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	11/26/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50916 Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI), record review, interview, and policy review, the provider failed to administer physician-ordered antibiotic treatment and monitoring for one of one resident (1) who had an infection and was readmitted to the hospital. Findings include: 1. Review of the provider's submitted SD DOH FRI regarding resident 1 revealed: *His Brief Interview for Mental Status (BIMS) assessment score was 7 which indicated he had moderate cognitive impairment. *He had been hospitalized and returned to the facility on [DATE] with a diagnosis of clostridium difficile (an infection that causes inflammation of the colon and diarrhea). *He had an order for Vancomycin HCl Oral Suspension 50 milligrams (mg)/milliliter (ml) give 2.5ml by mouth four times a day (antibiotic to treat infection) for clostridium difficile. *Upon his re-admission the admitting team incorrectly entered his antibiotic order into the electronic medical record (EMR) system as unsupervised medication administration (which indicated a resident gave themself the medication unsupervised). *On 11/19/24 the Minimum Data Set (MDS) coordinator registered nurse (RN) F had found the incorrect transcription error. *Resident 1 had not received any of the physician-ordered doses of Vancomycin. *Physician ordered to start vancomycin doses as originally prescribed until all doses were given. *He was readmitted to the hospital on 11/20/24 for hyponatremia (low sodium) and hyperglycemia (high blood sugar) and loose stools. *Audits were completed on all residents to ensure no one else had a medication order in their EMR for unsupervised medication administration. (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 0684 Level of Harm - Actual harm Residents Affected - Few	2. Review of resident 1's EMR revealed: *He was readmitted to the facility on [DATE] at 12:46 p.m. following a hospitalization for a syncope episode (sudden loss of consciousness), pancolitis (a type of inflammatory bowel disease), and clostridium difficile. *He missed 16 scheduled doses of his physician-ordered vancomycin which were marked as U-SA for unsupervised self-administration (indicating he gave himself the vancomycin) on his medication administration record (MAR). *Nurses charted that he did not have any adverse side effects from the vancomycin medication on 11/15/24, 11/17/24 (three times), and on 11/18/24 (two times). *He received scheduled daily glycolax powder (used for constipation) on 11/16/24, 11/17/24, 11/18/24, and on 11/19/24. *He had bowel movements on 11/16/24, 11/17/24, 11/18/24, 11/19/24, and on 11/20/24. *A nursing progress note indicated he complained of frequent loose stools on 11/18/24 at 9:44 p.m. *He received his first dose of vancomycin on 11/19/24 at 3:16 p.m. when RN B was notified of the error and corrected the order on resident 1's MAR. *On 11/20/24 he had a basic metabolic panel (BMP) lab test completed which indicated hyponatremia and hyperglycemia and he was readmitted to the hospital. 3. Interview on 11/25/24 at 3:39 p.m. with RN B revealed: *She received education on 11/22/24 about medication administration and if they have concerns to check with the nurse manager. *She stated she was unaware of any concerns of wrong resident medication orders. 4. Interview on 11/26/24 at 8:23 a.m. with licensed practical nurse (LPN) I revealed: *An unsupervised medication administration is care planned and staff must ensure it is safe for residents to have that medication in their room and be able to administer it themselves appropriately. *If a medication is labeled as unsupervised medication administration on a resident's MAR then it would be shown as a green box. *The green box would indicate a medication had already been given during that medication pass time. *Medications shown as a red box would indicate they need to be administered. *The medication aides (CMAs) would give the residents their medications which included any antibiotics. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*She stated the nurses were to chart the resident's signs and symptoms of adverse effects of antibiotics use: -They would go into the resident's room to ask the resident how they were feeling. -The nurse would not know if they had received that medication or not. 5. Interview on 11/26/24 at 08:36 a.m. with staff development RN C and resident care manager (RCM) E revealed: *They were on the admission team and would participate in the process for admitting residents to the facility. *On admission, one person would transcribe the resident's medication orders and another person would double-check they were correct. *On 11/15/24 RCM J entered the vancomycin order into resident 1's EMR as unsupervised instead of clinician by accident. *RCM J had put the vancomycin in the medication refrigerator and said the nurses were aware that it was in there. *Resident 1's discharge order from the hospital included the glycolax powder, give 17 grams by mouth one time a day for constipation (in liquid). *They changed their order entry process of the double-check for medication orders to ensure that this type of incident would not happen again. *Admit orders would be reviewed against a printed MAR to visualize any errors. *They were not aware of anyone having questioned why they were not giving a resident on clostridium difficile precautions antibiotics. 6. Interview on 11/26/24 at 9:32 a.m. with certified medication aide (CMA) H revealed: *If a resident had orders for a scheduled constipation medication, she would administer it even if they had a bowel movement. *She stated if a resident were on precautions for an infection such as clostridium difficile and they still wanted the constipation medication she would administer it. 7. Interview on 11/26/24 at 10:55 a.m. with director of nursing services (DNS) A revealed: *She stated communication among the CMAs and nurses only happened if there was an issue such as when a medication was not given. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*She felt the nurse should not need to verify with the CMA that a medication had been given in order for them to complete their medication assessment on a resident because the medication should be labeled on the residents MAR as given or not given. *She agreed that the CMAs should have questioned the green box which indicated resident 1's vancomycin was already given. *She confirmed that resident 1 had not received his doses of vancomycin as ordered. *She agreed resident 1 should not have been given glycolax powder while he was on precautions for clostridium difficile and was having loose bowel movements. *Education was provided to staff to report any time a medication was shown on a resident's EMR as an unsupervised medication administration green box which would indicate the medication was already given. 8. Review of providers Certified Medication Assistant Job Description policy updated April 2019 revealed: *Administers prescribed medications to residents and maintains related medical records under supervision of Nurse. *1. Verifies identify of resident receiving medication and records name of drug, dosage, and time of administration on specified forms or records. *2. Presents medication to resident and observes ingestion or other application, or administers medication, using specified processes. *3. Takes vital signs or observes resident to detect response to specified types of medications and prepares report or notifies designated personnel of unexpected reactions. *4. Documents reasons prescribed drugs are not administered. Review of providers Medication Administration policy updated June 2017 revealed there was no indication of how nurses were to oversee medications administered by CMAs to ensure proper documentation and follow-up nursing assessments were completed appropriately.