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	12/18/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the provider failed to ensure one of one sampled resident (3) had a palm protector (a foam device that fits over the hand to prevent severe finger contractures (curling) from digging into the palm) applied as ordered by the physician for contracture management of his right hand. Findings include:1. Observation on12/17/25 at 4:00 p.m. of resident 3 revealed he was seated in his recliner with a blanket covering his lap. His hands were on top of the blanket. His right hand was curled tightly, with his fingers appearing to be digging into the palm of his hand. Observation and interview on 12/18/25 at 9:30 a.m. of resident 3 in his room revealed the fingers on his right hand were curled and closed tightly. There was no device to separate his fingers from the palm of his hand. When asked if he had something to help open his hand, he stated he only wore the device when he was working. 2. Review of resident 3's electronic medical record (EMR) revealed:*His admission date was 2/24/21.*His 8/22/25 Brief Interview of Mental Status assessment score was a 6, which indicated his cognition was severely impaired. *His diagnoses included: ataxia (a nervous system dysfunction that results in poor control of voluntary movements), stiff-man syndrome (a rare autoimmune neurological disorder that commonly causes muscle stiffness and painful spasms), dementia (a group of symptoms affecting memory, thinking, and social abilities), mood disorder, weakness, repeated falls, malignant neoplasm of the brain (cancer), and epilepsy (a brain condition causing repeated seizures).*A 9/18/24 physician's order to wear a Palm protector on [his] right hand during the day and off at meals. every [Every] day shift for contracture management.*His December 2025 treatment record revealed on 12/17/25 and 12/18/25, the palm protector was documented as being applied by the day shift nurse.*A 10/10/25 nurse progress note indicated Residents [3] right hand is contracted but he is able to open it and hold onto the ez [EZ] (a mechanical lift used to assist from a seated to a standing position) stand with assistance and cueing.-A 10/23/25 nurse progress note indicated Resident [3] is transferring better in the EZ stand, standing up straighter and is able to open his right hand more, as it has been contracted. 3. Interview and record review on 12/18/25 at 9:35 a.m. with certified nursing assistant (CNA) M revealed:*She was newly hired and had worked at the facility for three days.*She had never seen resident 3 wear a palm protector.*She was provided a cheat sheet (a typed form that outlined the basic care each resident needed) by the charge nurse.*The cheat sheet was reviewed with CNA M and indicated resident 3 was to have a palm protector on in [the] morning, [and] off at bedtime. 4. Interview on 12/18/25 at 9:45 a.m. with certified medication aide (CMA) I revealed:*She knew how to care for residents by looking at their Kardex (a report of the resident's care needs and interventions). There was also a banner (an area in the resident's electronic medical record (EMR) that indicates any special instructions on how to care for a resident) that a staff member could reference for each resident.*She indicated that resident 3 wore a brace (palm protector) on his hand, and she thought that was to be in place every day.*It was the responsibility of the CNAs to put the palm protector on for resident 3, then the CMA or nurse would document in the EMR that the palm protector was placed on his right hand.-Resident 3 would be brought to the nurse's desk in the mornings for the CMA or nurse to see that his palm protector was on and to document that in his EMR.-The palm protector was to be removed at mealtimes and put back on after the meal. 5. Interview on 12/18/25 at 1:05 p.m. with director of nursing (DON) B revealed:*Resident 3 would come to the nurses' desk, and the nurse would then verify that he had his palm protector in place on his hand.-The palm protector was to be taken off when resident 3 was transferring, and for meals, and then put back on after the transfer was completed or when he was done eating.-There were no further scheduled verification checks to ensure resident 3's palm protector was placed on his hand after the transfer was completed and after his meals. 6. A policy regarding following physician's orders was requested during the survey, but it was not provided by the end of the survey period.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review, the provider failed to ensure the staff provided supervision and accident prevention interventions according to the resident's care plans for one of one sampled resident (2) who fell and sustained multiple facial fractures when left unsupervised in the dining room by a nursing staff member and one of one sampled resident (4) who fell from a mechanical lift when being transferred by certified nursing assistant (CNA) L. Findings include:1. Review of the provider's 11/24/25 SD DOH FRI regarding resident 2 revealed:*On 11/24/25 at 1:45 p.m. resident 2 was found face down on the dining room floor.*The fall was not witnessed.*This was resident 2's third fall in the dining room.*Staff had left him in the dining room to finish eating his meal while they assisted other residents.*Upon a nurse assessment resident 2 had blood coming from his nose and a cut on the top of his nose.*Resident 2's family was notified and requested that he be evaluated in the emergency department.*The injuries identified while in the emergency department were, Multiple facial fractures [broken bones in the face] including bilateral [both sides] [NAME] fractures [patterns of midface bone breaks] (probable combination of left-sided [NAME] III [3; severe break that can separate the entire midface from the skull base involving the cheekbones, eye sockets, and nasal bridge] superimposed upon [NAME] I [1; the upper jaw separates from the skull]), left-sided zygomaticomaxillary complex fracture [involves the cheek bone and the connections to the cheek bone], and comminuted nasal bone fracture [nasal bone shattered into multiple pieces].*Resident 2 was receiving hospice services prior to the fall on 11/24/25 and died on [DATE].2. Review of resident 2's electronic medical record (EMR) revealed:*He was admitted on [DATE].*His 11/19/25 Brief Interview of Mental Status (BIMS) assessment score was 0, which indicated his cognition was severely impaired.*His diagnoses included repeated falls, progressive supranuclear ophthalmoplegia (a rare, degenerative brain disorder causing gradual worsening of movement, balance, vision, speech, and swallowing), dementia (a group of symptoms affecting memory, thinking, and social abilities), and anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability).*He was placed on hospice on 11/18/25 and died in the facility on 11/29/25.*He fell in the dining room on 6/17/25 at 9:10 a.m., on 10/25/25 at 10:45 a.m., and again on 11/24/25 at 1:30 p.m.*On 6/17/25 he was found in the dining room lying face down on the floor. A dietary staff member was in the dining room at the time he fell. There were no injuries identified with that fall.-The fall prevention intervention identified on 6/18/25 after the interdisciplinary team (IDT) review was, Do not leave resident in the dining room unattended without [a] CNA [certified nursing assistant].*On 10/25/25 he was found in the dining room lying face down on the floor. He sustained a cut near his left eye and required an emergency room visit for treatment. There was no staff in the dining room to monitor him and his chair was not reclined.-The 10/27/25 fall intervention was, Ensure resident is not taken to dining room early. Should be in room or where staff can visualize him.*On 11/24/25 he was again found lying on the floor in the dining room face down. His nose was bleeding, and he had a cut to the bridge of his nose and was transferred to the emergency room for treatment after he had fallen in the dining room and he returned to the facility on [DATE] at 6:40 p.m.-The interdisciplinary team (IDT) note written by administrator A dated 12/1/25 on the 11/25/25 fall incident report stated fall prevention interventions were, 1.) Staff educated not to leave resident in dining room unattended. 2.) Med [medication] aide will obtain meals and assist resident to start right away upon arriving at dining room so that he might be done around the time staff are assisting residents out of the dining room. 3.) Interventions added to care plan.*Review of resident 2's care plan that was last revised on 12/1/25 revealed an identified problem of, The resident is at risk for falls r/t [related to] Gait/balance problems, Unaware of safety needs, psychotropic [drugs that affect brain activities associated with mental processes and behavior] use, antihypertensive [medications used to treat high blood pressure].-Identified interventions for that problem area included that staff were to: Continue to use two staff members for all transfers due to hx [history] of fainting at times with transfers which was initiated on 6/10/24, Assist resident back to room after eating, not to leave him alone in dining room which were initiated on 6/18/25, Ensure resident is not taken to dining room early. Should be in room or where staff can visualize him and Resident not to be left alone in dining room which was initiated on 10/27/25, Staff was educated on not leaving him alone in dining room which was initiated on 11/25/25, and [Resident 2] cannot be in the dining room alone and for the med [medication] aide to start him eating as soon as he arrives which was

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review the provider failed to ensure one of one sampled resident (1) who committed suicide had received the necessary behavioral health services to treat a diagnosed serious mental illness. Findings include:1. Review of the provider's 12/11/25 SD DOH FRI regarding resident 1 revealed:*On 12/11/25 at 12:50 a.m. a CNA (certified nursing assistant) responded to resident 1's roommate's call light and found resident 1 hanging by a string around his neck off the side of the bed.*That CNA had assisted resident 1 with his urinal at approximately 11:00 p.m. during the routine two-hour rounds (periodic checking on residents' status and assistance needs).*The CNA notified the nurse, the nurse responded to resident 1's room and cut the string that the resident was hanging from.*At the time resident 1 was released from the side of the bed he was cyanotic (bluish discoloration of the skin, lips, or nails due to the lack of oxygen in the blood), his body was cold to the touch, and there was no pulse, or respirations.*The CNA discovered a goodbye note on resident 1's bedside table.*Resident 1 had a do not resuscitate (DNR) directive on record at the facility.*Law enforcement and resident 1's family were notified.*Law enforcement arrived at the facility at 1:15 a.m., and requested that the staff leave the resident's room as the investigation was conducted. *Resident 1's body was released to the funeral home at 2:15 a.m.*The preliminary investigation suggested resident 1 had raised his bed into the highest position, placed a string around his neck, and moved his body off the side of his bed independently. 2. Review of resident 1's electronic medical record (EMR) revealed:*He was admitted to the facility from a hospital on [DATE].*His 10/31/25 Brief Interview of Mental Status (BIMS) assessment score was 12, which indicated his cognition was intact.*His diagnoses included depression. -Suicidal ideations (thoughts of suicide) was not included on his diagnosis list.*There was a 10/27/25 physician's order for Escitalopram Oxalate Oral Tablet 20 MG [Milligrams] (Escitalopram Oxalate) [a medication used to treat depression] Give 1 tablet by mouth one time a day related to depression.*Resident 1's 10/27/25 Level II (2) Preadmission Screening and Resident Review (PASRR) revealed:-Resident 1 was taking Lexapro (Escitalopram) medication for depression.-He had made statements in the past about suicide. -He fell into the category of having a diagnosis that the PASRR program was designed to assess. Your condition is likely to require expert treatment in the future.--The reason for that decision was indicated as, You have a condition of Depression, unspecified that has impacted your day-to-day needs and has led to the need for mental health and medication management services to treat your mental health needs.- You need 24/7 [24 hours per day/ 7 days per week] care and supervision to ensure your health and safety because you may neglect self-care, your daily activities, and your medications due to your physical limitations, and mental health diagnoses.- You will need to be provided the following specialized services:Psychiatric medication management/monitoring:Individual mental health therapy:- You should see a psychiatrist, psychiatric nurse practitioner, or primary care physician to assess your medications to see how well they are working for you at treating your symptoms. The frequency of your visits can be determined by your treatment team.- Counseling (optional) can help you adjust to the changes you've had in your health, and you can learn new coping skills for managing your mental health symptoms.*His 10/31/25 PHQ-9 (a tool used to assess for depression) score was 5, which indicated he had mild depression symptoms.*On 11/3/25 resident 1 had an initial visit to evaluate their psychiatric conditions and determine if [redacted company name] can assist in the management, education and support of these conditions. At that time, he consented for Behavioral Health Integration (BHI) and Collaborative Care Management (CoCM) services.-BHI and psychiatric CoCM services, including the scope of care coordination, availability of 24/7 access to clinical support, and the monthly non-face-to-face nature of services-The note from that visit indicated he denied having suicidal ideations, homicidal ideations, or hallucinations.*An 11/19/25 progress note written by Minimum Data Set (MDS) coordinator D stated, Visited with resident today about his mood. Smiling as he visits with this writer. Stated some days I am more down than others. Stated 'I am [AGE] years old and I do not know why I am still here' as he smiled at this writer. Spent time talking with resident about how none of us know how long we will have, and that it is all in God hands. Asked this writer if he feels his antidepressant medication needs to be increase. [resident] Stated 'No, some days I am just more down than other days.' Counseling was offered to resident [1] at care conferences- [the resident] declined.*An 11/26/25 progress note at 9:02 a.m. written by licensed practical nurse (LPN) resident care manager (RCM) H stated, This writer spoke with [resident 1's