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	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Firesteel Healthcare Center	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)
F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on observation, interview, record review, and resident rights review, the provider failed to ensure staff were available to promptly respond to call lights for seven of seven sampled residents (1, 2, 3, 4, 5, 8, and 9) who used call lights to alert staff of their assistance needs. Findings include: 1. Observation on 9/16/24 at 3:45 p.m. throughout the facility revealed there was: *A sit-to-stand lift (mechanical lift used to assist to a standing position for transfers) and total lift (a mechanical lift with a body sling used for transfers) located in the hallway between rooms [ROOM NUMBERS]. *A sit-to-stand lift located in the 400 hallway outside of room [ROOM NUMBER]. -The lift had two safety slings stacked on top of it. *Two sit-to-stand lifts and two total lifts located in the 200 hallway. *A sit-to-stand lift located in the 100 hallway. Interview on 9/16/24 at 3:50 p.m. with certified nursing assistant (CNA) C revealed: *She worked as a bath aide in the 400 and 500 hallways. *She would have completed eight to ten baths during an 8-hour shift. *She estimated ten residents who resided in those hallways required a sit-to-stand lift for all transfers. -Some residents required one staff to assist them with that lift, some required two staff to assist with that lift. *She estimated five residents who resided in those hallways required a total lift for all transfers. (continued on next page)

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

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F 0725 Level of Harm - Actual harm Residents Affected - Few	-Residents always required two staff to assist them with a total lift. *She reported that they had two sit-to-stand lifts and two total lifts. *She stated, Residents sometimes have to wait for a lift to be available. *Residents who required two staff to assist with the transfer sometimes have to wait longer for two staff to be available. Interview on 9/16/24 at 3:54 p.m. with resident 1's daughter revealed: *She visited every day. *Her mother required a total lift for transfers. *It sometimes took 30 to 45 minutes or longer for one person to come to answer the call light and It's even longer if you have to wait for a second person. -She stated, They will come and shut off the call light while they wait for a second person to come to assist with transfers. *She did not feel the long wait times were not limited to a certain time of day or a certain day of the week. It varies. Review of resident 1's call light audit report from 8/29/24 to 9/3/24 revealed: *There were two call light response wait times over 25 minutes. *On 9/3/24 at 6:47 p.m. the wait time was 30 minutes. Interview on 9/16/24 at 4:12 p.m. with resident 2 revealed: *She required the sit-to-stand lift for transfers. -Sometimes one staff assisted her and sometimes they needed two staff to assist. *Sometimes they don't come for a very long time. I pull the string and they just don't come. -She clarified she felt a long time to wait was over 15 minutes. -She became visibly upset when she discussed how long she had waited for someone to answer her call light. *She preferred her bathroom door to be open just a little. If they close it [the door], I get scared because I have to wait so long. Interview on 9/16/24 at 4:19 p.m. with resident 3 revealed: (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	*She shared a room and bathroom with resident 2. *She could walk to the bathroom, But I am supposed to wait for help. -I just can't wait that long. *She stated she fell next to her bed last week. -After putting my light on I waited 25 minutes [for staff assistance] then, I got up and went by myself. -She reported that was when she fell . Review of resident 3's electronic medical record (EMR) revealed: *She had a Brief Interview for Mental Status (BIMS) score of 13 which indicated she was cognitively intact. *A 9/14/24 progress note indicated Resident was self-transferring from bed to recliner and lost her balance. Resident call light was on prior to the fall. Review of residents 2 and 3's room call light audit report from 8/23/24 to 9/17/24 revealed: *There were 88 call light response wait times over 15 minutes. -21 of those were over 30 minutes. -6 of those were over 45 minutes. -On 9/5/24 at 4:44 a.m. the wait time was 64 minutes. *On 9/14/24 the call light was activated at: -4:53 p.m. -6:55 p.m. -9:00 p.m. -9:15 p.m. -9:37 p.m. -10:17 p.m. Interview on 9/16/24 at 4:26 p.m. with resident 4 revealed she said: *They get mad at me for pushing my call light. They think I am playing with it. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	*She knew when she needed to use the bathroom, But when they don't come I just go in my pants. *I can't hold it as long as it takes them to get here. *She could not state how long it took staff to answer her call light in minutes. *They don't have enough people working here. Review of resident 4's EMR revealed: *She had a Brief Interview for Mental Status (BIMS) score of 8 which indicated she was moderately cognitively impaired. *From 8/27/24 through 9/17/24 she was incontinent of urine 34 times. -She had been continent 24 times in that same period. * From 8/27/24 through 9/17/24 she was incontinent of bowel two times. -She had been continent 11 times in that same period. Review of residents 4's room call light audit report from 8/26/24 to 9/17/24 revealed: *There were 45 call light response wait times over 15 minutes. -Six of those were over 30 minutes. -Two of those were over 45 minutes. -On 9/13/24 at 7:08 p.m. the wait time was 88 minutes. Interview on 9/16/24 at 5:08 p.m. with resident 8 and resident 9 revealed: *Resident 8 and resident 9 shared a room and a bathroom. *They said staff could take a long time to respond to their call lights. -Resident 9 felt a long time was over 20 minutes. *They both acknowledged the staff was trying hard but there isn't enough of them. Review of residents 8 and resident 9's shared room call light audit report from 8/26/24 to 9/17/24 revealed: *There were 38 call light wait times over 15 minutes. -12 of those were over 30 minutes. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	-6 of those were over 45 minutes. *On 9/11/24 at 7:11 p.m. the wait time was 57 minutes Interview on 9/16/24 at 5:40 p.m. with CNA D revealed: *There were 40 residents who resided between the 400 and 500 hallways. *There were two CNAs assigned to care for the residents on the 400 and 500 hallways. -There was a third CNA there that day, but that was not always the case. *Ten residents required the use of a sit-to-stand lift, and five residents required the use of a total lift. -They had two sit-to-stand lifts and two total lifts available for use that day. *There were not enough lifts or staff to assist the residents. *Residents got frustrated because they had to wait to be assisted with a lift or for two staff to help them. Interview on 9/16/24 at 5:54 p.m. with resident 5 revealed: *She required the sit-to-stand lift for assistance with all of her transfers. *There were only two CNAs assigned to the 400 and 500 hallways over the weekend *She had to wait over 30 minutes for staff to respond to her call light. -They know I only call when I need to use the bathroom. -There are not enough lifts or staff. *Two weeks ago, I had to wait so long that I was incontinent of BM [bowel] while sitting in my wheelchair and it leaked on the floor. -It's so embarrassing. *She had not filed a grievance about the long wait times but was aware of the process. *She did not attend the resident council. She stated, All we do is complain and nothing gets done. Review of resident 5's EMR revealed she had a Brief Interview for Mental Status (BIMS) score of 15 which indicated she was cognitively intact. Review of resident 5's room call light audit report from 8/23/24 to 9/17/24 revealed: (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	*There were 35 call light response wait times over 15 minutes. -Five of those were over 30 minutes. *On 9/14/24 at 4:54 p.m. the wait time was 38 minutes. Interview on 9/16/24 at 4:34 p.m. director of nursing (DON) B revealed: *They do not have a lift policy or a call light policy. *She confirmed that the call lights are not visible outside the resident rooms when the call lights are activated. -Staff carried a walkie-talkie that announced when a call light was on. *There was a monitor that CNAs could look at that indicated which call light was active and for how many minutes it had been waiting for staff response. Interviews on 9/17/24 between 8:00 a.m. and 4:00 p.m. with staff members E, F, G, H, and I who requested anonymity for fear of retaliation revealed: *Issues with insufficient staff have impacted residents' having to wait to be toileted, dressed, repositioned, and changed. *At times one CNA may be responsible for the care of up to 20-33 residents. *At night when a CNA needs to leave their assigned area to help another staff member there was no staff available to assist residents in that area for over 15 minutes. -We are doing the best we can with what we have. *A bath aide was assigned 12 baths in an 8-hour shift. *We are always rushed. *Some of the residents require two [staff to] assist [them] and there is only two of us on the hallway so they have to wait while we help the others. *Sometimes we have to tell the resident we will come back as soon as we can, but then two more people need help. Interview on 9/17/24 at 3:15 p.m. with activities director K revealed: *Resident council meetings are held monthly. *Residents raised concerns about food and call lights at almost all resident council meetings. *She assisted residents individually to complete a grievance when needed. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	-The resident group did not complete a grievance form when they had concerns during the resident council meetings. Interview on 9/17/24 at 3:36 p.m. with resident 6 and resident 7 about the resident council meetings revealed: *Resident 6 became the president of the resident council last month but had attended those meetings regularly before that. *Resident 7 attended all of the resident council meetings. -She confirmed the resident council met monthly. *Residents are unhappy about the food and long call wait times. *Executive director (ED) A had attended resident council meetings. -Resident 6 stated, We tell him about the food and call lights -Resident 7 stated, .but [it] doesn't do any good. Interview on 9/17/24 at 5:00 p.m. with ED A and DON B revealed: *Two additional sit-to-stand lifts had been ordered and were expected to be received the following week. *Nurse staffing is based on the facility assessment. -They considered the facility adequately staffed. *They conducted call light audits for Quality Assurance (QA) and had not identified a problem with extended call light times. *ED A stated he was not aware of resident concerns about long call light wait times. *ED A stated there had been a problem with the call light system activating lights when residents were not in the room and staff were not able to turn those lights off. *There was no time range provided to staff on how quickly call lights were expected to be answered. -Don stated, As quickly as we can. -DON B would not confirm that 15 minutes was a reasonable time for a call light to be answered, but confirmed that 30 minutes was a long time. *They did not have a call light policy or a lift policy. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Review of the provider's updated November 2016 Notice of Resident Rights under Federal Law handout revealed: *The Resident has the right to a dignified existence and self-determination. *The Resident has the right to be treated with respect and dignity. *The Resident has the right to reside and receive services in the Center, with reasonable accommodation of Resident needs, except when doing so endangers the health and safety of other Residents. Review of the provider's The 4 R's of Resident Satisfaction Employee Acknowledgement form revealed: * .the 4R's of resident satisfaction that ALL employees adhere to and implement. *Relieve- We want to relieve any and all pain! *Reposition - We want our residents comfortable! *Restroom- We want our residents dry! Assist the resident to the restroom, if needed or as scheduled. *Reach- We want our residents to have what they need!