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 _____	01/31/2023

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

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 1/29/23 through 1/31/23. Firesteel Healthcare Center was found not in compliance with the following requirements: F658, F758, F801, and F880.	F 000		
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 observation, interview, record review and policy review, the provider failed to ensure timely physician notification for one of two sampled (66) with significant weight gain. Findings include: 1. Observation and interview on 1/29/23 at 7:59 a.m. with resident 66 revealed she: *Was confused and not orientated to time or place. *Had what appeared to be an ace wrap on her left leg. Both of her lower legs appeared to be swollen. *Stated her "legs swell up." Observation and interview on 1/30/23 at 2:20 p.m. with registered nurse (RN) M regarding resident 66's left leg revealed there was a lymphedema wrap on her left leg and RN M stated she previously had wounds on both lower	F 658	1. Resident 66 provider was notified of weight gain on 1/30/2023. All residents have the potential to be affected. 2. The ED, DNS and interdisciplinary team reviewed the weight policy on 2/1/2023. The DNS or designee educated all nursing staff on the weight policy by 2/23/23. All staff not in attendance were educated prior to their next working shift. 3. The DNS or designee will audit the weight variance report weekly times four weeks and monthly times two months to ensure provider was notified of any significant gain or loss. The DNS or designee will bring the results of the audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	3/9/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Petar Mirkovic* | TITLE: *Executive Director* | (X6) DATE: *2/22/23*

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 658	Continued From page 1 legs that had healed. Review of resident 66's medical record revealed: *She had been admitted on 12/23/21 and her diagnoses included: kidney failure, lymphedema, delusional disorders, and vascular dementia. *Her physician orders had included: -On 9/26/22, to be weighed weekly for "monitoring." -On 12/16/22, occupational therapy to evaluate and treat for lymphedema. *Between 12/19/22 and 1/2/23, her weights were between 217.0 pounds (lbs) and 239.0 lbs, a 24 pound weight gain. *On 1/3/23, there was a nutrition note from the dietitian that suggested the resident's physician should be updated regarding her weight gain. *Between 1/3/23 and 1/23/23, her weights were not obtained weekly but showed fluctuation of four weights between 231.5 lbs. to 238.5 lbs., with 233.0 lbs on 1/23/23. *Her physician noted a routine visit with her on 1/13/23. There was no notation to indicate the physician had been notified of her significant weight gain. Interview and record review on 1/30/23 at 2:15 p.m. with RN M revealed: *Resident 66 had a weight gain of 24 lbs. from 12/26/22 to 1/2/23. *The dietitian monitored resident weights and came to the facility on a weekly basis. *The interdisciplinary team (IDT) had a clinical meeting each morning and reviewed resident weights to see if any resident needed to be reweighed due to a significant weight loss or weight gain. *They had not identified and addressed resident 66's weight gain.	F 658		

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F 658	Continued From page 2 *She reviewed resident 66's medical record and could not determine whether the provider had been notified of her weight gain. *Nursing staff or the dietitian should have notified the physician of the weight gain but had not. Interview on 1/30/23 at 3:32 p.m. with regional nurse consultant (RNC) E and director of nursing (DON) B regarding resident weight's revealed: *The IDT monitored weight loss/gain as a care team. *The dietitian monitored resident weight loss. *When a resident's weight was over 3 lbs from the previous recorded weight, the nurse would have been notified by the staff member who had weighed the resident, and then the nurse would have notified DON B. *DON B thought resident 66's physician had been notified of the weight gain. *No documentation was provided to demonstrate the physician had been notified of the significant weight gain. Interview on 1/31/23 at 2:15 p.m. with RNC E revealed the provider did not have a policy for physician notifications regarding resident change in condition. Review of provider's "Weights" policy revealed: *"Policy Statement: The Center uses weights as one component of data collection needed to evaluate a resident's nutritional status, fluid retention, or diuresis." -"b. Weekly Weights The following are guidelines for residents who may need to be weighed weekly (not all inclusive):" -"Significant weight loss/gain. --5% [percent] 30 days (CA: 5 lbs./one month considered significant weight change)."	F 658		

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F 658	Continued From page 3 -"c. Re-weigh --Any weight with a 5-lb. variance is re-weighed within 24 hours." --"If a significant variance is actual after re-weigh, the nurse documents in the medical record ...and notifies the physician and resident/resident's authorized representative. These notifications are recorded in the nursing progress notes of the medical record." -"2. Obtaining and Recording Weights" --"e. The nurse reviews the current weight and compares to prior weight on Weight Worksheet. The nurse requests a re-weight in accordance with the re-weight definition outlines above." --"g. Licensed nurse will notify physician, resident/responsible party of significant change in weight and document notification in progress notes. Progress note to include responses."	F 658	1. Resident #72 on 2/1/23 provider ordered to continue medication. On 2/15/23 and order was received to discontinue the medication. All residents receiving PRN psychotropics were reviewed and addressed as necessary. All residents receiving PRN psychotropics have the potential to be affected. 2. The ED, DNS and clinical nursing team reviewed the CMS guidance regarding PRN psychotropic medications. The DNS or designee provided this education to all licensed nursing staff prior to 2/23/23. All licensed staff not in attendance will be educated prior to their next working shift. 3. The DNS or designee will audit all PRN psychotropics monthly times 6 months to ensure they are either discontinued or have an order from the provider to extend the use. 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.	3/9/2023
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		

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F 758	Continued From page 4 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of two sampled residents (72) with a PRN (as needed) order for psychotropic drugs had physician documentation of the rationale for continued use beyond the limited 14 day use. Findings include:	F 758		

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F 758	Continued From page 5 1. Observation on 1/29/23 at 8:05 a.m. of resident 72 revealed she: *Was sitting at the dining room table in her wheelchair. *Appeared to be sleeping, with her forehead resting on the table. Review of resident 72's medical record revealed: *She had been admitted on 9/8/22, and she had a diagnosis of dementia with behavioral disturbances. *Her physician orders included an 11/11/22 order for lorazepam PRN for anxiety. *Her electronic medication administration record revealed the PRN lorazepam had been administered: -Two times in November 2022. -Thirteen times in December 2022. -Five times in January 2023. *Consulting pharmacist recommendations from 11/21/22 through 1/23/23 revealed three notifications regarding the need to have the PRN lorazepam renewed with duration. *Two "Psychotropic Drug and Behavior Monthly & PRN" nursing assessments completed on 12/8/22 and 1/9/23 indicated in section "4. PRN Psychotropic or Antipsychotic Medication" that resident 72 was on a PRN psychotropic medication and there was no documentation to support rationale for extended use. Interview on 1/30/23 at 3:28 p.m. with regional nurse consultant (RNC) E and director of nursing (DON) B regarding anti-anxiety medications revealed RNC E believed PRN psychotropic medications did not have to be re-evaluated by the physician every 14 days for continued use. Interview on 1/31/23 at 11:30 a.m. regarding	F 758		

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F 758	Continued From page 6 anti-anxiety medication for resident 72 revealed DON B agreed resident 72 should have been evaluated every 14 days by her the primary physician for continued use of PRN lorazepam. Review of provider's October 2022 Psychotropic Drugs policy revealed: *"1. Psychotropic drugs are any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to:" -"c. Anti-anxiety" *"12. PRN Psychotropic Drugs are limited to 14 days EXCEPT if the prescribing physician or practitioner believes that it is appropriate for PRN orders to be extended beyond 14 days. -a. The practitioner documents their rationale in the medical record."	F 758		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by	F 801	1. A cook in the kitchen due to the absence of a dietary manager completed the International Food Service Executive Association Certified Food Manager class and is scheduled to take her exam on 2/27/23. All residents have the potential to be affected. 2. The ED was educated by the Divisional Director of Clinical Operations by 2/23/23 on ensuring there is someone in the dietary department in the the absence of a dietary manager that has completed the International Food Service Executive Association Certified Food Manager class. 3. The DDCO or designee will audit monthly times six months the presence of a International Food Service Executive Association Certified Food Manager or certified dietary manager. The results of these audits will be taken to the monthly QAPI committee meeting for further review and recommendation to continue or discontinue the audits.	3/9/2023

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F 801	Continued From page 7 a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or	F 801		

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F 801	Continued From page 8 D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to employ a full-time qualified registered dietician or dietary manager who met the requirements to serve as the director of food and nutritional services. Findings include: 1. Interview on 1/29/23 at 7:40 a.m. with food and nutrition services (FANS) aide F, while she served the breakfast meal in the kitchen, revealed: *She had worked for the provider for 25 years, was not ServSafe certified, and was not a certified dietary manager (CDM). *The provider did not currently have a dietary manager (DM).	F 801		

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F 801	Continued From page 9 Continued interview on 1/29/23 at 11:20 a.m. with FANS aide F revealed: *She was the only cook during the day. *They served approximately 80 residents at each meal. *There was a dishwasher and a dietary aide working with her. Interview on 1/29/23 at 11:32 a.m. with administrator A revealed and confirmed: *They did not have a current DM or CDM. *In the absence of a CDM, he was the interim DM and oversaw the dietary department. *He was attempting to hire a CDM. Interview on 1/31/23 at 9:47 a.m. with administrator A regarding employment of a CDM revealed: *The provider hired a CDM on 11/1/22 but that CDM left employment on 12/23/22 and had not been replaced. *Prior to 11/2/22 there had not been a CDM or an interim CDM for approximately two months. *The registered dietitian was not full-time and was at the facility one day per week.	F 801		
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 10 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 hand hygiene and glove as well as procedural technique during personal cares and medication administration via a PEG tube. 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 DNS or designee by 2/23/23. 2. **Identification of Others:** ALL residents and staff have the potential to be affected by lack of: *appropriate processes and follow through for the above identified items. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by the DNS or designee by 2/23/23. See next page.	3/9/2023

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F 880	Continued From page 11 (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, and policy review, the provider failed to ensure one of one licensed practical nurse (LPN) had performed appropriate hand hygiene in between glove changes when providing personal cares and medication administration for one of one sampled resident (25) with a percutaneous endoscopic gastrostomy (PEG) tube, who was in enhanced barrier precautions (gown and gloves during high contact resident care for those with implanted or inserted devices to reduce potential transmission of multi-drug resistant organisms). Findings include: 1. Observation on 1/31/23 from 7:20 a.m. through 7:41 a.m. of LPN L providing cares to resident 25 revealed she: *Entered the room without performing hand hygiene, and put on a pair of gloves and a gown. *Removed the gown then, with her gloves on, she exited the room. *Removed her gloves while she walked down the	F 880	**System Changes:** 1. Root cause analysis conducted answered the 5 Whys: Identified in the 5 Whys were the need to increase availability of hand sanitizer, have adequate storage space for supplies to be stored in the room, increase monitoring of staff during cares to avoid being uncomfortable with someone observing the cares. 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. The nurse consultant contacted the South Dakota Quality Improvement Organization (QIN) on 2/20/23 and include call was held on 2/23/23 to evaluate the effectiveness of the root cause analysis and offer support to the center. Nurse consultant, ED, DNS and QIN were all on the call. **Monitoring:** 2. Administrator, DON, and/or designee will conduct auditing and monitoring of above identified items 2-3 times weekly over all shifts. 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. See next page.	

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 _____	01/31/2023

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

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F 880	Continued From page 12 hallway to retrieve an item and returned to the resident's room without performing hand hygiene. *Put on a new pair of gloves and the same gown she had removed, mentioned above. *Administered medications, gave a water bolus, and Isosource to the resident through her PEG tube and removed her gloves. *Without performing hand hygiene, she put on a new pair of gloves. *Cleaned the PEG tube site, applied bacitracin around the tube, and then placed a drain sponge around the PEG tube site. *Removed her gloves and gown, performed hand hygiene, and put on a new pair of gloves. *Performed oral care for resident 25 with a mouth swab. *Removed her gloves and, without performing hand hygiene, she put on a new pair of gloves. *Applied Carmex to resident 25's lips and removed her gloves. *Without performing hand hygiene, she put on a new pair of gloves and cleaned a scab to the resident's left leg with a Betadine swab. *Removed her gloves, exited the resident's room, walked into the hallway, and used a hand sanitizer dispenser that was attached to the wall. Interview on 1/31/23 at 7:42 a.m. with LPN L regarding the above observation with resident 25 revealed she: *Should have performed hand hygiene when changing her gloves and before moving from one task to another. *There was no hand sanitizer available in the resident rooms for staff to use and she had forgotten to perform hand hygiene. *Stated staff used to have small hand sanitizer bottles to keep in their pockets but that was not available anymore.	F 880	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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	435109	A. BUILDING _____ B. WING _____	01/31/2023

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F 880	Continued From page 13 *Agreed she could have washed her hands in the sink that was in resident 25's room. Interview on 1/31/23 at 8:35 a.m. with director of nursing B and regional nurse consultant E regarding the above observation and interview of LPN L revealed: *They would expect all staff to perform hand hygiene between glove changes and before moving from one task to another. *There had been individual hand sanitizing wipes at each nurse's station for staff to carry with them into residents' rooms. Review of the provider's March 2018 Handwashing/Hand Hygiene policy revealed: *"Policy Statement: This Center considers hand hygiene the primary means to prevent the spread of infections." *"7. Use an alcohol-based hand rub containing at least 62% [percent] alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:" -"b. Before and after direct contact with residents; -c. Before preparing or handling medications; -d. Before performing any non-surgical invasive procedures; -e. Before and after handling an invasive device (e.g. [for example] urinary catheters, IV [intravenous] access sites);" -"g. Before handling clean or soiled dressings, gauze pads, etc. [etcetera]; -h. Before moving from a contaminated body site to a clean body site during resident care;' -"m. After removing gloves." *"8. Hand hygiene is the final step after removing and disposing of personal protective equipment."	F 880		

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

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	435109	A. BUILDING _____ B. WING _____	01/31/2023

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

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E 000	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 from 1/29/23 through 1/31/23. Firesteel Healthcare Center was found in compliance.	E 000		

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

Petar Mirkovic | *Executive Director* | *2/22/2023*

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.

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 **01 - MAIN BUILDING 01** B. WING _____	**01/30/2023**

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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/30/23. Firesteel Healthcare Center was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K372 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain a smoke barrier at cross-corridor doors in three of nine smoke compartments (cross-corridor doors near room 102, cross-corridor doors near room 109, and	K 372	1. Fire doors near room 102, room 109, and between the 200 wing and administration have had True Flex placed on them by 2/20/23 by maintenance. 2. The ED reviewed the life safety code regarding smoke barriers with maintenance staff prior to 2/23/23. All residents have the potential to be affected. 3. The maintenance director or designee will audit four random smoke doors weekly times four weeks and monthly times two months to ensure the gap between the doors is no greater than 1/8 inch. The maintenance director or designee will take the results of these audits to the monthly QAPI committee for further review and recommendations to continue or discontinue the audits.	3/9/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Petar Mirkovic	*Executive Director*	*2/22/2023*

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

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	435109	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/30/2023**

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

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K 372	Continued From page 1 cross-corridor doors between the 200 wing and administration). Findings include: 1. Observation beginning on 1/30/23 at 10:40 a.m. revealed the cross-corridor doors near room 102 had a gap between the doors greater than 1/2 inch. The maximum gap allowed between smoke separation doors is 1/8 inch. 2. Observation beginning on 1/30/23 at 10:55 a.m. revealed the cross-corridor doors near room 109 had a gap between the doors of 1/2 inch. The maximum gap allowed between smoke separation doors is 1/8 inch. 3. Observation beginning on 1/30/23 at 11:05 a.m. revealed the cross-corridor doors between the north 200 wing and administration had a gap between the doors greater than 1/2 inch. The maximum gap allowed between smoke separation doors is 1/8 inch. Interview with the maintenance supervisor at the time of the observations confirmed those findings. The deficiency affected three smoke compartment locations required to maintain corridor separations and could affect all occupants of those smoke compartments.	K 372		

South Dakota Department of Health

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	10653 S	A. BUILDING: _____ B. WING _____	01/31/2023

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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 1/29/23 through 1/31/23. Firesteel Healthcare Center was found not in compliance with the following requirement: S301.	S 000		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and record review, the provider failed to ensure nine of nine required dietary training's (food safety, handwashing, food handling/prep, food-borne illness, serving and distribution, leftovers, time/temp controls, nutrition/hydration, and sanitation) were completed by five of five dietary staff (F, G, H, I, and J). Findings include: 1. Interview and record review on 1/31/23 at 11:00 a.m. with administrator A regarding dietary training revealed: *They used a combination of in-person training and an online training program. *The certified dietary manager (CDM) was responsible for ensuring the training had been completed, but: -There had not been a CDM for two months prior	S 301	1. All dietary staff have completed a dietary orientation checklist with education provided on food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements by the dietician by 2/3/23. Any dietary staff who have not completed the orientation checklist will be re-quires to do so prior to their next working shift. All residents have the potential to be affected. 2. The dietician or dietary manager will ensure that all newly hired di-etary staff receive initial orientation on the topics addressed in number one (above). The ED or designee will ensure that all dietary staff fol-low the ongoing annual inservice education calendar to ensure all topics are educated on annually. 3. The ED or designee will audit all new dietary staff monthly times six months to ensure all received and completed a dietary orientation checklist as well as (continued)	3/9/2023

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

TITLE: Executive Director

(X6) DATE: 2/22/2023

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S 301	Continued From page 1 to 11/1/22. -A CDM had been hired on 11/1/22, but that CDM resigned on 12/23/22, and the position had been vacant since then. -In the absence of the CDM, administrator A was responsible to ensure the training had been completed. *The dietitian had been developing the required dietary training. *He confirmed the required dietary training had not been completed for all dietary employees. Interview on 1/31/23 at 11:07 a.m. with dietitian K regarding the required dietary training revealed: *She was hired May of 2022. *She was at the facility once or twice per week. *She had been developing an orientation checklist. *There was a plan to have monthly in-services. *She and the administrator had been providing orientation to new dietary employees. *The CDM would have been responsible for ensuring training was completed.	S 301	audit all dietary staff have completed the monthly education assigned monthly times six months. The ED or designee will take the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or dis-continue the audits.	
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/29/23 through 1/31/23. Firesteel Healthcare Center was found in compliance.	S 000		