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

ORIGINAL

PRINTED: 10/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435043	A. BUILDING _____ B. WING _____	10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVID M DORSETT HEALTHCARE COMMUNITY	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
F 000	*Addendums noted with an asterisk per 11/9/15 per telephone with facility administrator LH/SDOH/EL INITIAL COMMENTS Surveyor: 32572 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/5/15 through 10/7/15. David M. Dorsett Healthcare Community was found not in compliance with the following requirements: F156, F176, F241, F242, F253, F273, F274, F276, F280, F371, and F514.	F 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.	
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)	F 156	**F156** 1. No immediate action could be taken for Resident #6. Facility has the correct forms, including the Nursing Facility Advanced Beneficiary Notice (SNFABN). All residents on a skilled Medicare stay are at risk. 2. The Administrator has educated the Social Service Director and Business	10-25-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/29/15

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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F 156	Continued From page 1 (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	Office Manager on the use of the Notice of Medicare Provider Non-Coverage and the SNFABN forms that are to be issued when a resident reaches the end of a skilled stay or end of therapy services. 3. The Administrator or designee will audit all residents who end their skilled stay each week to ensure the correct forms are being used. This audit will continue weekly for 4 weeks and then monthly thereafter. Audit will be discussed by the Administrator in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations of continuation/discontinuation of monthly audit. 4. November 25, 2015	

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F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review and interview, the provider failed to ensure the Notification of the Medicare denial process was accurately presented with the CMS (Centers for Medicare and Medicaid Services) standardized forms for one of one sampled resident (6). Findings include: 1. Review of resident 6's financial records revealed: *He had only received the Notice of Medicare Provider Non-coverage. *That form had been used to notify the resident Medicare would no longer pay for his skilled nursing or therapy services. *He had not received the Nursing Facility Advanced Beneficiary Notice (SNFABN) when his skilled coverage had ended. *The SNFABN form would have given him the option to have a demand bill issued (having his care reviewed to continue Medicare coverage).	F 156		

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F 156	Continued From page 3 Interview on 10/7/15 at 8:10 a.m. with the business office manager (BOM) revealed: *She had been the BOM for many years. *The social services designee (SSD) provided her with a copy of the signed notices. *She was not aware of the SNFABN form. Interview on 10/7/15 at 8:40 a.m. with the SSD revealed: *She had never given residents the SNFABN form when their Medicare coverage ended. *She did not have a copy of that form to give to residents. *She had previously worked at this facility and now had just returned in the last few months.	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, record review, interview, and policy review, the provider failed to ensure three of five sampled residents (12, 21, and 22) who self-administered a medication had been assessed for their capability to self-administer medications. Findings include: 1. Review of resident 21's medical record revealed: *She had diagnoses that included:	F 176	**F176** 1. No immediate correction could be taken for Resident #21, 22, and 12. Nurses and Med Aides were educated at the time of occurrence on the Self-Administration of Medication policy. All residents are at risk. 2. The Director of Nursing (DON) or designee will educate all nurses and medication aides on the Self-Administration of Medication Policy no later than November 5, 2015. Those who are not in attendance during education meeting will receive education prior to their working their next scheduled shift. 3. The DON or designee will audit 4 random medication passes per week to ensure medications are not left with residents who do not have a self-administration of medication assessment or MD order. This audit will occur	11-25-15

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F 176	Continued From page 4 -Chronic obstructive pulmonary disease (difficulty taking a deep breath and shortness of breath). -Chronic respiratory failure due to low oxygen levels. -Dependence on oxygen. -Cough. *She had a 3/3/15 physician's order for ipratropium-albuterol nebulizer (inhaled medication to open the airways in lungs) every eight hours as needed for shortness of breath. *A 9/2/14 at 1:37 p.m. interdisciplinary progress note revealed "Daughter stated that she is getting a cough and RCM [resident care manager] noted that she would pass on to the RCM at that unit and share that she does not leave her neb [nebulizer] treatment on." *There was no physician's order or assessment for her to have self-administered the nebulizer treatment. Review of resident 21's last care plan, review date 10/1/15, revealed there was no focus area, goal, or intervention related to her self-administering her nebulizer treatment. Surveyor: 32572 2. Observation on 10/6/15 at 8:09 a.m. revealed: *Resident 22 siting in the dining room with her back to certified medication aide (CMA) B. *CMA B had poured the physician prescribed amount of liquid protein into a glass of red juice. *She then took that medication/juice mixture to the resident and instructed the resident to let her know when she had finished it. *The CMA went on to administer medications to other residents. *During that time the resident had her back to the CMA, and the CMA had her back to the resident. -The CMA would not have been able to see if the	F 176	weekly for 4 weeks and then monthly thereafter. Audit will be brought to the monthly QAPI meeting by the DON for review/recommendations of continuation/discontinuation of monthly audit. 4. November 25, 2015	

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F 176	Continued From page 5 resident had consumed the whole amount of medication/juice mixture. 3. Observation on 10/6/15 at 11:00 a.m. revealed resident 12 sitting in his reclining wheelchair with the nebulizer (breathing treatment) in his room. There were no staff present. Review of resident 12's medical record revealed the following diagnoses: *Persistent vegetative state (only involuntary body functions). *Seizure disorder. Review resident 12's paper and electronic medical record revealed they did not contain an assessment or a physician's order for self-administration of the nebulizer medication. 4. Review of the provider's May 2015 Medication Administration policy revealed: *"Each nurse administering medication will follow the six rights of medication administration: -Right resident. -Right medication. -Right time. -Right dose. -Right route. -Right documentation." *"Medications will not be left in the dining areas for the resident to take at a later time unless ordered by the resident's physician." *"If the attending physician approves self-administration of medication, then it will be the responsibility of the interdisciplinary care plan team/RN [registered nurse] to determine that it is safe for the resident to self-administer drugs before the resident may exercise that right."	F 176		

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F 176	Continued From page 6 Review of the provider's September 2010 Medication Administration Nebulizer policy revealed a statement: "Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer." Interview on 10/7/15 at 8:20 p.m. with the director of nursing confirmed she would have expected residents who self administer medications to be deemed appropriate.	F 176		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Surveyor: 32573 A. Based on observation, record review, and interview, the provider failed to ensure resident dignity had been maintained by preventing and investigating inappropriate resident-to-resident interactions for two of six sampled residents (2 and 16) in the special care unit (SCU). Findings include: 1. Observation on 10/5/15 at 5:45 p.m. of the supper meal in the SCU dining room revealed resident 2 touching and stroking resident 16's	F 241	**F241** 1. No immediate corrective action could be taken for residents 2 and 16 or for not offering soup as a choice for residents on the Special Care Unit. The dietary aide was educated at the time of occurrence that residents will be given dining choices, including soup. All residents are at risk. 2. The Administrator, DON, Social Services and Interdisciplinary Team have reviewed the policy on what constitutes dignity and respect, including challenging behaviors. Policy will be in-serviced to all staff by the Administrator no later than November 5, 2015. Those staff not in attendance prior to November 5, 2015 will be educated prior to their next shift worked. 3. The Administrator or designee will conduct walking rounds within the facility 4 times a week at various times, to include meal times, to ensure dignity and respect is maintained and residents are offered meal choices. This audit will occur weekly for 4 weeks and then monthly thereafter. Audit will be brought to the	11-25-15

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F 241	Continued From page 7 hands, arms, and face for approximately twenty minutes. Surveyor: 29162 Interview on 10/5/15 at 6:00 p.m. with licensed practical nurse D revealed she stated resident 2 had really taken a liking to resident 16 since she had moved back to the special care unit. She stated resident 2 sat by resident 16 in the dining area and patted his hands and his face often. It was not unusual for her to have her face only inches from his. Surveyor: 32573 Review of resident 2's 9/16/15 Brief Interview for Mental Status (BIMS) assessment score (measure of mental capacity) revealed she had a score of four, indicating severe cognitive (thinking and reasoning) impairment. Review of resident 16's BIMS score revealed he had a score of ninety-nine, indicating an interview could not be performed. He was severely cognitively impaired. Further record review and interview revealed staff and administration had not considered those actions inappropriate and the incident had not been documented or investigated. Refer to F514, finding 1. Refer to F280, finding 2. Surveyor: 26632 B. Based on observation, interview, and policy review, the provider failed to ensure residents' dignity was maintained during one of three observed meals for the SCU residents. Findings include:	F 241	monthly QAPI meeting by the Administrator for review and recommendations of continuation or discontinuation of the monthly audit. 4. November 25, 2015	

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F 241	Continued From page 8 1. Observation and interviews on 10/5/15 from 5:00 p.m. through 5:45 p.m. 10/6/15 from 10:45 a.m. through 12:30 p.m.; and 10/6/15 from 5:15 p.m. through 6:00 p.m. revealed: *The SCU residents' meals were dished up and placed on trays to have been delivered there. *On 10/5/15 from 5:00 p.m. through 5:45 p.m. SCU residents were not provided with the alternate of chicken noodle soup if they did not like or want the main menu food. *Cook C stated the SCU residents were not served soup as they had "Alzheimer's [memory loss] and it was too 'messy' for them." Interview on 10/6/15 at 6:15 p.m. with the CDM agreed the statement by cook C was not appropriate, and the residents should have been offered the soup. Review of the provider's 2010 Customer Service policy for dietary services revealed: *All individuals (resident) would be treated with respect and prompt service. *Staff members should have an attitude of truly wanting to help and serve people. *Staff would be trained to treat each individual with the utmost respect and care.	F 241		
F 242 SS=C	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.	F 242	F242 1. No immediate action could be taken for the Special Care Unit (SCU) residents not offered meal choices. The residents on the SCU are now being offered a meal choice. All residents on the SCU are at risk.	11-25-15

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F 242	Continued From page 9 This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Surveyor: 26632 Based on observation, interview, and policy review, the provider failed to ensure all residents in the special care unit (SCU) were offered the same menu as those residents not in the SCU for three of three observed meals. Findings include: 1. Observation and interviews on 10/5/15 from 5:00 p.m. through 5:45 p.m. 10/6/15 from 10:45 a.m. through 12:30 p.m.; and 10/6/15 from 5:15 p.m. through 6:00 p.m. revealed: *The SCU residents' meals were dished up and placed on trays to have been delivered there. *On 10/5/15 from 5:00 p.m. through 5:45 p.m. SCU residents were not provided with the alternate of chicken noodle soup if they did not like or want the main menu food. *On 10/6/15 from 10:45 a.m. through 12:30 p.m. cook F dished one-half of the meals with fried chicken, roasted red potatoes, and Malibu veggie blend.The other one-half of the meals dished was pork roast, mashed potatoes and gravy, and Malibu veggie blend. Those meals were sent to the SCU. *Cook F stated she always dished the meals that way for the SCU residents. -If a resident wanted the other meal staff could ask for it for the resident. -The residents in the SCU were not given a choice for their meals. *On 10/6/15 from 5:15 p.m. through 6:00 p.m., cook G dished all the meals for the SCU the same as cook F. *That meals was a sloppy joe,	F 242	2. Administrator or designee will educate all staff on ensuring residents on the SCU are offered meal choices not later than November 5, 2015. Staff not in attendance will be educated prior to their next scheduled shift. 3. Administrator or designee will audit 4 random meals a week on the SCU to ensure residents are offered meal choices. This audit will occur weekly for 4 weeks and then monthly thereafter. Audit will be brought to the monthly QAPI meeting by the Administrator for review and recommendations of continuation or discontinuation of monthly audit. 4. November 25, 2015	

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F 242	Continued From page 10 potato chips, prince edward blend vegetables, and fruit fluff dessert. *The other meal choice was shrimp instead of the sloppy joe. Surveyor: 32573 Observation on 10/6/15 at 5:40 p.m. of the supper meal in the SCU dining room revealed: *Some residents had been given shrimp. *Some had been given sloppy joes. *Resident 1 had been overheard saying "Well, I would have preferred shrimp." Surveyor: 26632 Interview on 10/6/15 at 6:15 p.m. with the certified dietary manager agreed the residents in the SCU should have been offered a menu choice for those meals. Review of the provider's 2010 Customer Service policy for dietary services revealed: *All individuals (resident) would be treated with respect and prompt service. *Staff members should have an attitude of truly wanting to help and serve people. *Staff would be trained to treat each individual with the utmost respect and care.	F 242		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Surveyor: 29162	F 253	**F253** 1. The facility has repaired or replaced the surfaces that are not cleanable, including: legs on two blue chairs, wooden molding by bird cage, the gouge in the wall by the bird cage, the wall in the SCU entering the dining room, the north wall in the SCU dining room, the doors of resident rooms 106, 111, 203, 311, 315, 401, 603, 606 and 707, and the wood panel in room 201. The Pro-Assist lift has	11-25-15

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F 253	Continued From page 11 Based on observation and interview, the provider failed to ensure a clean and sanitary environment had been maintained for the following: *Cleanable wood and metal surfaces in randomly observed areas of the building: -Two of two observed lounge chairs in the entry area to Clarkson hall. -One of one wall and wooden corner molding in the Clarkson hall resident lounge. -Two of two randomly observed walls in the Special Care Unit (SCU). -Nine of nine random residents' rooms (106, 111, 203, 311, 315, 401, 603, 606, and 707) with chipped and gauged door frames. -One of one random resident room (201) observed with wooden panels covering the heating vents inside the room. *One of one observed Pro-Assist lift on Clarkson hall had dit and crumbs in the foot placement area. *Two of two resident bathroom floors in the main dining room with chipped, torn, and raised tile. *One of two observed isolation equipment tables outside of room 204. Findings include: 1. Random observations from 10/5/15 through 10/7/15 revealed random surfaces throughout the building had not been cleanable surfaces: *The legs on two blue lounge chairs at the entrance area to Clarkson had scrapes and gouges of on all of the wooden legs. *The corner wooden molding beside the bird cage by the entrance to the resident lounge area had multiple scrapes and gouges. The wall had been gouged near the floor and created a dust-like surface behind the paint on the wall. *In the SCU the wall on the right side when entering the dining room had gouges in it near the	F 253	been cleaned. The Resident bathroom floors in the main dining room have been scheduled to be repaired/replaced. The cracked isolation supply table has been replaced.* 2. The Administrator will educate all staff no later than November 5, 2015 on ensuring surfaces are cleanable, equipment is clean, and to report any disrepair within the facility to the Administrator and Maintenance Department. Those staff not in attendance will be education prior to their next shift worked. 3. The Administrator or designee will conduct walking rounds weekly to ensure surfaces are cleanable and equipment is clean. This audit will occur weekly for 4 weeks and then monthly thereafter. Audit will be brought to the monthly QAPI meeting by the Administrator for review and recommendations of continuation or discontinuation of monthly audit 4. November 25, 2015 *The maintenance director has ordered tile. No other residents were found to be negatively affected. Maintenence personnel and administrator will audit the process and it will be included in the QAPI notes. LA/SDDOH/EL	

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	435043	A. BUILDING _____ B. WING _____	10/07/2015

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F 253	Continued From page 12 floor. The north wall in the dining room had several gouged areas that had been approximately four feet off the floor. Those areas had been made by the medication cart. Those gouged areas on the wall had also created dust-like areas making them uncleanable. *The lower-half of the wooden or metal doors and door frames of nine randomly observed residents' rooms (106, 111, 203, 311, 315, 401, 603, 606, and 707) had multiple scratches, scrapes, and gouges in them of varying sizes that made them uncleanable. *One randomly observed resident's room 201 had wooden panels in front of the heating system on the walls that had gauges in it and had been dusty and dirty behind it. *One observed Pro-Assist lift on Clarkson hall was not clean. The lift had coffee stains on the legs and crumbs in the resident's foot placement area. *Both resident's bathroom floors in the main dining room were chipped, cracked, and raised off from the floor, making the floor uncleanable. *One isolation supply table by resident room 204 had an approximate twelve inch crack across the top of it. Interview on 10/7/15 at 9:00 a.m. with the maintenance director revealed he agreed with the above findings. He stated there had not been a lot of preventative maintenance done lately.	F 253		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's	F 273	F273 1. No immediate correction could be taken for Resident 1's late Minimum Data Set (MDS). All residents are at risk.	11-25-15

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F 273	Continued From page 13 physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review, interview, and manual review, the provider failed to ensure 1 of 12 sampled residents (1) had a Minimum Data Set (MDS) admission assessment completed according to the time frame set by The Centers for Medicare and Medicaid. Findings include: 1. Review of resident 1's admission MDS revealed it should have been completed on 9/27/15. It had been completed on 9/28/15. Interview on 10/7/15 at 11:30 a.m. with the MDS coordinator confirmed resident 1's admission MDS assessment had not been completed within the required timeframe. She stated she had been very busy, and many assessments were late. Review of the 2014 MDS 3.0 User's Manual revealed admission MDS assessments should have been completed within fourteen days after a resident's admission. The provider used that manual as a policy for the above.	F 273	2. The Director of Reimbursement will educate the MDS Coordinator no later than November 5, 2015 on ensuring timely completion of the MDS. 3. The Director of Reimbursement or designee will audit 4 resident MDS to ensure they were completed/submitted timely. This audit will occur weekly for 4 weeks and then monthly thereafter. Audit will be brought to the monthly QAPI meeting by the Administrator for review and recommendations of continuation or discontinuation of monthly audit 4. November 25, 2015 **The MDS coordinator was counseled on making sure the assessments for MDS are completed timely. NO residents were affected negatively. The MDS assessments are monitored daily by the administrator with the MDS coordinator. LA/SDDOH/EL	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the	F 274	**F274** 1. No immediate correction could be taken for Resident 1's missed significant change MDS which occurred in July 2015. All residents are at risk. **→ see next page	11-25-15

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F 274	Continued From page 14 resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review, and interview, the provider failed to determine a significant change in condition had been coded on the Minimum Data Set (MDS) assessments for 1 of 12 sampled residents (1) who had MDS assessments completed. Findings include: 1. Review of resident 1's medical record revealed MDS assessments had been completed on the following dates: *4/17/15, an annual assessment. *7/16/15, a quarterly assessment. Review of the above MDS assessments for the resident revealed the following activities of daily living (ADL) (assistance with bathing, dressing, eating, and grooming) areas were coded as follows: *Bed mobility (movement in bed): -4/17/15 she needed extensive assistance of one person. -7/16/15 she needed extensive assistance of two persons. *Walk in her room:	F 274	*^ 2. The Director of Reimbursement will educate the MDS Coordinator no later than November 5, 2015 on requirements for completing a significant change MDS. 3. The Director of Reimbursement or designee will audit 4 resident MDS to ensure resident did not have a significant change. This audit will occur monthly and will be brought to the monthly QAPI meeting by the Administrator for review and recommendations of continuation or discontinuation of monthly audit 4. November 25, 2015 *The MDS coordinator and the administrator meet daily about any possible significant changes to residents. This will be reviewed at monthly QAPI. NO other residents were found to be negatively affected. LA/SDDOH/EL	

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F 274	Continued From page 15 -4/17/15 she needed extensive assistance of one person. -7/16/15 that activity no longer occurred. *Walk in corridor: -4/17/15 she needed extensive assistance of one person. -7/16/15 that activity no longer occurred. *Toilet use: -4/17/15 she needed extensive assistance of one person. -7/16/15 she needed extensive assistance of two persons. Interview of 10/7/15 at 11:30 a.m. with the MDS coordinator confirmed a significant change in condition MDS should have been completed for resident 1 on 7/16/15 when her ADL assistance needs had changed.	F 274		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on record review, interview, and manual review, the provider failed to ensure Minimum Data Set (MDS) (assessment of resident needs) assessments had been completed every three months for 1 of 12 sampled residents (5). Findings include: 1. Review of resident 5's MDS assessments from	F 276	*The MDS coordinator and the administrator meet daily about any possible late MDS. No other residents have been negatively affected. This will be reviewed at the monthly QAPI meetings. F276 LA/SDDOH/EC 1. No immediate correction could be taken for Resident 5's late Minimum Data Set (MDS). All residents are at risk. 2. The Director of Reimbursement will educate the MDS Coordinator no later than November 5, 2015 on ensuring timely completion of the MDS.* 3. The Director of Reimbursement or designee will audit 4 resident MDS to ensure they were completed/submitted timely. This audit will occur weekly for 4 weeks and then monthly thereafter. Audit will be brought to the monthly QAPI meeting by the Administrator for review and recommendations of continuation or discontinuation of monthly audit 4. November 25, 2015	11-25-15

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F 276	Continued From page 16 2/5/15 to 9/4/15 revealed: *She had been admitted on 2/5/15. *Her admission MDS had been done on 2/5/15. *A modified admission MDS assessment was done on 2/11/15. *A quarterly MDS assessment was done on 6/4/15. *A quarterly MDS assessment was done on 9/4/15. Interview on 10/7/15 at 11:35 a.m. with the director of clinical services revealed resident 5's first quarterly MDS assessment should have been done at the beginning of May. She agreed it had been done late. Review of the 2014 MDS 3.0 User's Manual revealed quarterly MDS assessments should have been done every three months after a resident's admission. The provider used that manual as a policy for the above issue.	F 276		
F 280 SS=F	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280	**F280** 1. Resident 1, 2, 4, 6, 7, 8, 9, 10, 11, 12, 17 and 21 care plans have been updated to reflect their current status. All residents are at risk. 2. The DON and Interdisciplinary Team have reviewed the Care Plan policy and reviewed the cited deficiency. The DON or designee will educate all staff on care plans and ensuring they are kept accurate and up to date with each resident's individual needs by November 5, 2015. Those not in attendance will be educated prior to their next scheduled shift.	11-25-15

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F 280	Continued From page 17 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Surveyor: 32573 Surveyor: 32572 Surveyor: 26632 Surveyor: 29162 Based on observation, interview, and record review, the provider failed to ensure 12 of 18 sampled resident's (1, 2, 4, 6, 7, 8, 9, 10, 11, 12, 17, and 21) care plans reflected their current status. Findings include: 1. Review of resident 1's current care plan revealed: *A focus area that stated "I take clonazepam daily for Restless Leg Syndrome (tingling or crawling like sensations deep within the legs)." -There had not been a current physician's order for that medication. -A focus area that stated "I was admitted to this facility on April 16, 2014." -That focus area had a goal stating the resident would like to feel at home in her new environment. -The intervention and goal for that focus area had remained unchanged since 4/29/14.	F 280	3. DON or designee will audit 4 care plans per week to ensure that the care plan reflects the care and services provided to the resident. This audit will be done weekly for 4 weeks and then monthly thereafter. Audit will be brought to QAPI by the DON for review and recommendations of continuation or discontinuation.* 4. November 25, 2015 * The MDS coordinator, director of nursing, and the administrator meet daily about updated care plans. All residents affected have been updated. No other residents have been negatively affected. This will be reviewed at the monthly QAPI meetings. LA/SDDOH/EL	

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F 280	Continued From page 18 *That had been the resident's first care plan. Interview on 10/7/15 at 11:30 a.m. with the Minimum Data Set (MDS) assessment coordinator confirmed: *Resident 1 did not have an order for clonazepam. *That medication had been discontinued in July 2015, and her care plan had not been updated. *The care plan focus area related to her admission to the facility was not current and should have been updated. Surveyor 32573 2. Observation on 10/5/15 at 5:45 p.m. of the supper meal in the special care unit (SCU) dining room revealed: *Resident 2 had been caressing resident 16's hands and arms. *She was leaning in very close to him and talking to him. *She touched and stroked the side of his face several times. *She continued that behavior for approximately twenty minutes. Observation on 10/6/15 at 5:45 p.m. of the supper meal in the SCU dining room revealed resident 2 was caressing the hands and arms of the residents seated on either side of her. Review of resident 2's current care plan revealed: *A focus area of behavior issues. *Behaviors stated were "hitting/kicking, yelling at others, threatening others, rejecting care and wandering." *Her observed behavior of touching and caressing other residents had not been included in the care plan.	F 280		

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F 280	Continued From page 19 *Interventions had not included what to do if she had any of the above behaviors. Interview on 10/7/15 at 8:30 a.m. with the administrator revealed all of resident 2's behaviors should have been included in her care plan. Surveyor 32572 3. Review of resident 4's medical record revealed: *She had fallen on 9/22/15. *She had been seen in the emergency room on that date. -She had a right hip fracture (broken bone). -The family had decided no surgical repair was to have been done for that fracture. *The physician had ordered the following: -"Toe touch weight bearing status [very limited weight bearing on the fractured leg]. -No independent transfers (moving from one area to another). -Hydrocodone [strong pain medication] 5/325 mg [milligram, unit of measurement] 1/2 [one-half tablet] PO [by mouth] q [every] six hours prn [as needed] pain." Review of resident 4's initiated 7/23/15 care plan revealed no mention of the following: *Right hip fracture. *Change in her weight bearing status. *No independent transferring. *Use of the pain medication for the hip pain. Surveyor: 26632 4. Review of resident 6's medical record revealed: *He had been admitted on 4/20/15. *He had a urinary catheter due to urine retention	F 280		

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F 280	Continued From page 20 (unable to pass urine). *He had a urinary tract infection on 7/20/15. Review of resident 6's 8/18/15 care plan revealed no focus area, goals, or interventions related to his urinary catheter (tube to drain urine from bladder) and urinary tract infection. Surveyor 32572 5. Review of resident 7's medical record revealed: *Pain in her left shoulder. *She had been seen by the physician on 9/17/15. -She had received an "injection in the shoulder at the physician's office." -She was to "continue with PT [physical therapy] on her neck and L [left] shoulder for ROM [range of motion, movement] and massage + [plus] light traction [pulling]." -"F/U [follow up] in four weeks in not improving for recheck." Review of resident 7's care plan revised on multiple dates revealed no mention of the following: *Pain as a focus area. *PT services. *She had received an injection at the clinic as was to return to the clinic if not improving. Surveyor: 26632 6. Observation on 10/5/15 at 4:00 p.m. revealed resident 8 had a hearing aide in her left ear. Continued observation during the survey from 105/15 through 10/7/15 revealed she had the hearing aide in her left ear. Review of resident 8's 7/20/15 reviewed care plan revealed:	F 280		

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F 280	Continued From page 21 *A focus area it was moderately difficult for her to hear. *A goal she would like to maintain useful hearing for as long as possible. *Interventions did not include the use of hearing aides. Surveyor: 36413 7. Review of resident 9's medical record revealed he had been a Hospice client from 1/21/15 to 4/15/15. Review of 1/22/15 care plan revealed no mention of Hospice services. Interview on 10/7/15 at 3:10 p.m. with the resident care manager confirmed resident 9 had received Hospice services. His care plan did not include those Hospice services. Review of the provider's undated Agreement for Hospice Services revealed the following: *"The Hospice plan is a written document which will include a detailed description of the scope and frequency of hospice services and supplies needed to meet the resident's needs." *"The Hospice shall furnish a copy of such Plan of Care for such resident to the Care Center at the time of the resident's admission into the Hospice program." *"The Care Center understands that the Hospice may use the Care Center's nursing personnel where permitted by State law and as specified by the Care Center to assist in the administration of prescribed therapies included in the hospice plan of care only to the extent that the Hospice would routinely use the services of a hospice patient's family in implementing the plan of care." Surveyor 29162 8. Review of resident 10's current care plan	F 280		

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F 280	Continued From page 22 revealed a focus area for Advanced Directives (AD)(pre-planning individual healthcare wishes). That focus area had stated she did not want life saving measures to be taken to save her life. Review of her current physician's orders revealed she was to have full life saving measures implemented as her healthcare wishes. Interview on 10/7/15 at 11:30 a.m. with the MDS assessment coordinator revealed she agreed the resident's care plan had not been revised. I should have been updated to accurately reflect the resident's AD wishes. Surveyor: 26632 9. Review of resident 11's care plan revised 7/14/15 revealed a focus area related to his behaviors and coping. It stated he used the medication Sertraline (anti-depressant) for his behaviors. He still continued to receive the Sertraline. Review of his physician's orders revealed an order for lorazepam (anti-anxiety) on 9/2/15. His care plan had not included the use of lorazepam for any of his behaviors. Surveyor 32572 10. Review of resident 12's care plan revealed no mention of self-administering of the nebulizer (breathing) treatment. Refer to F176. Surveyor: 26632 11. Review of resident 17's medical record revealed a 9/14/15 self-medication assessment to self-administer his albuteral nebulizer treatments. Review of his revised 8/14/15 care plan revealed	F 280		

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F 280	Continued From page 23 a focus area that he would receive all his medications from staff. 12. Review of resident 21's care plan revealed no mention of self-administering of the nebulizer (breathing) treatment. Refer to F176. Surveyor 29162 B. Based on record review, interview, and manual review, the provider failed to ensure one of two newly admitted sampled residents (10) had a care plan completed according to the time frame set by The Centers for Medicare and Medicaid. Findings include: 1. Review of resident 10's current care plan revealed it should have been completed on 10/3/15. It had been completed on 10/4/15. Interview on 10/7/15 at 11:30 a.m. with the MDS coordinator confirmed resident 1's care plan had not been completed in a timely manner. She stated all of the resident's care plans' needed updating. Review of the 2014 MDS 3.0 User's Manual revealed care plans should have been completed within seven days after a resident's comprehensive assessment. The provider used that manual as a policy for the above issue.	F 280		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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	F 371	F371 1. The oven, range top, grills, stainless steel tables, can opener walk-freezer, and breakfast cart have been cleaned. No immediate correction could be taken for improper hand hygiene. All residents are at risk.	11-25-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435043	A. BUILDING _____ B. WING _____	10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVID M DORSETT HEALTHCARE COMMUNITY	1020 N 10TH STREET SPEARFISH, SD 57783

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F 371	Continued From page 24 under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, and policy review, the provider failed to: *Maintain one of one kitchen in a clean and sanitary manner for equipment, floors, and appliances. *Ensure appropriate hand hygiene occurred during one of three meal observations by one of one certified nursing assistant (CNA) (C). Findings include: 1. Observations on 10/5/15 from 3:10 p.m. through 3:30 p.m., on 10/6/15 from 11:30 a.m. through 12:30 p.m., and on 10/6/15 from 5:15 p.m. through 6:00 p.m. of the kitchen revealed: *Two ovens, two range tops, and the one grill were soiled with spilled and burnt food. The sides of those appliances had a sticky and greasy residue on them. *A sticky and greasy residue was present on the lower shelf and legs of the stainless steel preparation tables. *One electric can opener had a black build-up on the blades that could be scraped off. *The walk-in freezer floor had a moderate amount of crumbs on it. *The breakfast cart wood frame was sticky and the inside of the drawers had crumbs and food debris in them. Interview on 10/6/15 at 6:00 p.m. with the certified	F 371	2. The Dietary Manager and Registered Dietician have reviewed the kitchen cleaning and maintenance policy and the hand washing/glove use policy. The Administrator will educate dietary personnel on ensuring cleanliness of the kitchen and will educate all staff on hand hygiene and glove use no later than November 5, 2015. Those staff not in attendance will be educated prior to working their next shift.* 3. Administrator or designee will audit kitchen cleanliness weekly and 4 random meal services to ensure staff are completing appropriate hand hygiene and glove use. Audits will occur weekly for 4 weeks and then monthly thereafter. Audit will be brought to the monthly QAPI meeting by the Administrator for review and recommendations of continuation or discontinuation of monthly audit 4. November 25, 2015 *CNA C recieved training at the November 2, 2015 all staff meeting regarding proper handwashing education and Proper glove use. No other residents have been negatively affected. This will be reviewed at the monthly QAPI meetings. LA/SDDOH/EL	

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F 371	Continued From page 25 dietary manager revealed: *They had a cleaning schedule in the past, but due to staffing issues it was not being used. *She agreed the kitchen was in need of a deep cleaning. Review of the provider's 2010 Cleaning Instructions policies for the freezers, food carts, can opener, ranges, cabinets, and drawers revealed: *Freezers would be defrosted as needed when frost was greater than one-quarter inch thick. *Mop floors, wash walls, and ceilings as needed. *Food carts would be cleaned and sanitized immediately after each use. *The can opener would be cleaned after each use. *The cook on each shift was responsible for keeping the range as clean as possible during the preparation of the meal. The range would be cleaned after each use. *Ovens would be cleaned as needed, according to the cleaning schedule, and at least once every two weeks. *Cabinets and drawers would be free of food particles and dirt and they would be cleaned at least twice a month. Surveyor: 32573 2. Observation on 10/5/15 at 6:10 p.m. of the supper meal in the main dining room revealed: *CNA C put gloves on without washing her hands first and did the following before removing those gloves: -She went into the kitchen to get drinking mugs. -She poured residents' drinks. -She cut up a resident's food. *She removed the gloves and used hand sanitizer.	F 371		

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F 371	Continued From page 26 *She put on a new pair of gloves without washing her hands first and did the following before removing those gloves: -She assisted a resident with eating utensils. -She went into the kitchen and got a cart with residents' meals on it. -She used the coffee machine. -She served a resident the meal. *She removed those gloves and used hand sanitizer. Interview on 10/7/15 at 8:45 a.m. with the director of clinical services revealed staff were expected to wash their hands before and after glove use. Review of the provider's May 2014 Glove Use policy revealed: *Gloves were not required when serving/assisting/feeding residents in the dining room. *Hands "must be washed before and after using gloves."	F 371		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	**F514** 1. No immediate correction could be taken for failure to document Resident 2's behavior or family notification of such for Resident 2 and 16. Resident 10's code status has been corrected in the medical record. No immediate correction could be taken for Resident 9 and 17's fluctuating weights. All residents are at risk. 2. The Administrator, DON and Interdisciplinary Team have reviewed the medical records policy and cited deficiencies. The DON will in-service nursing staff on documentation, including the re-weigh policy, to ensure the medical record is complete and accurate. Education will occur no later than	11-25-15

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F 514	Continued From page 27 This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, record review, interview, and policy review, the provider failed to ensure records had been accurately maintained for 6 of 17 sampled residents (2, 9, 10, 16, and 17). Findings include: 1. Observation on 10/5/15 at 5:45 p.m. of the supper meal in the special care unit dining room revealed: *Resident 2 had been caressing resident 16's hands and arms. *She was leaning in very close to him and talking to him. *She touched and stroked the side of his face several times. *She continued that behavior for approximately twenty minutes. Review of resident 2's nursing progress notes revealed the above observed incident had not been noted. Review of resident 16's nursing progress notes revealed the above observed incident had not been noted. Interview on 10/7/15 at 11:45 a.m. with resident care manager A revealed: *Resident 2's actions had not been viewed as harmful. *Resident 2 touching other residents had not been considered an incident. -It had not been investigated or reported. *She agreed neither resident involved could	F 514	November 5, 2015. Those staff not in attendance will be educated prior to their first shift worked. 3. The DON or designee will audit 4 resident medical records to ensure they were complete and accurate. This audit will occur weekly for 4 weeks and then monthly thereafter. Audit will be brought to the monthly QAPI meeting by the DON for review and recommendations of continuation or discontinuation of monthly audit* 4. November 25, 2015 *Both residents 2 and 16 have been more heavily monitored. The administrator has instructed staffing coordinator to add more staff to the MCU. All staff were educated on proper monitoring and caring of residents with dementia and behaviors. No other residents including resident 2 and 16 have not been affected negatively. LA/SDDOH/EL	

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F 514	Continued From page 28 distinguish between right and wrong. *She agreed the above observation could be considered a reportable incident. Interview on 10/7/15 at 8:30 a.m. and at 12:00 noon with the administrator revealed family members had been notified of resident 2's behavior towards other residents. However it had not been documented anywhere. She had been told by staff resident 2 and 16's families "were fine with it." She agreed the behavior could be considered an incident since neither resident was cognitive (able to think and reason) enough to understand the behaviors. She agreed the above observations and family notifications should have been documented in the residents' charts. Surveyor: 29162 2. Review of resident 10's complete medical record revealed: *Hospital discharge instructions dated 9/14/15 that stated "Code Status: No Code" [Do no resusitate, do not provide treatment to sustain life]. *A 9/15/15 physician's order received after a treatment out of the facility ordered "Code Status DNR." That physician had not been the resident's primary physician. *The provider's "Consent for DO NOT RESUSCITATE" form signed by the resident on 9/14/15 had been checked "Full Code"[Do no resusitate, do not provide treatment to sustain life]. That same form had been signed by the resident's physician on 9/15/15. *The provider's "Consent for DO NOT RESUSCITATE" form signed by the resident on 9/18/15 had been checked "Full Code." That same form had been signed by the resident's physician on 9/18/15.	F 514		

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F 514	Continued From page 29 *A physician's order signed on 9/18/15 to change the resident's code status to Full Code. *The resident's care plan had stated "I have a DNR (no life saving measures) order." Interview on 10/7/15 at 11:30 a.m. with the Minimum Data Set assessment coordinator revealed the documentation on the resident's care plan for DNR had been incorrect. She agreed the code status of the resident had been documented incorrectly throughout her medical record. Review of the provider's Advanced Directives/Cardiopulmonary Resuscitation policy revealed: *"It is the policy of the facility to honor the resident's healthcare wishes set forth in their Advanced Directives, including initiating/withholding CPR according to the resident's (or resident's healthcare power of attorney, if applicable) wishes." Surveyor: 36413 Preceptor: 26632 Review of the provider's 1/31/13 Reweighing Residents policy revealed: *"The bath aid will be responsible for reporting residents that have a three pound weight gain or loss within one week time frame to the nurse manager or charge nurse on the day the weight is detected." *"The nurse will decide whether or not a reweigh is needed." *"The bath aid will reweigh the resident prior to the end of his/her shift and document the weight." *"The resident will be weighed the next day prior to the end of his/her shift and the re-weight will be	F 514		

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F 514	Continued From page 30 documented and reported to the nurse manager or charge nurse." *"The nurse manager or charge nurse will assess the resident for possible reasons for the weigh change, notify the Dietician and make further referrals to the Doctor as needed." 3a. Review of resident 9's medical record revealed the following weights: *8/8/15, 145.5 pounds (lbs). *8/14/15,150.0 lb. *8/21/15,149.5 lb. *8/28/15,152.0 lb *9/4/15,150.5 lb. *9/15/15,157.5 lb. *9/18/15,151.0 lb *9/25/15,157.0 lb. *10/2/15,144.5 lb. *Observation on 10/6/15 at 11:00 a.m. of an unidentified certified nursing assistant (CNA) weighing resident 9 revealed he weighed 159.5 lb. *Review of residents 9's medical record on 10/7/15 revealed the weight had not been charted. Surveyor: 26632 b. Review of resident 17's weight summary record revealed the following weights: *4/27/15, 205 lb. *5/4/15, 208.5 lb. *5/14/15, 211.5 lb. *5/21/15, 215 lb. *5/25/15, 210.5 lb. *7/27/15, 214 lb. *8/6/15, 208.5 lb. *8/10/15, 217.5 lb. *8/24/15, 218 lb. *9/3/15, 208 lb.	F 514		

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F 514	Continued From page 31 *9/18/15, 212.6 lb. *9/22/15, 217 lb. *10/5/15, 256.5 lb. c. Interview on 10/7/15 at 10:20 a.m. with the resident care manager revealed the resident care managers were to have reviewed weights and to coordinate the resident's re-weights per provider policy. She agreed weights for residents 9 and 17 had not been reported and re-weights had not been completed. She stated those weights recorded for resident's 9 and 17 indicated either weight loss or weight gain in significant amounts at times. Interventions would have been required had those weights been correct.	F 514		

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

ORIGINAL

PRINTED: 10/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435043	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/07/2015

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K 000	INITIAL COMMENTS *Addendums noted with an asterisk per 11/4/15 per interview with facility administrator. CHV/SDDOH/EL Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted from 10/6/15 through 10/7/15. David M. Dorsett Healthcare Community 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 K029, K062, K069, K144, and K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on random observation, testing, and interview, the provider failed to maintain proper separation of the following hazardous areas: *One of two doors (east) to the soiled linen room	K 029	**K029** a. The east soiled linen room door in the 200 Wing was found to missing a latching mechanism. A new latch was installed on 10/15/2015. b. The business suite door that has a ninety minute fire rated self-closing door to the business suite was found to be	11-25-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 10/29/15

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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	435043	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/07/2015**

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K 029	Continued From page 1 in the 200 wing had no latching mechanism. *One of one ninety minute fire rated self-closing door to the business suite was propped open with an unapproved device. *One of one metal self-closing door to the large wheelchair parts room would not close and latch into the frame. *One of three walls (north) in the large wheelchair parts room had a large hole. *One of two metal doors to the large clean linen storage room was not locked in place to provide a latching frame for the self-closing door. *One of two doors (west) to the laundry supervisor's office had a broken closer. Findings include: 1. Random observation from 10/6/15 through 11:00 a.m. on 10/7/15 revealed: a. The east door of the soiled linen room for the 200 wing was a swinging passage door with no latching mechanism. Interview with the environmental services supervisor (ESS) at the time of the observation confirmed that finding. He stated he was not aware there was another entrance into that soiled linen room. He was also unaware that swinging door had no latching mechanism. b. The ninety minute fire rated self-closing door to the business office suite was propped open with a rubber wedge. Interview with the ESS at the time of the observation confirmed that finding. He stated he was aware doors could not be propped open and removed the wedge. c. The metal self-closing door to the large wheelchair parts storage room in the basement would not close and latch into the frame. Interview with the ESS at the time of the observation confirmed that finding. d. The gypsum board on the north wall of the	K 029	propped open. Door was unlatched by the Environmental Supervisor on 10/06/2015. c. One metal self-closing door to the large wheelchair parts room would not close and latch into the frame. New latches were installed on the door in question on October 28, 2015. d. The gypsum board on the north wall of the wheelchair storage room had a hold approximately 18 to 30 inches with a view of the cinder block wall. Environmental Services Supervisor has repaired the hole as of October 29, 2015. e. Two metal doors to the large clean linen storage room was not locked in place to provide a latching frame for the self-closing door. No frame was found on the south leaf to keep in place. All locks and latched to this door were properly placed on October 28, 2015 All residents are at risk. 2. The administrator or designee will provide training to all staff regarding proper door procedure by no later than November 5, 2015. Those staff not in attendance will be educated prior to working their next shift. 3. Weekly rounds with audits for three months will be in place to check all fire safe doors to ensure proper latches and closures are in place. All audits will be entered and reviewed during monthly QAPI meetings with discussion as to continue or discontinue the audits. 4. November 25, 2015	

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K 029	Continued From page 2 large wheelchair storage room in the basement had a hole approximately 18 by 30 inches. That hole gave a view of the large sprinkler pipe penetration in the cinder block wall. That penetration had not been sealed. Interview with the ESS at the time of the observation confirmed that finding. He stated he was unaware a hole had been cut in that gypsum board. e. The dual assembly of the metal self-closing doors to the large clean linen room in the basement could be pushed open in one step. Further observation and testing revealed the north leaf was not locked in place at the top and bottom. It provided no frame to latch the south leaf in place. Interview with an unidentified laundry aide at the time of the observation confirmed the staff had to open both doors for the large clean linen carts. Interview with the ESS at the time of the observation also confirmed that finding. He stated he was unaware staff were not educated to relock the north leaf after removing the large clean linen carts. f. The west wooden door to the laundry supervisor's office entered into the large laundry room. That door had a broken closer. The east supervisor's office door entered into the corridor and had no closer. Neither door maintained the hazardous rating of the laundry area. Interview with the ESS at the time of observation confirmed that finding. He stated he was unaware that closer had broken. g. Continued interview on 10/7/15 at 10:45 a.m. with the ESS revealed he had a monthly preventive maintenance program for all doors.	K 029	*The MS will conduct the weekly audits for 3 months and the MS or administrator will report the audit findings at the monthly QAPI. CKV/SODOH/EL	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062	**K062** 1.The clean linen closet in the secured unit had an automatic sprinkler head at the top of the closet shelves. The top shelf	11-25-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435043	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/07/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVID M DORSETT HEALTHCARE COMMUNITY	**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 062	Continued From page 3 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 20031 A. Based on observation and interview, the provider failed to maintain unobstructed space adjacent to the sprinkler deflector, so the water discharge was not interrupted in one of one clean linen closet in the secured unit. Findings include: 1. Observation on 10/6/15 at 1:55 p.m. revealed the clean linen closet in the secured unit had an automatic sprinkler head at the top of the closet shelves. The top shelf held stacks of blankets that surrounded the sprinkler head. Interview with the ESS at the time of that observation confirmed that finding. He stated he was aware there must be an 18 inch clearance of sprinkler heads. B. Based on record review and interview, the deficiencies listed on the last two of two (2014 and 2015) automatic sprinkler inspection reports had not been corrected. Findings include: 1. Review of the provider's automatic sprinkler system inspection reports dated 7/29/14 and 7/23/15 revealed the following comments in the deficiency area: *7/29/14: "Flow test could not be performed accurately due to main drain going into garden hose." *7/23/15: "Main drain not piped outside; did flow test through 1" [inch] inspector's test." Interview with the ESS at the time of the record	K 062	was found to be not in compliance with the 18 inch clearance of sprinkler heads. The shelf was immediately removed by the Environmental Service Supervisor on 10/06/2015. All residents are at risk. B. After review of the automatic sprinkler system inspection reports on 7/29/14 and 7/23/15 flow tests were not properly performed due to the main drain into garden hose. The main drain was found to be not piped outside for proper testing of water flow. No immediate action was taken. Environmental Supervisor contacted the contracted professional service Rapid Fire who has conducted the last two flow tests to perform another test with proper hose placement by November 5, 2015. 2. The Administrator or designee will provide proper training on 18 inch clearance for all storage in the facility. Proper testing for automatic sprinkler system will be re-tested by November 5, 2015. Those staff not in attendance will be trained prior to their next shift. 3. The administrator or designee will be conducting weekly audits for three months to check for proper 18 inch clearance for sprinkler heads. Audits will be brought to the monthly QAPI meeting to review by the Interdisciplinary team if the audits will need to continue. 4. November 25, 2015.	

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	435043	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVID M DORSETT HEALTHCARE COMMUNITY	1020 N 10TH STREET SPEARFISH, SD 57783

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K 062	Continued From page 4 review confirmed those notations. He stated he had become the ESS approximately two months ago and was not aware of the prior findings on the inspection reports.	K 062	*The administrator or MS will review/audit all commercial inspections for the building. The MS or administrator will report the audit findings at the monthly QAPI. CKV/SDDOH/EL	11-25-15
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: 20031 Based on record review and interview, the contractor for the commercial hood inspections failed to provide the hydrostatic test date and six year maintenance date of the kitchen hood extinguishment system. Findings include: 1. Review of inspection records for the kitchen hood extinguishment dated 1/26/15 and 7/23/15 revealed no given documentation for the most recent hydrostatic test date and six year maintenance date of the kitchen hood extinguishment system. A hydrostatic pressure test of the extinguisher container must be conducted at intervals of not less than twelve years. Interview with the environmental services director at the time of the record review confirmed those findings.	K 069	**K069** 1.The kitchen hood extinguisher inspection that was dated 1/26/15 and 7/23/15 revealed no given documentation for the most recent hydrostatic test date and six year maintenance date of the kitchen hood extinguishment system. All residents at risk. 2. The hydrostatic pressure test has been scheduled. The Maintenance Supervisor has been educated on this requirement 3. No audits necessary as this is a required only every 12 years 4. 11-25-15 *The administrator or MS will review/audit all commercial inspections for the building. The MS or administrator will report the audit findings at the monthly QAPI. CKV/SDDOH/EL	
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	**K144** 1.After review of the past twelve months September 2014 to September 2015 of monthly load tests for the generator revealed all transfer times to emergency power were 15 seconds. The standard load is 10 seconds. All residents at risk.	11-25-15

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	435043	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVID M DORSETT HEALTHCARE COMMUNITY	1020 N 10TH STREET SPEARFISH, SD 57783

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K 144	Continued From page 5 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on document review and interview, the provider failed to ensure the transfer time to the emergency power was ten seconds or less. Findings include: 1. Review of the past twelve months (September 2014 through September 2015) of monthly load tests for the generator revealed all transfer times to emergency power were 15 seconds. Interview with the environmental services supervisor (ESS) at the time of the record review confirmed those notations. He stated he had become the ESS approximately two months ago and was not aware of the 10 second requirement. He used the provider's computer program for the given information.	K 144	2. The administrator or designee will be conducting weekly audits for four weeks for three months testing the count of seconds for the generator re-set. 3. The audits will be reviewed at the monthly QAPI meeting. The audits will be determined to continue following the three months. 4. November 25, 2015. *The maintenence Supervisor (MS) or administrator will report the audit findings at the monthly QAPI. CW/SDDOH/EL	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to provide permanent wiring by using power strips and extension cords in one of one laundry supervisor's office. Findings include: 1. Observation on 10/6/15 at 3:30 p.m. revealed	K 147	**K147** 1Power strips and extension cords in-use in the laundry supervisor's office. One power strip was found to be plugged into another power strip. Another strip had been used for a radio. All residents are at risk. 2. All power strips and extension cords were removed from the laundry service office by the Environmental Services Supervisor on October 6, 2015. All staff will be educated about the use of	11-25-15

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	435043	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/07/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVID M DORSETT HEALTHCARE COMMUNITY	**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 147	Continued From page 6 power strips and extension cords in-use in the laundry supervisor's office. One power strip had been plugged into another power strip. Another power strip had been used for a radio. The cord to the radio was within reach of the electrical receptacle. Interview with the environmental services supervisor at the time of the observation revealed he did not know the extension cord and excessive amount of power strips were in-use. He removed them at that time.	K 147	extension cords and power strips in the facility by November 5, 2015. 3. Weekly audits of power strips and extension cords will be used for the entire facility for four weeks for three months. All audit will be reviewed by the Interdisciplinary team at monthly QAPI meetings for the next three months. Audits will be continued or discontinued following the review of the third months findings. 4. November 25, 2015. *The MS will conduct the weekly audits for 3 months and the MS or administrator will report the audit findings at the monthly QAPI. CKV/SDDOH/EC	

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PRINTED: 10/19/2015
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10686	A. BUILDING: _____ B. WING _____	10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVID M DORSETT HEALTHCARE COMMUNIT	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) COMPLETE DATE
S 000	Initial Comments *Addendums noted with an asterisk per 11/4/15 per interview with facility administrator. CKV/SDDOH/EL 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 10/5/15 through 10/7/15. David M. Dorsett Healthcare Community was found not in compliance with the following requirement: S153.	S 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.	
S 153	44:04:02:10 PLUMBING Facility plumbing systems must be designed and installed in accordance with SDCL 36-25-15 and 36-25-15.1. Plumbing must be sized, installed, and maintained to carry required quantities of water to required locations throughout the facility. Plumbing may not constitute a source of contamination of food equipment or utensils or create an unsanitary condition or nuisance. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to install a vacuum breaker on one of two shampoo sinks(north) in the beauty shop. Findings include: 1. Observation on 10/6/15 at 2:00 p.m. revealed two shampoo sinks in the beauty shop. The north shampoo sink did not have a vacuum breaker for the spray hose. Interview with the environmental services supervisor (ESS) at the time of the observation confirmed that condition. The ESS further revealed he was not aware the vacuum breaker had been removed from that sink.	S 153	**S153** 1. The vacuum breaker has been installed. All residents are at risk. 2. The Maintenance Supervisor was educated of requirement at time of survey. 3. Weekly audits to ensure vacuum breakers are present for 4 weeks will be conducted by the Maintenance Supervisor or designee. Results will be reported to monthly QAPI to determine if audits need to be continued. 3. November 25, 2015. *The maintenance supervisor (MS) or administrator will report the audit findings at the monthly QAPI. CKV/SDDOH/EL	11-25-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Administrator

(X6) DATE 10/29/15

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