

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ORIGINAL

PRINTED: 07/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435043	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2014
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NAME OF PROVIDER OR SUPPLIER DAVID M DORSETT HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 N 10TH STREET SPEARFISH, SD 57783
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F 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32572 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/15/14 through 7/16/14. David M. Dorsett Healthcare Center was found not in compliance with the following requirement(s): F222, F371, F431, and F441.</p>	F 000	<p><i>Addendums noted with an asterisk per 8/13/14 telephone to facility administrator. JAW/SDDOH/ME</i></p>	
F 222 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS</p> <p>The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on record review, interview, and policy review, the provider failed to ensure that an as needed (PRN) antipsychotic (mind-altering) medication (Haldol) had not been used for staff convenience and to restrain one of four sampled residents (12) with a PRN antipsychotic medication. Findings include:</p> <p>1. Review of resident 12's complete medical record revealed: *A diagnosis of dementia with delirium. *A 6/16/14 physician's order to change Haldol from 0.25 milligrams (mg) by mouth one time a day for agitation to Haldol 0.5 mg by mouth three times a day. *A 6/16/14 physician's order to change his Haldol order from 0.25 mg by mouth every four hours</p>	F 222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>8-7-14</i>
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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.

DISCLOSED

AUG 11 2014

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F 222	<p>Continued From page 1</p> <p>PRN for agitation to Haldol 0.5 mg every four hours PRN for agitation.</p> <p>Review of resident 12's June 2014 medication administration record revealed: *Haldol 0.5 mg by mouth every four hours PRN for agitation. *That medication had been administered multiple times.</p> <p>Review of resident 12's 6/21/14 electronic medication administration note at 7:31 p.m. revealed Haldol had been given for the following reason: "Resident will not stop trying to amb [ambulate] and self transfer and go from place to place without assistance -1:1 [one-to-one] help not available at this time[.]"</p> <p>Interview on 7/16/14 at 10:30 a.m. with the medical director regarding resident 12 revealed it was not her intent for Haldol to have been used to stop the resident from ambulating or self transferring as noted above. She had not intended this medication to be used for staff convenience because help had not been available or as a chemical restraint. Her intent of the use of this medication was to prevent resident 12 from documented behaviors such as cutting his wound vac (wound drainage device) and drain tubes.</p> <p>Interview at the same time with the director of nursing and the nurse consultant confirmed the PRN Haldol should not have been used for staff convenience or as a chemical restraint as noted above.</p> <p>Review of the provider's revised August 2013 Restraints Chemical policy revealed "Chemical</p>	F 222	<p>Resident 12 will be assessed to ensure he is free of any chemical restraint not required for his medical condition. The assessment results will be communicated to resident 12's physician for review to ensure appropriate medication use and dose.</p> <p>Any resident's receiving a chemical restraint/antipsychotic medication will be assessed by the Director of Nursing or designee to ensure the medication is being used according to policy and not as a substitute for individualized care.</p> <p>The Director of Nursing or designee will monitor antipsychotic medications monthly for 3 months to ensure appropriate use according to policy. The Director of Nursing or designee will report audit results to the QAPI team monthly for 3 months for further recommendation.</p>	8/15/14 * [REDACTED] JASCOCHINE

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F 222 F 371 SS=D	<p>Continued From page 2 restraints will not be used to limit or control resident behavior for the convenience of the staff or as a substitute for individualized care.”</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, and policy review, the provider failed to ensure proper handwashing and glove usage had been used by one of two cooks (A) and one of four dietary aides (B) during two of two observed meals. Findings include:</p> <p>1. Observation on 7/15/14 at 5:15 p.m. revealed during the supper meal cook A: *Had placed gloves on his hands without first washing them causing them to be contaminated. *Then handled ready-to-eat buns that were served to the residents. *Also handled plates he had removed from a shelf with those same gloves. *Removed his gloves several times and handled the following items without washing his hands before putting clean gloves on again:</p>	F 222 F 371	<p>The Director of Dining Services will educate all dining services staff regarding the facility hand washing and glove use policy.</p> <p>The Infection Control Nurse or designee will monitor the dining services staff to ensure appropriate hand washing and glove use is being done each month for 3 months. The Infection Control Nurse or designee will report audit results to the QAPI Team monthly for 3 months for further recommendation.</p>	8/15/14

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F 371	<p>Continued From page 3</p> <ul style="list-style-type: none"> -Menu cards. -Opened the freezer and removed a bag of shrimp. -Filled the fry basket with the shrimp and put it into the fryer. -Opened a drawer and removed utensils. -Moved a cart by pushing the handle. *Then continued serving the ready-to-eat buns to the residents. <p>2. Observation on 7/15/14 at 5:50 p.m. revealed dietary aide B put gloves on without washing her hands and:</p> <ul style="list-style-type: none"> *Handled a gallon container of salad dressing, a bag with cheese slices, and a knife. *Changed her gloves without washing her hands and put the unwrapped cheese slices on the bread. *Removed her gloves and opened the container of salad dressing. *Put clean gloves on without washing her hands and applied salad dressing to the bread slices with a knife. *Held the sandwich with the contaminated gloves as she cut it. <p>3. Further observation at that same time revealed dietary aide B:</p> <ul style="list-style-type: none"> *Washed her hands and turned the faucet off with her bare hand instead of using a clean paper towel. *Had contaminated her hands again when she had done that. *Had washed her hands several times during the meal service. *Had turned the faucet off every time with her bare hands. <p>4. Review of the provider's 2010 Bare Hand</p>	F 371		

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F 371	Continued From page 4 Contact with Food and Use of Plastic Gloves policy revealed: *Hands were to have been washed before gloves had been applied. *Gloves were to have been used for only one task. *Hands were to have been washed when gloves had been removed. Review of the provider's 2010 Handwashing policy revealed faucets were to have been turned off with a paper towel when employees had finished washing their hands. Interview on 7/16/14 at 9:00 a.m. with the dietary manager confirmed: *Clean gloves were to have been used to handle ready-to-eat foods. *A paper towel was to have been used by staff to turn the faucet off after washing their hands. *Gloves were to have been changed between uses. *Hands were to have been washed before gloves had been put on for use with food.	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431			

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F 431	<p>Continued From page 5</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, interview, and policy review, the provider failed to ensure a system was in place to account for controlled medications (any drug commonly understood to include narcotics, with a potential for abuse or addiction, which is held under strict government control) awaiting destruction in two of two medication rooms. Findings include:</p> <p>1. Interview on 7/16/14 at 2:15 p.m. with the resident care manager (RCM) for the special care unit (SCU) regarding the storage of schedule II and III medications (drug that alters perception of</p>	F 431	<p>All narcotic medication that is awaiting destruction will be placed in the lock box in each unit's medication cart and continued to be counted with each medication count. Nursing will notify the RCM (Resident Care Manager-RN) that a medication needs to be placed in the destruction box.</p> <p>The RCM will collect the medication and sign the quantity of the narcotic on the Controlled Drug Record sheet with the nurse or trained medication aide.</p>	8/15/14 * [Signature]

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F 431	<p>Continued From page 6</p> <p>pain, induces sense of wellbeing) awaiting destruction revealed:</p> <p>*She was in charge of the schedule II and III medications awaiting destruction with the pharmacist.</p> <p>*The medications were kept in a locked cupboard on the Clarkson unit.</p> <p>*When there were medications that needed to be placed in the cupboard the staff would let her know and brought them to her, or she went and got them.</p> <p>*If she was not working and there were medications that needed to be placed in the cupboard the staff wrapped the medication accountability sheet around the package and placed them in the locked drawer on the medication cart.</p> <p>*The staff had not continued to count those medications until the SCU RCM removed them.</p> <p>*After she had picked them up she completed the pharmacy form and wrapped that form around the medication package. She then placed the package in the locked cupboard in the medication room.</p> <p>*She had not kept an ongoing record of what was in the locked cupboard.</p> <p>*She was the only person on staff that had a key to that cupboard.</p> <p>*She stated she knew the licensed nurses and unlicensed assistive personnel (medication aide) (UAP) had not been counting the schedule II and III medications at shift change that were kept in the medication awaiting destruction.</p> <p>Observation on 7/16/14 at 2:15 p.m. of the above mentioned locked cupboard revealed there were many medications in the cupboard waiting to be destroyed. There had not been a record located in the medication room or at the nurse's desk that</p>	F 431	<p>RCM and DON will then take the medication to the destruction box located in the Clarkson Unit medication room. The DON will sign the Controlled Drug Record sheet to verify count of narcotic. A copy of the Controlled Drug Record sheet will then be made and placed in the Narcotic Destruction binder in the DON's office.</p> <p>The medication will be added to the Medication Disposition Record flow sheet awaiting destruction from the Pharmacist and RCM.</p> <p>When the Pharmacist and RCM complete the medication destruction, they will obtain the Narcotic Destruction binder from the DON's office and verify that all medications are located in the narcotic box and have been destroyed. Both the Pharmacist and RCM will sign both the original and copy of the Controlled Drug Record along with the Medication Disposition Record. The original Controlled Drug Record sheet will be placed in each resident's chart, the copy of the Controlled Drug Record sheet along with the white carbon copy of the Medication Disposition Record sheet will be archived by the DON and pharmacist.</p>	<p>X [REDACTED] JASDDH/MF</p> <p>X [REDACTED] JASDDH/MF</p> <p>X [REDACTED] JASDDH/MF</p>	

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F 431	Continued From page 7 would have listed the medications in the cupboard. Interview on 7/16/14 at 2:30 p.m. with the director of nurses (DON) and nurse consultant regarding storage and destruction of schedule II and III medications revealed: *There was not a record kept listing the schedule II and III medications that were placed in the locked cupboard by the SCU RCM. *They agreed the medications awaiting destruction stored in the medication carts were not being accounted for. *The DON stated she thought those medications were counted at change of shift by the nurses and UAPs until given to the SCU RCM. *The nurse consultant agreed the schedule II and III medications waiting to be destroyed were not being accounted for and could have been diverted (stolen). Review of the provider's last updated September 2008 Controlled Medication Storage policy revealed controlled substances had been subject to special handling, storage, disposal, and record keeping according to federal, state, and other applicable laws and regulations.	F 431	The DON or designee will monitor all discontinued narcotics ensuring this process is being completed correctly for 3 months. The DON or designee will report audit findings to the QAPI Team monthly for 3 months for further recommendation.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		

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F 441	<p>Continued From page 9</p> <p>*Multiple resident use nail clippers had been free from rust in one of two in-use whirlpool tub rooms (400 hall).</p> <p>*An unlabeled razor had been stored in a sanitary manner free from hair and skin debris in one of two in-use whirlpool tub rooms (400 hall).</p> <p>*Chemicals for cleaning had not been stored with resident use items in one shower room (300 hall) and one of two in-use whirlpool tub rooms (400 hall).</p> <p>*Three randomly observed ice machines (400 hall, dining room, and Clarkson hall) had been clean and free from lime build-up.</p> <p>Findings include:</p> <p>1. Observation and interview on 7/15/14 at 10:00 a.m. with bath aide (C) while she had been cleaning the whirlpool tub in the 100 hall revealed she verbalized she sprayed the tub and tub chair with Classic disinfectant cleaner. She stated she immediately rinsed them with water and did not allow the disinfectant to sit on the surface for any length of time. She then would run the jets for ten minutes.</p> <p>Review of the Classic disinfectant manufacturer's label revealed directions to allow the product to remain wet on the surface for ten minutes to disinfect.</p> <p>Interview on 7/16/14 at 1:05 p.m. with the director of nursing and the nurse consultant revealed they would expect the disinfectant to have been left on the tub surfaces for ten minutes to disinfect the surfaces.</p> <p>Review of the provider's July 2013 Integrity Bath policy revealed directions to allow contact time as detailed on the disinfectant.</p>	F 441		

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F 441	<p>Continued From page 10</p> <p>2. Observation on 7/15/14 at 9:55 a.m. of the 400 hall whirlpool tub room revealed: *A container on the countertop next to the whirlpool tub with two nail clippers in it. Those nail clippers were rusted (photo 1). *An unlabeled electric razor with hair and skin debris in it (photo 2). *A cabinet with Classic disinfectant stored with resident use items including shampoo/body wash, and a heel protector (photo 3).</p> <p>Observation on 7/15/14 at 10:15 a.m. of the 300 hall shower room revealed a countertop with Classic disinfectant stored with resident use items including shaving cream, shampoo, and foaming body cleanser (photo 4).</p> <p>Interview on 7/16/14 at 1:05 p.m. with the director of nursing and the nurse consultant revealed: *They agreed chemicals should have been stored separately away from resident use items. *The unlabeled electric mens' razor should have been discarded when the provider went to single resident use razors. *The rusted nail clippers should have been discarded when they had become rusted.</p> <p>3. Random observations on 7/15/14 and 7/16/14 of three randomly observed ice machines on the 400 hall, in the dining room, and on Clarkson hall revealed lime build-up on all three machines on the front of the machines, where the ice is dispensed in the trays (photo 5).</p> <p>Interview on 7/16/14 at 2:20 p.m. with the maintenance supervisor revealed: *The ice machines had been cleaned quarterly. *He agreed they should have been cleaned more</p>	F 441		

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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/16/14. David M. Dorsett Healthcare Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K017, K038, and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	<p><i>Addendums noted with an asterisk per 8/11/14 telephone to facility Director of Environmental Services. LE/SDD/HMF</i></p> <p>The identified grated ceiling tiles will be replaced with a standard acoustic ceiling tile to provide resistance to smoke into the plenum above the tiles.</p>	8/15/14
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017	<p>The Plant Operations Director or designee will inspect the facility for other grated tiles that may be present and replace these with a standard acoustic ceiling tile.</p> <p>The Plant Operations Director or designee will monitor the facility for 3 months ensuring grated tiles are not in use. The Plant Operations Director or designee will report audit results to the QAPI team monthly for 3 months for further recommendation.</p>	* [REDACTED] LE/SDD/HMF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator DATE 8-7-14

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2014
NAME OF PROVIDER OR SUPPLIER DAVID M DORSETT HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 N 10TH STREET SPEARFISH, SD 57783	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 017	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain a smoke tight corridor in two randomly observed locations (500 wing and 600 wing). Findings include: 1. Observation at noon on 7/16/14 revealed acoustic ceiling tile in the 600 wing. Further observation near exit 4 of that wing revealed a grated ceiling tile. That tile would not resist the passage of smoke into the plenum above the ceiling tile. Interview with the environmental services director at the time of observation revealed that grated ceiling tile had been installed to provide additional heat for the newly installed fire sprinkler piping above. He further indicated he was unaware of the smoke tight requirements of the corridor. He also indicated the sprinkler installation company had advised him that the grated ceiling tile would be ok. Further observation at 12:15 p.m. in the 500 wing near exit 2 revealed the same condition as observed in the 600 wing.	K 017		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider	K 038	The doors near exit 9 will be equipped with a graspable door handle that does not latch either leaf since this is considered a smoke barrier by code. The Plant Operations Director or designee will inspect all smoke and fire barrier doors to ensure they meet regulation requirements. The Plant Operations Director or designee will communicate the inspection results to the QAPI team for further recommendation.	8/15/14 * [REDACTED] LE/SDDH/ME

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2014
NAME OF PROVIDER OR SUPPLIER DAVID M DORSETT HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 N 10TH STREET SPEARFISH, SD 57783	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 2 failed to ensure exits were readily accessible at all times in one randomly observed location (cross corridor door near exit 9). Findings include. 1. Observation at 12:45 p.m. on 7/16/14 revealed a set of cross-corridor doors near exit 9 held open by a magnetic hold open device. Testing of those doors revealed the doors closed and latched into the door frame. Further testing revealed one leaf of those doors was equipped with a graspable door handle, and the other was not provided with a releasing device. Each leaf must be provided with its own releasing device. Each device must not depend on the release of one door before the other. Interview with the environmental services director at the time of the observation revealed he was not aware of that requirement. Further interview revealed that door would only be classified as a smoke barrier door and advised him that latching of those doors was not required.	K 038		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on document review and interview, the provider failed to ensure a full inspection of the kitchen range exhaust system was performed on a semiannual basis for one of one commercial kitchen hood. Findings include: 1. Document review of the commercial kitchen exhaust system and fire suppression inspection	K 069		

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NAME OF PROVIDER OR SUPPLIER DAVID M DORSETT HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 N 10TH STREET SPEARFISH, SD 57783	
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K 069	Continued From page 3 report revealed there was no documentation indicating the entire exhaust system had been inspected. The exhaust system including the exhaust fan, exhaust duct, and kitchen hood must be inspected on a semiannual basis. Interview with the environmental services director at 8:30 a.m. on 7/16/14 at the time of the document review revealed he was unaware if the entire exhaust system had been inspected. Interview with kitchen hood inspection company at 1.30 p.m. on 7/16/14 at the time of inspection of that kitchen hood revealed they did not perform inspections of exhaust fan and exhaust duct. They only inspected the fire suppression system and the kitchen hood.	K 069	The Plant Operations Director or designee will inspect the entire commercial kitchen exhaust system and document the results. Any necessary maintenance/cleaning will be completed. The Plant Operations Director or designee will inspect the entire commercial kitchen exhaust system and document the results on a semi-annual basis. The Plant Operations Director or designee will communicate the inspection results to the QAPI team semi-annually for a year.	8/15/14 

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10686	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2014
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NAME OF PROVIDER OR SUPPLIER DAVID M DORSETT HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 N 10TH STREET SPEARFISH, SD 57783
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	<p>Initial Comments</p> <p>Surveyor: 32572 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/15/14 through 7/16/14. David M. Dorsett Healthcare Center was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

6ERG11

Administrator

