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

ORIGINAL

PRINTED: 09/06/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435043		08/24/2016

NAME OF PROVIDER OR SUPPLIER
DAVID M DORSETT HEALTHCARE COMMUNITY

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
F 000	*Addendums noted with an asterisk per 9/28/16 per email with facility DON. KW/SDDOH/EL INITIAL COMMENTS Surveyor: 26632 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/22/16 through 8/24/16. David M. Dorsett Healthcare Community was found not in compliance with the following requirements: F274, F281, F368, F431, and F441. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/22/16 through 8/24/16. Areas surveyed included: inaccurate medication records, pharmaceutical services, dietary services, and infection control. David M. Dorsett Healthcare Community was found in compliance.	F 000	3. The Director of Reimbursement will educate the MDS coordinators on what constitutes a Significant change MDS no later than September 22. 2016. 4. The Director of Reimbursement or designee will conduct audits on four completed MDS's each week to ensure MDS is a signification change MDS if needed. Audits will be weekly for four weeks and then monthly for two months. Audits will be discussed by the Administrator/Director of Reimbursement at monthly Quality Assurance Process Improvement (QAPI) meeting for review and recommendations of continuation/discontinuation of audit. 5. October 7, 2016	10-7-16
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 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	F 274		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 9/14/16

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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.

reverse

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F 274	Continued From page 1 by: Surveyor: 26632 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) assessment for 3 of 11 sampled residents (2, 6, and 8) who had MDS assessments completed. Findings include: 1. Review of resident 2's medical record revealed MDS assessments had been completed on the following dates: *4/19/16, an significant change in condition assessment. *7/19/16, a quarterly assessment. Review of the above MDS assessments for resident 2 revealed the following ADL areas were coded as follows: *Brief Interview for Mental Status: -4/19/16 her score was a 5 that indicated severely impaired cognition. -7/19/16 her score was an 11 that indicated moderate impaired cognition. *Activities of Daily Living: -4/19/16 she required extensive assistance of one staff person with bed mobility, transfers, locomotion on unit, and toilet use. -7/19/16 she required supervision of one staff person with bed mobility, transfers, locomotion on unit, and toilet use. *Urinary incontinence: -4/19/16 she was occasionally incontinent. -7/19/16 she was frequently incontinent. *Bowel incontinence. -4/19/16 she was frequently incontinent. -7/19/16 she was never incontinent. 2. Review of resident 6's medical record revealed	F 274	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. F274 10-7-16 1. Residents 2, 6 and 8 have had a significant change MDS completed. 2. All residents are at risk. MW/SDDOH/EL *All MDS's will be reviewed going foward. We will review all MDS's that flag for significant changes at our quality conference meeting every morning.	

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F 274	Continued From page 2 MDS assessments had been completed on the following dates: *3/28/16, an admission assessment. *6/28/16, a quarterly assessment. Review of the above MDS assessments for resident 6 revealed the following ADL areas were coded as follows: *Activities of Daily Living: -3/28/16 he required supervision of one staff person with transfers and walking in his room. -6/28/16 he required extensive assistance of one staff person with transfers, and limited assistance of one staff person with walking in his room. *Urinary incontinence: -3/28/16 he was occasionally incontinent. -6/28/16 he was frequently incontinent. *Bowel incontinence: -3/28/16 he was occasionally incontinent. -6/28/16 he was frequently incontinent. *Falls since admission: -He had one fall with major injury on his 6/28/16 quarterly MDS assessment. 3. Interview on 8/24/16 at 9:30 a.m. with the MDS coordinator and the assistant confirmed a significant change in condition MDS should have been completed for resident 2 on 7/19/16 and for resident 6 on 6/28/16. Surveyor: 29162 4. Review of resident 8's medical record revealed MDS assessments had been completed on the following dates: *5/12/16, a significant change in condition assessment. *8/12/16, a quarterly assessment. Review of the above MDS assessments for	F 274		

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F 274	Continued From page 3 resident 8 revealed the following ADL areas were coded as follows: *Urinary incontinence: -5/12/16 she was occasionally incontinent. -8/12/16 she was frequently incontinent. *Bowel incontinence: -5/12/16 she was never incontinent. -8/12/16 she was frequently incontinent. *Weight: -5/12/16 she weighed 142 pounds. -8/12/16 she weighed 122 pounds. Interview on 8/24/16 at 10:00 a.m. with the MDS coordinator and the assistant confirmed a significant change in condition MDS should have been completed for resident 8 on 8/12/16. Interview on 8/24/16 at 10:30 a.m. with the DON and nurse consultant revealed they agreed resident 8 had two areas of significant change in her condition. A significant change in condition MDS should have been completed. 5. Review of the 2015 Resident Assessment Instrument manual revealed: "A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting' (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan."	F 274		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	**F281** 1. No immediate corrective action was taken for Resident 21. At the time of	10-7-16

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F 281	Continued From page 4 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, record review, interview, professional standards, manufacturer's recommendations review, and policy review, the provider failed to ensure: *Two of three professional nurses (F and G) had followed professional standards for the administration and documentation of insulin for two of three observed residents (20 and 21). *One of eleven sampled residents (2) medical record had all allergies listed. *One of three discharged resident's (18) medical record had complete documentation in regards to a change of condition. *One of one sampled resident (6) with a head injury after two falls had neurological assessments completed per policy. *One of one randomly observed resident (1) was monitored when she had been given medications. Findings include: 1. Observation on 8/23/16 at 11:28 a.m. of licensed practical nurse (LPN) G revealed: *She gave resident 21 her Humalog insulin of seven units to inject. *The resident injected the insulin. *The resident did not receive any food until 12:30 p.m. Review of the manufacturer's recommendations for Humalog insulin revealed food should have been eaten within fifteen minutes after receiving the insulin.	F 281	discovery, the nurse was educated to ensure resident has food within 15 minutes of insulin administration. No immediate correction could be made to resident 20's Medication Administration Record (MAR) documentation. The nurse was educated about signing the MAR after administration at the time of discovery. Resident 2's medical record has been updated to include her allergy to Cipro. No immediate correction could be taken for Resident 6's missing neurological assessments. No immediate correction could be made for Resident 1's self-administration of medications. The Medication Aide was educated on ensuring medications are taken at the time of discovery. Nursing staff are administering the resident's medications. 2. All residents are at risk. 3. The DON will educate the nursing staff no later than September 22, 2016 on the following: - Ensuring residents eat within 15 minutes of administration of short acting insulin. - Medication Administration Record is annotated after the resident takes the medication - Resident allergies need to be recorded on the medical chart and in Point Click Care - Ensuring neurological checks are performed per policy - The need for on-going documentation when a resident has a change of condition. *Nothing could be done for resident 18 as had been discharged. KW/SDOTHEL *Nurses F and G were educated immediately at the time of survey as well as September 15 at the all staff meeting. KW/SDOTHEL	

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F 281	Continued From page 5 2. Observation on 8/23/16 at 5:15 p.m. of LPN F revealed: *She documented on resident 20's medication administration record (MAR) she had given him his Novolog and Lantus insulin injections. *She gave those insulin injections after she had documented them. Review of the provider's February 2014 Insulin Administration policy revealed documentation was to have occurred afterthe insulin injection had been given. 3. Review of resident 2's medical record revealed physician's documentation on 1/7/16, 3/16/16, 3/30/16, and 6/1/16 she had an allergy to the medication Cipro. That allergy had not been listed on her MAR, treatment administration record, or her care plan. Interview on 8/24/16 at 8:30 a.m. with the director of nursing (DON) confirmed the above finding. She agreed the allergy had not been documented on resident 2's medical record. Review of the provider's June 2013 Resident Allergies policy revealed all resident allergies would have been noted in the medical record. 4. Review of resident 6's medical record revealed he had been found on the floor on 6/20/16 and 7/3/16. Both of those incidents had resulted in him hitting his head. Review of the neurological observation forms revealed on both incidents the examinations had not been completed every four hours for twenty-four hours. At twenty-four house that would have been the last part of the neurological observation required.	F 281	- Residents must not be left with medications unless they are deemed safe to self-administer their medications Those not in attendance at education session will be educated prior to their first shift worked. 4. The DON or designee will audit all the following: - Observe four observations of a resident with short acting insulin ordered to ensure the resident eats within 15 minutes of administration of the insulin - Observe four medication passes to ensure medications are signed after the medication is given - Review four medical charts to ensure any allergy is recorded on the medical chart and in Point Click Care - Audit all residents who receive neurological checks to ensure they are done per policy - Review four charts to ensure any change of condition has appropriate on-going documentation and appropriate follow up - Observe four medication passes to ensure there are no residents who are left with medications who do not have a medication self-administration assessment that deems them safe to do so. *Nurses and residents will be identified on the audits All audits will be weekly for four weeks and then monthly for two months. Audits will be discussed by the DON at the monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.	

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F 281	Continued From page 6 Interview on 8/24/16 at 8:30 a.m. with the DON confirmed the above findings. She agreed the neurological observations should have been completed every four hours for twenty-four hours as required. Review of the provider's February 2014 Neurological Assessment policy revealed neurological assessments were indicated: *Upon a physician's order. *Following an unwitnessed fall. *Following a fall that involved head trauma. *There was no indication of how often the assessment was to have been completed. Review of the provider's undated Neurological Observation form revealed: *Neuro checks and vital signs should have been observed and recorded as follows: -Every fifteen minutes times four. -Every thirty minutes times four. -Every hour times four. -Every four hours times twenty-four hours. 5. Review of resident 18's closed medical record, nursing progress notes revealed: *5/22/16 at 4:34 p.m. "Was passed thru from day shift LPN that resident's lung sounds are getting worse, that resident is filling up with fluid." "This writer did listen to resident's lung sounds, noted rhonchi in right lower lobe, little air exchanged in the lower left lobe. Resident also had audible wheezing in the upper lobes. Resident was given a nebulizer treatment, which only helped a little." *5/23/16 at 12:13 p.m. "Scopolamine patch applied behind ear per nurse." *5/23/16 at 2:11 p.m. "Scopolamine patch as need for noisy breathing behind ear was	F 281	5. October 7, 2016	

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F 281	Continued From page 7 effective." *5/23/16 at 9:10 p.m. "Resident resting in recliner. Low response to stimuli. Eyes closed. Respirations easy and unlabored." *5/23/16 from 9:13 p.m. through 9:22 p.m. of all evening and bedtime medications "Held d/t low response to stimuli." *The next documentation was on 5/24/16 at 10:04 a.m. of a dietary note for his Minimum Data Set documentation. *There was no further documentation of resident 18's medical status. Interview on 8/24/16 at 8:30 a.m. with the DON confirmed the above documentation. She agreed the nursing progress notes did not reveal resident 18's ongoing condition. Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, pages 350 and 351, revealed: *"The record is the most current and accurate continuous source of information about a patient's [resident] health care status (p. 350)." *"The record must describe exactly what happened to a patient and follow agency standards (p. 350)." *"Legal guidelines for recording: -Guidelines - Chart only for yourself. -Rationale - You are accountable for information you enter into the patient's chart. -Correct Action - Never chart for someone else." (p. 351). Surveyor: 29162 6. Review of resident 1's medical record revealed: *On 7/12/16 she had scored ten on a Brief Interview for Mental Status assessment (BIMS).	F 281		

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F 281	Continued From page 8 *That score indicated she had moderate mental impairment. *There was no order or care plan documentation for self-administration of medication. Observation and interview on 8/23/16 at 11:50 a.m. with resident 1 revealed: *She was: -Sitting at a table in the special care unit (SCU). -Holding a clear plastic medicine cup that contained several white tablets. *She stated: - "These are my pills. They keep me from dying." - "She gave them to me, the one giving the pills today." [unlicensed assistive personnel (UAP). *She swallowed the pills. *There had been several other SCU residents in the dining area with resident 1 at that time. There had been medications initialed as administered for the midday time on her medication administration record. Interview on 8/23/16 with UAP H revealed she had gone on her lunch break at 11:20 a.m. That had been thirty minutes resident 1 had her pills before she had taken them. Interview on 8/24/16 at 10:30 a.m. with the DON and nurse consultant confirmed resident 1 should not have been left alone before she took her medications. UAP H should have waited and observed the resident swallow her pills. Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, pages 584 and 587, revealed: *"To administer medication safely, many critical thinking skills are essential. For example, be	F 281		

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F 281	Continued From page 9 disciplined and take adequate time to prepare and administer medications (584)." *"Responsibility and accountability are other critical thinking attitudes essential to safe medication administration. Accept full accountability and responsibility for all actions surrounding the administration of medications (584)." *"Never document that you have given a medication until you have actually given it (587)."	F 281		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on record review, interview, and policy review, the provider failed to ensure bedtime (HS) snacks were offered consistently to all residents	F 368	**F368** 1. Residents are being offered a bedtime snack. 2. All residents are at risk. 3. The Administrator, DON, Dietary Manager and RD have reviewed the policy on providing snacks, frequency of meals, and reviewed the cited deficiency. The DON will educate all nursing and dietary staff on the above, as well as, ensuring documentation of acceptance and refusal of snacks and ensuring residents are not required to "come out" of their room to receive a snack. Those not in attendance at education session will be educated prior to their first shift worked. 4. The DON or designee will audit the following: - Eight random interviews with residents to confirm that they were offered snack at bedtime.	10-7-16

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F 368	Continued From page 10 for twenty-three of twenty-three days reviewed (8/1/16 through 8/23/16). Findings include: 1. Review of the provider's electronic and paper HS snack documentation for August 1, 2016 through August 23, 2016 revealed: *There had not been consistent documentation snacks had been offered every night for every resident. *Paper documentation had columns with resident's names and spaces to check off if a snack had been accepted or refused. *The above paper copies had been left blank. *Electronic documentation had not been entered every day. -One randomly reviewed resident had five days with no snack documentation during the above time. -Another randomly reviewed resident had no electronic documentation available for snacks. Review of the provider's June 2015 meal service schedule policy revealed residents should have been offered a snack at bedtime. Interview on 8/23/16 at 10:00 a.m. during the group resident meeting revealed: *All nine residents in attendance agreed they had not been offered a snack every night. *If they asked for a snack staff would have given them one. Interview on 8/24/16 at 8:30 a.m. with the director of nursing revealed: *Certified nursing assistants (CNA) should have documented HS snacks on the paper documents and in the computer. *She had been unaware that documentation had been inconsistent and missing.	F 368	- Review the documentation four times a week to ensure all residents have documentation as either receiving a snack or refusing a snack. Audits will be weekly for four weeks and then monthly for two months. Audits will be discussed by the DON at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit. 5. October 7. 2016	

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F 368	Continued From page 11 *She believed snacks had been offered every night but CNAs had not documented it properly.	F 368		
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 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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.	F 431	**F431** 1. The undated Aplisol TB vial and the TB vial past the 30 day open period were discarded. The narcotic medication was secured in the Omnicell pharmacy machine. 2. All residents are at risk. 3. The DON will educate nurses no later than September 22, 2016 that TB solution must be dated when opened and is only good for 30 days after opening and ensuring that narcotic medications must be accounted for each shift, including those awaiting destruction or awaiting placement into the Omnicell. Those not in attendance at the education session will be educated prior to their first shift worked. 4. The DON or designee will audit each medication cart each week to ensure all schedule II, III, and IV medications are accounted for while in the medication cart, awaiting destruction, or awaiting placement in the Omnicell and that all TB vials are dated when opened and discarded within 30 days of opening. Audits will be weekly for four weeks and then monthly for two months. Results of the audits will be discussed by the DON at monthly QAPI meeting for review and	10-7-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435043		08/24/2016

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 431	Continued From page 12 This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, manufacturer's review, and policy review, the provider failed to ensure: *Narcotics were accounted for in one of three observed medication carts (Greene wing). *Aplisol had been dated when opened in one of two medication refrigerators (Greene wing). *Aplisol had been disposed of thirty days after first accessed in one of two medication refrigerators (Clarkson). Findings include: 1. Observation and interview on 8/24/16 from 10:00 a.m. through 10:30 a.m. with the director of nursing (DON) revealed: a. One bottle of Aplisol tuberculin (TB) testing solution in the Greene unit medication refrigerator that had been accessed. There was no date as to when it had been first accessed. *Controlled medications had not been accounted for on each shift in the Greene unit medication cart. Those controlled medications included: -Hydrocodone with acetaminophen 5 milligram (mg)/325 mg, two tablets. -Lorazepam 0.5 mg, two tablets. -Oxycodone with acetaminophen 5mg/325mg, four tablets. -Oxycodone 5mg, two tablets. -Lorazepam 1 mg, one tablet. *The controlled medications were in separate plastic bags with pharmacy labels that indicated the type of medication, how many tablets, and when they had been dispensed. b. One bottle of Aplisol TB testing solution in the Clarkson unit medication refrigerator that had	F 431	recommendations for continuation or discontinuation of audit. 5. October 7, 2016	

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F 431	Continued From page 13 been opened on 6/28/16. That was past the thirty day manufacturer's recommendation period. *The DON stated she: -Was aware of the dating requirements for the Aplisol TB testing solution. -Had not realized the controlled medications had not been put into the Omnicell Pharmacy machine when they had arrived. -Agreed those medications had not been accounted for each shift. Review of the provider's June 2016 Storage of Medications policy revealed: *No outdated medications/solutions were available for use in the facility. *All such medications/solutions would have been destroyed. *Stock solutions were dated when opened. Review of the provider's January 2016 Narcotics - Counting and Destruction policy revealed no procedure for when controlled medications had been delivered from the pharmacy, There was no procedure as to who was to have placed the medication in the Omnicell pharmacy machine.	F 431		
F 441 SS=E	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 Program under which it - (1) Investigates, controls, and prevents infections	F 441	**F441** 1. The whirlpools and showers are being disinfected per policy. The Medication Aide who failed to wash hands properly and dropped items on the floor was educated at the time of discovery. The items dropped on the floor, as well as, adjacent items were disinfected. Staff member was educated at the time of survey. *CNA's B and C were educated on 8/23/16 and again at all staff meeting on September 15. KW/SDDOH/EL	10-7-16

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DAVID M DORSETT HEALTHCARE COMMUNITY	1020 N 10TH STREET SPEARFISH, SD 57783

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F 441	Continued From page 14 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 A. Based on observation, document review, policy review, and interview, the provider failed to follow manufactures' guidelines for the disinfection of three of three shower stalls. Findings include: 1. Observation on 8/23/16 at 9:30 a.m. revealed certified nurse assistant (CNA) B was taking resident 5 into the memory care bathing room. Interview with CNA B at that same time revealed	F 441	2. All residents are at risk. 3. The Administrator and DON have reviewed the policy on cleaning and disinfection of resident showers. Disinfection procedures will be displayed prominently in each whirlpool and shower area. Education to nursing staff on the whirlpool and shower disinfection procedures, as well as, handwashing and disinfection of dropped items will be provided by the DON no later than September 22, 2016. Those not in attendance at education session will be educated prior to their first shift worked. 4. The DON or designee will audit four shower disinfection procedures each week to ensure the correct procedure is followed and will audit four staff's handwashing procedures to ensure handwashing is performed per policy. Audits will be performed weekly for four weeks and then monthly for two months. Audits will be discussed by the DON at monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit. 5. October 7, 2016	

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F 441	Continued From page 15 she was going to give resident 5 a shower. When questioned how she disinfected the shower chair, stall, and floor, and what she used she replied: *"I pour some of the disinfectant directly on the chair and swish it around." *"Then I leave it sit for ten minutes." *"I should have a spray bottle with the disinfectant in it and use it. But I haven't done that yet." *"I don't have any directions on how to disinfect the shower, I was just shown one time." *"I use the disinfectant in the square bottle (Penner). I don't use the other disinfectant (Classic)." Interview on that same day at 5:40 p.m. with CNA C on to how she disinfected the shower and what she used revealed: *"CNA D showed me how to disinfect the showers." *"I use the MicroKill Wipes for the chair." *"Then I would pour some disinfectant into the mop bucket, add water, and then mop the shower floor." *When questioned how much disinfectant she would use she replied "I don't know. CNA D just poured some into the mop bucket, so that's what I would do." *"I use whatever disinfectant is in the bathing room." Interview on 8/24/16 at 8:20 a.m. with the administrator revealed directions were posted in all the bathing rooms on how to disinfect the whirlpools and the showers. Observation at that same time revealed there were no posted instructions in the bathing room of the memory care unit or the bathing room near the director of nurses (DON) office. The administrator confirmed that finding.	F 441		

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F 441	Continued From page 16 Continued interview at that same time with CNA A revealed she had laminated the instructions and posted them in all bathing rooms. She then found the instructions behind a cabinet in the bathing room by the DON's office. She stated "The instructions were only for the whirlpools, there were no instruction or guidelines for the disinfection of the showers." She stated "All bath aides should know to use two ounces of disinfectant and add it to one gallon of water. You leave the disinfectant sit for ten minutes and then rinse it off. All the directions and instructions should be the same for all three bathing rooms." Review of the manufacture's instructions for the Penner Patient Care Whirlpool Disinfectant Cleaner revealed: *Dilute two ounces of disinfectant with one gallon of water. *Thoroughly wet all surfaces. *Contact time must be at least ten minutes for proper disinfection. *Then let air dry. Review of the manufacture's instructions for the Classic Whirlpool Disinfectant Cleaner revealed: *Dilute two ounces of disinfectant with one gallon of water. *Thoroughly wet all surfaces. *Contact time must be at least ten minutes for proper disinfection. *Then let air dry. Review of the July 2013 dated Integrity Bath MB-80R policy revealed at the end of the policy "If a resident receives a shower, spray the shower chair with the disinfectant. Allow the disinfectant to sit on chair surfaces for 10 minutes. Wipe	F 441		

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F 441	Continued From page 17 shower chair down and rinse." Review of the May 2014 Infection Prevention Program Overview revealed "D. Staff Education: Training of staff in infection prevention begins with orientation of new hires and occurs at least annually." Surveyor: 29162 B. Based on observation, interview, and policy review, the provider failed to ensure sanitary technique was used during one of two sampled resident's (5) treatment by unlicensed assistive personnel (UAP) H. Findings include: 1. Observation on 8/23/16 from 12:30 p.m. through 12:40 p.m. of a treatment provided to resident 5 by UAP H revealed: *UAP H washed her hands two times. Both of those times she: -Washed her hands for five seconds. -Turned the water faucet off with her clean hands. *She dropped a tube of resident 5's ointment on the floor. Picked the ointment tube up and took it to the medication cart. Put a rubber band around it and another tube of ointment. Put both of those ointment tubes into the medication cart. *Did not clean the ointment tube that had been on the floor before she put it back into the medication cart. Interview on 8/24/16 at 10:30 a.m. with the director of nurses and the nurse consultant confirmed: *UAP H had not correctly washed her hands. *The ointment tube that had been on the floor should have been cleaned before it was put back	F 441		

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F 441	Continued From page 18 into the medication cart. Review of the provider's last revised August 2014 Handwashing/Hygiene policy revealed: *"All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." *Employees must wash their hands for at least twenty (20) seconds using antimicrobial or nonantimicrobial soap and water before and after direct resident contact. *Faucets were to have been turned off with a clean, dry paper towel.	F 441		

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

ORIGINAL

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	435043		08/23/2016

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 000	INITIAL COMMENTS *Addendums noted with an asterisk per 10/3/16 per telephone with facility administrator. CH/SDDH/EL Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/23/16. 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 K038 and K050 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 038 SS=F	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: 18087 Based on observation, testing, and interview, the provider failed to ensure three randomly observed marked exits were readily accessible at all times (Exit B by the Beauty Shop, the main dining room, and the main entrance). Findings include: 1. Observation at 11:15 a.m. on 8/23/16 revealed the Exit B door was equipped with a magnetic lock. *Signage at that door stated to push on the door for 15 seconds in order to exit. *Testing of the magnetically locked door by pressing against the panic bar for three seconds would not initiate a delayed egress unlocking sequence. A second test by the environmental services director revealed the panic bar for the	K 038	**K038** 1.Exit B door near beauty shop did not have correct signage addressing the magnetic lock egress. The timing was set for 15 seconds on the push bar, but it should be set for three seconds and then re-set at 15 seconds. The exit doors in the main dining room did not have proper	10-7-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator

RECEIVED
SEP 19 2016
SD DOH L&C

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	435043		08/23/2016

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 038	Continued From page 1 door had to have pressure placed on it for the entire 15 seconds before the door would release. *Interview with the environmental services director at the time of the observation and testing confirmed those conditions. He stated he was a new employee with the provider in the past nine months and was unaware the operation of the magnetic lock to egress was not correct. The deficiency had the capability to affect the occupants of three smoke compartments. 2. Observation at 12:45 p.m. on 8/23/16 revealed the exit door for the main dining room was a set of doors equipped with magnetic locks. *Interview with the environmental services director at the time of observation revealed the magnets would energize and lock when a wandering device came within close proximity of the doors. He stated the doors were also locked in the evening by entering a code into a keypad mounted to the side of the doors. *Testing of the doors by manually locking them as well as using a wandering device at the time of the observation revealed they functioned as delayed egress type locks. There was not a sign stating how to egress with the delayed egress function. *Interview with the environmental services director at the time of the observations and testing confirmed those conditions. He stated he was unaware the lack of signage was not correct. The deficiency had the capability to affect the occupants of three smoke compartments. 3. Observation at 1:30 p.m. on 8/23/16 revealed the exit door for the main entrance/exit was a set of doors equipped with magnetic locks.	K 038	signage acknowledging egress function. The exit door on the main entrance with magnetic locks did not have proper signage signaling the egress function. 2. Proper signage was ordered for all three doors. The exit by the beauty will be re-set for the three second program. 3. All residents are at risk. 4. October 7, 2016 *The maintenance Supervisor will perform the work and will also report to QA. CH/SDOH/EL	

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K 038	Continued From page 2 *Interview with the environmental services director at the time of observation revealed the magnets would energize and lock when a wandering device came within close proximity of the doors. He stated the doors were also locked in the evening by entering a code into a keypad mounted to the side of the doors. *Testing of the doors by manually locking them as well as using a wandering device at the time of the observation revealed they functioned as delayed egress type locks. There was not a sign stating how to egress with the delayed egress function. *Interview with the environmental services director at the time of the observations and testing confirmed those conditions. He stated he was unaware the lack of signage was not correct. The deficiency had the capability to affect the occupants of four smoke compartments.	K 038		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider	K 050	**K050** 1.The fire drill was not properly administrated by staff. The resident in the room was not initially removed from the fire location. The fire alarm pull was not activated until the responding staff were coached. The door to the resident remained opened throughout the event. 2. Proper training for the fire drill will be conducted for all staff by September 22, 2016. 3.Maintenance director will be conducting random fire drills weekly for the next	10-7-16

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K 050	Continued From page 3 failed to ensure staff were familiar with the facility's fire drill policy and procedures. Findings include: 1. Observation of the fire drill beginning at 1:25 p.m. on 8/23/16 revealed two staff responded to the simulated fire in resident room 214. At the onset of the fire drill the staff asked the environmental services director for instructions on what to do during the drill. The resident in the room was not initially removed from the fire location. The fire alarm manual pull station was not activated until the responding staff had been coached to do so. The door to the resident room remained open throughout the drill. Interview with the environmental services director at the time of the observation revealed the staff who initially responded to the simulated fire were one year and fourteen year tenured employees. The deficiency had the capability to affect 100% of the building occupants.	K 050	three months to ensure all staff are educated on various fire emergency scenarios. 4. All residents and staff are at risk. 5. October 7, 2016. *The maintenance supervisor will report to QA. CH/SDDOH/EL	

ORIGINAL

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	10686		08/24/2016

NAME OF PROVIDER OR SUPPLIER: DAVID M DORSETT HEALTHCARE COMMUNIT

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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement *Addendums noted with an asterisk per 9/28/16 per email with facility DON. KW/SDDOH/EL Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/22/16 through 8/24/16. David M. Dorsett Healthcare Community was found not in compliance with the following requirements: S210, S236, and S238.	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 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 29162 Based on record review and interview, the provider failed to ensure five of five sampled employees (I, J, K, L, and M) had a health evaluation completed within fourteen days of	S 210	**S210** 1. Based on record review and interview, the provided failed to ensure five out of the five samples employees (I, J,K, L and M)had health evaluation completed within fourteen days of being hired. All of those records were identified and completed on September 15th, 2016. 2. The HR director was educated of requirement at time of survey. 3. Weekly audits for three months to ensure all new hires have their Associate medical history questionnaire completed and reviewed by a licensed health care professional and signed by them to ensure the employee had been free of *DON or designee will do audits KW/SDDOH/EL	10-7-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]

TITLE: [signature]

(X6) DATE: 9/14/16

STATE FORM 6899 ZT6011 If continuation sheet 1 of 5

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	10686		08/24/2016

NAME OF PROVIDER OR SUPPLIER: DAVID M DORSETT HEALTHCARE COMMUNIT

STREET ADDRESS, CITY, STATE, ZIP CODE: 1020 N 10TH STREET SPEARFISH, SD 57783

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S 210	Continued From page 1 being hired. Findings include: 1. Review of the following employees' personnel records revealed: *Employee I had been hired on 7/26/16. *Employee J had been hired on 7/6/16. *Employee K had been hired on 7/20/16. *Employee L had been hired on 6/15/16 *Employee M had been hired on 5/25/16. *All five of the above employees had completed an Associate Medical History Questionnaire. That same questionnaire had not been reviewed and signed by a licensed heath care professional to ensure the employees had been free of communicable disease. Interview on 8/24/16 at 10:00 a.m. with the health information manager revealed she had been unaware the Associate Medical History Questionnaire should have been reviewed and signed by a licensed health professional. Interview on 8/24/16 at 10:30 a.m. with the director of nurses and nurse consultant confirmed employees I, J, K, L, and M, had not had a completed health evaluation within fourteen days of hire. That evaluation would have ensured they were free of communicable disease.	S 210	communicable disease. Results will be reported to monthly QAPI to determine if audits need to be continued. 3. All new hires and residents are at risk. 4. October 7, 2016. * DON will report findings to QA MW/SDDOH/EL	
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented	S 236	**S 236** 1.Based on record review, interview and policy review, the provider failed to ensure two of the five sampled employees (K and L) had completed the two-step	10-7-16

South Dakota Department of Health

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S 236	Continued From page 2 tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 29162 Based on record review, interview, and policy review, the provider failed to ensure two of five sampled employees (K and L) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being hired. Findings include: 1. Review of the following employees' personnel records revealed: *Employee K had been hired on 7/20/16. He had received a TB skin test on 7/20/16 and on 8/17/16. Both of those tests had not been read. *Employee L had been hired on 6/15/16. She had the first TB skin test on 6/24/16, and it had been read on 6/27/16. The results of that test had been negative. The second TB test had not been	S 236	method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being hired. 2. HR Director was educated on company policy regarding TB test. Those employees not in compliance were brought in to ensure their TB tests were properly administered as per company policy. 3. All new hire employees and residents are affected. 4. All new hires TB testing will be audited for proper administration as per company policy. 5. All new hires TB testing will be audited weekly for three months to ensure proper TB testing is in place. 6. October 7, 2016. *Staff K and L have had their 2nd step TB completed. However we are re-doing their 2-step so that the 2 steps will be completed within 14 days for both steps. KW/SDDOH/EL *DON or designee will do audits. DON will report findings to QA. KW/SDDOH/EL	

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S 236	Continued From page 3 completed until 7/28/16. That had been greater than fourteen days since she had been hired. Interview on 8/24/16 at 9:15 a.m. with the health information manager revealed she had been aware some of the new employees had not completed their TB skin testing. Interview on 8/24/16 at 10:30 a.m. with the administrator and nurse consultant confirmed employees K and L had not had their TB skin testing completed within fourteen days of being hired. Review of the provider's Tuberculosis Prevention & Control Program policy last revised 12/27/13 revealed each new healthcare worker shall receive a two-step tuberculin skin test to establish a baseline within fourteen days of employment.	S 236		
S 238	44:73:04:12(3) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (3) Each healthcare worker or resident with a history of a positive reaction to the tuberculin skin test or blood assay shall be evaluated annually by a physician, physician assistant, nurse practitioner, clinical nurse specialist, or a nurse and a record maintained of the presence or absence of symptoms of Mycobacterium tuberculosis. If this evaluation results in suspicion of active tuberculosis, the person shall be referred for further medical evaluation to confirm the presence or absence of tuberculosis. This Administrative Rule of South Dakota is not met as evidenced by:	S 238	**S 238** 1.After review of resident 2 medical record, who had a positive reactor to TB has not been properly assessed for signs and symptoms of TB. 2. Director of nursing completed proper assessment on resident in question. →#2 KW/SDDOH/EL 3. All residents and staff can be affected. 4. Weekly audits on all new and current residents regarding TB testing and proper documentation for residents will be reviewed and updated. 5. October 7, 2016. → *DON or designee will do audits. DON will report findings to QA. KW/SDDOH/EL	10-7-16

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S 238	Continued From page 4 Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to ensure one of one sampled resident (2) who had a positive tuberculosis (TB) test had been evaluated for signs and symptoms annually. Findings include: 1. Review of resident 2's medical record revealed: *She had been admitted on 8/28/12. *She had a history of a positive TB test when she had been admitted. *The last annual TB assessment for signs and symptoms of TB had been completed on 1/13/14. Interview on 8/23/16 at 5:15 p.m. with licensed practical nurse E revealed she had not been aware resident 2 was a positive TB reactor. She had not completed any TB assessments for resident 2. Review of the provider's 12/27/13 Tuberculosis Prevention and Control Program policy revealed all skin-test positive residents should have been clinically evaluated on an annual basis. Documentation would include the presence or absence of symptoms consistent with TB.	S 238		
S 000	Compliance/Noncompliance Statement Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/22/16 through 8/24/16. David M. Dorsett Healthcare Community was found in compliance.	S 000		