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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435109	A. BUILDING _____ B. WING _____	01/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/2/24 through 1/4/24. Firesteel Healthcare Center was found not in compliance with the following requirements: F584, F812, and F880.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584	1. Quotes will be obtained on the replacement of mentioned couch and two arm chairs, as well as the windows in the dining are being quoted for replacement or repairs. Said replacement or repairs will be completed prior to 4/30/24. All residents have the potential to be affected. 2. The ED and maintenance director are receiving quotes on the replacement/repair of widows and furniture. ED or designee educated staff on the importance of reporting of items in need of repair or replacing by 2/5/2024. All staff not in attendance will be educated prior to their next working shift. 3. The ED or designee will audits 4 random areas in the facility for items in need of repair or replacing weekly times four weeks and monthly times two months. The ED or designee will bring the results of these audits to the monthly QAPI committee for further review or recommendation to continue or discontinue the audits.	2/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Petar Mirkovic* | TITLE: *Executive Director* | (X6) DATE: *1/26/2024*

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 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review the provider failed to ensure: *One of one artificial leather couch and two of two artificial leather chairs were maintained in good repair in one of one memory care unit. *Four of four dining room windows were clean and maintained in good repair in one of one main dining room. Findings include: 1. Observation and interview on 1/3/24 at 8:05 a.m. in the memory care unit commons area with certified nursing assistant H revealed: *There was an artificial leather couch and two artificial leather chairs. -The artificial leather couch had a bedsheet placed over the seat cushions. -The seat cushions on the artificial leather couch had large areas where material was worn off and peeling. -The armrests and backrests of the artificial leather couch and the chairs had areas where the artificial leather was worn off and was peeling. *The bedsheet was placed on the artificial leather couch seat cushions to prevent further peeling and flaking of the seat cushions.	F 584		

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F 584	Continued From page 2 Interview on 1/3/24 at 8:18 a.m. with administrator A revealed: *He was not aware that the furniture had areas were the artificial leather was worn off and peeling. *He agreed there were multiple areas where the artificial leather had worn off and was peeling. *He confirmed it was not a cleanable surface. 2. Observation on 1/3/24 at 11:30 a.m. in main dining room revealed: *There were four windows on one side of the dining room. -The first window had cobwebs in between the window and the screen. --The latches to lock the window in place were not in the lock position, and you could feel cold air coming from the window. -The second window had a red clothes protector lying on the windowsill. --The screen was bent. --The latches to lock the window in place were not in the lock position and you could feel cold air coming from the window. -The third window had an open space in the trim where the window crank was missing. --Cold air could be felt coming from the window. -The fourth window had a bent screen and you could feel cold air coming from the window. Interview on 1/3/24 at 11:40 a.m. with administrator A revealed: *He agreed that the screens were bent and one window had a cobweb in it. *He noticed that some of the windows were not closed and tried to close them and latch them. *He agreed that you could feel cold air coming from the windows.	F 584		

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F 584	Continued From page 3 *He confirmed that the windows need to have been cleaned and repaired. *He was not aware of repairs unless residents or staff brought it to his attention. Interview on 1/4/24 at 1:55 p.m. with resident 55 revealed: *Three weeks ago he had informed an unidentified kitchen staff member and administrator A about the cold draft that was coming from the dining room window directly behind him. *The unidentified kitchen staff member had placed the red clothes protector on the windowsill to prevent the cold draft from hitting the back of his neck. Interview on 1/4/24 at 2:00 p.m. with maintenance supervisor I revealed: *He was not aware of the cold air coming from the dining room windows. *He agreed that some of the window screens were bent, and the windows were not closed tight and the latches were not locked. *He had received no maintenance request for the dining room windows. *He confirmed the windows needed to have been repaired. A furniture and window repair policy was requested on 1/4/24 at 3:00 p.m. from the administrator A and the provider had no policy.	F 584		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812	See next page	

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F 812	Continued From page 4 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *Two of two convection ovens, two of two ovens, one of one stovetop and two grease trap drawers underneath the stovetop, and one of one flattop grill were maintained and cleaned in a sanitary manner in one of one kitchen. *One of one top of the metal electrical box under the dishwasher was maintained as a cleanable surface. *Food items were appropriately covered, and dated in two of two refrigerators and in one of one walk-in freezer in one of one kitchen and one of one refrigerator in one of one memory care unit. Findings include: 1. Observation on 1/2/24 at 3:30 p.m. revealed: *Two of two convection ovens had unidentified brown and black residue throughout the ovens. *Two of two ovens had unidentified brown and black residue throughout the oven.	F 812	1. The two convection ovens and two other ovens were cleaned by 2/5/24. The stove-top, grease traps and flat top grill were cleaned prior to 1/24/24. All food items were disposed of immediately. The metal around the electrical box will be repaired prior to 2/5/24. All residents have the po-tential to be affected. 2. The ED or designee will educate all di-etary staff on the importance of maintaining equipment and keeping it sanitary, as well as following cleaning schedules for equip-ment. The ED or designee will also educate dietary staff on the proper storage and la-beling of foods by 2/5/24. All staff not in at-tendance will be educated prior to their next working shift. 3. The ED or designee will audit the clean-ing schedules weekly times four weeksv and monthly times two months, the actual surfaces of the convection ovens, the ovens, the flat top grill, the stove top and the grease traps for evidence of clean sani-tary surfaces. The ED or designee will au-dit all refrigerator and freezers for the proper storage and labeling of foods weekly times four weeks and monthly times two months. The ED or designee will bring the results of these audits to the monthly QAPI meeting for further review and rec-ommendation to continue or discontinue the audits.	2/10/24

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F 812	Continued From page 5 *The gas stove top had chucks of burnt bits of food and unidentified black build-up. *The two grease drawers under the stovetop had aluminum foil on them with burnt food particles and under the aluminum foil was unidentified black residue. *One of one flattop grill had crusted food particles on it and unidentified black streaks down the front of it. Interview on 1/2/24 at 4:00 p.m. with food and nutrition services cook (FANS) E revealed: *Ovens were cleaned once a month. *He agreed the above items were not maintained and cleaned in a sanitary manner. *He was in training to be the dietary manager and that administrator A was the acting dietary manager. Interview on 1/4/24 at 9:00 a.m. with administrator A revealed: *He agreed the areas noted above were unclean. *He had no dietary manager for the last year and was in the process of training a new dietary manager. Interview on 1/4/24 at 10:00 a.m. with registered dietitian D revealed: *She agreed that the above areas in the kitchen were unclean and not sanitary. *She would conduct quarterly kitchen audits and was aware of the issues in the kitchen. Review of the 10/12/23 Food and Nutrition Service Comprehensive Summery (kitchen audit) revealed an 88% overall score suggesting a written and submitted action plan was needed. 2. Observation and interview on 1/4/24 at 9:00	F 812		

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F 812	Continued From page 6 a.m. in the kitchen next to the dishwasher with administrator A revealed: *Two one-inch rusted out holes on the top of a metal electrical box under the dishwasher. *He agreed that it was not a cleanable surface. 3. Observation on 1/2/24 at 3:28 p.m. of the kitchen revealed: *The walk-in refrigerator contained several food items that were not covered, labeled, or dated. That included the following: -A pan of brownies that were not labeled or dated. -A Tupperware container with a green lid that was not labeled or dated. -A container of pickles that did not have an opened or use-by date. -A container of cottage cheese that did not have an opened or use-by date. -A container of minced garlic that did not have an opened or use-by date. -A bag of shredded cheese that did not have an opened or use-by date. -An opened bag of onions that were open to air without an opened or use-by date. -An opened bag of spinach that did not have an opened or use-by date. *The refrigerator by the walk-in freezer contained pitchers of liquids that were not labeled or dated. *The walk-in freezer contained food items that were not properly covered, labeled, or dated. That included the following: -An opened container of ice cream that did not have an opened or use-by date. -A box of beef steaks left open to air appeared freezer burnt. Interview on 1/2/24 at 4:00 p.m. with food and nutrition services cook (FANS) E revealed: *He agreed that the food identified in the	F 812		

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F 812	Continued From page 7	F 812		

refrigerator and the freezer should have been covered and dated.
*He stated that he had not had time to go through the refrigerator and the freezer to ensure food was properly labeled, dated, and discarded.

Interview on 1/2/24 at 4:15 p.m. with administrator A revealed that he agreed that the food items identified should have been covered and labeled with a use-by date.

4. Observation on 1/2/24 at 5:50 p.m. of the refrigerator/freezer in the memory care unit revealed:
*A Red Baron pizza that was dated 6/3/23 that had a use-by date of 9/30/23.
*A 16 oz brick of butter that was not labeled with an opened or use-by date.
*An opened one-gallon container of ice cream that was not labeled with a use-by date.
*An opened half-gallon of whole milk that had no use-by date.
*An opened 46 oz jar of applesauce that had no use-by date.

Interview at the time of the above observations with infection preventionist C revealed:
*She agreed that all food items should have been labeled with an open or use-by date.
*The kitchen staff were responsible for the memory care refrigerator.

Interview on 1/4/24 at 9:00 a.m. with administrator (acting dietary manager) A revealed:
*He had been acting as the interim dietary manager.
*The contracted traveling certified dietary manager (CDM) walked off the job in November

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F 812	Continued From page 8 2023 after only 2 weeks on the job. *The provider has had no dietary manager for the last year and was in the process of training a new dietary manager. Interview on 1/4/24 at 10:00 a.m. with regional registered dietitian D revealed: *Opened food containers should have been labeled with opened and/or use-by dates. *She was able to provide a Food Labeling Reference Guide for Opened Items sheet that dietary staff were to have used for reference. *All dietary staff had access to the above reference sheet which included how to determine use-by dates for specific food items. *She would conduct quarterly kitchen audits that included food handling/storage/sanitation. Review of the Food and Nutrition Services Comprehensive Summary of the Quarterly Kitchen audits on 7/12/23 and 10/12/23 revealed that under repeated key concerns it had been noted that dating of food items had improved but was still a work in progress. Review of the provider's October 2017 Food Storage Policy revealed that opened food items should have had a use-by date on them. The Food Labeling Reference Guide was referenced for appropriate use-by dates for opened items. Review of the provider's September 2019 Sanitation Policy revealed: *Cleaning schedules were developed by the FANS manager or the person in charge. *The FANS manager or person in charge monitors compliance with cleaning schedule. *The regional registered dietitian completes the FANS comprehensive summary reports.	F 812		

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F 812	Continued From page 9 *The FANS manager maintained completed cleaning schedules for a minimum of 60 days.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880	**Directed Plan of Correction** **Firesteel Healthcare Center** **F880** **Bloodborne pathogen risk.** **Corrective Action:** 1. For the identification of: Lack of appropriate and consistent infection control practices by all facility staff including housekeeping when working in and around a resident's room who was identified as resident with active C. diff. **The administrator, DON, infection control nurse and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas.** **Please do read 2567 findings.** All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 2/5/2024, by DNS or designee. All staff not in attendance will be educated prior to their next working shift. See Next Page.	2/10/24

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F 880	Continued From page 10 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure appropriate infection control techniques and practices were maintained by one of one certified nursing assistant (CNA) H and one of one housekeeper (G) by not following proper contact precautions when entering one of one sampled resident's	F 880	**Identification of Others:** 1. Individual residents and other residents as well as staff have potential to be impacted when residents identified with C. diff are not cared for with a consistent infection control practice by all facility staff including housekeeping. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by DNS or designee by 2/5/2024. All staff not in attendance will be educated prior to their next working shift. **System Changes:** . Root cause analysis conducted answered the 5 Whys: Root cause: Education failure Plan of correction – Education needs to be completed in a language staff can understand and comprehend. Signage for active infection needs to stand out as an additional reminder of change from EBP to an active infection. Infection control practitioner will meet with all staff on hire including contracted staff and all departments at a minimum of annually to complete education on Isolation types and required PPE. Signs will be color coded. Spanish instructions have been printed and are on all of the cleaning carts.	

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F 880	Continued From page 11 (148) room with clostridioides difficile (C. diff). Findings include: 1. Observation and interview on 1/3/24 at 8:37 a.m. with CNA H revealed: *The door to resident 148's room had a sign requiring all visitors to take proper contact precautions and put on a mask, gown and gloves when entering the room. *CNA H enter resident 148's room without wearing any personal protective equipment (PPE). *She said that she was just placing a calendar in the resident's room. *She did not have to wear any PPE due to her not touching the resident or their medical devices. *She was aware that resident 148 had active C. diff. Interview on 1/3/24 at 8:46 a.m. with CNA J revealed: *She was not aware of any policy that required donning PPE when entering a resident's room who has active C. diff. *She did know that you are to wear all PPE when entering an active C. diff resident's room whether you are doing personal cares or not. 2. Observation and interview on 1/4/24 at 12:34 p.m. with housekeeper G revealed: *She entered resident 148's room with only a mask and gloves on. *She was wiping off the red recliner in the room. *A mop was in the room. *She did not speak English at all and had to use an interpreter to answer questions. *She was not aware that she needed to have had the complete PPE on to enter resident 148's	F 880	Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. Divisional Director of Clinical Operations contacted the South Dakota Quality Improvement Organization (QIO on 1/25/24 and discussion was spent reviewing the 5 why's and root cause analysis of the deficient practice. **Monitoring:** 3. Administrator, DON, and/or designee will conduct auditing and monitoring of above identified items 2-3 times weekly over all shifts. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435109	A. BUILDING _____ B. WING _____	01/04/2024

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

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F 880	Continued From page 12 room due to them having C. diff. *She was using a "Virus Plus" spray which did not have bleach in the ingredients list to clean the multiple surfaces in the room. *She did not always use bleach to clean the rooms only when they were "too dirty with feces." *She did not use bleach to mop the floors and did not know what was in the liquid she was using to mop the floors. Interview on 1/4/24 at 12:49 p.m. with housekeeping manager F revealed: *She trained the staff but would sometimes have a staff member who has been there longer complete some of the training. *She was aware that resident 148 has active C. diff. *All housekeeping staff are to wear the proper PPE to enter and clean those rooms. *All cleaning of C. diff rooms was to have been done with bleach products. *She verified that the "Virus Plus" spray and mopping solution did not have bleach in it. *She advised that housekeeper G did not speak English and was trained by another staff member who spoke both Spanish and English. Interview on 1/3/24 at 8:53 a.m. with registered nurse/infection preventionist (RN) C revealed: *All staff were to don the proper PPE to enter a room with active C. diff. *Her expectation was that all staff wear a mask, gown and gloves when entering a resident's room that has active C. diff and that a resident's with C. diff room was to have been cleaned with bleach. Interview on 1/4/24 at 1:20 p.m. with director of nursing (DON) B and administrator A about the	F 880		

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	435109	A. BUILDING _____ B. WING _____	01/04/2024

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FIRESTEEL HEALTHCARE CENTER	1120 EAST 7TH AVENUE MITCHELL, SD 57301

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F 880	Continued From page 13 above observations and interviews revealed: *They would expect all staff to wear the proper PPE when entering a resident's room that had active C. diff. *They would expect all housekeeping to wear the proper PPE and use the proper cleaning solutions when entering or cleaning a room that has active C. diff. Review of May 2015 C-Diff policy states: *"5. Steps toward prevention and early intervention include: -f. Disinfection of items with potential fecal soiling (e.g., bedpans, commode chairs, bedrails, etc.) using a disinfecting agent recommended for C. difficile (e.g., household bleach and water solution or an EPA registered germicidal agent effective against C. Difficile spores)." *"14. Due to the persistence of C. difficile spores for prolonged periods of times, the environment is disinfected with a disinfecting agent recommended for C. difficile (e.g. household bleach and water solution or an EPA registered germicidal agent effective against C. difficile spores)."	F 880		

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

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	435109	A. BUILDING _____ B. WING _____	01/04/2024

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

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 1/2/24 through 1/4/24. Firesteel Healthcare Center was found in compliance.	E 000		

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

Petar Mirkovic | Executive Director | 1/26/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435109	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/03/2024**

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

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/3/24. Firesteel Healthcare Center was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills). Findings include: 1. Record review on 1/3/24 at 11:54 a.m. revealed there was no documentation of fire drills	K 712	1. Unable to correct deficient practice noted during survey. All residents have the potential to be affected. 2. The ED educated the maintenance personnel prior to 2/5/2023 on following the provider's police and NFPA 101 practice related to the timing and routine of fire drills. 3. The ED will audit fire drills monthly times three months and quarterly times three quarters to ensure fire drills are conducted appropriately. The ED will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	2/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Petar Mirkovic* | TITLE: *Executive Director* | (X6) DATE: *1/26/2024*

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435109	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/03/2024**

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FIRESTEEL HEALTHCARE CENTER	**1120 EAST 7TH AVENUE** **MITCHELL, SD 57301**

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K 712	Continued From page 1 conducted for the first shift in quarter two (April, May, June) or the third shift quarter three (July, August, September) of 2023. Interview with the maintenance director at the time of the record review confirmed those findings. He stated he was unaware the minimum number of fire drills per the required frequency had not been met for each shift in 2023. The deficiency had the potential to affect 100% of the occupants of the building.	K 712		

South Dakota Department of Health

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	10653 S	A. BUILDING: _____ B. WING _____	01/04/2024

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/2/24 through 1/4/24. Firesteel Healthcare Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/2/24 through 1/4/24. Firesteel Healthcare Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Petar Mirkovic* | TITLE: *Executive Director* | (X6) DATE: *1/26/2024*