

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/30/2026
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)		
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on observation, interview, and record review, the provider failed to ensure an environment free from accident hazards for seventeen of seventeen sampled residents (3, 22, 23, 24, 29, 43, 48, 70, 74, 78, 83, 84, 86, 92, 102, 106, and 110) who resided within a memory care unit (an area where specialized care is provided in a structured, safe and supportive environment to meet the unique needs of residents with significant memory and cognitive decline, that is secured to minimize unsafe wandering) and had access to the memory care unit exit door key. Findings include: 1. Observation on 7/28/26 at 11:57 a.m. in the memory care unit kitchenette revealed resident 86 and her visitor were standing by the refrigerator, which was located by the exit door of the memory care unit. That door exited into one of the main hallways in the facility. Resident 86's visitor stated to resident 86, it's still up here. Resident 86's visitor grabbed a staff member's badge from the top of the refrigerator, touched the badge to the badge reader on the memory care unit's exit door and unlocked the door. Resident 86's visitor placed the badge back on top of the refrigerator, said goodbye to resident 86, and exited the unit. There were no staff members present. 2. Observation on 7/28/26 at 12:10 p.m. revealed that medical memory care unit director W grabbed the badge from the top of the refrigerator and put it on her shirt. 3. Interview on 7/28/26 at 2:31 p.m. with resident 86 revealed that she did not have concerns about being able to leave the unit. She said I just need the key the staff wear. 4. Observation on 7/28/26 at 4:32 p.m. revealed that certified medication aide (CMA) X's badge was sitting on top of the refrigerator and there were no staff members in that area. 5. Interview on 7/29/26 at 2:21 p.m. with memory care unit director W revealed that if there was a visitor who visited a resident in the memory care unit often, the staff would give the visitor a badge to unlock the memory care unit door and instruct them to place it on top of the refrigerator so they could leave the unit and not have to wait for the staff to let them out. She left her badge on top of the refrigerator on 7/28/26 so resident 86's visitor could leave the unit without waiting for her. She was not supposed to do that because a memory care resident could get out of the unit without the staff knowing. 6. Interview on 7/30/26 at 10:42 a.m. with administrator A revealed that all the residents who resided in the memory care unit had a physician's order to be on a locked unit for their safety. The residents (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 0689 Level of Harm - Actual harm Residents Affected - Few	facility. 5. Interview on 7/28/26 at 4:37 p.m. with resident 96's family member revealed they were informed about his fall from the whirlpool bath chair and had no concerns. 6. Observations from 7/28/26 through 7/30/26 of four of four tub rooms revealed they had the [NAME] Bath System Bed to Bath Transfer Procedures posted for the staff to use during resident baths. This procedure included when staff were to apply the safety belt and remove the safety belt from the resident. 7. Review of the 6/26/26 Quality Assurance and Performance Improvement (QAPI) meeting minutes regarding resident 96's fall revealed the interdisciplinary team evaluated the resident after his fall, interviewed the staff members involved, and an initial audit was completed. The facility's correction actions for the deficient practice (not using the safety belt in the whirlpool bath) included providing education to the bath aides and then demonstrating the placement and use of the safety belt, and providing education to all staff who have the potential to use the bath chair before they assist a resident with a bath. Audits were to be completed by the director of nursing (DON) or designee daily, with three to five observations each day for one week. Then weekly for three weeks. Then monthly for 2 months. The QAPI meeting determined this will be a performance improvement plan (PIP) and would be ongoing with a goal of 100% compliance. 8. Review of the whirlpool tub daily audits completed from 6/29/26 through 7/3/26 revealed that each tub room was audited and in compliance with the safety belt being used when a resident was in the tub chair. There were nineteen individual audits completed of residents with the safety belt on. 9. Review of the whirlpool tub weekly audits completed from 7/6/26 through 7/24/26 revealed that sixteen individual audits were completed and in compliance with the safety belt being used when a resident was in the tub chair. 10. Interview on 7/30/26 at 10:58 a.m. with CNA Z regarding resident 96's fall revealed that resident 96 fell as he grabbed onto the side of the whirlpool tub as she pulled the whirlpool bath chair backward. She immediately opened the tub room doors and hollered for help. CMA V and LPN I came to assist the resident. After LPN I said it was safe to get him off the floor, the three staff members used the total body lift and transferred him into his wheelchair. They then took him to his room to get him dressed before taking him to the ED. CNA Z was suspended pending the facility's investigation until further notice. She was given verbal education on how to use the whirlpool bath chair and the safety belt after resident 96's fall. CNA Z said, This was 100% my fault. I was rushing and trying to get as many baths done as possible, and I missed that step. I have learned to be extra cautious. Now I take my time, and everyone gets the [safety] belt in the whirlpool [bath] chair. 11. Interview on 7/30/26 at 11:09 a.m. with LPN I regarding resident 96's fall revealed that she was alerted to the tub room by CNA Z because resident 96 was on the bathroom floor. He was bleeding from the left side of his face, so she put a cloth over it to help clean it up. After it was cleaned up, we placed ice over the bleeding area. She completed her head-to-toe assessment and then helped transfer him into his wheelchair with a total body lift. She notified contracted travel LPN J, who was (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the assigned nurse for resident 96 that day. 12. Interview on 7/30/26 at 11:56 a.m. with contracted travel LPN J revealed that she was the nurse for resident 96 on 6/26/26. She assessed the resident, notified the director of nursing (DON) B, called the resident's physician, and received an order to send the resident to the ED for further evaluation. When he returned, she continued his neurological checks. 13. DON B was unavailable during the survey and could not be interviewed. 14. Review of the [NAME] Bathtub System Preparation manufacturer's instructions manual revealed, 9. All residents must always be securely safety belted at the waist when using any of the [NAME] Lift Systems. Ensure that the safety belt is routed through the loose buckle end. 15. Based on the above information, non-compliance at F689 occurred on 6/26/26, and based on the provider's corrective action plans that were initiated on 6/26/26 and implemented for the deficient practice, the non-compliance is considered past non-compliance.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, document review, and policy review, the provider failed to ensure that the resident's grievances were addressed, and documentation reflecting the staff's efforts to resolve those grievances was communicated to the residents and approved as effective resolutions for eight of eight sampled residents (16, 30, 31, 63, 79, 81, 108, and 109) who attended the resident council meeting on 7/29/26 that reported concerns in grievance resolution. Findings include: 1. Interview with residents 16, 30, 31, 63, 79, 81, 108, and 109 during the resident council meeting on 7/29/26 revealed that they have not had grievances resolved, and the staff had not come to discuss with the council or any members the resolution of grievances brought from the resident council. 2. Review of resident 16's electronic medical record (EMR) indicated she admitted to the facility on [DATE]. Her 6/4/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. 3. Review of resident 30's EMR indicated she admitted to the facility on [DATE]. Her 6/29/26 BIMS assessment score was 11, which indicated her cognition was moderately impaired. 4. Review of resident 31's EMR indicated she admitted to the facility on [DATE]. Her 7/17/26 BIMS assessment score was 15, which indicated her cognition was intact. 5. Review of resident 63's EMR indicated he admitted to the facility on [DATE]. His 7/7/26 BIMS assessment score was 14, which indicated his cognition was intact. 6. Review of resident 79's EMR indicated he admitted to the facility on [DATE]. His 6/5/26 BIMS assessment score was 15, which indicated his cognition was intact. 7. Review of resident 81's EMR indicated she admitted to the facility on [DATE]. Her 7/28/26 BIMS assessment score was 13, which indicated her cognition was intact. 8. Review of resident 108's EMR indicated she admitted to the facility on [DATE]. Her 7/10/26 BIMS assessment score was 15, which indicated her cognition was intact. 9. Review of resident 109's EMR indicated she admitted to the facility on [DATE]. Her 4/3/26 BIMS assessment score was 15, which indicated her cognition was intact. 10. Review of grievances from May 2026 through July 2026 revealed 37 of 77 grievances have not had the grievance resolution documented, with the complainant notified and by what method they were communicated with. 11. Interview on 7/30/26 at 12:45 p.m. with Administrator A revealed that she was the grievance official in charge of reviewing and ensuring the completion of the grievances. She expected the grievances to be resolved, completed, and followed up with the complainant in 5 days. The grievance resolution, person notified, date and time of notification, and method of communication she would expect to have filled in with the appropriate information. 12. Review of the provider's updated March 2025 Grievance Procedure Policy revealed The administrator oversees the grievance procedure and coordinates the center system for collecting, tracking, and responding to grievances. The administrator is designated as the Grievance Official for the center. Their contact information is posted with the policy in prominent areas throughout the center. The Administrator/designees routes the Grievance Form to the appropriate department manager, who reviews the grievance, responds within five business days, and returns the Grievance Form to the Administrator. The person with the grievance has the right to a written decision regarding his/her grievance.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the provider failed to ensure the staff responded promptly to four of five sampled residents (31, 46, 105, and 108) who reported concerns about extended call light times. Findings include: 1. Interview on 7/28/26 at 9:06 a.m. with resident 46 revealed he had waited a long time, up to two hours, for the staff to answer his call lights. He said that if he had to go to the bathroom, it really hurt waiting, and that he was incontinent (involuntary urine or bowel leakage) if he had to wait too long. 2. Review of resident 46's EMR indicated he admitted to the facility on [DATE]. His 6/10/26 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated his cognition was moderately impaired. His diagnoses included myelodysplastic syndrome (a type of blood and bone marrow disorder where the bone marrow produces too few healthy blood cells and some abnormal cells), type 2 diabetes mellitus (a condition involving disruptions in how the body regulates blood sugar), benign prostatic hyperplasia (an enlargement of the prostate gland) without lower urinary tract symptoms, and dorsopathy (disorders of the spine or back). His 6/10/26 MDS assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs), section GG, indicated he required partial/moderate assistance with oral hygiene, toileting hygiene, dressing his upper body, personal hygiene, and transfers between surfaces. He required substantial/maximum assistance with dressing his lower body and putting on and taking off his footwear. He was dependent on the staff for showering/bathing. 3. Review of resident 46's call light log (a structured record used in healthcare settings to track patient call button usage and staff responses) from 7/1/26 to 7/29/26 revealed that there were sixteen call light wait times longer than 15 minutes, eight call light wait times longer than 30 minutes, seven call light wait times longer than 40 minutes, and one call light wait time was 1 hour and 6 minutes. 4. Interview on 7/28/26 at 10:31 a.m. with resident 31 revealed that she had to wait up to 45 minutes for the staff to assist her to the commode (a portable chair with a built-in toilet seat and removable bucket, used for toileting). She felt like she had lost her independence because she was incontinent of bowel while waiting for the staff. 5. Review of resident 31's EMR indicated she admitted to the facility on [DATE]. Her 7/17/26 BIMS assessment score was 15, which indicated her cognition was intact. Her diagnoses included parkinson's disease without dyskinesia (a progressive disorder of the nervous system that gradually damages dopamine-producing cells in the brain, leading to symptoms like tremors (shaking), muscle stiffness, slowed movement, and balance problems), rheumatoid arthritis (an autoimmune, chronic disease where the body's immune system attacks the lining of the joints), neuromuscular dysfunction of the bladder (a condition where nerve or muscle issues disrupt the signals between the bladder and the brain/spinal cord), type 2 diabetes, major depressive disorder, morbid (severe) obesity (excessive weight that significantly impacts health and well-being), and anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). Her undated care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated she was dependent on one to two staff members when repositioning in bed and getting dressed. She transferred using a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) with two staff members. She used the sit-to-stand to get into her wheelchair, bathe, and use the restroom. 6. Review of resident 31's call light log from 7/1/26 to 7/28/26 revealed that there were fifteen call light wait times longer than 15 minutes, and one call light wait time of 33 minutes. 7. Interview on 7/28/26 at 3:54 p.m. with resident 105 revealed she was incontinent when she had to (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wait 15-20 minutes for the staff to assist her to the bathroom. That made her feel humiliated. She knew when she had to use the restroom but could not get there on time because she had to wait for the staff.8. Review of resident 105's electronic medical record (EMR) revealed she admitted to the facility on [DATE]. Her 7/9/26 BIMS assessment score was 15, which indicated her cognition was intact. Her diagnoses included anxiety disorder, and depression. Her undated care plan revealed she had an activities of daily living (ADL) self-care performance deficit due to an impaired balance, limited mobility, and limited range of motion. The 7/15/26 added interventions for her bathing/showering indicated she was to have two baths per week and as needed (prn).9. Review of resident 105's call light log from 7/1/26 to 7/29/26 revealed there were seven call light wait times longer than 15 minutes, four call light wait times longer than 30 minutes, one call light wait time longer than 40 minutes, and two call light wait times longer than 50 minutes.10. Interview on 7/28/26 at 9:25 a.m. with resident 108 revealed that she has had her call light on for up to one hour. That made her mad because the staff knew she had put the call light on because she needed their help.11. Review of resident 108's EMR indicated she admitted to the facility on [DATE]. Her 7/10/26 BIMS assessment score was 15, which indicated her cognition was intact. Her diagnoses included chronic kidney disease stage 3b (a moderate to severe decline in kidney function) and major depressive disorder. Her undated care plan indicated resident 108 is at risk for falls related to gait (walking) and balance problems. The interventions added on 4/10/25 indicated anticipating and meeting the resident's needs. Ensure the call light is within reach, and the staff was to encourage the resident to use it for assistance when needed. The resident needed prompt response to all requests for assistance. 12. Review of resident 108's call light log from 7/1/26 to 7/28/26 revealed there were twenty-one call light wait times longer than 15 minutes, and one call light wait time of 33 minutes.13. Interview on 7/30/26 at 7:55 a.m. with contracted travel licensed practical nurse (LPN) K revealed that the residents should not wait more than 5 minutes for their call light to be answered. Any nurse or certified nursing assistant (CNA) can answer a call light to assist the resident. She said they know the call lights are alarming by using a phone that the facility provided. She had a facility phone with her at the time of the interview. 14. Interview on 7/30/26 at 8:00 a.m. with contracted travel CNA AA revealed the resident's call lights should be answered within 15 minutes. She did not have a phone device on her to indicate who had a call light on at the time of the interview.15. Interview on 7/30/26 at 1:15 p.m. with staff development registered nurse (RN) D revealed the facility had a phone system that alerted the staff visually and auditorily when a resident's call light was activated. Each nurse's station had a screen that would show the call lights in each area. She expected each staff member to have a phone with them during their scheduled shift to answer the call lights. She expected the staff to answer the call lights within 15 minutes.16. Review of the provider's 6/1/26 Call Light Education and Expectations revealed although anyone can answer a call light, the care staff assigned to the residents are responsible for ensuring call lights are available, answered, and addressed promptly. The call light system is arranged to notify us as the call light escalates through Excellent, acceptable, needs improvement. Excellent is call answered in less than 10 minutes. Acceptable is call answered in less than 10-15 minutes. Needs improvement is call answered in over 15 minutes.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, record review, and policy review the provider failed to ensure sanitizer solutions were tested and documented for one of one main kitchen. Findings include: 1. Observation, interview, and July sanitizer log review on 7/28/26 at 9:37 a.m. in the main kitchen with dietary aide EE revealed a bucket of sanitizer solution with a wash rag inside of it was on one of the food prep tables. Dietary aide EE used the rag to wipe down the food prep table after she put cookies into Ziplock bags for snacks. She confirmed the sanitizer solution was changed three times a day or if the water was dirty. the July sanitizer log was hanging on a wall in the kitchen next to the dish room, and dietary aide EE confirmed that was where the dietary staff documented the sanitizer tests for the bucket of sanitizer solution. The July sanitizer log was missing 4 of 28 sanitizer test results for breakfast, 4 of 28 sanitizer test results for lunch, and 26 of 28 sanitizer test results for dinner. 2. Interview and April sanitizer log review on 7/29/26 at 4:30 p.m. with registered dietitian L, dietary supervisor M, senior certified dietary manager (CDM) GG, and senior CDM HH revealed they expected the dietary staff to test the sanitizer solution three times a day at each meal time. They agreed that was not being completed. Review of the April sanitizer log revealed 11 of the 30 breakfast sanitizer test results were missing, and 11 of the 30 lunch sanitizer test results were missing. Dietary supervisor M was unable to locate the sanitizer logs for May and June. 3. Interview on 7/30/26 at 1:43 p.m. with administrator A revealed she expected the dietary staff to follow the provider's policy for testing the sanitizer in the kitchen. She agreed that was not being done. 4. Review of the provider's updated November 2020 Sanitizer Solution policy revealed that, Policy Statement: A sanitizing solution is used in the Dietary Department for sanitizing work surfaces. 2. New solution is tested three times daily for proper concentration by using Sink and Sanitizer cleaner test strips or the visual compliance indicator test strips.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to minimize the risk of residents acquiring and transmitting pneumococcal disease by ensuring that three of five sampled residents (35, 56, and 60) were offered the pneumococcal vaccination. Findings include: 1. Review of resident 35's electronic medical record (EMR) revealed that he admitted to the facility on [DATE]. He had received the PCV 13 (an immunization that protects against thirteen types of streptococcus pneumoniae bacteria) vaccination on 8/21/20. There was no documentation that he was offered and received or declined the additional recommended pneumococcal vaccine. 2. Review of resident 56's EMR revealed that he admitted to the facility on [DATE]. He had received the PCV 13 vaccination on 11/21/19. There was no documentation that he was offered and received or declined the additional recommended pneumococcal vaccine. 3. Review of resident 60's EMR revealed that he admitted to the facility on [DATE]. He received the PPV 23 (a vaccine that protects against 23 types of streptococcus pneumoniae bacteria) vaccine on 11/12/10. There was no documentation that he was offered and received or declined the additional recommended pneumococcal vaccine. 4. Interview on 7/30/26 at 1:06 p.m. with registered nurse (RN) unit manager/infection preventionist (IP) C revealed she started using a new computer system on 6/1/26 for monitoring resident immunizations. When a resident admitted to the facility, they were offered immunizations that were needed according to the new computer system and the state immunization records. She stated, It's a work in progress. She agreed that resident's 35, 56, and 60 were not offered the recommended pneumococcal vaccines, and that they did not decline or refuse the vaccines. She expected new admit immunization records to be reviewed on admission, and that residents were offered the needed immunizations after admission. 5. Review of the updated 6/19/25 Pneumococcal Vaccination of Residents policy revealed The facility offers the Pneumococcal vaccination to facility residents among facility residents in accordance with Centers for Disease Control (CDC) recommendations and Federal requirements. Each resident's pneumococcal immunization status is determined upon admission or soon afterwards and is documented in the resident's EHR [electronic health record] medical record.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the provider failed to ensure resident bathing choices were being followed for one of one sampled residents (105). Findings include: 1. Interview on 7/28/26 at 3:54 p.m. with resident 105 revealed that she requested two baths per week since her admission to the facility. That request was not fulfilled. She then requested her physician to write an order for two baths per week. She said she felt uncomfortable and unclear, not being able to shower two times per week. 2. Review of resident 105's electronic medical record (EMR) revealed she admitted to the facility on [DATE]. Her 7/9/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnoses included anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and depression. Her undated care plan (personalized plan that addresses a resident's care needs, goals, and interventions) revealed she had an activities of daily living (ADL) self-care performance deficit due to an impaired balance, limited mobility, and limited range of motion. The 7/15/26 added interventions for her bathing/showering indicated she was to have two baths per week and as needed (prn). Her 6/26/26 Minimum Data Set (MDS) assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) section GG functional abilities and goals indicated that resident 105's self-care assessment for bathing was that she needed partial staff assistance. Her physician's order dated 7/14/26 indicated she was to have two baths weekly. 3. Review of the 400 hallway daily bath schedule revealed resident 105's bath was scheduled on Monday. There was not a second bath day scheduled for resident 105 that week. 4. Interview and 400 hallway daily bath schedule review on 7/30/26 at 1:15 p.m. with staff development registered nursing (RN) D revealed the staff had daily bath sheets that identified who was to get a bath each day. The bath sheets were kept in the tub rooms. These sheets were updated weekly by medical records S. If she was not available, then director of nursing (DON) B updated them. Staff development RN D expected that if there was a doctor's order for a resident to receive two baths weekly, the facility would follow that order. Staff development RN D reviewed resident 105's bath schedule and confirmed the resident was scheduled to receive a bath on Mondays, despite her physician's order for two baths per week. 5. Interview on 7/30/26 at 1:35 p.m. with medical records S revealed that she updated the bath schedule two times per week. She received updates on the physician's orders from staff development RN D or DON B and would follow those physician's orders if they regarded the resident's bath schedule. She said that RN D just fixed a bath schedule for resident 105 earlier after she found a physician's order. Medical records S was not aware of the order for resident 105. 6. The survey team requested the bathing policy on 7/29/26 at 9:49 a.m. 7. The facility did not provide a bathing policy. When administrator A returned the requested documents to the team, she said the facility follows the Resident Assessment Instrument (RAI) (an official guide published by the Centers for Medicare & Medicaid Services (CMS) that provides instructions for the Resident Assessment Instrument) for bathing guidelines. 8. Review of the provider's updated April 2024 Physician Order Recaps policy revealed the licensed nursing staff is responsible for inputting admission, telephone, and verbal physician's orders into the EHR [a digital electronic health record of a medical chart that stores health information] immediately upon receipt from the provider. The Director of Nursing establishes the licensed clinician responsible for recap and reconciliation of New, Discontinued, or Completed orders in the EHR daily and initiates corrections daily.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure that two of five sampled residents (65 and 73) had a Preadmission Screening and Resident Review (PASRR) level II (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) completed. Findings Include: 1. Review of resident 65's EMR revealed she admitted to the facility on [DATE] and had diagnoses that included depressive disorder, hallucinations, and hoarding disorder. She had a 5/25/23 PASRR Level 1 completed. Her 9/11/23 PASRR Level II screening form determined resident 65 was exempt from a Level II review as the diagnosis of a mental illness was unsubstantiated. On 9/5/24, resident 65 received a new diagnosis of delusional disorders. Social Services director (SSD) N's notes documented on 10/24/24 indicated that the PASRR is appropriate-we do monitor to update. Resident currently has a psychiatric diagnosis. PASRR II screen is not indicated. Resident 65's 11/8/24 quarterly Minimum Data Set (MDS) assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) completed by SSD N did not identify delusions. The 5/8/26 MDS assessment completed by SSD N did not identify delusions. Resident 65's November 2024 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated Resident is exhibiting delusion thoughts. Her 6/2/25 care plan identified she had behaviors including: delusions, hallucinations, hoarding, and neglecting the doctor's orders. SSD N indicated in a 1/24/25 progress note that Resident thought process and decisions are based on her perceived perceptions and beliefs. These are not always realistic and can often be delusional in nature. These do get in the way of her thinking and ability to manage her own needs. Resident does like to take her time with things so that she can sort the details out. These details turn from real to some delusional. Safety awareness is poor at times. Diagnoses were major depressive disorder, single episode, mild and delusional disorders. Continue to see thoughts on delusional side. We have seen resident not making good decisions surrounding her healthcare choices. She has certain beliefs that she follows regardless if they are true or not. 2. Interview and EMR review on 7/29/26 at 4:14 p.m. with SSD N regarding the Level 1 and Level II PASRR provided by the facility for resident 65 revealed that the PASRRs provided by the facility were from 2023. SSD N stated there were no additional PASRRs completed on resident 65. She expected a PASRR to be done if there was a new diagnosis of delusional disorders present. She confirmed in resident 65's EMR that the diagnosis of delusional disorders was added during her stay at the facility and that no PASRR was completed. 3. Review of resident 73's EMR revealed he admitted to the facility on [DATE]. His 6/16/26 Brief (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview for Mental Status (BIMS) assessment score was 0, which indicated his cognition was severely impaired. His diagnoses included unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities) and unspecified psychosis (a diagnostic category used when a person experiences clear psychotic symptoms) not due to a substance or known physiological condition, diagnosed on [DATE]. A PASRR level 1 screen was completed on 10/26/23 with Maximus (a clinical service that evaluates individuals applying for or residing in Medicaid-certified nursing facilities). The level I screen indicated that resident 73 did not show that you have a serious mental illness or an intellectual/developmental disability (IDD). You do not need more screening unless you have or may have a serious mental illness or an IDD and experience a significant change in treatment needs. His 9/11/2025 pharmacy medication review had a signed order acknowledging he was prescribed the antipsychotic medication Olanzapine 2.5 milligrams (mg) twice a day (BID) for the treatment of unspecified psychosis since July 2024. 4. Interview and EMR review on 7/30/26 at 10:35 a.m. with SSD N revealed that she would submit a PASRR level II for a resident who had a serious mental illness diagnosis. She reviewed resident 73's EMR and confirmed he had a serious mental illness. SSD N was not notified if a resident received a new diagnosis. No additional mental health authorities were notified of resident 73's psychosis diagnosis. 5. Review of the provider's revised 1/1/25 PASRR Process Policy and Procedure revealed 4. If there is a significant change of condition that affects their diagnosed need for a PASRR 2, staff refer for a NEW PASRR Level 2. a. The Level 2 evaluator determines if the resident's current care needs are able to be met at the NF [nursing facility]. b. If the resident remains appropriate for the nursing facility (NF), there may be new recommendations to be placed on the care plan. c. If the resident is no longer deemed appropriate for the NF setting, the evaluator will discuss with the Administrator and/or the social services Director. 8. Follow up as needed per federal PASRR rules.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and policy review, the provider failed to ensure one of one portable oxygen cylinder (a pressurized container that stores and transports compressed or liquid oxygen) was securely transported. Findings include:1. Observation on 7/30/26 at 10:23 a.m. in hallway 400, outside the nurse's station, revealed contracted travel licensed practical nurse (LPN) K removed an oxygen cylinder from the back of a resident's wheelchair and carried it down the hallway towards the 100 hallway.2. Observation on 7/30/26 at 10:28 a.m. revealed contracted travel LPN K carried an oxygen cylinder from the direction of the 100 hallway to the 400 hallway, outside the nurse's station and placed the oxygen cylinder on the back of the same resident's wheelchair as the observation above.3. Observation on 7/30/26 at 11:28 a.m. of the oxygen storage room revealed there were five wheeled carts available to transport oxygen tanks. Three of those wheeled carts had oxygen cylinders in them. There was an orange sign posted on the wall in the oxygen storage room, which stated Do not leave oxygen tanks standing alone! They must be in a holder at all times! 4. Interview on 7/30/26 at 10:25 a.m. with registered nurse (RN) medication nurse H, who witnessed LPN K remove and replace the resident's oxygen cylinder, revealed that the oxygen cylinder should have been in a wheeled cart for both the empty and full oxygen cylinders during transport. 5. Interview on 7/30/26 at 10:32 a.m. with contracted travel LPN K, regarding the oxygen cylinders revealed the oxygen cylinder she removed from the resident's wheelchair was empty and that she retrieved a full oxygen cylinder from the oxygen storage room. She carried the full oxygen cylinder down the hallway and placed it on the resident's wheelchair. She confirmed there were wheeled carts available in the oxygen room for transport, but they are way down the hallway so I just carry them. She would normally carry the oxygen cylinders back and forth from the oxygen storage room when she needed to change out a resident's empty oxygen cylinder. 6. Interview on 7/30/26 at 11:40 a.m. with RN unit manager/infection preventionist C and staff development RN D revealed, staff development RN D would get a wheeled cart from the oxygen storage room or bring the resident to the oxygen storage room to switch out the oxygen cylinders. RN unit manager/infection preventionist C agreed with that process. Staff development RN D stated she had told the staff to put the oxygen cylinders in a cart and wheel them down to the resident; however, she did not provide specific education on switching out the oxygen cylinders. 7. Interview on 7/30/26 at 12:14 p.m. with contracted travel certified nursing assistant (CNA) CC revealed she had seen someone drop an oxygen cylinder before and it made a big hole in the wall. She changed out oxygen cylinders by bringing the residents to their room and using a wheeled cart to transport the oxygen cylinders. She has seen other staff members carrying the oxygen cylinders instead of using the wheeled carts for transportation. 8. Interview on 7/30/26 at 12:21 p.m. with RN medication nurse G revealed, she used the oxygen cart to transport the empty and full oxygen cylinders back and forth from the oxygen storage room. She identified the oxygen carts as the wheeled carts located in the oxygen storage room. 9. Interview and staff education review on 7/30/26 at 2:28 p.m. with staff development RN D revealed she provided the staff members with a five-minute video regarding oxygen use and safety and had them take a test. She confirmed that the printed content of the video identified that the oxygen cylinders should always be kept upright and be in a carrier. She stated that she does not do training with the contracted travel staff as they have their competencies through their agency.10. Review of LPN K's employee file revealed she was provided, fire safety training through Relias (the provider's education training system) on 6/13/25; however, nothing specific related to oxygen safety. 11. Review of the provider's December 2017 Respiratory Care policy revealed Safety precautions and care of oxygen delivery (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	equipment are performed according to State and Federal regulation and manufacturer guidance. The Center observes precautions to prevent explosions, fire, etc. that are associated with oxygen use and storage. All oxygen tanks are secured in appropriate storage containers/stands or secured to a wall with a chain or heavy cable. Center personnel receive training regarding oxygen administration and safety.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, document review, and interview, the provider failed to ensure the daily posted nurse staffing information reflected the actual resident census and hours worked by registered nurses (RNs), licensed practical nurses (LPNs), certified medication aides (CMAs), and certified nursing assistants (CNAs) per shift, and was posted in a location visible and accessible to the residents, staff, and visitors. Findings include: 1. Observation on 7/28/26 at 8:30 a.m. revealed the facility resident census and daily nurse staffing information was posted in the window of the facility's main entrance. The information included the date, resident census, and the number of nursing personnel and their total hours scheduled to work for that day. 2. Review of the provider's nursing staff schedule for July 2026 revealed that no registered nurse was scheduled for 7/14/26 and 7/22/26. 3. Review of the provider's daily posted nurse staffing information for 7/14/26 and 7/22/26 revealed that on both days, one registered nurse was scheduled for a 12-hour day shift and one registered nurse was scheduled for a 12-hour night shift. 4. Interview on 7/30/26 at 9:00 a.m. with RN medication nurse H revealed that when the staff called in or missed their scheduled shift, the nurse on duty provided a call-in sheet to director of nursing (DON) B, staff development RN D, or administrator A. RN medication nurse H expected the call-in information to be relayed to receptionist U, who posted the daily nurse staffing information in the window of the main entrance. RN medication nurse H was not involved with completing the daily nurse staffing information and did not know if the posted information was updated throughout the day. 5. Interview on 7/30/26 at 9:15 a.m. with receptionist U revealed that she prepared and posted the daily resident census and nurse staffing information when she arrived at work each morning. She referenced the nursing schedule to obtain the number of CNAs and CMAs scheduled on each shift, but she did not know which nurses were RNs or LPNs. When she was hired in December 2025, receptionist T trained her to always write that one RN and two LPNs were scheduled for the day and night shifts. She did not post updates throughout the day as the census or nursing schedule changed. She agreed the posted information did not reflect the actual resident census or hours worked in each staffing category. 6. Interview on 7/30/26 at 9:48 a.m. with staff development RN D revealed that DON B and staffing coordinator P coordinated shift coverage to ensure that enough nursing staff were working to meet the residents' needs. Staff development RN D said three or four nurses were scheduled per shift, along with five CMAs and five CNAs for the day and evening shifts and four to six CNAs for the night shift. If staff called in for their scheduled shift, five nurse managers were expected to help cover the shift vacancies. The two scheduled bath aides and non-licensed staff activities and restorative therapy staff were also pulled to help where needed. We all just pitch in where we can. 7. Interview on 7/30/26 at 10:32 a.m. with administrator A revealed that she did not update the Facility Assessment since she was hired in November 2025. She expected to see at least three nurses working the day shift and three nurses working the night shift. The nurse managers primarily worked in their offices and were not included in the hours reflected in the Facility Assessment, but she expected them to cover vacant nursing shifts and help the direct care staff as needed. She said that a registered nurse is scheduled to work at least eight hours a day, and if an RN was not on the schedule for 7/14/26 and 7/22/26, then the nurse managers were considered the RN for that day. Administrator A was not aware that the daily posted nurse staffing information should reflect the resident census and the nurse staffing updates throughout the day. She said none of the nurses completed the daily resident census and nurse staffing information, just the receptionists. She expected that receptionists T and U would accurately list the number of LPNs and RNs working each day. 8. The provider did not have a policy on posting (continued on next page)		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the daily resident census and the nurse staffing posting information. 9. Review of the provider's 7/11/25 Facility Assessment, Staffing Plan, revealed that the staffing was evaluated and adjusted based on the resident census and residents' care needs. For a census of 125 residents, the Facility Assessment indicated that each day would include direct care hours performed by RNs (three or more per shift), LPNs (one or more per shift), and CNAs (three or more per shift).		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed standard infection prevention practices regarding enhanced barrier precautions (EBP) (gown and glove use when providing contact care) by one of one contracted travel certified nursing assistant (CNA) (BB) while she changed bed linens for one of one sampled resident (28) who required EBP. Findings include: 1. Observation on 7/28/26 at 11:04 a.m. revealed that contracted travel CNA BB made resident 28's bed. Resident 28 had a sign on his door indicating he required EBP. Contracted travel CNA BB was not wearing gloves or a gown, and the soiled bed sheet was lying on resident 28's floor. Contracted travel CNA BB picked up the soiled bed sheet with her bare hands, put it in a garbage bag, put that garbage bag on the floor, washed her hands in the resident's sink, picked up the garbage and linen bag, and brought them to the soiled utility room. 2. Review of resident 28's electronic medical record (EMR) revealed he admitted to the facility on [DATE]. He had diagnoses of end stage renal disease (permanent kidney failure where the kidneys no longer clean waste or remove extra fluid from the blood). His July 2026 treatment administration record (TAR) indicated he had a dialysis tunneled catheter (a device used for a treatment that removes waste products and excess fluid from the blood when the kidneys are unable to), to right chest. On 7/29/26, his TAR indicated he had a wound to both of his shins and his right foot that the nurse completed treatments for. 3. Interview on 7/28/26 at 11:08 a.m. with contracted travel CNA BB revealed that she removed resident 28's soiled bed sheet and made his bed without wearing a gown. She verified he was on EBP. She did not need to wear a gown when changing or making his bed, but she would have worn a gown if she was providing personal care to resident 28 or if he was in the room when she changed his bedding. 4. Interview on 7/30/26 at 11:07 a.m. with contracted travel licensed practical nurse (LPN) K revealed that resident 28 required EBP because he had a dialysis tunneled catheter and his legs sometimes were severely swollen that they wept (body fluid oozes directly through the skin), and he had open areas on his legs. When a resident required EBP, the staff were to wear a gown and gloves when changing the resident's bed linen because of the possibility of infectious material being on the sheets. 5. Interview and EBP policy review on 7/30/26 at 11:12 a.m. with registered nurse (RN)/unit manager/infection preventionist C revealed that if a resident required EBP, she expected the staff to wear a gown and gloves when handling the residents bedding. She had educated the staff regarding EBP and had educated contracted travel CNA BB regarding EBP before. 6. Review of the providers 3/26/24 EBP policy revealed that if a resident required EBP, the staff were to follow EBP when changing the resident's linens.		