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

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 09/10/2021

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

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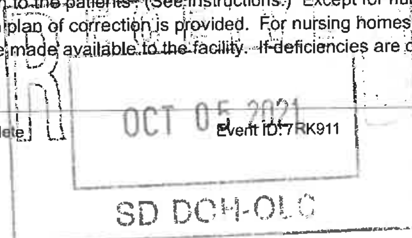
F 000	INITIAL COMMENTS Surveyor: 41895 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 9/7/21 through 9/10/21. Firesteel Healthcare Center was found not in compliance with the following requirements: F550, F678, F679, F686, F700, F755, F812, F838, and F880.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550	1. Unable to correct findings noted during survey. All residents are potentially at risk. Residents 3 and 59 have discharged from the facility. Residents 4, 55, and 76 will be offered open dining prior to 10/7/21, Resident 77 will be offered choice of dining experience prior to 10/7/21. 2. Executive Director or designee will educate all staff on residents that choose to open dine may do so following all Covid protocols per CDC and a dignified existence for our residents including the information in the 2567. The ED will form a committee of staff to address solutions for call light response staffing assignments and increase walkie use. ED or designee will educate all staff on the process of answering call lights timely to meet resident needs. Education will be completed by 10/9/2021. All staff not in attendance will be educated prior to their next working shift. 3. Executive Director or designee will audit a random sample of 4 residents weekly times four weeks and monthly times two months for choice of dining/where they dine and call light response being timely to meet the residents needs, and food temps and timely delivery. The ED will review resident council minutes to ensure education regarding resident rights, ombudsman information and survey results posting, as well as follow up to resident concerns monthly. The Executive Director or designee will bring the results to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	10/9/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Petar Mirkovic*
TITLE: *Executive Director*
(X6) DATE: *10/4/21*

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 550	Continued From page 1	F 550		

or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Surveyor: 06365
Based on observation, interview, record review and policy review, the provider failed to ensure:
*Five of seven residents (3, 4, 55, 59, and 76) had their dining location choice honored, were satisfied with the temperature or quality of food items and the timing of meal delivery, received satisfactory response to call lights.
*One of one sampled resident was assisted in the bathroom in a timely manner.
*One of one resident (17) had eaten one of one meal in the dining area of his choice.
Findings include:

1. Review of the resident group meeting minutes on 8/18/21 revealed the following resident concerns and facility responses were documented:
*Residents discussed communal dining and wanted to return eating in the dining room but were told "not at this time due to COVID concerns with the Delta variant."
*Some meals were cold when delivered and the facility response was to start up the food

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F 550	Continued From page 2 meetings again. *It takes "some time" for staff to respond to the call light with the facility response to "educate" staff about this and "remind staff to acknowledge the resident when working with them." During a resident group meeting on 9/9/21 at 10:30 a.m. revealed 5 of 7 residents (3, 4, 55, 59, and 76) reported the concerns documented in the 8/18/21 meeting minutes are still unresolved: *They do not like eating meals in their rooms. They wondered why they can do activities in the dining room but not eat there. They reported no further response had been provided since the last meeting. *The residents reported food items were "often cold" when served, and the quality of the food was "not good." Examples given included burnt and "poor" appearance. *Response to call lights was "still a problem" and "sometimes" it takes a "long time" for them to be answered. -Staff will "turn off the call light," say they will come back, and "return in an hour." -The situation "has been going on for a long time." -One resident (76) reported she had waited over an hour Monday night to use the bathroom. Additional concerns reported by the 5 residents noted above during the 9/9/21 meeting included: *It takes a "long time" for meals to be served, and they do not always receive what they want or need to go with their meal. Examples given included: no condiments, silverware, or the preferred cereal. *Delivery of snacks was "spotty" and "poor" access to ice for water. *Information about resident rights, facility rules	F 550		

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F 550	Continued From page 3 about resident conduct, and advance directives were not discussed with the residents during the resident group meeting or their care plan meetings. -They agreed resident rights were on posters and was given during admission, but there was no ongoing discussion of them. They were not aware of the Ombudsman, how to file complaints with the department of health, nor where to find prior survey results. -They said it would be difficult for the group to make suggestions about facility rules when they haven't been shared with the residents. -The residents reported they have not been provided with materials about advance directive options. *The residents agreed the responses given from "leadership" was "lip service." The resident (59) who had been serving as Resident Council president reported stepping down from that role because "nothing was done" in response to the concerns. Random individual interviews on 9/9/21 between 2:12 p.m. - 3:00 p.m. regarding the above concerns with 5 employees - registered nurse (RN) N, an unlicensed assistive personnel (CMA) EE, 2 certified nursing assistants (CNA) W and FF, and a nurse aide (NA) H - revealed the following comments: *About meal delivery: -RN N and CNAs W and FF stated communication between the residents and the kitchen regarding food choices before the meal would reduce the time it took to retrieve alternates to the food served or additional items from the kitchen. -RN N reported the carts coming from the kitchen are "usually later" than the scheduled time.	F 550		

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F 550	Continued From page 4 -RN N and NA H said it takes time to set-up the trays with drinks from the cart. -RN N, CMA EE, and CNA FF reported a need for more people serving. -CNA FF said some residents have asked her about eating in the dining room. *About call light response, RN N, CMA EE, and CNAs W and FF all reported: -The use of their "walkies" alerted them to an active call light. -They didn't have assigned rooms or residents. -They could use the walkies to communicate with each other when "tied up" with another resident but it has not been a practice. *About snack and ice water delivery: -They all knew where to obtain snacks and ice water for the residents -RN N, CMA EE, and CNA W stated the process has changed several times for who does it and when they are delivered but explained the same process. -CNA FF and NA H were not sure who delivers them nor when they were delivered. *All of the above employees reported they had been educated on resident rights, where to locate that information, who to direct a resident to if they had a concern, and advance directives in terms of where to find a resident's code status. Review of call light response times between 8/29/21 to 9/9/21 for one (resident 76) of the group residents revealed: *The average response time was 8 minutes and 55 seconds. *Over 19% of the response times were over the average minutes and needed improvement. *The number of call lights that exceeded the average response time included: -21 lights that were responded to after 10-20	F 550		

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F 550	Continued From page 5	F 550		

minutes
-9 that took between 20-30 minutes for a response
-8 that took over 30 minutes, including one that took 63 minutes before the call light response was completed.

Interview with administrator B on 9/9/21 at 5:38 p.m. revealed:
*They are working through dietary management training.
*Dining room options will be evaluated to separate the vaccinated residents from those who have not been vaccinated.
*They conduct call light response time audits.
*He is working on a "facility wide culture change" for the department managers to be out of their offices taking charge for the care that is provided.
*They will evaluate a more effective format to improve communication with the residents.
Surveyor: 43844

2. Interview on 9/8/21 at 12:24 p.m. with resident 46 revealed he had:
*To wait almost an hour to have help once he turned on his call light.
-Stated that on one occasion his feet fell asleep when he was left sitting on the toilet, waiting for his call light to be answered.

Review of provider's 8/29/21 through 9/11/21 call light report for resident 46 revealed the:
*Call light was activated 45 times.
*Provider's call light report stated there were 13 response times "needed improvement":
-On 9/2/21 at 6:51 p.m. from the bathroom the alarm was not answered for one hour twenty minutes.
Surveyor: 45095

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F 550	Continued From page 6 3. Observation and Interview on 9/8/21 at 9:04 a.m. with resident 18 revealed: *He did not get his cereal, apple, and bagel for breakfast. *He stated he has been missing his breakfast choices for the past month. *He thinks they have new kitchen staff. *Breakfast tray brought to his room by an unidentified staff member. -She asked him if he needed help eating. -He replied he did need help. -She stated she was not able to help him but would get someone to help him with eating. -At 9:33 a.m. an unknown staff member began assisting him with his meal. Surveyor: 40788 4. Observation and interview on 9/8/21 at 8:30 a.m. of resident 17 in his wheelchair in the hallway outside the entrance to his room revealed: *An over-the-bed table was in front of him and he was eating breakfast. *Breakfast was scheduled to be served at 7:30 a.m. *He "eats wherever they send me" and said "I should be in the main dining room". Observation and interview on 9/8/21 at 8:35 a.m. with minimum data set/registered nurse E regarding resident 17 revealed she: *Offered to get a chair, sit beside him, and help him with breakfast. *Stated he was positioned in the hallway outside of his room to eat because he was at risk for falling and needed supervision. *Agreed closer supervision and staff assistance were more readily available in the main dining	F 550		

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F 550	Continued From page 7 room. Dignity and Resident Dining policies were requested on 9/9/21 at 10:30 a.m. from the division director of clinical operations/registered nurse (RN) A and she stated: *There were none. *Resident 17 should have been taken to the main dining room to receive the mealtime assistance and supervision he needed.	F 550		
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on interviews, record reviews, and policy review, the provider failed to obtain a physician's order for code status for five of five sampled residents (3, 28, 36, 46, and 55). Findings include: 1. Review of resident 55's record and the Disaster Recovery Binder for advance directives documentation on 9/08/21 at 2:39 p.m. revealed: *An admission progress note dated 8/5/2021 at 1:50 PM noting the resident was admitted on that date for skilled therapy "with a goal of returning home." It was also noted she "signed to be a No Code." *A CPR/DNR Directive form dated 8/5/2021 and signed by the resident had the resident's initials	F 678	1. Residents 28, 36, 46 and 55 have a physician signed code status. Resident 3 has discharged from the facility. All residents have the potential to be affected. 2. The ED or designee will educate all licensed staff on obtaining a physician order for code status on admit or with a change in code status by 10/8/ 21. All residents were reviewed for a signed code status by 10/8/ 21. All staff not in attendance will be educated prior to their next working shift. 3. The ED or designee will audit a random sample of 4 newly admitted/readmitted residents weekly to ensure they have a physician signed code status weekly times 4 weeks and monthly times two months. The ED or designee will bring the results of these audits will be taken to the monthly QAPI committee for further review or recommendation to continue or discontinue the audits.	10/9/21

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F 678	Continued From page 8	F 678		

scribbled out on the line for CPR/Full Resuscitative Measures and an X with initials beside it on the line for No CPR/No Resuscitative Measures.
*There was no order for do not resuscitate.
*A scanned Avera eCARE Advance Care Planning Review dated 8/6/2021 at 10:09 a.m. noting that resident code status was not documented and a recommendation to discuss and document code status preference as part of the advance care planning conversation.

Interview on 9/8/21 at 5:45 p.m. with resident 55 revealed:
*She "kind of" remembered signing a form about CPR when she was admitted here.
*She explained that she would want the staff to do CPR if her heart stopped.
*She remembered saying that she did not want to be revived if there was "no possibility of return."
*She said she may not have fully understood what no CPR meant.

Interview on 9/8/21 at 5:00 p.m. with licensed social worker (LSW) U revealed:
*She had not completed the CPR/DNR Directive form with resident 55.
*The nurse manager reviews advance directive information with residents and obtains a decision on the form.
*She will follow-up with resident 55 to clarify her advance directive decision.

Review of resident 55's record and Disaster Recovery Binder on 9/9/2021 at 8:40 a.m. revealed:
*A nursing progress dated 9/8/21 at 6:43 p.m. noting that minimum data set coordinator/registered nurse (RN) E and LSW U

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"visited with resident regsrding [sic] the code status she signed on admit. Stated she would like to have CPR started if her heart were to stop. New code sheet signed for full code by resident-consent scanned into PCC."
*A CPR/DNR Directive form dated on 9/8/21 and signed by the resident with a checkmark and resident's initials on the CPR/Full Resuscitative Measure line.
*There was no order related to the resident's code status.

Interview on 9/9/21 at 9:21 a.m. with LSW U revealed she and the minimum data set coordinator/registered nurse (MDS/RN) E met with resident 55 before leaving the facility on 9/8/21 to clarify her advance directive decision and learned the following from the resident:
*She had scribbled out her own initials on the line for CPR on the 8/5/21 CPR/DNR Directive form when she had intended to initial the line for No CPR at that time.
*She had not understood the meaning of no CPR.

Surveyor: 43844
2. Review of resident 28's medical record for advance directive and code status revealed:
*He had been admitted on 7/15/16.
*There had been a 7/15/16 "CPR/DNR Directive" code status form for no CPR, signed by his representative, and scanned into his electronic medical record (EMR).
-It had not been signed by a physician.
*The EMR had a 6/18/19 physician order to locate the code status sheet in the "Disaster Recovery Binder at nursing station."
-The same 7/25/16 code status form signed by resident 28 was in this binder.
--It had not been signed by a physician.

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F 678	Continued From page 10 3. Review of resident 46's medical record for advance directive and code status revealed: *He had been admitted on 8/5/20. *There had been a code status form dated 8/5/20 signed by resident 28 scanned into his electronic medical record (EMR). -This code status had been for CPR to be performed. --It had not been signed by a physician. *There had not been a medical order where to located the code status sheet in the EMR. -The same 8/5/20 code status form signed by resident 46 was located in the disaster recovery binder. --It had not been signed by a physician. 4. Interview on 9/10/21 at 10:35 a.m. with interim director of nursing/RN C and division director of clinical operations (DDCO) A regarding CPR/Code Status for residents revealed: *The code status form was located in the disaster recovery binder. -None of the code status forms had a physician signature. -They believed every resident had a physician order where to find the code status in the EMR *They would have done CPR if there had been no advance directive regarding the code status for that resident in the disaster recovery binder. *They had not known a physician order was required for a code status. *DDCO stated, "we don't follow that part of the policy because SD does not require a POLST" *DDCO agreed each resident should have a medical order for code status. Surveyor: 45095 5. Review of resident 3's medical record for	F 678		

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F 678	Continued From page 11 advanced directive and code status revealed: *She had been admitted on 11/1/17. *There had been an 11/1/17 "CPR/DNR [Do Not Resuscitate] Directive" code status form checked for "NO CPR/NO RESUSCITATIVE MEASURES" signed by the resident. At the bottom of the form "12/8/17 Resident chooses No Code upon return from hospital." was written, scanned into her electronic medical record (EMR), and located at the nurse's station in the disaster recovery binder. -It had not been signed by a physician. *There had been a 2/7/21 CPR/DNR Directive code status form checked for "NO CPR/NO RESUSCITATIVE MEASURES." On the line for resident signature was written "Verbal from [resident name]" below was written "T.O. Verbal from husband [husband's name]." With a nurse's signature and scanned into her EMR. This form was not located in the disaster recovery binder at the nurse's station. -It had not been signed by a physician. *The EMR had "See Disaster Recovery Binder" listed under the advanced directive/code status section. *The EMR had a physician order to locate the code status sheet in the "Disaster Recovery Binder at nursing station." *There had been no order for code status signed by a physician. 6. Review of resident 36's medical record for advanced directive and code status revealed: *She had been admitted on 9/11/20. *There had been a 5/7/21 "CPR/DNR Directive" code status form checked for "NO CPR/NO RESUSCITATIVE MEASURES" signed by the resident. The form was scanned into her EMR and located at the nurse's station in the disaster recovery binder.	F 678		

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F 678	Continued From page 12 -It had not been signed by a physician. *The EMR had "See Disaster Recovery Binder" listed under the advanced directive/code status section. *The EMR had a physician order to locate the code status sheet in the "Disaster Recovery Binder at nursing station." *There had been no order for code status signed by a physician. *There had been an "Advance Care Planning Review" form from Avera eCare signed by a medical social worker dated 5/10/21 that had been scanned into the residents EMR with information as followed; -"Code Status Not Documented." -"There is a code status sheet from [Redacted] scanned into the hospital EMR that is dated 9/11/20 signed by [resident] who has selected NO CPR. This is not a medical order-It is a patient preference sheet." -"Recommendation" --"Please ensure code status has been verified and written as an order." 7. Review of provider's policy: Code Blue (Resident found without vital signs) revealed: *"4. CPR is initiated by the LN (Licensed Nurse) for those residents who:" -"c. Do not have a valid DNR order." 8. Interview and record review on 9/9/21 at 11:04 a.m. with (Staff Development/Infection Control/RN) D regarding Code Blue process revealed: *If called to or notified of a Code Blue she would grab the disaster recovery binder and go to the location of the Code Blue or delegate someone to grab the disaster recovery binder. *She would verify the resident's code blue status	F 678		

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F 678	Continued From page 13 using the CPR/DNR form located in the disaster recovery binder. *The physician signed the CPR/DNR resident election forms. *RN D reviewed the CPR/DNR forms located in the disaster recovery binder and stated, "I guess there is not a place for the physician to sign the form anymore." *She stated this was not a medical order for no CPR/DNR.	F 678		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation, interview, record review and policy review, the provider failed to update and implement an activity program for one of one resident (17) at risk for social isolation. Findings include: 1. Random observations on 9/7/21 at 6:45 p.m., on 9/8/21 at 8:00 a.m. , 10:30 a.m., and 11:30 a.m., on 9/9/21 at 8:00 a.m. and 12:01 p.m., and on 9/10/21 at 8:30 a.m. of resident 17 revealed she:	F 679	1. Unable to correct deficient practice noted during survey. Resident 17 activity program has been reviewed. All residents have the potential to be affected. 2. The ED or designee will educate all activity staff on providing an individualized activity program based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.for each resident in the center by 10/9/21. All residents activity programs will be reviewed prior to 10/ 9/21 for individuality. All activity staff not in attendance will be educated prior to their next working shift. 3. The ED or designee will audit a random sample of 4 residents for an individualized activity program and appropriate documentation of the activity program weekly times four and monthly times two months. The ED or designee will bring the results of these audits will be taken to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	10/9/21

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*Was either in bed or her recliner chair in her room with her eyes closed and music on.
*Received her nutrition in her room through a feeding tube in her stomach.
*Responded to some yes or no questions appropriately.
*Vocalized repetitive sounds loudly at different times of the day.
*Required staff to anticipate and meet all her activities of daily living needs.

Review of resident 17's care record revealed her diagnoses included: depression, dementia with a behavioral component, and schizophrenia.

Review of resident 17's activity progress note and assessment last completed by activity assistant J on 6/16/21 revealed:
*The resident's activity care plan "remained appropriate."
-Her activity goals were: "TV turned on for her daily. Room visits X5 per week."
*The problem changes, goal changes, and approach changes sections of that progress note and assessment had been left blank.

Review of resident 17's activity care plan last revised on 7/19/21 revealed a goal for room visits five times per week and daily television or music.

Review of resident 17's activity data between 8/15/21 and 9/9/21 revealed:
*One-on-one activity had been documented fourteen times.
*Five "independent" activities had been documented.
-There was no description of what those activities had included.
*All documented activities had occurred between

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11:32 a.m. and 5:02 p.m.
*No group activity had been documented.

Interview on 9/9/21 at 12:05 p.m. with activity assistant J regarding resident 17's activity participation revealed she:
*Was responsible for in room activities offered to the resident which included things like turning on music or television for her and applying lotion to her skin.
*Stated the resident was unable to self-initiate any activity on her own.
*Confirmed the resident was rarely out of her room because she thought group activities and louder environments agitated her.
*Had not tried taking her outdoors and was not sure why.

Interview on 9/9/21 at 3:40 p.m. with activity director I and activity assistant J regarding resident 17 revealed:
*Her spouse had died within the past six months.
-He had visited daily and taken her for wheelchair rides outside of her room, assisted her with her make-up, watched sporting events together on television, and were Nebraska Cornhusker fans.
*Her religious preference was Catholicism, but the Catholic priest who visited the facility had not been contacted about her specific spiritual needs.
*They agreed the resident was at risk for social isolation related to not leaving her room for meals, behavioral concerns that restricted the time, type, and duration of activities she was able to participate in, and the loss of her spouse who had provided daily companionship.
*They agreed her care plan had not been reassessed, individualized, and carried out in a manner that met her specific activity needs.

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F 679	Continued From page 16 Review of the provider's revisited July 2015 Activity Program policy revealed: *"Procedure: -1. The activity program: --"a. Is multifaceted to reflect the entire resident populations's needs and interests. --b. Is varied to provide stimulation or solace. --c. Promotes physical, cognitive, and/or emotional well-being. --d. Enhances to the extent practical each resident's physical, mental and psychosocial status."	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 45095 Based on observation, interview, record review and policy review, the provider failed to complete weekly skin assessments and reposition one of one sampled resident (36) at risk for pressure ulcers who developed two new stage I pressure ulcers.	F 686	1. Unable to correct deficient practice noted during survey. Resident 36 has a repositioning schedule in place as well as a weekly skin assessment. All residents have the potential to be affected. 2. All residents records reviewed to ensure a weekly skin assessment is in place by 10/9/21 by nursing leadership. The DNS or designee will educate all staff on turning/repositioning documentation as well as weekly skin assessment documentation and the skin policy by 10/9/21. All staff not in attendance will be educated prior to their next working shift. 3. The DNS or designee will audit a random sample of 4 residents to ensure turning/repositioning in place if indicated and ensure a weekly skin assessment is completed weekly times four weeks and monthly time two months. The DNS or designee will bring the results of these audits will be taken to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	10/9/21

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1. Review of resident 36's medical record revealed:
*She had been admitted on 9/11/20.
*Her diagnoses included: morbid obesity, weakness and, type 2 diabetes.
*She had a history of previous pressure ulcers that had been healed with dates as follows; 9/27/20, 2/25/21, and 3/9/21.
*On 5/7/21 her Braden Scale for predicting pressure sore risk had shown she was at risk for skin breakdown.
*There had not been documentation of weekly head to toe skin assessments done by a nurse.
*She was noted to have two new pressure ulcers to the left and right buttocks on 8/31/21.
*Skin and wound evaluations had been completed on 8/31/21 and 9/7/21 by a nurse for stage 1 pressure ulcers to the left buttocks and the second evaluation did not identify the location of the wound.
*Reposition every two hours was listed on the Treatment Administration Record and was signed off by a nurse once daily from 8/31/21 to 9/9/21.

Review of resident 36's documentation in the reposition history on:
*9/8/21 showed repositioning at 1:03 p.m. only for that day and resident's refusal for repositioning was documented at 1:03 p.m. and 1:04 p.m. only.
*9/9/21 showed repositioning at 5:21 a.m. only for that day and resident's refusal for repositioning was documented at 1:39 p.m. and 1:41 p.m. only.

Review of resident 36's physician order revealed on:
*8/31/21:
-Stage 1 pressure ulcer to right buttocks, and bilateral thigh excoriation.

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-Reposition every two hours.
*9/2/21:
-Turn every two hours limit side-lying to 30-degree tilt.
-Cleanse buttocks and posterior thigh apply antifungal.
-Wound Care appointment scheduled on 9/22/21 at 1:00 p.m.

Review of resident 36's progress notes:
*Dated 8/31/21 and signed by Registered Nurse (RN) N as follows; "[Certified Nurse Practitioner] saw resident today. Is a wound care referral due to bilateral thigh excoriation, stage 1 pressure ulcer to right buttocks at earliest available appt. [appointment] Reposition every two hours, Apply antifungal cream to bilateral arm pits and back folds."
*Dated 9/2/21 and signed by Licensed Practical Nurse (LPN) F as follows:
- Resident returned from wound clinic with new orders:
 -- cleanse the buttock and posterior thighs twice a day as well as with depends and when applying antifungal cream.
--Barrier ointment to protect skin.
--Antifungal twice a day to armpits, back folds, buttock, and posterior thighs.
--Also apply with depends changes after bowel movements.
--Follow up appointment 9-22-21.

Observation and Interview on 9/8/21 at 8:46 a.m. with resident 36 revealed:
*She had two painful sores at the top and back of both thighs from lying in bed.
*She goes to wound care at the hospital.
*She verbalized staff did not come and turn her like she is supposed to be turned.

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F 686	Continued From page 19 *She was lying in bed on her back with a pressure reduction mattress beneath her. Observation of resident 36 revealed her lying on her on: *9/8/21 at the following times: 12:05 p.m., 12:17 p.m., 5:40 p.m., 6:05 p.m. *9/9/21 at the following times: 9:06 a.m., 9:37 a.m., 10:57 a.m., 11:16 a.m., 4:18 p.m. *9/10/21 at 8:24 a.m. Interview on 9/9/21 at 9:45 a.m. with Certified Nurse Assistant (CNA) Q regarding resident 36 revealed: *She had sores on her bottom and between her thighs. -Nurse gave the CNA the antifungal and C guard creams that were to be applied to the resident with every brief change or reposition. *Skin or wound changes were reported to the nurse. *She tended to refuse to reposition often. -Repositioning was offered to the resident every two hours, sometimes the resident was ok with it and sometimes not. -Refusals for repositioning were documented on the iPad and reported to nursing. -Repositioning was offered again later or someone else tried. Observation and Interview on 9/9/21 at 11:16 a.m. with (CNA) R, (LPN) O, and (RN) N while assisting resident 36 revealed: *Antifungal cream was scheduled on the treatment administration record (TAR) and applied by nursing. *Pillows were placed under resident's hips to off load pressure when repositioning was refused. *Resident catheter care was completed by CNA.	F 686		

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*Resident was turned side to side by the CNA and LPN while the RN cleansed her skin folds and wounds and applied antifungal cream to the back of her thighs and buttocks where two-stage one pressure ulcers were observed at the right and left buttocks.
-Staff utilized infection control precautions.
*Resident refused to lay on her side.
-RN verbalized resident often refused to reposition to her side.
*CNA offered to come back and reposition resident to her side after lunch.

Interview and observation on 9/9/21 at 4:18 p.m. with resident 36 revealed:
*She was lying in bed on her back
*She verbalized no staff had come back after lunch to offer to reposition her.

Interview on 9/9/21 at 4:25 p.m. with Staff Development/Infection Control RN D regarding resident 36 revealed:
*Skin assessments were completed weekly by a nurse.
*Wound assessments were completed weekly.
*Her weekly skin assessments were discontinued on 5/7/21 and RN D was not sure why.
*Clarified the blank location on the resident's skin and wound evaluation dated 8/31/21 should be the right buttock.
*She is going to wound care for the excoriation to the back of her thighs.

Review of the EmpRes Policy: Skin Integrity revealed:
*"5. Ongoing evaluation continues weekly with the LN [Licensed Nurse] completing a full body skin audit. Completion of the skin audit is documented on the Treatment Administration Record (TAR)

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F 686	Continued From page 21 with their initials, and either a "- "or "+". -a. "- "indicates no skin impairment present. -b. "+" indicates skin impairment present."	F 686		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation, interview, record review, and policy review, the provider failed to ensure side rail safety assessments had been completed and documented for three of four sampled residents (17, 28, and 54). Findings include: 1. Observations on 9/7/21 between 7:30 p.m. and	F 700	1. Residents 17, 28 and 54 have had a device evaluation completed. All residents have the potential to be affected. 2. The DNS or designee will educate all nursing staff on the utilization of bedrails and the bed rail policy by 10/9/21. All residents will be reviewed for a potential device/bedrail by 10/9/21. Those not appropriate will be removed, all appropriate will have an evaluation completed. All staff not in attendance will be educated prior to their next working shift. 3. The DNS or designee will audit a mixed sample of residents with and without bedrails to ensure one hasn't been placed without knowledge of proper staff of 4 residents for a bed rail or potential device and that an evaluation has been completed weekly times four weeks and monthly times two months. The DNS or designee will bring the results of these audits will be taken to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	10/9/21

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8:15 p.m. and on 9/8/21 between 8:00 a.m. and 9:30 a.m. of sampled resident rooms revealed residents 17, 28, and 54 had quarter-length side rails on one or both sides of their beds.

Review of residents 17 and 54s' care records revealed:
*Resident 17's most recent side rail assessment was completed on 7/16/20.
*Resident 54 was admitted 8/4/21 had no side rail assessment completed.
Surveyor: 43844
Observation and interview on 9/9/21 at 9:13 a.m. with resident 28 revealed:
*There was a quarter rail in the up position on the upper left side of his bed.
*He stated it helped him to turn in bed.
*There had been no side rail assessments completed.

2. Interview on 9/8/21 between 5:15 p.m. and 5:40 p.m. with division director of clinical operations/registered nurse (RN) A and interim director of nursing/RN C revealed they confirmed:
*Resident 17's side rail assessment was not current.
*Residents 28 and 54 had no side rail assessments completed.
*It was their expectation a side rail assessment had been completed at admission, at the time a side rail was installed, and quarterly thereafter.

3. Observation and interview on 9/9/21 at 8:25 a.m. with maintenance director GG revealed he completed preventative maintenance assessments on each resident bed with side rails on a monthly basis.

4. Review of the provider's September 2017 Bed

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F 700	Continued From page 23 Rails policy revealed: *The Bed Rail Evaluation is: -a. Completed at admission prior to implementation. -b. Completed quarterly or upon a change in condition.	F 700		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755	1. Unable to correct deficient practice noted during survey. All residents have the potential to be affected. 2. The DNS or designee will educate all licensed staff on the medication storage policy and expectations by 10/9/21. All licensed staff not in attendance will be educated prior to their next working shift. 3. The DNS or designee will audit all narcotic logs for proper sign in/sign out per policy weekly times 4 weeks and monthly times two months. The DNS or designee will take the results of these audits to the monthly QAPI for further review or recommendation to continue or discontinue the audits.	10/9/21

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F 755	Continued From page 24	F 755		

order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Surveyor: 41895
Based on observation, interview, record review, and policy review, the provider failed to ensure accountability of controlled medications by ensuring counts of controlled medications had been documented by two staff at shift change on four of four observed medication carts. Findings include:

1. Observation and interview on 9/9/21 at 4:06 p.m. and at 4:35 p.m. with licensed practical nurse (LPN) F revealed:
*There were four medication carts.
*Each medication cart had controlled medications in a lock box.
*Each cart had a spiral bound book used to document counts of the controlled medications.
*All controlled medications were counted by two staff at shift change.
*The staff were to count each controlled medication and sign off on the Shift Audit Record, which was in the front of the spiral bound book, indicating the counts were correct.
*Signatures were missing on the September 2021 400 wing medication and treatment Shift Audit Records.

Review of the providers September 2021 Shift Audit Records used to document controlled medication counts revealed:
*The 400 wing medication cart had two Shift Audit Records used to document the count of controlled medications.
-Seventeen out of fifty-two missing signatures for the staff leaving the shift.

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F 755	Continued From page 25 -Seven out of fifty-two missing signatures for the staff coming on shift. *The 400 treatment cart had: -Seven out of seventeen missing signatures for the staff leaving the shift. -Two out of seventeen missing signatures for the staff coming on shift. *The 200 wing medication cart had: -Three out of twenty-six missing signatures for the staff leaving the shift. -Three out of twenty-six missing signatures for the staff coming on shift. *The 200 wing treatment cart had two Shift Audit Records used to document the count of controlled medications. -Three out of twenty-nine missing signatures for the staff leaving the shift. -Two out of twenty-nine missing signatures for the staff coming on shift. Observation and interview on 9/9/21 at 4:30 p.m. with unlicensed assistive personnel (UAP) DD of the 400 wing medication cart shift audit records revealed: *She counted controlled medications at the start and end of her shift with a nurse and they both signed the shift audit record. *She had agreed there were missing signatures on the shift audit record. Interview and review of the shift audit records on 9/9/21 at 5:15 p.m. with division director of clinical operations/registered nurse (RN) A regarding controlled medications count at shift change revealed: *She had confirmed there were missing signatures on the Shift Audit Records. *Staff were expected to count all controlled medications and sign each shift audit record at	F 755		

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FORM APPROVED
OMB NO. 0938-0391

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F 755	Continued From page 26 shift change. Review of the provider's revised August 2014 Medication Storage in the Facility policy revealed at shift change or when keys are transferred a complete inventory of all controlled medications was to be conducted by two licensed staff and documented.	F 755		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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: Surveyor: 45095 Surveyor: 43844 Based on observation, interview, and policy review, the provider failed to ensure: *Chicken strips and salad had been maintained at	F 812	1. No specific residents were identified. All residents potentially at risk. All unlabeled foods were disposed of during survey, the equipment and all other unclean areas were all cleaned during the survey and the freezer was fixed during survey. At this time the uncleanable surface will be repaired to be cleanable while the ED pursues quotes on replacing. 2. The Executive Director, Dietary Manager and RD reviewed policy and procedure for food storage, hand washing and glove use by 10/9/21. All staff providing assistance with food preparation and service provided education by the ED or designee on safe and sanitary practice that includes safe temperature of hot and cold food, proper labeling of food, appropriate hand hygiene and glove use by 10/9/21. Those not in attendance will be educated prior to their next working shift. 3. The Executive Director or designee will audit 4 random meal services to ensure food preparation and service is done in a sanitary manner with safe food temps, proper labeling, glove use and handwashing are done according to policy weekly times four weeks and monthly times two months cook S and L will be included in the audits. The Executive Director or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendations to continue or discontinue the audits.	10/9/21

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F 812	Continued From page 27	F 812		

a safe temperature during one of one observed meal service.
*Food had been stored in a sanitary condition and labeled.
*Proper hand hygiene and glove use techniques for one of one sampled (P) cook.

1. Observation on 9/7/21 at 6:29 p.m. of the meal service during the initial tour of the provider's kitchen revealed:
*Cook S was serving the supper meal:
-She picked up a food thermometer from the counter.
--Without sanitizing it, she placed it in a chicken strip that was being kept warm on the steam table to obtain the temperature.
---A temperature of 127 degrees was obtained from the salad.
--She then placed the thermometer on the counter.
-She opened a drawer that had crumbs in it and dry spots of what appeared to be liquid.
--She took a thermometer from that drawer.
---Without sanitizing it, she placed it in a pan of lettuce, that was being kept in a metal pan that was sitting on top of another metal pan filled with partially melted ice, in the steam table.
---A temperature of 66 degrees was obtained from the salad.

Interview on 9/7/21 at 7:14 p.m. with cook S regarding the temperature of the food revealed she:
*Was in training to become the DM.
*Had not enrolled in a DM course.
*Had a certified DM (CDM) training her.
*Stated, "I don't particularly know the holding temps, I am not ServSafe certified, nobody here is ServSafe certified, they have all quit."

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Interview on 9/8/21 at 8:38 a.m. with interim CDM X regarding safe handling of food revealed:
*She had been hired on an interim basis.
*She was ServSafe certified and did not know if anyone else was.
*Agreed the 9/7/21 supper food temperatures had not been appropriate and stated, "it is definitely a teaching moment, those were in the danger zone."
*Had conducted a recent in-service, but did not cover safe food temperatures at that in-service.

Review of the provider's July 2009 cleaning and sanitizing a thermometer revealed:
*"1. Dietary staff use alcohol swabs to sanitize thermometers.
2. Open the alcohol swab packet with clean hands and wipe down the sides of the thermometer. Let air dry.
4. When taking temperatures during meal service, the thermometer is re-sanitized before taking the next temperature.
5. To prevent cross contamination, clean and sanitize the thermometer and its case before replacing the thermometer back into the case."

Review of the provider's October 2017 food temperature policy revealed:
*"Food temperatures are taken and documented daily prior to meal service and monitored periodically throughout the meal service.
1. Food and Nutrition Services (FANS) staff takes and documents food temperatures using a sanitized and calibrated thermometer.
2. For potentially hazardous foods on the tray line, the temperature of the food is periodically monitored throughout the meal service to maintain proper hot or cold holding temperatures.

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F 812	Continued From page 29 3. Corrective action is taken for food temperatures outside of regulatory standards (hot foods should be 140*F or above, cold foods 41*F or less). It is suggested hot foods not exceed 180*F in the kitchen." 2. Observation on 9/7/21 from 6:29 p.m. through 7:14 p.m. during the initial tour of the provider's kitchen revealed: *In the tall standing refrigerator there had been the following items not dated and not labeled: -A plastic gallon pitcher containing a yellow liquid appearing to be lemonade. -A half-gallon pitcher containing a dark liquid appearing to be prune juice. -Two Styrofoam cups with lids in a plastic bag that contained food. *In the walk-in cooler there had been: -Two boxes of ground beef sitting on the floor with five cases Snack Pak pudding sitting on top of them. -One empty disposable plastic cup. -What appeared to be chicken patties without a label or date in a tin foil covered pan. -The following items opened and without an open date: --One gallon of creamy Caesar dressing. --One small bottle of Italian dressing. -One opened package of crab meat with no open date. -One open bag of cabbage/coleslaw exposed to the air. -A partial package of cream cheese wrapped in tinfoil and dated 7-27. *In the snack preparation area was the following a: -Cabinet door was labeled 'red cloth napkins' located underneath the juice machine and with what appeared to be liquid spilled and dried on	F 812		

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F 812	Continued From page 30 the top edge of the cabinet door. -Cabinet door was labeled "cup lids" with a chip, measuring approximately 4 inches by 3 inches, on the right side bottom of the door. --This made these uncleanable surfaces. *In the walk-in cooler was the following: -One brown tray, labeled "fruit and pudding", and a date of 9/1 with: --Seven individual plastic containers with what appeared to be salsa in them. --Three individual plastic containers with what appeared to be sour cream in them. --Two individual plastic containers with what appeared to be tartar sauce in them. --One blue bowl with a plastic lid covering it and a yellow substance in it. *In the main kitchen: -A metal container, with what appeared to be sugar in it, with a metal lid partially covering it. -A tan speckled worktable with: --One chip in the middle of the front edge measuring approximately one and one-half inches by one-half inch. --A crack, approximately 12 inches from the right edge, extending up into the worktable approximately 10 inches. ---This made it an uncleanable surface. -Pink cupboards, throughout the area, with excessive dirt and grime on them. -Multiple pink colored drawers with excessive dirt and grime on the outside of them. --On the inside of these drawers had been crumbs of food, and numerous areas that appeared to have had liquid spilled and dried on them. *In the walk-in freezer there had been: -Icicles measuring approximately three inches by one-half inch hanging from the top of the metal shelving.	F 812		

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F 812	Continued From page 31 -Frost, approximately one-fourth of an inch covering: --Two empty cookie sheet pans on the top shelf, under the fan. --The top of eight boxes of food that had been on the second and third shelves. --The floor, causing it to be slippery. -One partially used bag of french fries, unsealed, and with no date or label on it. -One individual container of ice cream on the floor. Observation on 9/8/21 at 8:25 a.m. of the main kitchen and storage areas revealed: *The meat slicer had a dried cream-colored substance by on the right front outer edge. *The freezer still had frost and icicles in it. -A 40-ounce jar of honey that had been opened with no open date on it. *The walk-in cooler had: -Celery that was wilted and brown on the bottom side in a metal pan that was dated "8/12". -The following Items were not labeled or dated: --Five pounds of fresh peeled garlic in a plastic container with approximately one-fourth of it gone with no opened date. --A brown serving tray with five bowls containing yellow pureed food. Interview on 9/9/21 at 3:13 p.m. with Administrator B and CDM X revealed: *The above observations had been correct. *All food items should all have been labeled and dated. -CDM X had removed the items that were not labeled or dated on the evening of 9/7/21 and the morning of 9/8/21. -Food delivery dates had been on Mondays and Thursdays.	F 812		

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-Due to the holiday, this week the delivery date had been on Tuesday.
-CDM X's expectation would have been for the food to be put away appropriately by the end of that day.
*CDM X had been aware of the frost and ice in the freezer.
-Had cleaned it "about 10 days ago."
-Notified the Administrator of the continued buildup of frost and ice.
-Thought maintenance was working on finding a vendor to fix it.
*The CDM had been at home and was called because the surveyors entered the building at approximately 6:00 p.m. on 9/7/21.
-She came to the facility arriving at approximately 8:30 p.m.
-She had put the food away at that time.

Review of the provider's updated October 2017 food storage policy revealed:
*"Food storage areas are maintained in a clean, safe, and sanitary environment.
Procedure:
1. Food storage areas are kept clean at all times.
2. Foods or food items not requiring refrigeration are stored upon surfaces (shelves, racks, dollies, etc.) a minimum of six inches above the floor to facilitate a thorough cleaning, in a ventilated room, not subject to sewage or wastewater backflow or contamination by condensation, leakage, rodents or vermin. Packaged food, canned foods, or food items stored are kept clean and dry.
3. Dry, bulk foods, (flour, sugar, dry beans, food thickener, spices, etc.) are stored in seamless metal or plastic containers with tight fitting covers or in bins that are easily sanitized."
"4. Remove food from the packing boxes upon

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F 812	Continued From page 33 delivery (to minimize pests.) .....Only food grade reusable containers are used for food storage. 5. Foods are dated with month and year of delivery to the Center." "9. Foods stored in walk-in refrigerators and freezers are stored above the floor on shelves, racks, dollies, or other surfaces to facilitate thorough cleaning. ... ... 10. Opened items have "use by" dates indicated on them ....." Review of the provider's July 2009 cleaning freezer policy revealed: *1. Remove food from freezer to be defrosted and place in another freezer. 2. Unplug freezer that is to be defrosted. 3. Let the freezer stand for several hours until the ice has melted. 4. Drain and/or dip out water. 5. Wash down thoroughly with baking soda and water. 6. Clean outside of freezer with detergent water, including the gaskets. 7. When freezer has been cleaned, re-plug and let freezer return to proper temperature. 8. When freezer has returned to proper temperature, replace food. 9. Repeat this process as often as necessary." 3. Observation on 9/8/21 from 11:25 a.m. to 11:55 a.m. of meal service revealed: *Cook L obtained tongs from a drawer. -Moved binders that were on the counter to the side. -There were two turquoise and gray potholders on the counter that had dried food on them. -Placed the tongs on the counter where the binder had been, next to the potholders. -On three different occasions she:	F 812		

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F 812	Continued From page 34 --Picked up the tongs and used them to take a hamburger bun from the plastic bag they came in. --Placed the bun on a plate. --Placed the tongs back on the counter *She had not sanitized the counter. Observation on 9/8/21 at 11:55 a.m. of meal serving tray line revealed: *Tomatoes and lettuce had been in plastic Cambro containers on a serving cart. -There had been tongs next to these in a metal pan holding ice. *Cook P had a plastic glove on her left hand and with this gloved hand she: -Touched meal tray tickets 10 times. -Touched brown trays 3 times that had been used and were dirty. -Laid her hand on an unclean counter. -With the potentially contaminated glove on, she picked up the lettuce and tomatoes and put them on a plate. --She had not used the tongs that had been located next to the lettuce and tomatoes. Interview on 9/8/21 at 12:01 p.m. with CDM X regarding the use of gloved hands to touch ready to eat foods revealed she agreed this was not safe food handling and stated she would educate cook P. Observation on 9/8/21 at 12:03 p.m. of cook P revealed she: *Removed the glove from her left hand and washed her hands. -The handwashing lasted for a count of ten seconds. *Resumed serving the meal. Review of the provider's updated July 2008 glove	F 812		

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F 812	Continued From page 35 use policy revealed: *"1. Proper utensils are used for food handling. 2. Bare hand food contact is prohibited. 3. Proper use of gloves:" ".......d. Gloves are single use and thrown away after each task." Review of the provider's updated March 2016 handwashing policy revealed: *"Handwashing procedure: 1. Wet hands with comfortably warm water then vigorously lather hands with soap and rub them together, creating friction to all surfaces, for 20 seconds."	F 812		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity,	F 838	1. Unable to correct deficient practice noted during survey. All residents have the potential to be affected. 2. The ED will ensure an appropriate facility assessment is completed by 10/7/21 to the areas addressed in F838. The ED will educate all staff on the facility assessment and it's purpose by 10/9/21. All staff not in attendance will be educated prior to their next working shift. 3. The ED will audit the facility assessment monthly times 6 months to ensure there are no necessary updates needed to the facility assessment. The ED or designee will bring the results of the audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	10/9/21

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 ______	09/10/2021

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 838	Continued From page 36 and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by:	F 838		

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	435109	A. BUILDING ______ B. WING ______	09/10/2021

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 838	Continued From page 37	F 838		

Surveyor: 43844
Based on observation, interview, record review, and facility assessment tool review, the provider failed to ensure they had evaluated the facility's resident population and identified resources that were needed to effectively implement the necessary care and services the residents had required. Findings include:

1. Review of the provider's undated facility assessment revealed:
*The assessment was thirty-nine pages long, and had not addressed:
-The care requirements of the resident population.
--How the acuity, diseases, conditions, and treatments would have impacted their care needs such as how much assistance the residents would have potentially required from the staff.
--How the cognitive, mental, and behavioral care requirements would have impacted their care needs such as how much assistance the residents would have potentially required from the staff.
-Cultural food and nutrition diets of the residents.
-Equipment, supply inventories, maintenance, and activity logs.
-The facility quality assurance process improvement plan, performance improvement projects, or corrective actions.
-How many staff were needed to care for the residents or how they would have been scheduled/assigned.
-Services provided by contract with a plan for annual reviews of them.
-Health information managing and sharing.

*There had been no mention of:
-The facility's memory care unit.

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F 838	Continued From page 38 -The usual amount of assistance required by the residents based on their medical and mental health diagnoses. -How the facility would have been staffed to ensure the residents' care needs were being met. Interview and facility assessment review on 9/9/21 at 5:14 p.m. with administrator B regarding the facility assessment revealed: *There was no specific process for the development of the facility assessment. *He had been the only person involved in the development of that assessment. *The facility assessment was a "work in progress". *He confirmed the assessment was missing critical components required to ensure appropriate care and services were available to the residents. See also F550, F565, F678, F679, F686, F700, F755, and F812.	F 838		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880	See next page.	

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F 880	Continued From page 39 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880	**Directed Plan of Correction** **Firesteel Healthcare Center, Mitchell** **F880** **Corrective Action:** 1. Time cannot be turned back to a time prior to the identification of lack of: *appropriate hand hygiene and glove use during provision of cares and transitions of tasks and locations. The ED and DNS in consultation with the medical director and infection control nurse and whomever else identified will review policies and procedures about: *Appropriate hand hygiene and glove use during provision of cares and transition of tasks and locations. *Necessary infection control and prevention plan that includes effective compliance. All staff who provide above care and services to residents will be educated/re-educated by ED or designee by 10/9/21. All staff not in attendance will be educated prior to their next working shift.	10/9/21

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F 880	Continued From page 40 §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: Surveyor: 40788 Based on observation, interview, and policy review, the provider failed to ensure infection prevention and control practices were maintained for: *Proper glove use by one of one minimum data set/registered nurse (MDS/RN) (E) prior to providing personal care for one of one observed resident (77). *Hand hygiene assistance for two of two observed residents (77 and 17) after toilet use by one of one MDS/RN (E), one of one licensed practical nurse (LPN) (F), one of one restorative aide (G), or one of one nurse aide (H). *Proper glove use and hand hygiene for one of one certified nursing assistant (CNA) (V) during transitions of tasks and locations. Findings include: 1. Observation and interview on 9/8/21 between 9:15 a.m. and 9:30 a.m. with MDS/RN E and LPN F assisting resident 77 use the toilet revealed: *MDS/RN E performed hand hygiene and put on a size small pair of gloves prior to helping the resident.	F 880	**Identification of Others:** 2. ALL residents have the potential to be affected if staff do not adhere to: *Appropriate hand hygiene and glove use during provision of cares and transitions of tasks and locations. ALL staff completing the care and/or assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by ED or designee by 10/9/21. **System Changes:** 3. Root cause analysis conducted answered the 5 Whys: Hand hygiene for residents: Lack of adequate training in this area. Glove use: lack of adequate size readily available during care. Hand hygiene/glove use during linen transport: Lack of adequate education/auditing.	

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 ______	09/10/2021

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 41

-Commented those gloves were too small for her hands.
-Tore the top of the right glove when she tried to pull it up to cover her hand.
-None of her fingers were able to reach the individual tips of those gloves for a proper fit.
*MDS/RN E stated she should have discarded her compromised gloves and put on properly sized gloves prior to assisting that resident.
*Neither MDS/RN E or LPN F had offered or helped the resident with hand hygiene after he had used the toilet.
-That was not a practice they consistently offered residents after toilet use, but should have been.

Review of resident 77's care plan last revised on 9/8/21 revealed:
*A goal to be free from infection.
-An intervention for that goal read: "Assist resident with hand hygiene prior to meals, after toileting, coughing, sneezing, and PRN [as needed]."

2. Observation and interview on 9/8/21 at 11:27 a.m. with restorative aide G and nurse aide H after assisting resident 17 use the toilet revealed they:
*Performed hand hygiene after they assisted her off the toilet and removed their gloves.
*Had not offered or helped her with hand hygiene after toilet use, but should have.
*Stated assisting residents with hand hygiene after toilet use was not their usual process, but it would be "a good idea".

Review of resident 17's care plan last revised on 7/19/21 revealed:
*A goal to be free from infection.
-An intervention for that goal read: "Assist

F 880

Administrator, DON, infection control nurse, 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.
Divisional Director of Clinical Operations contacted the South Dakota Quality Improvement Organization (QIN) on 10/1/21 discussion surrounded auditing, the fishbone breakdown and 5 why's education.

Monitoring:

4. Administrator, DON, infection control nurse, and whomever else determined necessary will conduct auditing and monitoring for areas identified above. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum 3-5 times weekly for 4 weeks, administrator, DON, and/or infection prevention nurse making observations across all shifts to ensure staff compliance with:

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F 880	Continued From page 42 resident with hand hygiene prior to meals, after toileting, coughing, sneezing, and PRN [as needed]." Interview on 9/9/21 at 11:48 a.m. with division director of clinical operations/registered nurse (RN) B and interim director of nursing (DON) C regarding resident hand hygiene revealed it was expected staff remind and if needed assist all residents with hand hygiene following bathroom use. Review of the provider's March 2018 revised Handwashing/Hand Hygiene policy revealed: *"Policy Statement: This Center considers hand hygiene the primary means to prevent the spread of infection." -"5. Residents, family members, and /or visitors are encouraged to practice hand hygiene through the use of fact sheets, pamphlets, and/or other written materials provided at the time of admission and/or posted throughout the Center." Surveyor: 06365 3. Observation on 9/8/21 at 8:24 a.m. in the Memory Care Unit revealed 3 full soiled linen plastic bags sitting on the floor next to a wheeled cart for 3 bins for soiled linens. At 8:29 a.m., certified nursing assistant (CNA) V approached the cart and proceeded to complete the following transition of tasks and locations without the use of gloves and washing or sanitizing hands between transitions: *Touched the soiled linen bags with ungloved hands. *Lifted the linens from the plastic bag in one bin to the plastic bag in another bin then pulled that bag out, tied it shut, and stuffed it into one of the	F 880	*Necessary infection control and prevention plan that includes compliance in the above identified areas. *Any other areas identified thru the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month.	

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	435109	A. BUILDING ______ B. WING ______	09/10/2021

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 43 plastic bags sitting on the floor. *Touched her face mask and eye shield several times throughout the process. *Picked up three plastic bags and carried them against her body while walking through the dining room to the kitchen area for the unit. After setting them down on the floor, she did not wash her hands. *Stopped to talk with resident 52 who was sitting at a dining room table eating, and held the resident's hand in hers after the resident said her hands were cold. *Returned to the laundry bins and tied up one more plastic bag of linen and carried the bag against her body while pulling a wheeled cart with an ice bin on top of the cart through the dining room to the memory care unit kitchen. *Left the unit with all of the plastic linen bags piled on top of the cart. *Returned to the unit and then washed her hands upon entering the unit. Interview on 9/10/21 at 11:10 a.m. with interim director of nursing (DON) C confirmed CNA V did not follow proper hand hygiene and glove use.	F 880		

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 _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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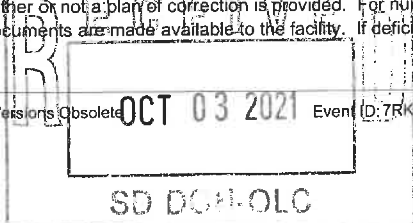
E 000	Initial Comments Surveyor: 41895 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 9/7/21 through 9/10/21. Firesteel Healthcare Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Petar Mirkovic	Executive Director	10/4/21

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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PRINTED: 09/24/2021
FORM APPROVED
OMB NO. 0938-0391

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 ______	**09/09/2021**

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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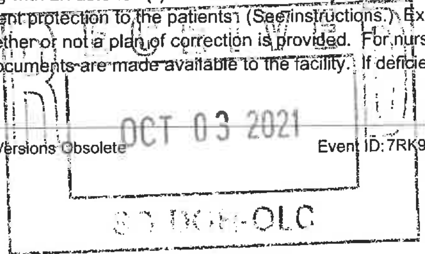
K 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/9/21. Firesteel Healthcare Center was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Petar Mirkovic*
TITLE: *Executive Director*
(X6) DATE: *10/4/21*

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10653 S	A. BUILDING: ______ B. WING ______	09/10/2021

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

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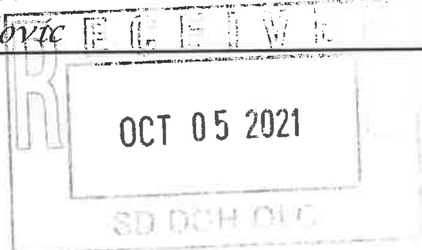
S 000	Compliance/Noncompliance Statement Surveyor: 41895 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/7/21 through 9/10/21. Firesteel Healthcare Center was found not in compliance with the following requirements: S296 and S301.	S 000		
S 296	44:73:07:11 Director of Dietetic Services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are	S 296	1. Unable to correct deficient practice noted during survey. All residents have the potential to be affected. 2. The ED or designee will ensure 2 staff in dietary are enrolled in a food safety class by 10/9/21. Two staff are currently starting the class with a completion date of 10/31/21. Cook S will test prior to 10/31/21. 3. The ED or designee will audit monthly times 6 months to ensure there are a minimum of 2 staff food safety certified in the dietary department. The ED or designee will bring the results of these audits to the monthly QAPI for further review and recommendation to continue or discontinue the audits.	10/9/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Petar Mirkovic	Executive Director	10/4/21



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 296	Continued From page 1	S 296		

scheduled to meet the dietetic needs of the residents shall be on duty daily over a period of 12 or more hours in facilities.

This Administrative Rule of South Dakota is not met as evidenced by:
Surveyor: 43844
Based on interviews the provider failed to ensure one of one cook (S) had completed a ServSafe Food Protection Program (ServSafe.) Findings include:

1. Interview on 9/7/21 at 7:30 p.m. with cook S revealed she:
*Was in training to become the dietary manager.
*Had not completed ServSafe.
*There were no current cookes employed with SerrvSafe.
-"Everyone who had been [ServSafe certified] has quit."

Interview on 9/8/21 at 8:38 a.m. with interim certified dietary manager (CDM) X revealed she had:
*Been hired on a temporarily basis to provide training and improvement to the dietary department.
*Completed ServSafe.
*Been aware a cook needed to complete ServSafe.
*Known there was not a cook who had completed ServSafe.

Interview on 9/8/21 at 3:03 p.m. with divisional director of clinical operations A revealed she had known:
*Interim CDM X had completed ServSafe.
*Cook S was enrolled in ServSafe and had not completed the program.

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10653 S	A. BUILDING: ______ B. WING ______	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESTEEL HEALTHCARE CENTER	1120 E 7TH AVE 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) COMPLETE DATE
S 301	Continued From page 2	S 301		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 43844 Based on in-service record review and interview the provider failed to ensure 7 of 7 dietary staff (P, S, Y, Z, AA, BB, and CC) had completed 2 of 2 annual dietary in-service trainings (safe food handling, and nutrition and hydration.) Findings include: 1. Review of monthly dietary in-service reports from 1/1/2020 through 9/9/21 revealed: *Dietary staff P, S, Y, Z, AA, BB, and CC had not completed annual in-service education for: -Safe food handling. -Nutrition and hydration. Interview on 9/8/21 at 8:38 a.m. with interim certified dietary manager (CDM) X revealed she had: *Been hired on a temporary basis to provide training and improvement to the dietary department. *Been working at the facility for less than one month. *Conducted a "recent in-service but had not covered temperatures of food [part of safe food	S 301	1. Unable to correct deficient practice noted during survey. All residents have the potential to be affected. 2. The ED or designee will ensure the dietary staff will be educated on food safety, handwashing, food handling and preparation techniques, food borne illnesses, serving and distribution procedures, leftover food handling, time and temperature controls for food prep and service, nutrition and hydration, and sanitation requirements by 10/9/21. All employees who serve/pass food will be educated on safe food handling by 10/9/21. All staff not in attendance will be educated prior to their next working shift. 3. The ED or designee will audit all dietary staff and food handling staff for ongoing education completed per the schedule monthly times 6 months to ensure compliance. The ED or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	10/9/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10653 S	A. BUILDING: ______ B. WING ______	09/10/2021

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

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S 301	Continued From page 3 handling]." Interview on 9/9/21 at 8:32 a.m. with divisional director of clinical operations A revealed she agreed the annual dietary in-service training had not been completed. Interview on 9/9/21 at 3:45 p.m. with administrator B and CDM X revealed: *CDM X had been working in South Dakota for the last ten years as a CDM. -She stated she knew the state regulations regarding required training. *Administrator B had thought the required annual dietary training had been completed. Review of provider's June 2021 food and nutrition services in-service education policy revealed: *"The Food and Nutrition Services Manager or designee coordinates monthly in-services for the year." "3. Meeting contents and participants are documented. The Center may use the Summary Report of Meeting Form."	S 301		
S 000	Compliance/Noncompliance Statement Surveyor: 41895 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 9/7/21 through 9/10/21. Firesteel Healthcare Center was found in compliance.	S 000		