STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/26/26 through 5/28/26. Areas surveyed included quality of care. Firesteel Healthcare Center was found not in compliance with the following requirements: F609, F684, F755.	F0000		
0609 S = E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD	F0609	CORRECTIVE ACTION FOR OBSERVED RESIDENTS No additional corrective action was taken for Resident #1 as she is no longer in the facility. A full investigation of the incident had been completed and documented on the grievance that was filed at the time of the event 2/26/26 A late facility report was submitted to the SD DOH for Resident #6 4/9/26	

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that oth afeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable) 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 disclosab 4 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 ogram participation.

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Veronnica J. Smith	Administrator	6/17/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026
NAME OF PROVIDER OR SUPPLIER **FIRESTEEL HEALTHCARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE **1120 EAST 7TH AVENUE , MITCHELL, South Dakota, 57301**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
0609 S = E	Continued from page 1 DOH) complaint records, interview, and policy review, the provider failed to report an incident to the SD DOH within the required time frame regarding two of two sampled residents (1 and 6) who had a reportable incident. Findings include: 1. Review of the 2/24/26 SD DOH complaint report revealed resident 1 reported an allegation of verbal abuse and neglect by travel certified nursing assistant (CNA) C and travel CNA D on 2/24/26 at 6:12 p.m. via an email to the director of nursing (DON) B, and administrator A, and the South Dakota Department of Health (SD DOH) complaints department. In her email, resident 1 alleged that travel CNA C and travel CNA D had told her she should have better time management regarding her use of the call light because they were busy delivering meal trays to other residents when she activated her call light. Then, when the travel CNAs were assisting her from the toilet to her wheelchair, her bare buttocks touched the arm of her wheelchair and they refused to clean it. DON B responded by email to resident 1's emailed complaint on 2/24/26 at 8:43 p.m., stating, "I am sorry this happened to you today. I will pull the call light report tomorrow and talk to them both." Resident 1 passed away and no interview was possible regarding the provider's follow-up with her concerns. 2. Interview on 5/27/26 at 11:20 a.m. with DON B revealed that although resident 1 had made a formal verbal abuse/neglect complaint, she did not file a facility reported incident (FRI) with the SD DOH as required. DON B verified that the initial and final FRI reports regarding resident 1's incident on 2/24/26 were not reported or submitted to the SD DOH within the required time frame. She indicated that she was aware of the SD DOH required reporting time frames and was responsible for doing so. Immediately after resident 1's complaint was brought to her attention, travel CNA C and travel CNA D were both suspended pending the	F0609	IDENTIFICATION OF OTHERS AFFECTED DNS and Administrator reviewed incidents and grievances occurring May 17-30 to identify if any should have been reported and that those that were reported were according to reporting timeframes. SYSTEMIC CHANGES Randy Cheeks, Regional VP provided. Re-education ~~was provided~~ to DNS and Administrator regarding required reporting and timely reporting per regulations on 5/28/26 MONITORING All incident reports and grievances will be audited to ensure there are no late/missed reports per regulation. Audits will be completed by the ~~Administrator~~* or designee daily on business days for one week then 3 x week x 2 weeks and then weekly x4. Administrator or designee will report to QAPI monthly. *Shelbi Petrik, Staff Development Coordinator edited 6/22/26 VJS	edited 6/22/26 VJS 5/28/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
0609 S = E	Continued from page 2 investigation results. They remained off schedule until the conclusion of the investigation. Because the SD DOH was included in the emailed complaint by resident 1, DON B thought that the email had fulfilled their reporting requirement. The facility's investigation into the incident did not verify verbal abuse had taken place, as it was witnessed by three staff members and they all stated no abuse had occurred. The allegation of neglect for the long response time to resident 1's call light was validated. DON B interviewed resident 1 after the incident and the resident was satisfied with the provider's response to the incident. Travel CNA C and travel CNA D acknowledged they were assisting another resident when resident 1's call light was initiated and that she had to wait a long time for staff assistance. Resident 1 required three staff to assist her with transfers, so they needed a third staff member to come in to assist them, which delayed her care. Travel CNA C and travel CNA D were educated about responding promptly to call lights along with all other nursing staff. Travel CNA C and travel CNA D were both contracted travel staff and their contracts were not renewed. They were unavailable for interview during this survey. No documentation was provided that proved education was completed for all staff regarding this incident. 3. Interview on 5/28/26 at 4:10 p.m. with DON B and administrator A revealed incidents that required reporting to the SD DOH were abuse/neglect, falls with injury, medication errors, falls with unknown origin, allegations, and missing medications. Allegations, falls of unknown origin, and falls with major injury were to be reported to the SD DOH within two hours. All other incidents needed to be reported to the SD DOH within 24 hours. The final investigation report needed to be submitted to the SD DOH within five days. Administrator A and leadership staff were responsible for completing the initial and final FRI reports to the SD DOH. Both administrator A and DON B acknowledged the facility should have submitted a FRI to the SD DOH for resident 1 and failed to do so. They had also failed to document the education that was provided to all staff. But all annual abuse/neglect education was up to date with their staff.	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
0609 S = E	Continued from page 3 4. Review of the provider's 4/9/26 SD DOH FRI initial report involved resident 6 who was on hospice care. He had a physician's order for Morphine (an opioid medicine prescribed for pain relief). The medication was administered to him on 2/19/26 and 2/20/26. The medication count was correct, but the nurse on 4/2/26 believed the original blue color of the liquid Morphine was a lighter blue color, and again on 4/9/26. The pharmacy was consulted and confirmed if the Morphine was lighter in color to assume it was tampered with, but there was no way to verify the medication in the bottle. The facility's final report revealed the Morphine color discrepancy was reported to the director of nursing (DON) B on 4/2/26 and again on 4/9/26 had notified registered nurse (RN) J who investigated the Morphine and found that it was lighter in color when she drew it into a syringe; it looked more like water than Morphine. The staff who worked on that unit were interviewed on 4/9/26 regarding the color of the Morphine. Licensed practical nurse (LPN) L reported she did recall the color, LPN M thought it always looked lighter, LPN N noted it was blue to her, contracted LPN O noted it was blue and she [he] thought it looked a lot lighter, and LPN P was unsure. 5. Interview on 5/28/26 at 11:25 a.m. with DON B regarding reporting resident 6's morphine revealed she had forgotten to inform her other staff to begin the investigation of the Morphine on 4/2/26 because she was involved in a family emergency. She stated on 4/9/26 the liquid Morphine's lighter color was brought to her attention again, and she had RN J investigate the Morphine color discrepancy as a possible drug diversion. She stated the amount was correct and her staff had signed off on their shift-to-shift report (a report that the staff signed and acknowledged the controlled substance amount was correct). She acknowledged she submitted the report to the state for the possible drug diversion late and knew it was reportable. She called her supervisor, and she was given a verbal warning for submitting the report late. 6. Interview on 5/28/26 at 4:15 p.m. with administrator A revealed she expected incident reports to be completed at the required time and	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
0609 S = E	Continued from page 4 submitted to the SD DOH. 7. Review of the provider's Abuse Reporting and Response policy published in September 2017, revealed, "The Center immediately reports all suspected and/or allegations of abuse, neglect, and exploitation of residents, misappropriation of resident property, mistreatment, and injuries of unknown source in accordance with state and federal law." "Staff immediately reports all alleged or suspected violations to the supervisor and Executive Director." "The Executive Director or designee reports alleged violations to the state survey agency and other officials in accordance with state law...as follows: Immediately but not later than 2 hours-All allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, if the events that cause the allegation involve abuse or result in serious bodily injury." "Note-reporting requirements are based on real clock time, not business hours." "The Center reports the results of all investigations to the Executive Director and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident." "The Center identifies staff responsible for implementation of corrective actions, expected date of implementation, and those responsible for monitoring." "Additional training is conducted with staff, and staff competency is evaluated as necessary." "Failure to report suspicion or allegations of abuse timely by staff will result in disciplinary action up to and including termination."	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
0684 S = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: A. Based on interview, record review, document review, and South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, the provider failed to ensure the staff responded promptly to four of five sampled residents (1,2,4,and 5) who reported they had to wait a long time for their call light to be answered. Findings include: 1. Interview on 5/26/26 at 12:30 p.m. with resident 5 revealed he was admitted to the facility recently and was unhappy with the care he received from the staff. When he first came to the facility, he needed more assistance from the staff because his muscles were weaker at that time. His call lights were not answered quickly, and there were times that he was incontinent (involuntary urine or bowel leakage) before the staff arrived which embarrassed and upset him. Now that he was stronger, he avoided using his call light. He was frustrated with waiting for the staff to respond and said, "they are here for me and not the other way around". 2. Review of resident 5's electronic medical record (EMR) revealed his Brief Interview for Mental Status(BIMS) assessment score was 15, which indicated he was cognitively intact. He had diagnoses of chronic respiratory failure with hypoxia (not enough oxygen in the blood which makes it difficult to breath), chronic obstructive pulmonary disease (an ongoing progressive lung condition that damages the airways and makes it increasingly harder to breathe), multiple sclerosis (an autoimmune disease that affects the brain, spinal	F0684	CORRECTIVE ACTION FOR OBSERVED RESIDENTS No additional corrective action taken for Resident #1 & #2 as they are no longer in the facility. Call light reports were run for Resident # 4 & #5 for the previous week and incidents in the "needs improvement" category investigated. For Resident #5, the catheter bag was replaced with a new one and a bag to store the catheter was also placed on 5/28/26. An order was added to the TAR for weekly replacement of the bag. The order for the condom catheter was updated with published standards of practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
0684 S = E	Continued from page 6 cord and optic nerves), and congestive heart failure (a chronic, progressive condition where the heart muscle is too weak or stiff to pump blood efficiently). Resident 5's 2/18/26 revised care plan indicated he needed the assistance of one staff member with transfers when he was first admitted. He got stronger with physical therapy (PT) sessions and on 3/25/26 was cleared by PT to take himself to and from the bathroom and be independent within his room. 3. Review of resident 5's call light response time report (a report that indicated how long a call light was on before it was turned off) from 2/13/26 through 3/11/26 revealed he had 20 call light response times over 15 minutes long and six call light response times over 30 minutes long. He moved to a new room within the nursing home on 3/11/26. From 3/11/26 through 5/28/26 in the new room location, he had four call light response times over 15 minutes long, two call light response times over 30 minutes long, and one call light response time that was over 53 minutes long. 4. Review of resident 1's 2/24/26 emailed complaint sent to the SD DOH complaint department at 6:12 p.m. revealed resident 1 had also sent her complaint email to director of nursing (DON) B, and administrator A. The email stated she pushed her call light at 4:30 p.m. on 2/24/26 when she was finished on the toilet, and there was no response from the staff for nearly an hour. Contracted travel certified nursing assistants (CNAs) CNA C and CNA D entered her room and told resident 1 she needed to use better time management. They were delivering resident meal trays and were unable to assist her at that time. When they assisted her from the toilet to her wheelchair, her bare buttocks touched the arm of her wheelchair and the CNAs refused to clean the arm of the chair when she requested it. It was then cleaned by another staff member. DON B responded to resident 1's complaint email on 2/24/26 at 8:43 p.m. stating, "I am sorry this happened to you today. I will pull the call light report tomorrow and talk to them both."	F0684	IDENTIFICATION OF OTHERS AFFECTED Call lights - a facility audit of call light response times for the past 1 week was conducted. Response times triggering in the "needs improvement" were identified and reviewed for adverse outcomes. There were no additional residents with condom catheter. A 100% review of all residents with catheters (condom, Foley, suprapubic) was completed to ensure clear physician orders, accurate TAR instructions and proper storage and infection control processes. SYSTEMIC CHANGES Call lights - call light system was upgraded and smart phones purchased so that each team member on the floor has one. The call light rings directly to the phones. Education was provided to staff on use of the phones, the need to sign out each shift, and timeliness of response on 6/1/26. Condom Catheter- procedure was developed with standards of practice from Lippecot. Education of procedure completed with nurse staff on 6/1/26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
0684 S = E	Continued from page 7 5. Review of the provider's grievance form for resident 1's 2/24/26 complaint and interview with DON B on 5/27/26 at 11:15 a.m. revealed that resident 1's call light was not answered for 57 minutes. Travel CNA C and travel CNA D were suspended pending their investigation. A skin assessment by nursing was completed on resident 1 with no skin alteration identified following the incident. When interviewed by DON B, both travel CNA C and travel CNA D, who were named as the staff responsible in resident 1's complaint, stated they were in another resident room at the time. They confirmed that resident 1 had waited an extended time for a response. Resident 1 required the use of a Hoyer mechanical lift (a mechanical lift and sling used to lift a person's full body) with the assistance of three staff members, which made it difficult for a timely response. Education was given to travel CNA C and travel CNA D to ensure response times for all resident call lights were completed promptly. DON B interviewed resident 1 after the incident, and she was satisfied with the results of the investigation. Resident 1 was not available for interview during the survey as she passed away in April 2026. 6. Documentation was requested to confirm that all staff were re-educated about abuse, neglect of care, and answering call lights promptly. No documentation was provided before the survey exit. 7. Review of resident 1's closed EMR revealed her Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had diagnoses of edema (excess fluid trapped in the body's tissues), morbid obesity (excess weight that creates a serious health hazard that can significantly reduce life expectancy), chronic obstructive pulmonary disease, and osteoarthritis (a chronic degenerative joint disease where the protective cartilage cushioning the ends of the bones gradually wears away causing the bones to rub together usually causing pain and stiffness). 8. Review of resident 1's call light response time report for 2/24/26 revealed she had two call light response times over 15 minutes long, three call light	F0684	MONITORING Call lights – Call light reports will be run by the Administrator or designee daily x one week then 3 times/week x2 weeks and weekly x 4. Administrator will report to QAPI monthly. Condom Catheter – DNS will audit weekly x 4 then monthly x3 for compliance with TAR instructions, proper storage, and care plan accuracy.	6/1/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026
NAME OF PROVIDER OR SUPPLIER: **FIRESTEEL HEALTHCARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE: **1120 EAST 7TH AVENUE , MITCHELL, South Dakota, 57301**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0684 S = E	Continued from page 8	F0684		

response times over 30 minutes long, and one call light response time that was over 57 minutes long.

9. Review of the provider's 4/23/26 SD DOH FRI regarding resident 2 revealed DON B was in his room asking about his plan of care since he admitted on 4/16/26. He informed DON B that there was an incident with the staff that made him mad over the last weekend. He had put his call light on for assistance to use the restroom, and the staff came into his room, turned off the call light, and left. He waited over an hour for the staff to return to assist him, and by that time he was incontinent of urine.

DON B identified travel CNA Q was the CNA who had come to resident 2's room, turned off his call light, and did not return. Travel CNA Q was immediately suspended pending the facility's investigation, which validated neglect had occurred. Travel CNA Q resigned on 4/27/26 when informed of the investigation results and did not return to the facility.

10. Review of resident 2's closed EMR revealed his BIMS assessment score was 10, which indicated his cognition was moderately impaired.

His 4/22/26 care plan indicated he was independent with transfers at times, but needed moderate staff assistance at other times. Resident 2 was discharged from the facility on 5/4/26.

11. Review of resident 2's call light response report from 4/26/26 through 5/4/26 revealed he had 6 call light response times over 15 minutes long.

12. Interview on 5/27/26 at 11:20 a.m. with DON B confirmed she had met with resident 2 on 4/23/26 to check on how the staff were taking care of resident 2's needs. He informed DON B that he was upset about a situation over the past weekend when a CNA answered his call light, turned off the call light, and did not return to assist him. This resulted in an incontinent episode for him. He waited over an hour for staff assistance and was upset that this had happened. He did not report the incident at the time to any staff member.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **435109**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/28/2026**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
0684 S = E	Continued from page 9	F0684		

With the description resident 2 provided DON B, she was able to identify that travel CNA Q was the staff responsible. DON B immediately suspended travel CNA Q until their investigation of the incident could be completed. When the investigation concluded, the provider confirmed the incident had occurred as reported by resident 2. Travel CNA Q resigned when she was informed of the investigation results and did not return to the facility. Abuse and neglect education was provided to all staff on 4/30/26.

13. Interview on 5/27/26 at 3:05 p.m. with resident 4 revealed she had concerns with long call light response times from the staff. The response times had gotten worse in the past few months, and she had waited more than an hour for assistance at times. Some staff would come into her room, shut off the call light and then leave again without assisting her. She was frustrated about that. She had a supra-pubic catheter (a flexible tubing surgically placed through the abdomen into the bladder to drain urine), and the insertion site was to be cleaned daily by the nursing staff. She preferred to receive her catheter care assistance for times when she was already in her bed or wanted to lay in her bed.

She required two staff members to assist her with transfers with a sit-to-stand mechanical lift (a mechanical lift used to assist from a seated to a standing position). In the mornings, she preferred to have assistance by 9:00 a.m. The amount of time she had to wait for her call light to be answered depended on who was working. The contracted travel staff generally were not as fast at responding to her call light. At times she needed to request pain medication from the nurse, and the wait could feel long if she was already in pain.

She had overheard the CNAs and nurses voice their frustration with there not being enough walkie-talkies to go around for everyone to use during their shift. The walkie-talkies alerted the staff when a call light was activated by the residents, and if one was not available, they would have to watch the monitor at the nurse station for that information. There were no call light indicators outside of the resident room doorways or audible sounds that sounded within the resident rooms. If the staff did not have a walkie-talkie for the day, it made it more difficult for them to be aware of when a resident's call light was activated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **435109**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/28/2026**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
0684 S = E	Continued from page 10 14. Review of resident 4's EMR revealed her BIMS assessment score was 15, which indicated her cognition was intact. She had diagnoses of rheumatoid arthritis (a chronic autoimmune disease where the immune system mistakenly attacks the lining of the joints), morbid obesity, Parkinson's disease (a progressive disorder of the central nervous system that primarily affects movement), and neuromuscular dysfunction of the bladder (nerve damage that disrupts communication between the brain, spinal cord, and bladder muscles). Resident 4's 4/17/26 care plan indicated she required the assistance of two staff members with transfers and the use of a sit-to-stand mechanical lift. 15. Review of resident 4's call light response report from 4/28/26 through 5/28/26 revealed she had 28 call light response times over 15 minutes long, and one call light response time that was 1 hour and 16 minutes long. 16. Interview on 5/26/26 at 12:53 p.m. with certified medication aide (CMA) E revealed there were not enough walkie-talkies to go around for all of the scheduled staff at times. When this happened, the staff had to check the computer screen at the nurse stations for any activated resident call lights. Her expectation was to answer the call lights as soon as possible. To her knowledge, the facility did not have an expected call light response time. 17. Interview on 5/26/26 at 12:58 p.m. with CNA F revealed there were not enough walkie-talkies available for all staff. For the staff who did not have a walkie-talkie, they would not be alerted of an activated resident call light unless they checked at the nurse station computer monitor. 18. Interview on 5/27/26 at 8:54 a.m. with activities aid/CNA G revealed the facility had a problem with not having enough walkie-talkies available for all scheduled staff to use. There were long call light wait times for the residents. The staff sometimes took the walkie-talkies home or forgot to take them out of their pocket before leaving the building. There were frequently staff calling in and not showing up	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **435109**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/28/2026**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
0684 S = E	Continued from page 11 for their scheduled shift, which reduced the number of CNAs available to assist the residents with their needs. She was not aware of the facility's expectation for resident call light response times. 19. Interview on 5/27/26 at 2:10 p.m. with CNA H revealed there were not enough walkie-talkies available for all staff who were scheduled. The staff without a walkie-talkie would have to check the nurse station often to see if there were any call lights activated. She had known resident 1 well and had a good relationship with her. Most of the complaints from resident 1 involved contracted travel staff who had resisted doing things in the order that she instructed them to do. There were no issues if the staff followed resident 1's instructions for her care in the order that she preferred. CNA H was not aware of the facility's expectation for response time to call lights. Her expectation was that call lights be answered as quickly as possible, within just a few minutes of being activated. 20. Interview on 5/27/26 at 2:42 p.m. with LPN I revealed there were times that the walkie-talkies were not available for all staff to use because some staff would forget to turn them in at the end of their shift and take them home. During busy times such as meals, activities, or a resident emergency, call light wait times could be delayed. She was not aware if the facility had an expectation for how quickly staff were to respond to call lights. 21. Interview on 5/28/26 at 3:20 p.m. with staff development/RN J, DON B, and RN unit manager K revealed staff development/RN J was responsible for ensuring the staff were up to date on their training and education. She expected that the staff were trained to answer all call lights promptly. The facility did not have a policy for call light response times. The staff should not enter a resident's room, turn off the call light, and then leave without assisting the residents. There was not a designated time established that the call lights were expected to be answered by the staff. The facility leadership had conducted interviews with the residents, and the feedback that was received indicated that a response time of under 15 minutes was generally acceptable for the residents. They looked at call light response times and assessed the results each month. They analyzed the call light audit reports and tried to find ways to improve the	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026
NAME OF PROVIDER OR SUPPLIER **FIRESTEEL HEALTHCARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE **1120 EAST 7TH AVENUE , MITCHELL, South Dakota, 57301**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
0684 S = E	Continued from page 12 call light response times. When there were staff who called in or the staff did not show up for their shift, the leadership staff assisted with answering resident call lights to ensure a timely response for the residents. 22. Interview on 5/28/26 at 4:10 p.m. with administrator A revealed they did not have a policy or procedure for call light response times. But her expectation for staff response to call lights is less than 15 minutes. During busy times, it may be longer, but she would expect CNAs to answer all call lights within 15 minutes of activation. She confirmed they had problems with the availability of walkie-talkies for all scheduled staff and were working on a solution. B. Based on interview, observation, record review, and document review, the provider failed to ensure the nursing staff were provided clear instructions to care for the physician ordered condom catheter care for one of one sampled resident (5). Findings include: 1. Interview and observation on 5/27/26 at 3:35 p.m. with resident 5 revealed he used a condom catheter during the night. The nursing staff were to ensure that the condom catheter was on each night and removed in the morning. What upset him was that the nursing staff did not come in each night and ensure his catheter needs were met. He felt the nursing staff should be assisting him without him having to make a request. The condom catheter was to be removed in the morning, and the nursing staff did not ensure the tubing and catheter bag were stored properly. The nursing staff expected him to rinse out and store his catheter bag and tubing independently. His catheter bag and tubing were not replaced for six weeks or longer and had a very strong urine odor. He felt it was the nursing staff's responsibility to ensure his catheter needs were met, and he should not be expected to do it himself or to have to request supplies from the nursing staff. His catheter tubing, which was wrapped around a dresser drawer handle, was attached to a catheter bag and was located in his bathroom. There was a	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026
NAME OF PROVIDER OR SUPPLIER **FIRESTEEL HEALTHCARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE **1120 EAST 7TH AVENUE , MITCHELL, South Dakota, 57301**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
0684 S = E	Continued from page 13 strong urine odor surrounding the catheter bag and tubing. It was not stored inside a bag for infection control purposes, and there was no date to indicate when it was last replaced. 2. Review of resident 5's EMR revealed he had a 2/19/26 physician's order for a condom catheter to be applied at night prn (as needed). His care plan indicated an intervention for his condom catheter added on 3/10/26 that stated, "condom catheter 26mm [millimeter] on at HS [hour of sleep] off at AM, per patient request." Review of resident 5's February 2026, March 2026 and April 2026 treatment administration record (TAR) revealed an entry for "condom cath [catheter] on at night and off in the morning every night shift". Resident 5's TAR since his admission indicated the nursing staff had documented that his condom catheter care was completed. 3. Interview on 5/27/26 at 4:15 p.m. with LPN I revealed she was not sure what the nursing staff was responsible for regarding resident 5's condom catheter care. The overnight staff took care of that, and it was removed before the day shift staff arrived. She was unable to find instructions for his catheter care, but stated it should be on resident 5'sTAR for the overnight shift staff. Instructions for what was expected to be done should have been listed in resident 5's care plan and on his TAR. At times, he came to the nursing station and requested catheter supplies. She thought he was doing his catheter care mostly independently, and the nurses just checked with him to ensure he had what he needed. He could be demanding at times, but she agreed it should not be his responsibility to request new supplies when needed or to clean and store the catheter bag and tubing when not in use. 4. Interview on 5/27/26 at 4:35 p.m. with DON B revealed there were no physician instructions for how often resident 5's catheter tubing and bag were to be replaced. Because it was a condom catheter and it was not inserted into his body, she had researched and found no guidance on how often the tubing and bag were to be replaced. She would not	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI(DATE
0684 S = E	Continued from page 14 have expected to need a physician's order for that. She acknowledged that new staff may not know the expectations of what needed to be done for resident 5's condom catheter because it was not clear in his care plan or on his TAR, and the instructions should be clarified. The catheter bag and tubing should have been stored inside a dated storage bag indicating when they were last replaced, which was their policy. She expected the nursing staff to store his catheter tubing and catheter bag in a dated catheter bag in his bathroom to avoid any infection control concerns. 5. Interview on 5/28/26 at 3:20 p.m. with staff development/RN J confirmed she had discovered resident 5's condom catheter tubing and bag was stored inappropriately in his bathroom. She replaced them, and put them in a dated storage bag in an appropriate area. She agreed that the information on resident 5's TAR and care plan did not have enough information regarding his catheter care instructions, and a new nurse may not know what to do. The catheter bags and tubing should be stored in a catheter bag, dated and changed weekly. 6. Review of the provider's resident handbook revealed "In a spirit of partnership, we design care plans that embrace your individual preferences, desires, and needs to the best of our ability. Here are some standard skilled nursing services you may receive: 24-hour clinical care, comprehensive wound care, post-acute care, intravenous and enteral therapies, restorative nursing care...catheter care." 7. Review of the provider's revised 3/19/25 Infection Control Policy revealed "The objectives of facility infection control policies, protocols, and practices are to ...support maintenance of a safe, sanitary, and comfortable environment for personnel, residents, and visitors."	F0684		
0755 S = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026
NAME OF PROVIDER OR SUPPLIER: FIRESTEEL HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1120 EAST 7TH AVENUE , MITCHELL, South Dakota, 57301	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0755 S = D	Continued from page 15 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), document review, interview, and policy review, the provider failed to secure a controlled medication (medication with risk for abuse and addiction), for one of one sampled resdient (7)'s Dilaudid (an extremely potent schedule II prescription opioid painkiller) that was received at the facility on 3/20/26 was not accounted for the following day on 3/21/26. Findings include: 1. Review of the provider's 3/20/26 SD DOH FRI revealed on 3/21/26 resident 7's Dilaudid was unaccounted for. The Dilaudid was received and signed for by licensed practical nurse (LPN) S from the pharmacy. That Dilaudid was taken by LPN S to the Hall 400 medication room, but was not properly signed or secured in the locked medication cart.	F0755	CORRECTIVE ACTION FOR OBSERVED RESIDENTS Resident #7 was assessed at time of incident. Tylenol was offered while medication was reordered/administered 2 hours from time due. A full facility search was conducted and medication unable to be located. Staff that failed to follow the controlled substance procedures were terminated. All nursing staff and medication aids were educated on the storage and securing of controlled medication 4/9/26. The medication was later found with no resulting diversion. IDENTIFICATION OF OTHERS AFFECTED 100% audit of all controlled substances (Schedule II-V) was completed by the Director of Nursing, verifying all resident medications were accounted for 3/21/26. SYSTEMIC CHANGES Nursing and Med Aide staff were re-educated regarding the handling of controlled substances and ensuring that meds are secured per the Controlled Medication Storage Policy. On 4/9/26. edited 6/22/26 VJS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026
NAME OF PROVIDER OR SUPPLIER **FIRESTEEL HEALTHCARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE **1120 EAST 7TH AVENUE , MITCHELL, South Dakota, 57301**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
0755 S = D	Continued from page 16 The next day, on 3/21/26, the certified medication could not be found by the medication aide (CMA) T, and she notified the nurse. The medication was confirmed to be missing after a facility-wide search was completed. The pharmacy confirmed the medication was sent to the facility and had not been returned. Leadership, authorities, and resident 7 was notified of the incident. 2. Review of the pharmacy shipping manifest revealed resident 7's Dilaudid 2 mg (milligram) was received at the facility in the quantity of 60 tablets on 3/20/26. 3. Interview on 5/27/26 at 3:30 p.m. with director of nursing (DON) B revealed she was notified of the missing medication on 3/21/26, and she, along with other staff, completed a facility-wide search for that medication. She had completed staff interviews, and those who were immediately involved with the signed-in medication and not securing it were terminated for not following the facility process of checking in a controlled medication and securing it. The medication was signed in as received at the front desk from the pharmacy and left in the locked medication room. The medication was not locked in the locked medication cart drawer as it should have been. The CMA had seen the medication in the medication room, but did not put the medication into the locked medication cart drawer or tell anyone before she left. DON B stated LPN R had seen the medication and placed it by LPN S, but did not lock it up. DON B acknowledged that the medication should have been double locked in the medication cart. She did not think to view the camera footage and was not sure how long the footage was available. The CMAs and nurses had keys to the medication rooms. DON B stated she did not completed medication audits until they had another incident of a controlled medication of morphine being diluted.	F0755	MONITORING DNS or designee will complete weekly medication cart audits to identify any concerns and report results to QAPI monthly. (this is a scheduled weekly audit and is ongoing).	5/28/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
0755 S = D	Continued from page 17 4. Interview on 10/28/26 at 10:51 a.m. with administrator A revealed that the facility camera footage went back 30 days, and any footage of the incident was no longer available. 5. Review of the provider's undated Controlled Medication Storage policy revealed that scheduled II-V medications must be maintained in separately locked, permanently affixed compartments.	F0755		