

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/07/2016
NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301	
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F 000	INITIAL COMMENTS Surveyor: 32331 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/5/16 through 1/7/16. Firesteel Healthcare Community was found not in compliance with the following requirements: F164, F252, F309, F323, F431, and F441. Surveyor: 16385 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/5/16 through 1/7/16. Areas surveyed included resident neglect, quality of care/treatment, and resident rights. Firesteel Healthcare Community was found in compliance.	F 000	*Addendums noted with an asterisk per 2/8/16 per telephone with facility administrator. JT/SDDO/H/EL	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164	F164 1. No specific residents were cited. 2. All residents are potentially at risk. 3. a. Facility Administrator or designee will in-service by 2/4/2016 all staff regarding walkie-talkie communication per facility policy. Those who are not in attendance during education meeting will receive education prior to their working their next scheduled shift.	2/4/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Carey Beaman* TITLE *Administrator* (X6) DATE *1/25/16*

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

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F 164	<p>Continued From page 1</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354</p> <p>Surveyor: 35625 Based on observation, interview, and policy review, the provider failed to keep residents' information confidential when staff were using a walkie-talkie (two-way communication radio) in multiple locations regarding multiple residents. Findings include:</p> <p>1. Multiple observations on 1/6/16 from 7:30 a.m. through 8:05 a.m. at the Central nurses station revealed: *A resident's name was used in staff communication at 7:32 a.m. *At 7:37 a.m. "[Resident's name] is here in the front, where would you like her to go?" *At 8:02 a.m. four residents' names were used over the walkie-talkie instructing staff to bring them to the dining room.</p> <p>Surveyor: 29354 Observation on 1/6/16 at 9:55 a.m. with registered nurse (RN) B during a medication</p>	F 164	<p>b. Administrator or designee will complete [redacted] audits weekly x 4, then monthly x 2 on ensuring proper walkie-talkie communication. Audit selection is random with a maximum of four. The following area will be audited: Ensure confidentiality of residents by use of only initials and/or room numbers to identify residents on the walkie-talkies.</p> <p>4. Administrator or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.*</p> <p>→ *Written visual/sensory observations of walkie-talkie usage JT/SDDO/H/EL</p> <p>↓ *or until audits meet 100% compliance. JT/SDDO/H/EL</p>		

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F 164	Continued From page 2 (med) pass revealed: *She had been standing by the med cart in the hallway outside of room C16N. *Several staff and resident's had walked by the med cart. *During the above time she had received a call on the walkie-talkie and the resident's first name could be heard. Surveyor: 35625 Observation on 1/7/16 at 8:40 a.m. of RN B at the Central nurses station revealed she communicated with another staff member over the walkie-talkie to notify them of a phone call regarding "[Resident's name]." Observation on 1/7/16 at 9:40 a.m. in the Central hallway revealed a resident's name used for needing assistance to the dining room. Interview on 1/7/16 at 10:15 a.m. with the director of nursing revealed: *It was her expectation that a resident's name was not to be used when communicating over the walkie-talkie. *She acknowledged the potential for the walkie-talkie signal to carry outside of the building. Review of the providers May 2015 Use of Walkie Talkies policy and procedure revealed: **"Staff needing assistance will use room number, resident initials or area where help is needed. *No resident names or resident information will be relayed over the walkie-talkie."	F 164		
F 252 SS=B	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	F 252	F252 1. No specific residents were cited. 2. All residents are potentially at risk.	2/4/16

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F 252	Continued From page 3 The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation and interview, the provider failed to provide a homelike environment due to lack of odor control in the Central hallway north. Findings include: 1. Observation on 1/5/16 from 9:55 a.m. to 11:00 a.m. of the Central hallway north revealed a strong odor of urine throughout most of the hallway. This hallway consists of twenty resident rooms. Observation on 1/5/16 at 3:00 p.m. of the above hallway revealed the same smell. Observation on 1/6/16 at 9:30 a.m. of the above hallway again revealed a strong urine odor. Observation and interview on 1/6/16 at 10:10 a.m. with the head of maintenance revealed: *Air vents in that hallway had been working and were checked on a regular basis. *Hallway carpets were cleaned on a regular basis or as needed. *Resident room carpets were cleaned when they move out or as needed. There was no set schedule for this. *Resident recliners were cleaned by housekeeping. *He was unsure what was causing the smell.	F 252	3. a. Facility Administrator or designee will in-service by 2/4/2016 all staff regarding minimizing odors by proper room cleaning/linen changing/carpet cleaning/chair cleaning. Those who are not in attendance during education meeting will receive education prior to their working their next scheduled shift. b. Administrator or designee will complete _____ audits of minimizing odors weekly x 4, then monthly x 2. <u>Audit selection</u> is random with a maximum of four. The following area will be audited: No odors present or lingering in hallways. 4. Administrator or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3. → *visual/sensory observations of hallways and residents rooms. JT/SDDCH/EL *or until audits meet 100% compliance. JT/SDDCH/EL	

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F 252	Continued From page 4 Interview on 1/6/16 at 10:50 a.m. with the head of housekeeping and laundry revealed: *Resident's beds were cleaned once a month. *Resident's recliners were cleaned when the nurses told her they needed to be done. There was no set schedule to do so. *She was unsure what was causing the smell. Interview on 1/7/16 at 11:00 a.m. with a resident's family member who wanted to remain confidential revealed: *The resident lived in the above hallway. *The family member mentioned the urine smell in the hallway seemed to be an ongoing problem. Interview on 1/7/16 at 9:40 a.m. with the director of nursing revealed there was no policy regarding this.	F 252		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary 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. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Surveyor: 36413 Based on interview, record review, and policy review, the provider failed to ensure there was	F 309	F309 1. Resident's 7 and 17 were assessed upon discovery of the deficient practice. 2. All residents receiving dialysis treatments are potentially at risk.* *All residents receiving dialysis have been assessed for the deficient practice. JT/SPDOH/EL	2/4/16

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F 309	<p>Continued From page 5</p> <p>communication between the provider and two of two dialysis (procedure when kidneys no longer function properly) units for two of two sampled residents (7 and 17). Findings include:</p> <p>1. Review of resident 7's medical record revealed: *He received dialysis three times a week outside of the facility. *There was no documentation of communication with the dialysis unit after each visit. *Information between the dialysis unit and the provider consisted of the following: -Laboratory (labs) test results. -Medication orders.</p> <p>Review of resident 7's 12/16/15 care plan revealed: *The staff would have monitored the dialysis shunt (a manmade tubular material inserted under the skin that moves blood from an artery to a vein) site for signs and symptoms of bleeding and infection. *Any signs and symptoms of bleeding and infection the provider was to have contacted dialysis for further orders. *Nursing staff would have checked bruit/thrill (audible sound and pulse of the area) of the dialysis shunt site, every shift and have reported changes to the resident's physician and/or dialysis unit.</p> <p>2. Review of resident 17's medical record revealed: *He received dialysis three times a week outside of the facility. *There was no documentation of communication with the dialysis unit after each visit. *Information between the dialysis unit and the</p>	F 309 3.	<p>a. Education to all nursing staff completed by the DON or designee on or before 2/4/16 on ensuring residents are provided care/services for their highest well being which includes communication with dialysis center for each visit by dialysis patients. A new form was developed and shared with the nursing staff during this educational session. Those who are not in attendance during education meeting will receive education prior to their working their next scheduled shift.</p> <p>b. Director of Nursing or designee will complete 4 random written audits weekly x 4, then monthly x 2 on ensuring residents are provided care/services for their highest well being regarding communication with the dialysis centers about dialysis residents. The sample selection is random. The following will be audited: Form will be used by facility and dialysis unit to communicate each time dialysis is received by the residents.</p> <p>4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3*¹Or until Audits meet 100% compliance. JTSD/BJEC</p>	

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F 309	<p>Continued From page 6</p> <p>provider consisted of the following: -Labs. -Medication orders.</p> <p>Review of resident 17's 12/23/15 care plan revealed nursing and dietary staff were to have reported changes in fluid needs or status changes to the dialysis unit.</p> <p>3. Interview on 1/6/16 at 7:15 a.m. with registered nurse (RN) E regarding residents 7 and 17 revealed communication with the staff at the dialysis units was only done when a need or a problem had occurred.</p> <p>Interview on 1/6/16 at 9:15 a.m. with the director of nursing revealed: *Communication with the dialysis units and the provider was only when necessary or if staff had questions. *The facility staff did not communicate with either dialysis units staff on a daily basis. *There was no consistent communication between the dialysis units and the provider with each resident's visit. *The communication with the dialysis units only occurred when additional information or clarification was needed regarding the resident's medications or laboratory values. *The staff would have received feedback regarding the dialysis units visits verbally from the residents.</p> <p>Interview on 1/7/16 at 10:10 a.m. with licensed practical nurse G regarding residents 7 and 17 revealed she had been unable to find communication documentation in their medical charts between the provider and the dialysis units.</p>	F 309		

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F 309	Continued From page 7 Interview on 1/7/16 at 10:15 a.m. with RN H revealed she had thought it had been "odd" there was not communication between the dialysis units and the provider on a daily basis. Review of the provider's 3/7/12 and 3/8/15 dialysis transfer agreements revealed the dialysis units would have provided the interchange of information useful or necessary for the care of the resident. Review of the provider's April 2014 Care of Resident with End Stage Renal Disease (ESRD) policy revealed: *Agreements between the facility and the contracted ESRD facility included all aspects of how the resident's care would have been managed including: -How the care plan would have been developed and implemented. -How information would have been exchanged between the facilities.	F 309			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 34030	F 323	F323 1. No specific residents were cited. The tanks were secured as soon as staff was made aware of the deficient practice. 2. All residents are potentially at risk.	01/14/16	

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F 323	Continued From page 8 Based on observation, interview, and policy review, the provider failed to secure four oxygen tanks in the oxygen supply room. Findings include: 1. Observation on 1/6/16 at 8:55 a.m. of the oxygen supply room located off of the Central and West halls revealed four oxygen tanks were standing alone and unsecured among others that were. When pointed out to a random staff member she secured the tanks at that time. Interview on 1/7/16 at 9:40 a.m. with the director of nursing regarding the above oxygen tanks revealed she agreed the tanks should have been secured and had not been. Review of the provider's revised January 2014 Oxygen Tanks policy revealed: **Follow facility protocol to notify oxygen supplier of its use. Oxygen cylinders must be stored in racks with chains, sturdy portable carts and/or approved stands." **"Oxygen cylinders may not be left free standing."	F 323	3. a. Education to all staff to be completed by the DON or designee on or before 2/4/16 on proper oxygen tank storage procedures. Those who are not in attendance during education meeting will receive education prior to their working their next scheduled shift. b. Director of Nursing or designee will complete 4 random audits weekly x 4, then monthly x 2 on proper oxygen storage. Audits will include the following: Proper storage of oxygen tanks. 4. DON or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3* <i>or until audits meet 100% compliance.</i> <i>JT/SDD/HEL</i>		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	F431 1. No specific residents were cited. 2. All residents are potentially at risk.	2/4/16	

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F 431	<p>Continued From page 9</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, and policy review, the provider failed to: *Destroy fentanyl (a narcotic pain medication) patches in a secured manner. *One randomly observed unauthorized staff person (D) had been left unattended in one of one medication rooms. Findings include: 1. Observation and interview on 1/6/16 at 3:40 p.m. in the Central hall medication room with registered nurse (RN) B revealed: *When a fentanyl patch had been removed from</p>	F 431	<p>3.</p> <p>a. Education to all licensed nursing staff by the Director of Nursing or designee on or before 2/4/16 on proper medication destruction, including disposal of used Fentanyl patches and education provided to all staff by the Director of Nursing or designee on or before 2/4/16 on unauthorized staff not having access to the medication rooms. Those who are not in attendance during education meeting will receive education prior to their working their next scheduled shift.</p> <p>b. Director of Nursing or designee will complete _____ audits of destruction of medications and supervision of un-authorized personnel while having access to medication rooms weekly x 4, then monthly x 2. Audit selection is random with a maximum of four. The following areas will be audited 1. Proper medication destruction 2. Proper supervision of un-authorized personnel in medication rooms. 4. Director of Nursing or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3.* Or until audits meet 100% compliance JT/SDDOT/EL</p>		

visual observations for each area audited JT/SDDOT/EL

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F 431	<p>Continued From page 10</p> <p>a resident it was folded in half and discarded into a sharps container attached to the medication cart.</p> <p>*When the sharps container was full it was placed in a locked soiled utility room.</p> <p>*The locked soiled utility room had a key pad on the outside of the door.</p> <p>*Maintenance staff and certified nursing assistants had access to that soiled utility room.</p> <p>Interview on 1/6/16 at 4:15 p.m. with the maintenance supervisor revealed:</p> <p>*There were three soiled utility rooms (west, central, and south-east).</p> <p>*There were barrels in each soiled utility room where used sharps containers were kept.</p> <p>*When the barrels were full an outside agency removed the soiled items for destruction.</p> <p>*All staff had access to the soiled utility rooms.</p> <p>Interview on 1/6/16 at 4:25 p.m. with the director of nursing (DON) regarding the destruction of fentanyl patches revealed:</p> <p>*Fentanyl patches were destroyed by flushing or placing in a sharps container.</p> <p>*She agreed all staff had access to the soiled utility rooms.</p> <p>Review of the provider's revised December 2015 Medication Destruction policy revealed "All narcotic containing pain patches must ensure the medication has changed from its original state and is non-retrievable. (Flushing is no longer an option.)"</p> <p>2. Observation on 1/7/16 at 9:10 a.m. outside the Central medication room revealed:</p> <p>*A nurse knocked on the medication door.</p> <p>*A staff member opened the medication door, and</p>	F 431			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/07/2016
NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	Continued From page 11 the nurse went inside and closed the door. *The nurse came out of the medication room followed by the staff member. Interview at the above time with staff member D who had been in the medication room unattended revealed: *She was a housekeeper. *She had been alone in the medication room. *She usually cleaned the medication room by herself and was left unattended in there. Interview on 1/7/16 at 9:15 a.m. with RN unit coordinator C revealed she agreed unauthorized staff should not be left alone in the medication room. Interview on 1/7/16 at 11:00 a.m. with the DON and nurse consultant revealed: *Unauthorized staff should not be left alone in the medication room. *There was not a policy for staff who were to have access to the medication room.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	F441 1. Residents #26, #27, #28 and #29 had oxygen filters placed and/or cleaned and fan was cleaned. 2. All residents are potentially at risk. *All residents with oxygen concentrator have had the filters cleaned. JT/SDDot/EL	2/4/16	

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NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301	
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F 441	Continued From page 12 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to maintain: *Clean oxygen concentrator filters for four of five (26, 27, 28, and 29) observed resident oxygen concentrators. *Two of two fans in the laundry room. Findings include: 1. Observation on 1/6/16 at 8:25 a.m. of resident 26 in her room on Central hallway north revealed: *She was receiving oxygen from a concentrator.	F 441	3. a. Education to all nursing staff by the Director of Nursing or designee on or before 2/4/16 on proper placement of filters on oxygen concentrators along with ensuring the filters cleanliness. and education provided to all staff by the Director of Nursing or designee on or before 2/4/16 on cleanliness of fans throughout facility. Those who are not in attendance during education meeting will receive education prior to their working their next scheduled shift. b. Director of Nursing or designee will complete _____ audits on the following areas: placement and cleanliness of oxygen concentrator filters and proper cleanliness of fans. <u>Audit selection is random with a maximum of four.</u> Audit sample will completed weekly x 4, then monthly x 2. The following areas will be audited 1. Oxygen concentrator filter placement and cleanliness 2. Fan cleanliness. 4. Director of Nursing or designee will report the results of the audits to the facility QAPI committee for review and recommendation monthly x 3.* *or until audits meet 100% compliance J T / 5/15/2016/EL	

**visual observations of areas audited. J T / 5/15/2016/EL*

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

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NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301
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F 441	<p>Continued From page 13</p> <p>*The filter appeared dusty and when touched a cloud of dust came off of it.</p> <p>*That was shown to RN (registered nurse) E who was passing by the room. She removed the filter, and it was covered front and back by particles of dust and dust balls.</p> <p>Interview with RN E immediately after the above revealed:</p> <p>*She would not have expected the filter to be dirty.</p> <p>*"Med [medication] aides cleaned the filters once a week on the weekend."</p> <p>*Instructions to clean them were written on the MAR (medication administration record) and should have been signed off by the med aide.</p> <p>*Nothing regarding filter cleaning was found on resident 26's MAR.</p> <p>-RN E then placed it there.</p> <p>Observation on 1/6/16 at 8:50 a.m. of resident 27's oxygen concentrator revealed the filter to be missing.</p> <p>Observation on 1/6/16 at 9:00 a.m. of resident 28's oxygen concentrator revealed dust and dust balls on the filter.</p> <p>Observation on 1/6/16 at 9:50 a.m. of resident 29's oxygen concentrator filter revealed dust covering it.</p> <p>Interview on 1/7/16 at 9:10 a.m. with the infection control nurse revealed she had been unaware of the dirty oxygen concentrator filters and she would have expected them to be clean.</p> <p>Review of the provider's revised April 2014 Oxygen Concentrator Use policy revealed "Clean</p>	F 441		
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NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301		
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F 441	<p>Continued From page 14 filter in concentrator on regular basis."</p> <p>2. Observation on 1/6/16 at 8:00 a.m. of the laundry room revealed two fans were covered with dust/lint. One was turned on and blowing onto the clean linen that was placed on the folding table.</p> <p>Interview on 1/6/16 at 10:50 a.m. with the head of housekeeping and laundry revealed: *She agreed the fans should have been clean. *The laundry room staff were responsible for cleaning them. *No schedule or policy for cleaning the fans existed.</p> <p>Interview on 1/7/16 at 9:40 a.m. with the director of nursing regarding the residents' oxygen concentrator filters and the fans in the laundry room revealed she would have expected them to be cleaned on a regular basis.</p>	F 441			

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

ORIGINAL

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/05/2016
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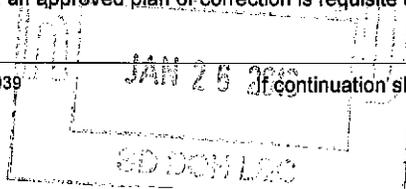
NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST 7TH AVENUE MITCHELL, SD 57301
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/5/16. Firesteel Healthcare Community was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Carrey Beaman* TITLE *Administrator* (X6) DATE *1/05/16*

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



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10653 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/07/2016
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NAME OF PROVIDER OR SUPPLIER FIRESTEEL HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E 7TH AVE MITCHELL, SD 57301
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S 000	Compliance/Noncompliance Statement Surveyor: 32331 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities and Article 44:74, Nurse Aide was conducted from 1/5/16 through 1/7/16. Firesteel Healthcare Community was found not in compliance for the following requirement: S139.	S 000	*Addendums noted with an asterisk per 2/8/16 per telephone with facility administrator. JT/SDPROTHIEL	
S 139	44:73:02:09 Linen The supply of bed linen and towels shall equal three times the licensed capacity. The facility shall have written procedures for the storage and handling of soiled and clean linens. The facility shall contract with a commercial laundry service or the laundry service of another licensed health care facility for all common use linens if laundry services are not provided on the premises. A facility providing laundry services shall have adequate space and equipment for the safe and effective operation of the laundry service. Commingled residents' personal clothing, common-use linen, any isolation clothing, and housekeeping items shall be processed by methods that assure disinfection. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32331 Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to maintain sufficient linen for residents. Findings include: 1. Observation on 1/5/16 at 11:00 a.m. during initial tour of the Central hallway north linen closet revealed no towels or washcloths and six fitted and flat sheets.	S 139	S139 1. No specific residents were cited. 2. All residents are potentially at risk. 3. a. Education to be provided to all staff on sufficient linen for residents by Director of Nursing or designee by 02/4/2016. Those who are not in attendance during education meeting will receive education prior to their working their next scheduled shift. b. Administrator or designee will complete written audits weekly x 4, then monthly x 2 on proper amount of linen. Audit selection is random with a maximum of four. The following area will be audited: Sufficient linen inventory. 4. Administrator or designee will report results of the audits to the facility QAPI committee for review and recommendations monthly x 3	2/4/16

*of unit audits meet 100% compliance
JT/SDPROTHIEL

*of closet or storage areas
JT/SDPROTHIEL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

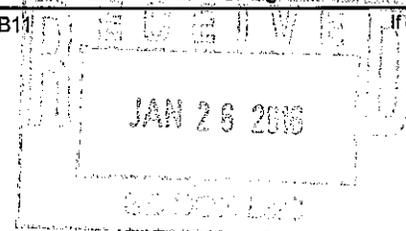
Lorey Benson

TITLE

Administrator

(X6) DATE

1/25/16



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10653 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/07/2016
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S 139	<p>Continued From page 1</p> <ul style="list-style-type: none"> - The above observation had not changed until 1/6/16 at 4:00 p.m. - Three other hallway linen closets were later observed to contain various amounts of linen. <p>Interview on 1/6/16 at 8:00 a.m. with laundry/housekeeping employee F revealed clean laundry was delivered to the floors daily at 11:00 a.m. and again later in the early afternoon.</p> <p>Surveyor: 32331 Interview on 1/6/16 at 10:45 a.m. with certified nursing assistant/medication aide A revealed: *When a resident's bed needed to be changed she "sometimes needed to wait until the flat and fitted sheets were processed from laundry." *There were a lot of residents that had needed their beds changed more frequently than once per week. *There were residents that needed to have the beds changed daily or more often if needed.</p> <p>Surveyor: 34030 Interview on 1/6/16 at 10:50 a.m. with the head of housekeeping and laundry revealed she could not find an inventory for the linen. She was unaware of the requirement regarding that linen inventory.</p> <p>Review of a handwritten linen inventory received on 1/6/16 at 4:10 p.m. revealed a total (including linen currently in resident rooms) of: *Pillow cases: 390. *Flat sheets: 342. *Fitted sheets: 248. *Bath towels: 176. *Hand towels: 376. *Wash cloths: 273. *Three times the resident capacity of 148 would be 444 for each of the above areas of linen. Therefore there was not a sufficient amount of</p>	S 139		

South Dakota Department of Health

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S 139	<p>Continued From page 2</p> <p>linens for the residents.</p> <p>Interview on 1/7/16 at 9:40 a.m. with the administrator and the director of nursing revealed they agreed the linen supply was not a sufficient amount for the residents.</p> <p>Review of the provider's undated policy on laundry/linen requirements revealed "The supply of bed linen and towels shall equal three times the licensed capacity [for residents]."</p>	S 139		