

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 04/23/2024
NAME OF PROVIDER OR SUPPLIER Firesteel Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 East 7th Avenue Mitchell, SD 57301	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43844</p> <p>Based on review of provider's 4/17/24 South Dakota Department of Health (SD DOH) facility reported incident (FRI), interviews, record review, and policy review, the provider failed to ensure two of two residents (1 and 2) who smoked were assessed for safety.</p> <p>1. Review of provider's SD DOH FRI revealed the following:</p> <p>*Resident 1 was at risk for elopement and wore a Wanderguard, (a device worn by the resident that would alarm and alert staff if the resident attempted to open and go through a door).</p> <p>*On 4/16/24 director of nursing (DON) B had notified receptionist F to allow resident 1 to go outside as she would be taking him for a car ride.</p> <p>-Receptionist F had interpreted DON B's comment to allow resident 1 to go outside independently, meant at any time.</p> <p>*On 4/17/24 receptionist F allowed resident 1 to go outside independently.</p> <p>2. Interview on 4/23/24 at 9:00 a.m. with administrator A revealed the following:</p> <p>*Smoking was not allowed on the property.</p> <p>*Resident 1 was taken off the property by his family to smoke.</p> <p>3. Interview on 4/23/24 at 11:00 a.m. with licensed practical nurse C revealed:</p> <p>*Resident 1 smoked.</p> <p>-There was a smoking area outside with a bench to sit on.</p> <p>-He was required to sign out when he went outside to smoke and sign in when he came back inside.</p> <p>-He used a vape pen for smoking.</p> <p>-That vape pen was kept in the medication cart.</p> <p>(continued on next page)</p>

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.

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

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 04/23/2024
NAME OF PROVIDER OR SUPPLIER Firesteel Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 East 7th Avenue Mitchell, SD 57301	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Interview on 4/23/24 at 11:05 a.m. with hospitality aide D revealed the following:</p> <ul style="list-style-type: none"> *She indicated resident 2 was the only resident who smoked. -Resident 2's friend visited and took her outside to the designated smoking area to smoke. <p>5. Interview on 4/23/24 at 11:12 a.m. with resident 2 regarding smoking revealed the following:</p> <ul style="list-style-type: none"> *She smoked cigarettes. *She was not aware of any designated smoking area. *Staff did not assist her with smoking. *She had a friend who came to visit and took her outside to smoke several times. *She did not remember having been assessed for smoking safety. *When asked if she had ever burned herself or her clothing with a cigarette, she looked away and would not respond. <p>6. Interview on 4/23/24 at 11:23 a.m. with DON B regarding smoking revealed the following:</p> <ul style="list-style-type: none"> *She was aware that resident 1 and resident 2 both smoked. *Resident 1 had recently started smoking a vape pen and his family would take him, daily, for a car ride, to smoke. *Resident 2 smoked cigarettes. *Smoking was not allowed on the facility property. -Residents were required to leave the property to smoke. *Smoking safety assessments were not routinely completed for those residents. -Resident 1 had a smoking safety assessment completed on 4/19/24, after he left the property without staff knowledge because he wanted to smoke a cigarette. -A smoking safety assessment for resident 2 had not been completed. *She was not aware that a smoking safety assessment should have been completed for all residents who smoked. <p>7. Interview on 4/23/24 at 12:15 p.m. with receptionist E revealed all residents were required to sign out when they left the facility.</p> <p>8. Review of resident 1's electronic medical record (EMR) revealed the following:</p> <p>(continued on next page)</p>

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 04/23/2024
NAME OF PROVIDER OR SUPPLIER Firesteel Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 East 7th Avenue Mitchell, SD 57301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*His admitted was 12/15/23.</p> <p>*His 3/18/24 Brief Interview of Mental Status (BIMS) score was a 15, that meant his cognition was intact.</p> <p>*His nurses progress notes revealed that:</p> <ul style="list-style-type: none"> -On 3/8/24 he had asked for cigarettes as he wanted to smoke. -On 4/15/24 he asked staff to take him outside to smoke, when staff refused, he became upset. -On 4/17/24 he went outside to smoke. <p>*His 4/23/24 care plan revealed the following:</p> <ul style="list-style-type: none"> -A 12/15/23 intervention indicating that he was a smoker and is aware he can not [cannot] smoke will have nicotine patch provide reassurance. -A 4/18/24 intervention indicating that he smoked a vape pen independently, off the property. <p>*A Smoking Safety Evaluation was completed on 4/19/24 that indicated he had the, Ability to safely hold, light and smoke cigarette or other smoking materials.</p> <p>9. Review of resident 2's EMR revealed the following:</p> <ul style="list-style-type: none"> *Her admitted was 11/30/23. *Her 2/29/24 BIMS score was a 15, that meant her cognition was intact. *Her 4/23/24 care plan revealed the following: <ul style="list-style-type: none"> -She had been educated on not smoking on-site. -She had impaired thought processes related to everyday choices, daily tasks, and safety. -She went on outings with friends and engaged in past behavior such as smoking. *There was no documentation to support a smoking safety assessment was completed. <p>10. Review of the provider's 11/2016 Smoke-Free Center Policy Acknowledgement form revealed the following:</p> <ul style="list-style-type: none"> *Smoking (including the use of e-cigarettes) is prohibited for everyone on the property owned and operated by the Center [provider], including residents, employees, visitors, volunteers, consultants, contractors, and government representatives. *The Center [provider] does not own the sidewalks and streets that border the grounds. <p>(continued on next page)</p>		

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 04/23/2024
NAME OF PROVIDER OR SUPPLIER Firesteel Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 East 7th Avenue Mitchell, SD 57301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Prohibiting smoking in the center and on the grounds preserves everyone's right to breathe clean, smoke-free air while allowing adults who smoke to continue to do so off grounds. This decision supports the rights and privileges of smokers and non-smokers alike as well as the state's Clean Indoor Act, as applicable.</p> <p>*Resident 1 and resident 2 both had signed a copy of that form on admission.</p> <p>11. Interview on 4/23/24 at 3:41 p.m. with DON B revealed the following:</p> <p>*They did not follow their updated 8/2019 Resident Smoking Safety policy.</p> <p>*They did not have a no smoking policy.</p> <p>-Their admission agreement included a Smoke-Free Center Policy Acknowledgement form that residents acknowledged and signed on admission.</p> <p>12. Review of the provider's updated 8/2019 Resident Smoking Safety policy revealed the following:</p> <p>*The Center [provider] completes the Smoking Safety Evaluation for residents desiring to smoke tobacco products (cigarettes, cigars, or pipes, including electronic e-cigarettes). Residents store tobacco products and fire materials at the nurses' station or other Center [provider] designated location. Residents only smoke with supervision.</p> <p>*The Licensed Nurse (LN) completes the Smoking Safety Evaluation, if the resident smokes (including e-cigarettes/vape products) on admission and with change in condition. The Evaluation is reviewed for accuracy, quarterly.</p> <p>*Smoking, including the use of Electronic Cigarettes (e-cigarettes/vaping devices), is not allowed inside the Center [facility] and is confined to designated smoking areas only.</p> <p>*Appropriate interventions are care planned and implemented based on the results of the Smoking Safety Evaluation.</p> <p>*A copy of Center Smoking Regulations (e.g. designated smoking times, locations, and Center-specific rules) is provided to the resident/resident's authorized representative and verbally explained as indicated.</p> <p>*A copy of the Center Smoking Regulations, this policy, and the Acknowledgement of Smoking Risks, is provided to the resident/resident's authorized representative and verbally explained as indicated. Residents choosing to smoke sign the Acknowledgement of Smoking Risks.</p> <p>*If a resident wants to smoke independently off grounds, the Center [provider] does not knowingly allow this to occur without supervision.</p> <p>*Residents who smoke (including e-cigarettes) are required to utilize NFPA 701 Compliant Smoking Aprons when they smoke.</p> <p>(continued on next page)</p>		

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 04/23/2024
NAME OF PROVIDER OR SUPPLIER Firesteel Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 East 7th Avenue Mitchell, SD 57301	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*When there is a potential or identified conflict between the resident's right to smoke and/or the resident's continued smoking while using oxygen and/or the risk of harm to self or others, a re-evaluation of the residents smoking is completed. Resident safety outweighs the resident's right to smoke.</p>