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 12/18/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/16/25 through 12/18/25. Areas surveyed included infection control regarding COVID-19, scabies, prompt disposal of incontinent products and unpleasant odors; and quality of care and nursing services regarding lost personal property, provision of assistive devices and staff assistance with care needs, call light response, fall prevention, and response to a resident with suicidal thoughts who subsequently passed away. Firesteel Healthcare Center was found not in compliance with the following requirements: F658, F689, and F740.	F0000		
F0658 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, and record review, the provider failed to ensure one of one sampled resident (3) had a palm protector (a foam device that fits over the hand to prevent severe finger contractures (curling) from digging into the palm) applied as ordered by the physician for contracture management of his right hand. Findings include: 1. Observation on12/17/25 at 4:00 p.m. of resident 3 revealed he was seated in his recliner with a blanket covering his lap. His hands were on top of the blanket. His right hand was curled tightly, with his fingers appearing to be digging into the palm of his hand.	F0658	1. CORRECTIVE ACTION FOR AFFECTED RESIDENT: Resident #3 was assessed immediately on 12/17/25; palm protector applied per physician order. Care plan updated and verified by DON. 2. IDENTIFICATION OF OTHERS: DON/designee completed a review of all residents with splints, braces or positioning devices on 12/18/25 to ensure compliance with physician orders. 3. SYSTEMIC CHANGES: Staff education was completed on kardex and importance of following careplan/provider orders 12/17/25 with all staff. For those that missed inservice, education was provided before their next shift	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Veronnica J. Smith	Executive Director	01/27/26

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F0658 SS = D	Continued from page 1 Observation and interview on 12/18/25 at 9:30 a.m. of resident 3 in his room revealed the fingers on his right hand were curled and closed tightly. There was no device to separate his fingers from the palm of his hand. When asked if he had something to help open his hand, he stated he only wore the device when he was “working”. 2. Review of resident 3’s electronic medical record (EMR) revealed: *His admission date was 2/24/21. *His 8/22/25 Brief Interview of Mental Status assessment score was a 6, which indicated his cognition was severely impaired. *His diagnoses included: ataxia (a nervous system dysfunction that results in poor control of voluntary movements), stiff-man syndrome (a rare autoimmune neurological disorder that commonly causes muscle stiffness and painful spasms), dementia (a group of symptoms affecting memory, thinking, and social abilities), mood disorder, weakness, repeated falls, malignant neoplasm of the brain (cancer), and epilepsy (a brain condition causing repeated seizures). *A 9/18/24 physician’s order to wear a “Palm protector on [his] right hand during the day and off at meals. every [Every] day shift for contracture management. *His December 2025 treatment record revealed on 12/17/25 and 12/18/25, the palm protector was documented as being applied by the day shift nurse. *A 10/10/25 nurse progress note indicated “Residents [3] right hand is contracted but he is able to open it and hold onto the ez [EZ] (a mechanical lift used to assist from a seated to a standing position) stand with assistance and cueing.” -A 10/23/25 nurse progress note indicated “Resident [3] is transferring better in the EZ stand, standing up straighter and is able to open his right hand more, as it has been contracted.” 3. Interview and record review on 12/18/25 at 9:35 a.m. with certified nursing assistant (CNA) M revealed: *She was newly hired and had worked at the facility for three days.	F0658	Kardex education was added to all agency staff orientation packet on 12/2/2025. Kardex reference sheets were placed at all nurses stations and in all CNA binder.Kardex reference sheets were placed at all nurses stations and CNA binders. 4. MONITORING: DON or designee will complete random staff audits via both verbal and written questions to verify staff understand and can demonstrate how to find care plan information. 10 audits completed weekly x 4 then monthly x 2. All audit findings will be reported to QAPI. Don or designee will complete random audits to observe resident care to ensure care plan/provider order is being followed appropriately. 10 audits completed weekly x 4 then monthly x 2. All audit findings will be reported to QAPI. 5. COMPLETION DATE:	12/22/25

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F0658 SS = D	Continued from page 2 *She had never seen resident 3 wear a palm protector. *She was provided a “cheat sheet” (a typed form that outlined the basic care each resident needed) by the charge nurse. *The cheat sheet was reviewed with CNA M and indicated resident 3 was to have a “palm protector on in [the] morning, [and] off at bedtime.” 4. Interview on 12/18/25 at 9:45 a.m. with certified medication aide (CMA) I revealed: *She knew how to care for residents by looking at their Kardex (a report of the resident’s care needs and interventions). There was also a “banner” (an area in the resident’s electronic medical record (EMR) that indicates any special instructions on how to care for a resident) that a staff member could reference for each resident. *She indicated that resident 3 wore a “brace” (palm protector) on his hand, and she thought that was to be in place every day. *It was the responsibility of the CNAs to put the palm protector on for resident 3, then the CMA or nurse would document in the EMR that the palm protector was placed on his right hand. -Resident 3 would be brought to the nurse's desk in the mornings for the CMA or nurse to see that his palm protector was on and to document that in his EMR. -The palm protector was to be removed at mealtimes and put back on after the meal. 5. Interview on 12/18/25 at 1:05 p.m. with director of nursing (DON) B revealed: *Resident 3 would come to the nurses’ desk, and the nurse would then verify that he had his palm protector in place on his hand. -The palm protector was to be taken off when resident 3 was transferring, and for meals, and then put back on after the transfer was completed or when he was done eating. -There were no further scheduled verification checks to ensure resident 3’s palm protector was placed on his hand after the transfer was completed and after his	F0658		

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F0658 SS = D	Continued from page 3 meals. 6. A policy regarding following physician's orders was requested during the survey, but it was not provided by the end of the survey period.	F0658		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review, the provider failed to ensure the staff provided supervision and accident prevention interventions according to the resident's care plans for one of one sampled resident (2) who fell and sustained multiple facial fractures when left unsupervised in the dining room by a nursing staff member and one of one sampled resident (4) who fell from a mechanical lift when being transferred by certified nursing assistant (CNA) L. Findings include: 1. Review of the provider's 11/24/25 SD DOH FRI regarding resident 2 revealed: *On 11/24/25 at 1:45 p.m. resident 2 was found face down on the dining room floor. *The fall was not witnessed. *This was resident 2's third fall in the dining room. *Staff had left him in the dining room to finish eating his meal while they assisted other residents. *Upon a nurse assessment resident 2 had blood coming	F0689	1. CORRECTIVE ACTION FOR AFFECTED RESIDENTS: Resident #2 - care plan was updated to reinforce supervision during meals and staff re-educated on 11/25/25. Resident passed away 11/29/25. Immediate review of incident/root cause analysis conducted. Resident #4 care plan reviewed; CNA L disciplined and re-educated on mechanical lift use and care plan compliance. 2. IDENTIFICATION OF OTHERS: DON reviewed all residents with fall risk and mechanical lift orders and those requiring supervision in the dining room on 12/18/25. Careplans reviewed and interventions updated to reflect current indidual care needs. 3. SYSTEMIC CHANGES: The Administrator, DON, and IDT reviewed the stand aide manufacturer's instructions/ procedure and updated fall management to include mandatory 2-person assist for mechanical lift use. The expectation was established to communicate resident specific needs through the Kardex. Staff education/competency was completed on Kardex and importance of following careplan/provider orders initially on 12/2/2025 amd repeated 12/22/25. Kardex education was added to all agency staff orientation packet on 12/2/2025. Kardex reference sheets were placed at all nurses stations and in all CNA binder.	

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F0689 SS = G	Continued from page 4 from his nose and a cut on the top of his nose. *Resident 2's family was notified and requested that he be evaluated in the emergency department. *The injuries identified while in the emergency department were, "Multiple facial fractures [broken bones in the face] including bilateral [both sides] LeFort fractures [patterns of midface bone breaks] (probable combination of left-sided LeFort III [3; severe break that can separate the entire midface from the skull base involving the cheekbones, eye sockets, and nasal bridge] superimposed upon LeFort I [1; the upper jaw separates from the skull]), left-sided zygomaticomaxillary complex fracture [involves the cheek bone and the connections to the cheek bone], and comminuted nasal bone fracture [nasal bone shattered into multiple pieces]. *Resident 2 was receiving hospice services prior to the fall on 11/24/25 and died on 11/29/25. 2. Review of resident 2's electronic medical record (EMR) revealed: *He was admitted on 11/4/24. *His 11/19/25 Brief Interview of Mental Status (BIMS) assessment score was 0, which indicated his cognition was severely impaired. *His diagnoses included repeated falls, progressive supranuclear ophthalmoplegia (a rare, degenerative brain disorder causing gradual worsening of movement, balance, vision, speech, and swallowing), dementia (a group of symptoms affecting memory, thinking, and social abilities), and anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). *He was placed on hospice on 11/18/25 and died in the facility on 11/29/25. *He fell in the dining room on 6/17/25 at 9:10 a.m., on 10/25/25 at 10:45 a.m., and again on 11/24/25 at 1:30 p.m. *On 6/17/25 he was found in the dining room lying face down on the floor. A dietary staff member was in the dining room at the time he fell. There were no injuries identified with that fall. -The fall prevention intervention identified on 6/18/25	F0689	Staff were educated on the need for two assist with lift use. Those not present for inservice were educated prior to their next shift. 4 MONITORING: DON or designee will audit by interviewing 10 staff about what they are doing for fall prevention, supervision needs and lift use on their current hall. Audit will be completed weekly x 4, monthly times 3. All results will be reported QAPI 5. COMPLETION DATE: ADDENDUM: Per directed inservice, education with competency was provided to all staff on their roles, responsibilities and assigned tasks regarding fall prevention and fall management. Education completed 1/9/26	01/09/2026

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F0689 SS = G	Continued from page 5 after the interdisciplinary team (IDT) review was, "Do not leave resident in the dining room unattended without [a] CNA [certified nursing assistant]." *On 10/25/25 he was found in the dining room lying face down on the floor. He sustained a cut near his left eye and required an emergency room visit for treatment. There was no staff in the dining room to monitor him and his chair was not reclined. -The 10/27/25 fall intervention was, "Ensure resident is not taken to dining room early. Should be in room or where staff can visualize him." *On 11/24/25 he was again found lying on the floor in the dining room face down. His nose was bleeding, and he had a cut to the bridge of his nose and was transferred to the emergency room for treatment after he had fallen in the dining room and he returned to the facility on 11/24/25 at 6:40 p.m. -The interdisciplinary team (IDT) note written by administrator A dated 12/1/25 on the 11/25/25 fall incident report stated fall prevention interventions were, "1.) Staff educated not to leave resident in dining room unattended. 2.) Med [medication] aide will obtain meals and assist resident to start right away upon arriving at dining room so that he might be done around the time staff are assisting residents out of the dining room. 3.) Interventions added to care plan." *Review of resident 2's care plan that was last revised on 12/1/25 revealed an identified problem of, "The resident is at risk for falls r/t [related to] Gait/balance problems, Unaware of safety needs, psychotropic [drugs that affect brain activities associated with mental processes and behavior] use, antihypertensive [medications used to treat high blood pressure]". -Identified interventions for that problem area included that staff were to: " Continue to use two staff members for all transfers due to hx [history] of fainting at times with transfers" which was initiated on 6/10/24, "Assist resident back to room after eating, not to leave him alone in dining room" which were initiated on 6/18/25, "Ensure resident is not taken to dining room early. Should be in room or where staff can visualize him" and "Resident not to be left alone in dining room" which was initiated on 10/27/25, "Staff was educated on not leaving him alone in dining room" which was initiated on 11/25/25, and "[Resident 2] cannot be in the dining room alone and for the med [medication] aide to start him eating as soon as he	F0689		

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F0689 SS = G	Continued from page 6 arrives" which was initiated on 11/26/25. *Review of resident 2's care plan last revised on 12/1/25 revealed an identified problem of, "Potential for Nutrition Hydration issues r/t mechanically altered diet and swallowing difficulties d/t [due to] progressive supranuclear palsy". -Identified interventions for that problem were, "Diet: Pureed and moderate thick liquids" which was initiated on 10/7/24, "Aspiration Precautions"(steps taken to prevent food, liquid, or saliva from entering the lungs), and "I eat out in [the] dining room due to my risk for choking" which was initiated on 7/16/25. 3. Interview on 12/17/25 at 11:36 a.m. with certified medication aide (CMA) I revealed: *She had worked on 11/24/25 when resident 2 fell, unwitnessed in the dining room. *She stated resident 2 had gotten up for lunch late, so he did not start eating his lunch at the beginning of the meal service. *CMA I had been told by registered nurse (RN) G that CNA M was to remain in the dining room with resident 2 until he finished eating. *A resident came out of the dining room and told her that resident 2 had fallen. *She then entered the dining room, and there was blood on the floor from resident 2's nose and a cut on his face. She was not sure what he had hit his head on when he fell. *She stated that the daily staffing assignments identified the staff member assigned to the dining room on each hallway for each shift, but the staff member assigned to remain in the dining room often did not. *CMA I stated a resident, such as resident 2, should not have been left unattended in the dining room, especially because he had difficulty with swallowing and was at risk for aspiration. 4. Interview on 12/17/25 at 1:40 p.m. with director of nursing (DON) B revealed the provider did not have policies about care planning, resident dining, or resident dining assistance. 5. Review of the provider's 11/24/25 Daily Staffing Assignment sheet revealed:	F0689		

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F0689 SS = G	Continued from page 7 *RN G was the nurse assigned to resident 2's hallway, CMA M was the medication aide, the CNAs were CNA M and CNA J. CNA M was identified to be the staff member assigned to the dining room for the day shift. *The Daily Staffing Dining sheet also stated, "All resident cleared out prior to laying residents down", "Refrain from breaks during resident meal times", and "Med-Aids [medication aides] and Nurses are to assist in [the] DR [dining room]". 6. Interview on 12/18/25 at 9:02 a.m. with RN G revealed: *She was the nurse assigned to resident 2's hallway on 11/24/25, when he fell in the dining room. *When she returned from her lunch break, she was alerted by activity staff N that resident 2 was lying on the floor in the dining room face down. *That was not the first time resident 2 had fallen out of his chair in the dining room while he was unsupervised. *After the staff assisted resident 2 off the floor, RN G applied pressure to the bleeding from his face and nose. When she applied pressure she felt "crunching" in his face. *Resident 2 was then taken to the emergency department by his family. *RN G stated there were no nursing staff members in the dining room at the time of resident 2's fall. *A nursing staff member was to remain in the dining room while resident 2 was in there. *RN G identified CNA J as the staff member who was supposed to have remained in the dining room that day. *RN G had spoken to CNA J twice that day because she had left the dining room unattended. *She stated that it had been a struggle to keep a staff member in the dining room to supervise the residents because there were so many other tasks they needed to complete on the main floor. *Staff had been educated after resident 2's previous falls in the dining room that someone was to remain in the dining room until he was finished eating and could	F0689		

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F0689 SS = G	Continued from page 8 be removed from the dining room. *RN G verified resident 2 was required to be closely monitored while he ate because of his difficulty swallowing and his risk for aspiration. 7. Interview and record review on 12/18/25 at 9:31 a.m. with CNA J revealed: *The CMAs were supposed to assist the residents during meal time because the CNAs had too many tasks to complete on the floor during meal times. *She verified that on 11/24/25 she was instructed by RN G to remain in the dining room to monitor the residents, but she did not because she was assisting CNA M with resident care needs. *She had told RN G that she was not able to remain in the dining room that day. *CNA J agreed that a staff member needed to remain in the dining room while the residents were present to monitor for the residents' safety. *She stated the person responsible for remaining in the dining room was identified on the Daily Staffing Assignment sheet, and the CMA for resident 2's hallway was always assigned to the dining room during the lunch service. *She referred to the resident's care plan to determine what cares a resident required, and verified that resident 2's care plan reflected he was not to be left in the dining room unsupervised. 8. Interview on 12/18/25 at 1:55 p.m. with DON B revealed: *She was hired after resident 2's 11/24/25 fall, but she had reviewed the records and documentation related to that fall. *After resident 2 fell in the dining room on 10/25/25, care plan was updated to include that he was not to be left unsupervised in the dining room. *After he fell on 11/24/25 his care plan was updated to include that the CMA was to get resident 2's meal early to allow him enough time to eat because he was a slow eater and that would minimize the time after the meal a staff member would have to remain in the dining room to supervise him.	F0689		

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F0689 SS = G	Continued from page 9 *She had not considered resident 2 as being unsupervised during his fall on 11/24/25 because there was an activity staff member in the dining room. *She verified a resident who had an altered diet and was at risk for aspiration needed to be monitored by a nursing staff member, which included resident 2. -She agreed that on 11/24/25 resident 2 was not supervised in the dining room by a nursing staff member at the time he fell. *She expected the nurse to be sure the staff member assigned to the dining room remained in the dining room while residents were present. *DON B stated CNA J should not have told RN G no when RN G asked her to remain in the dining room, and DON B expected the CMA to be in the dining room while residents were present. *Resident 2's care planned intervention to be supervised in the dining room by a nursing staff member was not followed when he fell on 11/24/25. 1. Review of the provider's 12/16/25 SD DOH FRI regarding resident 4 revealed: *On 12/16/25 at 8:30 a.m. CNA L was transferring resident 4 with a sit-to-stand mechanical lift (a mechanical lift used to assist from a seated to a standing position off the toilet to return to his chair. *During the transfer resident 4's hands slipped off the lift's handlebars, and resident 4 started to slide out of the lift. *CNA L called for assistance as she unbuckled resident 4's legs from the sit-to-stand lift and assisted him to the floor. *RN F and staff development RN entered resident 4's room, assessed him, and transferred him into his chair. *The provider's investigation of the fall from a sit-to-stand lift revealed that the lift was functioning properly, but CNA L did not follow resident 4's care plan, which indicated he was to be transferred with the sit-to-stand lift and the assistance of two staff members. 2. Interview on 12/17/25 at 10:49 a.m. with DON B regarding resident 4's 12/16/25 falling incident	F0689		

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F0689 SS = G	Continued from page 10 revealed: *CNA L used the sit-to-stand lift correctly, but did not follow resident 4's care plan, that indicated two staff members should have assisted resident 4 with the use of that lift while transferring the resident. *CNA L was given disciplinary action and provided education on mechanical lift use and following a resident's care plan. 3. Review of resident 4's EMR revealed: *He was admitted on 2/28/19. *His diagnoses included Parkinson's disease (a progressive neurological disorder that leads to symptoms like tremors, stiffness, slow movements, and balance problems), weakness, and abnormality of gait (walking) and mobility. *His 6/17/25 Morse Fall Scale assessment score was 40, which indicated he had a moderate risk for falling. *Review of resident 4's 12/17/25 care plan revealed an identified problem area that indicated “The resident is at risk for falls r/t [related to] Gait/balance problems, [and is] Unaware of safety needs" which was initiated on 2/5/24. -On 1/17/25 his bathing, chair to chair, chair to bed, and toilet transfer needs were identified as needing the use of a sit-to-stand lift with the assistance of two staff members due to his not standing well in the sit-to-stand lift. 4. Interview on 12/17/25 at 4:20 p.m. with RN F revealed: *She was the nurse on duty on 12/16/25 when resident 4 fell from the sit-to-stand lift. *She and staff development RN O assessed resident 4 after the fall and determined he was not injured as a result of the fall. *CNA L was transferring resident 4 from the toilet to his chair. *CNA L told RN F that resident 4's hands began to slip off the handlebars on the lift, and she lowered him to the foot stand on the sit-to-stand lift. *RN F stated that since resident 4’s 12/16/25 falling	F0689		

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F0689 SS = G	Continued from page 11 incident, he was transferred with the use of a full body mechanical lift (a mechanical lift and sling used to lift a person's full body), but prior to that, he was transferred with the use of a sit-to-stand lift and the assistance of one staff member. *She stated if she needed to know how a resident was to be transferred, she would refer to the resident's Kardex (a report of the resident's care needs and interventions) or the "cheat sheet" (a document that identifies residents' care needs and interventions). *RN F identified a sheet dated 12/14/25, with a list of residents and some of their basic care needs information, such as how each resident was to be transferred. *That "cheat Sheet" dated 12/14/25 identified that resident 4 was to be transferred with "2 [staff members to] assist [with the use of an] ez stand [sit-to-stand lift]". *RN F stated she was not aware that resident 4 needed the assistance of two staff members to be transferred and was unsure when that had changed. 5. Interview on 12/18/25 at 11:00 a.m. with CNA L revealed: *CNA L worked at the facility for two years. *She would reference the resident's Kardex if he needed to know how a resident transferred. *She stated he was learning how to use the Kardex to access how a resident's cares were to be provided. *On 12/16/25 while she was transferring resident 4 off the toilet, he let go of the right handlebar on the lift and then his left hand "gave out". CNA L unbuckled the leg strap and assisted resident 4 to the floor. *CNA L stated she was not aware resident 4 was to be transferred with the assistance of two staff members while in the sit-to-stand lift because he previously was to be transferred with the assistance of one staff member. 6. Interview on 12/18/25 at 1:50 p.m. with DON B revealed: *She expected the staff to follow the residents' care plans.	F0689		

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F0689 SS = G	Continued from page 12 *CNA L had not followed resident 4's care planned intervention to transfer him, which resulted in his falling from the sit-to-stand lift. *She agreed that staff members not following a resident's care plan had the potential to place a resident's safety at risk. 7. Review of the provider's January 2025 Fall Management and Neurological Check policy revealed: *"The center implements a fall management plan based on medical history review and resident evaluation. The center monitors neurological signs following head injury or suspected head injury." *"The residents [resident's] care plan is reviewed quarterly and after a fall to determine effectiveness of current intervention and considers the residents [resident's] goals, choices and preferences...A systematic review of current interventions is completed post fall and root cause is identified." *"In the event of a head injury or fall that is unwitnessed and the occurrence leads the nurse to conclude a head injury is likely, neurological checks are initiated."	F0689		
F0740 SS = G	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review the provider failed to ensure one of one sampled resident (1) who committed suicide had received the necessary behavioral health services to treat a diagnosed serious mental illness. Findings include:	F0740	CORRECTIVE ACTION FOR AFFECTTED RESIDENT: Resident #1 passed away on 12/11/25; immediate review of incident/root cause analysis completed. IDENTIFICATION OF OTHERS: All residents screened with PHQ-9; providers notified for concerning scores.	

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F0740 SS = G	Continued from page 13 1. Review of the provider's 12/11/25 SD DOH FRI regarding resident 1 revealed: *On 12/11/25 at 12:50 a.m. a CNA (certified nursing assistant) responded to resident 1's roommate's call light and found resident 1 hanging by a string around his neck off the side of the bed. *That CNA had assisted resident 1 with his urinal at approximately 11:00 p.m. during the routine two-hour rounds (periodic checking on residents' status and assistance needs). *The CNA notified the nurse, the nurse responded to resident 1's room and cut the string that the resident was hanging from. *At the time resident 1 was released from the side of the bed he was cyanotic (bluish discoloration of the skin, lips, or nails due to the lack of oxygen in the blood), his body was cold to the touch, and there was no pulse, or respirations. *The CNA discovered a "goodbye note" on resident 1's bedside table. *Resident 1 had a do not resuscitate (DNR) directive on record at the facility. *Law enforcement and resident 1's family were notified. *Law enforcement arrived at the facility at 1:15 a.m., and requested that the staff leave the resident's room as the investigation was conducted. *Resident 1's body was released to the funeral home at 2:15 a.m. *The preliminary investigation suggested resident 1 had raised his bed into the highest position, placed a string around his neck, and moved his body off the side of his bed independently. 2. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted to the facility from a hospital on 10/27/25. *His 10/31/25 Brief Interview of Mental Status (BIMS) assessment score was 12, which indicated his cognition was intact.	F0740	per directed education, Adm, DON, IDT and medical director reviewed and updated admission process to include escalating any potential residents with suicidal ideations/past attempts to admission team to review and ensure psychosocial needs can be met before admission. If approved for Admission safety interventions identified and implemented on admission. 12/11/2025 While no procedure was initiated, staff education/competency was completed to include overall emotional and wellbeing including the process for reporting and keeping residents safe if resident makes comments indicating they have suicidal thoughts or feelings. 12/11/2025 and additional education completed on 12/22/2025. Those not present at inservice were educated prior to their next shift. RN/LPN staff educated on the importance of notifying provider and family of any suicidal thoughts/ comments or change in condition/mood. 12/22/2025 and before next working shift.	

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F0740 SS = G	Continued from page 14 *His diagnoses included depression. -Suicidal ideations (thoughts of suicide) was not included on his diagnosis list. *There was a 10/27/25 physician's order for "Escitalopram Oxalate Oral Tablet 20 MG [Milligrams] (Escitalopram Oxalate) [a medication used to treat depression] Give 1 tablet by mouth one time a day related to depression". *Resident 1's 10/27/25 Level II (2) Preadmission Screening and Resident Review (PASRR) revealed: -Resident 1 was taking Lexapro (Escitalopram) medication for depression. -He had made statements in the past about suicide. -He fell into the category of having a diagnosis that the PASRR program was designed to assess. "Your condition is likely to require expert treatment in the future." --The reason for that decision was indicated as, "You have a condition of Depression, unspecified that has impacted your day-to-day needs and has led to the need for mental health and medication management services to treat your mental health needs." -"You need 24/7 [24 hours per day/ 7 days per week] care and supervision to ensure your health and safety because you may neglect self-care, your daily activities, and your medications due to your physical limitations, and mental health diagnoses." -"You will need to be provided the following specialized services: Psychiatric medication management/monitoring: Individual mental health therapy:" -"You should see a psychiatrist, psychiatric nurse practitioner, or primary care physician to assess your medications to see how well they are working for you at treating your symptoms. The frequency of your visits can be determined by your treatment team." -"Counseling (optional) can help you adjust to the changes you've had in your health, and you can learn new coping skills for managing your mental health symptoms."	F0740	4. MONITORING:ÝON or designee to audit admissions weekly x 3 months to ensure risk was identified and proper interventions in place. All results will be reported to QAPI meetings. 'dDON or designee will do 10 random staff audits via both verbal and wrutten questions weekly x 1 month and monthly x 2 to ensure staff have sufficient knowledge to identify and act on any suicidal comments. All results will be reported to QAPI. DON or designee will do random chart audits weekly x 4 and monthly x 2 to identify and confirm that any documented suicidal comments or resident change in condition/mood has documented provider notification. 5. COMPLETION DATE:	12/22/25

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F0740 SS = G	Continued from page 15 *His 10/31/25 PHQ-9 (a tool used to assess for depression) score was 5, which indicated he had mild depression symptoms. *On 11/3/25 resident 1 had an “initial visit to evaluate their psychiatric conditions and determine if [redacted company name] can assist in the management, education and support of these conditions.” At that time, he consented for Behavioral Health Integration (BHI) and Collaborative Care Management (CoCM) services. -BHI and psychiatric CoCM services, “including the scope of care coordination, availability of 24/7 access to clinical support, and the monthly non-face-to-face nature of services -The note from that visit indicated he denied having “suicidal ideations, homicidal ideations, or hallucinations.” *An 11/19/25 progress note written by Minimum Data Set (MDS) coordinator D stated, “Visited with resident today about his mood. Smiling as he visits with this writer. Stated some days I am more down than others. Stated ‘I am 84 years old and I do not know why I am still here’ as he smiled at this writer. Spent time talking with resident about how none of us know how long we will have, and that it is all in God hands. Asked this writer if he feels his antidepressant medication needs to be increase. [resident] Stated ‘No, some days I am just more down than other days.’ Counseling was offered to resident [1] at care conferences- [the resident] declined.” *An 11/26/25 progress note at 9:02 a.m. written by licensed practical nurse (LPN) resident care manager (RCM) H stated, “This writer spoke with [resident 1’s family member]. She explained that [the] resident expressed ‘I don’t want my oxygen and I want to get rid of my meds [medications] I just want to go. If I had a gun or knife I would just do it.’ His concerns are about taking care of his family and is reporting he was interested in hospice.” *Two additional progress notes written by LPN/RCM H on 11/26/25 stated, “Resident denies having a plan of harming himself” and “Spoke with resident [who] did mention feeling ‘down’ as his wife is home sick. But denies having any thoughts of suicide.” *A 12/4/25 care conference progress note indicated resident 1’s wife and son attended the care conference.	F0740		

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F0740 SS = G	Continued from page 16 It was reported [that] resident 1 had a decline in therapy. “Discuss hospice vs [versus] continuing skilled therapy to see if resident can get stronger again. Family wished to continue therapy. Wife still hopes to take [the] resident home.” *A 12/5/25 interdisciplinary team (IDT) meeting progress notes stated resident 1 “copes with stressful situations by verbalizing suicidal comments or negative comments” and the “latest talk is that [the] resident may not besafe [be safe] to be at ho me”. *There were no further progress notes regarding resident 1’s suicidal ideations or his mental health status. 3. Review of resident 1’s 11/26/25 through 12/11/25 daily skilled assessments revealed no documented notes or assessments to resident 1’s mental health status or mood. 4. Review of resident 1’s 10/22/25 psychiatry note revealed: *He was referred to psychiatry for evaluation of, “worsening mood, functional decline, and suicidal ideations.” *“He described increased psychological distress, marked by feelings of hopelessness, worthlessness, and being a burden to his family.” *“He reported being unable to reach the bathroom independently, contributing to embarrassment and loss of dignity. These limitations have led to frustration and a profound sense of helplessness.” *“He stated that ‘everything is falling apart’ and that he is ‘just wanting to die’. He expressed both passive and active suicidal ideations, stating he has ‘finally made up [his] mind’ to end his life.” *“He acknowledged that if a firearm were available, he would use it, though his family previously removed all guns from the home after similar statements. He further indicated he might consider alternative methods if available, expressing these thoughts with seriousness and resolve.” *During resident 1’s 10/22/25 psychiatry visit resident 1’s spouse, “expressed concern about his escalating despair and agreed that additional psychiatric	F0740		

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F0740 SS = G	Continued from page 17 intervention and structured support are needed." *"The addition of Seroquel was discussed to address mood instability and sleep disturbance. Given his advanced age, male gender, medical frailty, chronic pain, and persistent suicidal ideations, he is considered high risk for self-harm. Plans are underway for transfer [him] to a skilled nursing facility to provide closer supervision, reduce caregiver strain, and ensure safety." *"The treatment plan and need for ongoing psychiatric management were discussed in detail with the patient [resident 1] and his wife, both of whom were receptive to the recommendations." *Resident 1's "intent is serious. Long-term suicide risk is high due to multiple non-modifiable risk factors and ongoing distress. Short-term suicide risk is moderate to high given active ideation, intent, and lack of current means, but with close monitoring and removal of firearms, risk is somewhat mitigated." *"Increase supervision and safety monitoring through [his] transition to [a] skilled nursing facility." 5. Review of resident 1's 10/27/25 discharge summary revealed: *Resident 1 was seen by psychiatry during his hospital admission. *Psychiatry had recommended, "having 24- hour supervision at local SNF [skilled nursing facility], continuing Lexapro 20 mg daily, and adding Seroquel 25 mg nightly for mood stability and insomnia." *"Patient did reported [report] improved mood on the day of discharge." *Seroquel was not listed on the discharge medication list. *Follow-up with psychiatry services was not documented in the discharge summary. 6. Interview on 12/18/25 at 8:06 a.m. with medical director E revealed: *He was made aware of resident 1's suicide on 12/11/25 and reviewed resident 1's nursing home and hospital records.	F0740		

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F0740 SS = G	Continued from page 18 *While resident 1 was in the hospital just prior to being admitted to the facility he was seen by psychiatry for suicidal ideations with a suicide plan. *Psychiatry started him on Seroquel, an antipsychotic (a drug that alters neurotransmitters activity in the brain to reduce symptoms of mental health conditions) on 10/22/25 that he was able to take at bedtime. *When he was discharged from the hospital to the nursing home the discharging doctor documented there was improvement while he was on the Seroquel but did not order the Seroquel to be continued at the nursing home. *The psychiatry note had included a recommendation of increased supervision during resident 1's transition to the nursing home but identified his suicide risk classification as low. *Medical director E stated he expected the nursing home staff to review resident 1's records from the hospital and to have noticed the psychiatry note and discharge summary which had not continued the order for the Seroquel, even though it was noted to have improved resident 1's symptoms. *Resident 1 had seen his primary care doctor after he admitted to the nursing home on 11/6/25 and 12/4/25. -Neither of the progress notes on those dates from his primary care provider mentioned resident 1's mental health or suicidal ideations. *Medical director E expected resident 1's primary care provider to have reviewed the resident's notes from the hospital, which included the psychiatry note and the discharge summary. *Medical director E was not aware that resident 1 had suicidal ideations while he resided at the nursing home. *He expected that resident 1's primary care provider would have been notified of resident 1's suicidal ideations, even if it was reported to a family member and not directly to staff. *If resident 1's primary care provider had been notified of the suicidal ideations, medical director E would have expected the primary care provider to have developed a plan with psychiatry and to have made adjustments and recommendations to resident 1's	F0740		

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F0740 SS = G	Continued from page 19 medications or mental health plan of care. *Medical director E expressed that it was concerning to him that resident 1's mental health had only been addressed on the day of his reported suicidal ideations and there was no continued monitoring for his safety. *He stated he felt that there could have been measures put into place for resident 1's safety, such as searching his room for means of suicide and moving him to a room closer to the nurses' station to allow for increased supervision. -Resident 1's room was located at the end of the hall, where he was not easily visible to staff. 7. Interview on 12/18/25 at 11:40 a.m. with social services director (SSD) C revealed: *She completed the PASRR screenings and reviewed them to be sure the recommendations on the PASRR level II were implemented. *She was involved with residents' mental health services in addition to the resident care managers. *She was aware of resident 1's suicidal ideations, but was not aware of how serious it was. *When she talked about the resident's suicidal ideations during his admission assessment, resident 1 laughed about it, and his wife stated that resident 1 would talk about committing suicide anytime he was in a stressful or bad situation. *During the 12/4/25 care conferences, it was discussed that resident 1 may not be safe to go home due to his decline in therapy. Resident 1's son had stated he would be the "bad guy" and tell resident 1 he was not able to go home. -SSD C did not know if resident 1's son had told resident 1 that information prior to resident 1's suicide. *SSD C confirmed that after the initial mental health visit on 11/3/25, resident 1 had not been seen again by the contracted mental health services. *She verified that the services provided to resident 1 by the provider's current contracted mental health service were inconsistent.	F0740		

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F0740 SS = G	Continued from page 20 -The provider had changed to that contracted mental health service in October 2025 and they did not have a routine schedule for seeing residents. *SSD C was not asked to visit with resident 1 after the report of his suicidal ideations. *She did not know if resident 1 was referred for emergency mental health services with [redacted name] after his reported suicidal ideations. *She did not know resident 1 had suicidal ideations while he was in the hospital. *Resident 1 was not provided with any additional supervision measures when he was admitted to the facility or after his reported suicidal ideations after he resided at the facility. *She verified resident 1's care plan had not been updated to include more than a history of suicidal ideations. -She did not think staff would have understood that resident 1 had current suicidal ideations with his care plan only indicating a history of them, and the care plan should have been updated to include his current suicidal ideations. 8. Interview on 12/18/25 at 12:15 p.m. with MDS coordinator D revealed: *She was made aware of resident 1's suicidal ideations during the leadership meeting on 11/26/25. *Resident 1's care plan should have been updated to include his suicidal ideations while he resided at the facility and updated with interventions. *Resident 1 had not expressed interest in participating in any activities while he resided at the facility and ate most of his meals in his room. 9. Interview on 12/18/25 at 12:25 p.m. with LPN/RCM H revealed: *The information captured in the daily skilled assessment was determined according to what the resident had been admitted to the facility for, such as therapy or wound care. *If, during the resident's stay at the facility, there	F0740		

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F0740 SS = G	Continued from page 21 was a concern identified that was not related to what the resident was admitted for, she would expect a separate progress note to be entered with that information. *On 11/26/25 she was notified by resident 1's family member that resident 1 had expressed suicidal ideations to her. -Resident 1's family member told her that he had made suicidal comments before while he was in the hospital. -She was not aware that resident 1 had suicidal ideations and a suicide plan while he was in the hospital. *LPN/RCM H stated she followed up with resident 1 on 11/26/25, and he denied having a plan and made no further comments related to suicidal ideations. *She expected the corporate staff, who identify potential admissions, would have included the information about suicidal ideations with a plan while he was in the hospital in his admission information. *She did not know if resident 1's primary care provider had been notified of his suicidal ideations at the facility. *She verified his primary care provider should have been notified of his suicidal ideations. *Nursing staff had not been updated on resident 1's active suicidal ideations or to monitor him more closely because his daughter-in-law had made it sound like that was something he always said. *The nurses were not instructed to monitor more closely or to document behaviors or statements in resident 1's EMR. She thought resident 1's family member would give the nurses more information if it was needed. -LPN/RCM H stated she knew that was not best practice, but resident 1 did not say things to staff members that he said to his family. *She did not know if anyone had looked through his room for a means to commit suicide after he expressed his suicidal ideations. *She stated staff should have been notified to increase monitoring of resident 1, and resident 1's care plan should have been updated to include his active suicidal ideations with a suicide plan and interventions related	F0740		

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 12/18/2025

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

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F0740 SS = G	Continued from page 22 to that. *LPN RCM H verified that resident 1 had not received increased monitoring or supervision as was recommended within the psychiatry notes after he was admitted to the nursing home or after his reported suicidal ideations. 10. Interview on 12/18/25 at 2:05 p.m. with DON B revealed: *All potential resident admissions referred from the hospital were reviewed by a corporate staff member. *If the corporate staff member had a concern related to the admission referral, she would send the potential resident's history and physical, psychiatry notes, and progress notes to the facility's nursing department for review. *DON B was not aware that resident 1 had suicidal ideations with a suicide plan in the hospital and saw psychiatry. *She stated that the nursing staff should have been notified of his suicidal ideations and a suicide plan while he was in the hospital, so he could have been evaluated by the provider to determine if the nursing home could have provided the services, he required to keep him safe. *Resident 1 did not receive increased supervision and monitoring when he was admitted or after he reported suicidal ideations while he resided in the facility. *She stated resident 1's primary care provider was not notified of resident 1's suicidal ideations because he denied having suicidal ideations to the staff. *The provider did not implement any interventions after resident 1 reported his suicidal ideations. *No one had looked in resident 1's room for potential methods of suicide after he expressed his suicidal ideations. *Resident 1's care plan was not updated to include active suicidal ideations with a plan or interventions to be used. 11. Interview on 12/17/25 at 1:40 p.m. with director of nursing (DON) B revealed:	F0740		

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F0740 SS = G	Continued from page 23 *The provider did not have a physician notification policy. *The provider used Lippincott Manual of Nursing Practice 12th edition for a professional standard reference and the federal regulations for physician notification. *Resident 1's physician was not notified of his 11/26/25 suicidal statement because he had made the statement to a family member. -The family member who resident 1 reported his suicidal ideations to was a staff member in the facility. *The provider did not provide an increased in monitoring of resident 1's mental health and safety after he expressed the suicidal ideations. *She stated staff could document within resident 1's daily skilled assessments if there were concerns with resident 1's mood or behavior. *Review of the provider's interventions in response to resident 1's suicide with DON B included: -All staff had been provided education to remain with a resident if they were to report thoughts of suicide and notify the nurse immediately. -All residents had a PHQ-9 assessment completed and their primary care provider was notified if the resident had a score that was concerning for depression. -The provider was completing audits related to the PHQ-9 scores and physician notification. 12. Review of the provider's Lippincott Manual of Nursing Practice 12th edition revealed: Depression *"Observe [resident] for sadness, apathy, feelings of worthlessness, self-blame, suicidal thoughts, desire to escape, worsening of mood in the morning, anorexia [abnormal loss of appetite], weight loss, sleeplessness, lessening interest in sex, reduction of activity, or ceaseless activity." *"Anticipate that the patient [resident] may be suicidal."	F0740		

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F0740 SS = G	Continued from page 24 *"Attempt to find out if the patient [resident] has thoughts about or an attempted suicide and the lethality of the suicide plan." *"Do not leave the patient [resident] alone because suicide is usually an act committed in solitude." *"Refer for psychiatric consultation or to a psychiatric unit." Suicide Ideations *"Assess for risk factors: -Associated psychiatric illness… -Personality traits such as aggression, impulsivity, depression, hopelessness, borderline personality disorder, or an antisocial personality. -Persons who have experienced early loss, decreased social support, chronic illness, or recent divorce." *"Determine whether [the] patient [resident] has communicated suicidal intent, such as preoccupation with death or talking about someone else's suicide." *"Determine whether [the] patient [resident] has ever attempted suicide- the risk is much greater in these people." *"Determine whether there is a specific plan for suicide and a means to carry out the plan." *"If there was no active attempt made, "use crisis intervention (a form of brief psychotherapy) to determine suicide potential, discover areas of depression and conflict, find out about the patient's [resident's] support system, and determine whether hospitalization, psychiatric referral, and so forth is warranted." *"Prevent further self-injury –a patient [resident] who has made a suicide gesture may do so again." *"Arrange follow-up care, or admit to hospital or psychiatric unit, depending on assessment of suicide potential."	F0740		