no plan to resume communal dining.
*Communal dining had stopped in December 2021.
*In room dining had caused scheduled mealtimes to be delayed.

Interview on 2/9/22 at 10:30 a.m. with administrator A regarding communal dining

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F 684	Continued From page 6 revealed he: *Had kept up to date on current and revised Centers for Disease Prevention and Control (CDC), CMS, South Dakota Department of Health (SD-DOH), and company guidance and recommendations regarding COVID-19. *Was aware communal activities could have occurred using core principles of infection prevention such as hand hygiene, the use of face coverings, social distancing, cleaning, and disinfection even with positive staff and resident COVID-19 cases. *Did not have a plan for resuming day to day activities that had previously occurred outside of resident rooms. -"I may have made a mistake" by suspending those activities. *All residents had been at risk for psychosocial decline related to spending most days inside their rooms. 2. Interview on 2/9/22 at 12:15 p.m. with activities director N regarding group activities revealed: *Since December 2021 group activities had only occurred for the fifteen residents in the MCU. *Other residents were offered one-on-one in room activities, passed in room snacks, provided books from a library cart, and offered coloring sheets or word searches. *Only "a select few" residents had not participated in some form of group activity when it was able to offered in the past. *Several volunteers had been able and willing to offer or assist with group activities but were not allowed to do so at this time. Interview on 2/9/22 at 12:20 p.m. with administrator A revealed neither communal dining or group activities should have stopped in	F 684		

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F 684	Continued From page 7 December 2021. Random resident interviews on 2/9/22 between 3:10 p.m. and 4:25 p.m. regarding the cessation of communal dining and group activities revealed: *Resident 15 had only gone out of her room for baths since December 2021. -Stated "it feels like jail" and "it's old" being in her room most of the time. *Resident 16 just "wanted to be able to get outside of her room." -She had previously eaten her meals in the central dining room. -She had enjoyed playing bingo and cards outside of her room but now occupied her time watching television or reading the newspaper. *Resident 9 had missed socializing with others outside of her room. *Resident 3 was "bored and depressed" not being able to attend bingo or church. Interview on 2/10/22 at 9:00 a.m. with social services director O regarding group activities revealed: *Some residents had been bored or had trouble finding things to do to occupy their time while being in their rooms. *No residents had displayed significant mood or behavioral declines. -Little things such as television volume seemed to make some residents more irritable than usual. *Some residents may need "coaching" to re-acclimate themselves to "the culture" of being outside of their rooms when restrictions are lifted. Interview on 2/10/22 at 9:45 a.m. with minimum data set coordinator Q revealed she: *Had "maybe periodically" seen a resident decline functionally because of having been restricted to	F 684		

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F 684	Continued From page 8 their room. -Therapy evaluations were initiated for those residents. *Had mostly noted "some irritability" with some residents having to remain in their rooms. Interview on 2/10/22 at 10:15 a.m. with director of clinical operations C regarding the lack of communal dining and activities revealed: *Weekly company-wide COVID-19 calls provided management staff the latest information regarding current and updated CDC, SD-DOH, CMS, and company guidance and recommendations regarding COVID-19. *Communal activities should not have ceased in December 2021 based on information shared during those meetings. Follow-up interview on 2/10/22 at 10:30 a.m. with activities director N regarding group activities revealed: *Residents had resigned themselves to the fact that activity restrictions were expected with COVID-19. *Residents most "bothered" by the activity restrictions were those who played bingo and participated in spiritual programming. Review of the revised 2/2/22 Limiting the Spread of COVID-19 in Skilled Nursing Facilities policy revealed: *Group Activities and Volunteers: -"3. All group activities will follow social distancing guidelines and may be canceled or restricted when county positivity rates are high as directed by the regional or state Department of Health." -"4. Residents are encouraged to wear a mask and follow social distancing when out of their room."	F 684		

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F 684	Continued From page 9	F 684		

-"6. Unvaccinated/vaccinated group activities must ensure social distancing of 6 feet, source control masks are worn at all times, with no sharing of activities equipment. No more than 5 to a group is preferred."
*Communal Dining Guidelines:
-"2.a. Only fully vaccinated residents may sit together without social distancing at a table.
-b. Residents may remove masks once seated at a table for dining.
-c. Unvaccinated residents must ensure social distancing and source control mask when not actively eating or drinking. Plastic barriers can be implemented on tables for additional safety precaution."

Review of the revised 11/12/21 CMS memorandum QSO-20-39-NH revealed under Communal Activities, Dining and Resident Outings: "While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur."
Surveyor: 45095
3. Observation and interview on 2/9/22 at 11:30 a.m. with resident 5 revealed she:
*Had hyperbaric oxygen therapy (HBOT) at 8:00 a.m. Monday through Friday at the wound care clinic for a stage 4 pressure ulcer.
*Rode the facility van to her appointments that left the facility at 7:30 a.m.
*Had not received any of her medications today.
*Had medications scheduled for 8:00 a.m.
*Stated it depended on who was working if she received her 8:00 a.m. medications prior to leaving the facility at 7:30 a.m.

Record review of resident 5's care record revealed her:
*Admission date was 10/8/21.

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F 684	Continued From page 10 *Brief Interview for Mental Status (BIMS) Score 1/9/22 was 13 indicating she had no cognitive deficit. *Medical diagnoses included stage 4 pressure ulcer, hypotension, falls and, fracture of right clavicle. *Care plan included focus, goals and interventions for self-care deficit related to impaired balance, risk for falls, anticoagulation therapy, and pressure injury to sacrum. *February 2022 medication administration record (MAR) orders included: - "Midodrine HCL tablet 5 mg give 3 tablets by mouth three times a day related to hypotension, was scheduled at 8 a.m., 1 p.m., and 6 p.m." -"Calorie Dense Medication Pass three times a day 3 oz for wound healing was scheduled at 8 a.m., 1 p.m., and 6 p.m." *Progress notes dated 2-9-22 and signed by licensed practical nurse (LPN) L indicated: - Scheduled 8:00 a.m. midodrine and calorie dense medication pass medications were administered at 12:01 p.m. when she returned to the facility and her scheduled 1:00 p.m. doses were held. Interview on 2/9/22 at 4:40 p.m. with DON B regarding resident 5's medication administration revealed she: *Was not aware the resident's 8:00 a.m. medications were administered after 12:00 p.m. and would need to review the resident's medical record. *Agreed the physician should have been notified of medications given late. *Planned to call the wound care clinic to attempt to reschedule the HBOT appointment to 9:00 a.m. so the resident was not rushed in the morning as the resident did not like to get up	F 684		

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F 684	Continued From page 11	F 684		

early.
*Expected the resident's 8:00 a.m. medications were administered prior to her leaving the facility for her HBOT appointment at 7:30 a.m.

Interview on 2/10/22 at 10:20 a.m. with LPN L regarding resident 5 revealed:
*She arrived and started her shift at 7:30 a.m. and the resident was gone at 7:30 a.m.
*She gave the resident her 8:00 a.m. medications at 12:00 p.m. when the resident returned from her HBOT appointment.
*She held the next dose of midodrine and calorie dense medication pass scheduled at 1:00 p.m. and documented this on the MAR.
*She had been instructed by her charge nurse to give 8:00 a.m. medications when the resident returns from her outside appointment.
*She had voiced her concerns regarding late and held medications to nursing management and the administrator.
*Was aware the medication administration policy gives one hour before and one hour after the scheduled time to administer a medication.
*Was aware there was no physician order to administer medications late when the resident returned or to hold medications.
*There was no communication with the physician that medications are administered late or held.
*This was a facility practice.
*Other residents who were at dialysis or at outside appointments received their medications when they returned, with no physician order to administer medications late or communication to the physician, that medications were administered late or held.

Review of revised August 2014 EmpRes medication administration policy revealed:

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F 684	Continued From page 12	F 684		

*"A. Preparation"
-"4) FIVE RIGHTS - Right resident, right drug, right dose, right route and right time are applied for each medication being administered. "
* "B. Administration"
-"2) Medications are administered in accordance with written orders of the prescriber."
-"11) A schedule of routine dose administration times is established by the facility and utilized on the administration records.
-12) Medications are administered within [60 minutes] of scheduled time, except before, with or after meal orders, which are administered [based on mealtimes]. unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility."
Surveyor: 45901
4. Observation and interview on 2/9/22 at 9:35 a.m. with resident 11 in his room revealed he:
*Was lying in bed.
*Appeared pale and his cheeks were sunken in.
*Thought he had lost weight.
*Usually refused to eat breakfast.
*Lost his appetite if the other meal services were late being served.
*Had specific food preferences including fried chicken, pizza, and tacos.
-Did not care for many of the foods served.
*Had stopped completing his daily menu card because his choices had not been provided.
-Had spoken with unidentified dietary staff regarding this problem.
*Had refused to be weighed since July 2021 because his food preferences had not been accommodated.
*Had chosen to remain in bed in his room at most times.
*His room was cold this time of year especially

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 13	F 684		

when the wind blew.
*Refused to have his bed bath due to the cold room temperature.
*Had reported this to several staff persons including maintenance director S, LPN T, certified nurse aide (CNA) U and DON B.
*Had suggested plastic be affixed over the window to keep the room warmer.

Interview on 2/9/22 at 2:55 p.m. with maintenance director S regarding resident 11's room revealed he:
*Agreed on cold windy days that room was cold.
*Offered to move him to another room and he had refused.
*Could have covered the window with plastic but had not.
-Offered no other alternatives.

Interview on 2/9/22 at 3:15 p.m. with LPN T and at 4:15 p.m. on that same date with CNA U regarding resident 11 revealed:
*He had previously complained his room was cold in November 2021.
*Work orders had been submitted to maintenance director S to address that complaint.

Interview on 2/9/22 at 4:31 p.m. with DON B regarding resident 11's room revealed she:
*Was aware he had complained his room was cold.
*He was offered the option to move to another room and he refused.
-No other alternatives had been offered.

Review of resident 11's care record revealed his:
*Admission date was 1/28/20.
*Diagnoses included: a stage IV (deep wound that reaches muscles, ligaments or even bone)

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	435109	A. BUILDING _____ B. WING _____	C 02/10/2022

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F 684	Continued From page 14	F 684		

pressure ulcer on his left lower back, a history of a body mass index of less than 19%, and paraplegia related to a motor vehicle accident.
*Last documented weight on 7/7/21 was 86.9 pounds.
*Weights were taken with a mechanical lift with scale.

Review of the 10/27/21 through 2/9/22 interdisiplinary team (IDT) progress notes revealed:
*Four entries regarding resident 11 refusing to be weighed.
*No indication of why he refused to be weighed.

Review of the 2/10/22 revised care plan revealed:
*Interventions related to his risk for nutritional decline and poor skin integrity.
*Had not identified specific resident food preferences or a plan to provide for them.
*An intervention identifying the need to offer alternative methods of obtaining the resident's weight related to the resident refusing to be weighed.
-Alternative methods had not been defined.
*A goal for no unplanned weight loss or gain.
*The resident had signs and symptoms of nursing home adjustment difficulties evidenced by conflict with staff and repeat criticism of staff.
*Interventions included encouraging him to verbalize his feelings as needed and for staff to work with him to self-schedule his cares allowing him to have some control over when and how they were performed.
*His family was important to him.

Review of the 1/6/22 Nutrition Hydration Skin Committee Review revealed:
*IDT evaluation and recommendations included:

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F 684	Continued From page 15	F 684		

*"No recent weight as resident refuses. Resident is historically underweight. Intakes are fair on reg [regular] diet with double protein; Resident will often skip breakfast. Resident gets a homemade high calorie, high protein shake twice daily. Resident continues with stage 4 pressure area on back. No changes at this time; Cont [continue] to monitor weight, intakes and wound status."

Interview on 2/9/22 at 3:15 p.m. with LPN T regarding resident 11 revealed he:
*Was able to direct his care.
*For example, he refused his protein shake unless it had fruit in it.

Interview on 2/9/22 at 3:28 p.m. with social service director O regarding resident (11) revealed she:
*Was responsible for coordinating regular resident care conferences to discuss a resident's plan of care with the IDT, resident, and family.
-The IDT did not meet together as a group to discuss resident 11's plan of care because he refused to attend those care conferences.
-Agreed the IDT should still have gotten together to discuss how to manage more effectively resident 11's care refusals including refusing to be weighed.
*Was unaware the resident had refused to be weighed unless his food preferences had been accommodated.
*Knew his food preferences may not have been the same as other residents because his age was much younger than theirs.
*Knew pizza and chicken was on the facility menu but was uncertain how often they were served or if the chicken was fried.
*Stated carry out or delivery for his fast food preferences could have been arranged.

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F 684	Continued From page 16 *Received social work oversight from a licensed social worker who she consulted with by phone or on site. *Had not ever discussed resident 11's care refusals nor asked the consultant to meet with the resident and provide recommendations regarding how to manage his care refusals. -Agreed she should have. Interview on 2/9/22 4:31 p.m. with DON B regarding resident 11 revealed she: *Had known his preference for fried chicken, pizza, and tacos. *Had known he refused to be weighed because his food choices had not been met. *Had offered to arrange for him to receive his food choices in exchange for him being weighed, but he had declined. *Had not implemented any other strategies to ensure his weight was taken. Review of the revised 6/10/21 Weights policy revealed weekly weights have been obtained for residents with "Multiple Stage II and any Stage III or IV pressure ulcers." Review of the November 2016 Social Service Director job description revealed: *Essential Functions: -"2. Identification of needs and coordination of services so that bio-psychosocial needs of each resident are met." -"3. Participation in the development and reassessment, per schedule and as needed, of individualized social service and interdisciplinary care plans designed to meet the bio-psychosocial needs of residents." -"6. Coordinate and/or provide health and mental health social work services to residents to assist	F 684		

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F 684	Continued From page 17 with attaining or maintaining the highest practical metal and psychosocial well-being." Review of the November 2016 Notice of Residents Rights Under Federal law revealed: -"21. The resident has the right to reside and receive services in the Center, with reasonable accommodation of resident needs, except when doing so endangers the health and safety of other residents." -"22. The resident has the right to reasonable accommodation of individual needs or preferences, except where the health or safety of the resident or other residents is endangered." -"24. The resident has the right to make choices about aspects of his/her life in the center that are significant to the resident." -"29. The resident has the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely." On 2/9/22 at 4:10 p.m. a Quality of Care policy was requested from director of clinical operations C however, there was not one.	F 684		
F 880 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.	F 880	See next page.	

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F 880	Continued From page 18 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 §483.70(e) 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 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	F 880	**Directed Plan of Correction** **Firesteel Healthcare Center - F880** **Corrective Action:** 1. For the identification of lack of: *Appropriate use of personal protective equipment when providing resident care and/or assisting residents on isolation. *Disinfection of reusable medical equipment between resident use. *Appropriate handling and transport of soiled linen. **The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas.** All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 3/8/22 by ED, DNS or designee. All staff not in attendance will be educated prior to their next working shift. **Identification of Others:** 2. ALL residents and staff have the potential to be affected by lack of: *Appropriate PPE usage when providing resident care/assisting residents in isolation.	3/10/2022

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F 880	Continued From page 19 (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: Surveyor: 45095 Based on observation, interview, posted contact precautions signage, and policy review, the provider failed to ensure infection prevention and control practices were maintained for: *Correct use of personal protective equipment (PPE) by one of one occupational therapist (OT) (M) and one of one restorative aide (E). *Cleaning of re-usable medical equipment by one of one certified nurse aide (G). *Transporting soiled linen by one of one housekeeper (F). Findings include: 1. Observation on 2/8/22 at 4:44 p.m. of resident 10 revealed: *A contact precaution sign and a PPE sign was located outside the door to his room. *A plastic container with three drawers holding gowns, gloves, masks, and sanitizer wipes were located outside the door to his room. *He had been pushed back to his room in his	F 880	* Disinfection of reusable medical equipment between resident use. *Appropriate handling and transport of soiled linen. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by ED/DNS or designee by 3/8/2022. All staff not in attendance will be educated prior to their next working shift. **System Changes:** 1. Root cause analysis conducted answered the 5 Whys: **5 Whys- Failure to wear appropriate PPE** (OT) when in contact isolation resident room Contracted therapy department Education/competency was to be completed by contract entity 2 separate rules to follow PPE-outside of room since area covered did not need to wear PPE-inside room did need to wear Overcautious with contact isolation precautions Changed to PPE only when changing dressing for both in room and outside of room and education completed. **5 Whys- Failure to disinfect resident shared lift between resident use** When using last wipe of disinfectant CNA responsible to re-supply New CNA staff did not know where supply was stocked Lack of education of where supply is prior to working floor Process for education/competency was not hard-wired Completed education to all staff of supply stock and responsibility to re-stock	

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

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F 880	Continued From page 20 wheelchair after completing therapy with OT M. *The door to his room was open. *He had a wound vac dressing to his left hand. *OT M was in his room assisting him without PPE on. *She had on only a mask. *The OT observed the surveyor in the hallway speaking to the nurse and then she came out of his room, applied a gown, gloves, and returned to his room and closed his door. Interview on 2/8/22 at 4:45 p.m. with licensed practical nurse (LPN) K regarding resident 10 revealed: *He had a methicillin-resistant staphylococcus aureus (MRSA) infection to a surgical site on his left hand. *He was on contact precautions for MRSA. *He was able to go to the therapy room and therapy staff did not have to wear PPE, other than the mask all staff were wearing, at therapy as long as the wound was covered and contained with a dressing. *PPE was to be worn by staff when in the residents' room. Interview on 2/9/22 at 11:45 a.m. with infection prevention and control nurse D revealed: *Residents on MRSA contact precautions were able to come out of their room if the infected area was contained. *When the resident was out of their room staff had not needed to gown and glove. *Items used by the resident were to be wiped down and sanitized. *The expectation was once a resident was returned to their room staff must apply PPE in the residents' room which was considered a "dirty area."	F 880	**5 Whys- <u>Failure to transport soiled linen appropriately</u>** Housekeeping contracted entity Education/competency needs responsibility of contracting entity Did not realize need for responsibility follow through with contract agency ed/comp. Hsk that was to complete training/education of new staff but was ill New hsk was on own after 2 days No competency prior to being on own-need process design Education sessions to be completed prior to working on floor Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. Nurse consultant contacted the South Dakota Quality Improvement Organization (QIN) on 2/28/22 and reviewed RCA and 5 why's and other tools and resources available through the QIO. See next page.	

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F 880	Continued From page 21 Surveyor: 40788 2. Observation and interview on 2/8/22 at 9:00 a.m. with restorative aide E revealed she: *Entered resident 1's room wearing a face mask and goggles. -Contact precautions signage outside of that room indicated gloves and gowns were also indicated. *Physically touched resident 1 and manipulated her bed and the linen on her bed trying to determine why the electric bed was not functioning as expected. -It was unplugged. *Stated the reason resident 1 required contact precautions were due to a MRSA infection on her abdomen. -Glove and gown use was only required if she had provided personal care for resident 1. Interview on 2/8/22 at 9:40 a.m. with infection prevention and control nurse D regarding the above observation revealed she had expected face mask, eye covering, gown, and gloves had been worn inside resident 1's room at all times. Review of the Contact Precautions signage posted outside of resident 10 and 1s' rooms revealed: *Gloves: -"Don gloves upon entry into the room or cubicle. Wear gloves whenever touching the resident's intact skin or surfaces and articles in close proximity to the patient." *Gowns: -"Don gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the resident-care environment." *Patient Transport: -"Remove and dispose of contaminated PPE and	F 880	**Monitoring:** 1. Administrator, DON, and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 22	F 880		

perform hand hygiene prior to transporting patients on Contact Precautions. Don clean PPE to hand the patient at the transport destination."

3. Observation on 2/8/22 at 10:35 a.m. of CNA G revealed:
*She entered residents' 13 and 14's room with a mechanical lift.
*Exited that room, left the mechanical lift in the hallway outside of that room, and assisted other residents with their care.
*DON B moved that lift to the other side of the hallway and further down the hall.
-A pouch on that lift had no container of disinfectant wipes to wipe that lift between resident use.

Interview on 2/8/22 at 10:40 a.m. with CNA G regarding the mechanical lift use revealed she:
*Had not wiped that lift down with a disinfectant wipe after using is in residents' 13 and 14's room.
*Should have but was "very busy."

Review of the May 2015 Cleaning and Disinfecting Resident Care Items and Equipment policy revealed "Durable medical equipment is cleaned and disinfected before reuse by another resident."

4. Observation and interview on 2/8/22 at 12:15 p.m. with housekeeper F revealed she:
*Gathered unclean bedding from resident 6's room into her arms and without placing it inside of a bag or container exited that room.
*Carried that unclean bedding to the end of the hallway and placed it inside a dirty linen cart.
*Stated she was a new employee and was unaware of how linen should have been transported.

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F 880	Continued From page 23 Interview on 2/9/22 at 9:20 a.m. with housekeeping supervisor H regarding the observation above revealed she: *Had expected unclean bedding was bagged inside the resident room prior to placing it in a three bin laundry sorter or taking it to the laundry room. *Trained housekeeper F for only two days before she had taken an unexpected leave from work. -Housekeeper F may not have received laundry handling education. Review of the May 2015 Soiled Laundry and Bedding policy revealed: *"2. Place contaminated laundry in a bag or container at the location where it is used and do not sort or rinse at the location of use." *"3. Place and transport contaminated laundry in bags or containers in accordance with established policies governing the handling and disposal of contaminate items." *"4. anyone who handles soiled laundry wears protective gloves and other appropriate protective equipment."	F 880		