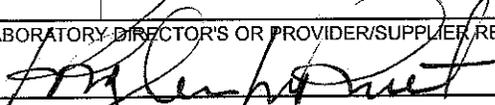


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ORIGINAL

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OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435035 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/30/2013 |
| NAME OF PROVIDER OR SUPPLIER BELLE FOURCHE HEALTHCARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2200 13TH AVE BELLE FOURCHE, SD 57717 | |
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| F 000 | INITIAL COMMENTS Surveyor: 29162 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/28/13 through 5/30/13. Belle Fourche Healthcare Center was found not in compliance with the following requirements: F281, F323, F332, F431, F441, and F514. | F 000 | Addendums noted with an asterisk per 7/3/13 telephone to facility administrator. MP/SDDOH/JJ | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, interview, record review, and policy review, the provider failed to ensure: *A physician's order to discontinue a medication was followed for 1 of 13 sampled residents (1). *Appropriate monitoring requirements were clarified with the physician for 1 of 1 sampled resident (11) with a pacemaker. Findings include: 1. Review of resident 1's May 2013 medication administration record (MAR) revealed an entry for Mobic (to treat arthritis) 7.5 mg (milligram) to have been given daily. That medication had been administered through May 13, 2013 and then discontinued. Review of resident 1's 4/30/13 physician's orders revealed an order to discontinue the Mobic. Those orders were noted by a nurse as having | F 281 | All residents potentially at risk. 1. Resident #1 medication was discontinued on May 13, 2013. 2. Resident #11 cardiac pace maker information was sent to primary physician on June 19, 2013 requesting further instruction regarding follow-up with cardiologist. All nursing staff will be educated on policies by the Director of Nursing (DON) or designee on or before July 19, 2013. Policies to be covered include 1) reception, transcription and clarification of physician orders and 2) appropriate monitoring requirements for cardiac pace makers. *Resident 11 has an appointment scheduled on 7/26/13 with his cardiologist for further follow-up. MP/SDDOH/JJ | 7/19/13 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
 Administrator 06/25/2013

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.

JUN 28 2013

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| F 281 | <p>Continued From page 1 been implemented on 4/30/13.</p> <p>Interview on 5/30/13 at 2:45 p.m. with the interim director of nursing and the nurse consultant revealed orders were to have been noted by a nurse and entered onto the MAR by the health unit coordinator. Nurses were to have completed twenty-four hour checks of all residents' charts to ensure accuracy. They confirmed that order had been missed until noticed by the Minimum Data Set (MDS) coordinator on 5/13/13.</p> <p>Interview on 5/30/13 at 2:55 p.m. with the MDS coordinator confirmed she had reviewed resident 1's physician's orders on 5/13/13. She had noted the Mobic had not been discontinued as ordered.</p> <p>Review of the provider's undated Physician's Orders policy revealed: **"A physician's order was obtained by a licensed nurse, either verbally, in-person, or written." **"Licensed nurse or HUC (health unit coordinator) then transcribes order into the EMR (electronic medical record)." **"Licensed nurse checks the EMR to assure it's transcribed correctly."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Edition, St. Louis Mo., 2005, page 419, revealed: **"The physician was responsible for directing medical treatment." **"Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm clients. Therefore, all orders must be assessed, and if one is found to be erroneous or harmful, further clarification from the physician is necessary."</p> | F 281 | <p>The DON or designee will complete written audits on discontinuation of medication per physician orders and appropriate monitoring of pace makers. Written audits will be completed weekly x 1 month then monthly x 3 months with a minimum of 3 examples per audit. DON or designee will report monthly to the QA (Quality Assurance) committee for review and recommendations.</p> | | |

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| F 281 | <p>Continued From page 2</p> <p>"The physician should write all orders, and the nurse must make sure that they are transcribed correctly."</p> <p>2. Review of resident 11's medical record revealed he had been admitted on 12/27/12. Review of his admission records on that same date revealed he had a cardiac pacemaker in place for a diagnosis of an irregular heart beat. Review of the resident's 6/2/11 cardiac consultation report revealed the pacemaker had been inserted on 6/2/11.</p> <p>Review of resident 11's 12/27/12 initial nursing evaluation revealed "no" in answer to the question if he had a pacemaker. Interview on 5/30/13 at 10:50 a.m. with the interim director of nursing who had completed the above assessment revealed she was unsure why the answer to that question had been no. She stated "I must have just missed it."</p> <p>Interview on 5/30/13 at 9:10 a.m. with the nurse consultant revealed the provider did not have any policy or protocol for residents with pacemakers. Interview at the same time with the MDS coordinator revealed she thought residents with pacemakers should have had their heart rate and rhythm checked periodically to ensure the pacemaker was functioning. She stated she was unsure how often that should have occurred. She stated she would have expected the physician to have indicated if any checks were necessary. She thought resident 11's pacemaker had been checked remotely over the phone. She confirmed there was no documentation showing that had ever been done. She confirmed the doctor had not been contacted to clarify if any checks for the</p> | F 281 | | | |

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| F 281 | Continued From page 3 pacemaker had been warranted. Review of the 2/28/12 National Institutes of Health guidelines for ongoing pacemaker care, http://www.nhlbi.nih.gov/health/health-topics/topics/pace/links.html , revealed: *The physician should check the pacemaker regularly (about every three months). A pacemaker could stop working properly because: -Its wires could get dislodged or broken. -Its battery could have become weak or failed. -The patient's heart disease could have progressed. -Other devices could have disrupted the electrical signal. *To check a pacemaker, a physician might schedule several office visits. *A pacemaker could have been checked remotely using a phone or internet. | F 281 | | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on random observation, interview, and record review, the provider failed to ensure the residents' environment and equipment were maintained and remained free from accident | F 323 | All residents potentially at risk. 1a. Call light string in resident bathroom 406 was replaced on June 5, 2013 by the Environmental Services Director. 1b. Resident #17, #22 and #23 wheelchair arms were replaced on June 20, 2013 by the Environmental Services Director. 1c. The dining room and dayroom chairs will be surveyed and those with torn and cracked arms will be repaired no later than July 19, 2013. | 7/19/13 | |

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| F 323 | <p>Continued From page 4</p> <p>hazards in the following areas:</p> <ul style="list-style-type: none"> *No call light string in one resident's bathroom (406). *Three torn and cracked residents' wheelchair arms. *Six torn and cracked dining room and dayroom chair arms. *A total of fifteen doors in three of three hallways had chipped or splintered wood edges and surfaces. *Exit door to the patio across from the dining room had a tight closure to keep water out and to prevent the flooring from peeling up. *One of one activity room had countertops and cupboards that were loose and falling apart. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Random observations from 5/28/13 through 5/29/13 revealed: <ol style="list-style-type: none"> a. No string on the call light in the bathroom in resident room 406 (photo 10). b. Three wheelchair arms had torn and cracked arms creating an uncleanable surface and a potential skin tear risk for residents 17, 22, and 23 (photo 2). c. Six dining room and dayroom chairs had torn and cracked arms creating an uncleanable surface and the potential for skin tears (photo 1). d. Hall 200, 300, and 400 had chipped or splintered edges and surfaces on fifteen resident room doors that had created a potential for skin tears. Those doors were in rooms 202, 205, 211, 213, 217, 314, 315, 316, 319, 402, 403, 404, 405, 410, and 414 (photos 11, 12, and 13). e. The exit door directly across from the dining room that lead to the patio did not have a tight closure to prevent water leaking in and creating a potential fall hazard to residents. The flooring had | F 323 | <p>1d. The doors in rooms 202, 205, 211, 213, 217, 314, 315, 316, 319, 402, 403 404, 405, 410 and 414 will be repaired by July 19, 2013 by the Environmental Services Director.</p> <p>1e. The exit door across from the dining room will be repaired with a weather strip seal by July 19, 2013. The flooring directly leading to the patio door will repaired no later than July 19, 2013.</p> <p>1f. The countertops and cupboards in the activity room will be removed and walls will be patched no later than July 19, 2013.</p> <p>All staff will be re-educated on or before July 19, 2013 by the Environmental Services Director or designee on writing work orders for the maintenance department when equipment or the building structure is a potential safety hazard to residents. The maintenance department will then collect the work orders daily and will do a quarterly preventative walk through to identify unreported needs.</p> | | |

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| F 323 | Continued From page 5 started to come up at that exit door (photo 3). f. The activity room had countertops and cupboards that were loose and falling apart. Sharp edges and uncleanable surfaces were exposed. Creating a potential accident hazard to residents (photo 6, 7, and 8). Observation on 5/29/13 at 6:00 p.m. of the patio exit door across from the dining room in the above finding 1e revealed: *It was pouring rain. *Water was leaking in that door and pooling on the hallway floor. *That created a potential fall risk to the residents.' | F 323 | The Environmental Services Director or designee will complete written audits to ensure that call light strings in resident bathrooms are intact, wheelchair arms are free from tears/ cracks, dining and dayroom chairs are free from tears/ cracks and resident corridor doors and bathroom doors are free from chipping or splintering. Written audits will be completed weekly x 1 month and monthly x 3 months with a minimum of 5 examples per audit. The Environmental Services Director or designee will report monthly to the QA committee for review and recommendation. | |
| F 332 SS=E | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, interview, and policy review, the provider failed to ensure medications were administered with less than a 5 percent (%) medication error rate. The medication error rate was 9.09%. Four errors for 4 of 44 medications administered by 2 of 2 unlicensed assistive personnel (UAP) (B and C) for 3 of 12 observed residents (17, 19, and 20). | F 332 | All residents potentially at risk. 1. Resident #19 medication administration technique noted during this survey is unable to be corrected but 1:1 education was provided to UAP C on May 29, 2013 by the interim DON after notified by the surveyors. 2. Resident #19 medication administration technique noted during this survey is unable to be corrected but 1:1 education was provided to UAP C on May 29, 2013 by the interim DON after notified by the surveyors. | 7/19/13 |

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| F 332 | <p>Continued From page 6</p> <p>Findings include:</p> <p>1. Observation on 5/29/13 at 7:40 a.m. of UAP C while she prepared resident 19's medication revealed she had crushed an erythromycin (antibiotic) 250 milligrams (mg) tablet and gave it to the resident. Review of the resident medication blister packet revealed it had stated "DO NOT CRUSH." There had been directions on the medication blister packet that had stated "swallow whole."</p> <p>2. Observation on 5/29/13 at 7:45 a.m. of UAP C while she prepared resident 19's medication revealed UAP C had mixed one tablespoon of polyethylene glycol (laxative) in eight ounces of water which was the required amount of liquid for mixture. She then gave it to the resident to drink. When the resident had drank one-half of the glass of water and medication UAP C took the glass. She then stated, "I got almost half of it down her. That is pretty good." UAP C then initialed the medication as given. One half glass of the polyethylene glycol did not match the dosage ordered by the physician.</p> <p>3. Observation on 5/29/13 at 10:00 a.m. of UAP C while she administered Refresh Optic Advanced eye drops (for dry eyes) to resident 20 revealed the label on the box of eye drops stated to instill in both eyes three times daily as directed. The physician's order had stated to use the Refresh Optive Advanced drops four times a day. There had been no directions on the label of the box or on the physician's order for the number of drops to have been given. UAP C stated "I just give the resident one drop in each eye when I give them."</p> | F 332 | <p>3. Resident # 20s Refresh Optic Advanced eye drops order states 4 times daily. On June 19, 2013 the pharmacy was contacted for a correct label to state 4 times daily.</p> <p>4. Resident #17 eye drop administration technique noted during this survey is unable to be corrected but 1:1 education was provided to UAP B on May 29, 2013 by the interim DON after notified by the surveyors.</p> <p>All licensed nursing staff will be educated by the DON or designee on or before July 19, 2013. Policies and education to be covered include 1) proper administration of medications with indications of 'do not crush medication,' 2) proper administration of eye drops and polyethylene glycol and 3) procedure to clarify when physician orders are contradicting to the medication label.</p> | | |

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| F 332 | Continued From page 7 4. Observation on 5/29/13 at 10:05 a.m. of UAP B while she administered Freshkote Eye Drops (for dry eyes) to resident 17 revealed she had dropped the medication directly onto the residents eyeball. She had not created a pocket with the lower lid for the medication to be dropped into. Interview with the interim director of nurses on 5/30/12 at 11:00 a.m. confirmed: *Resident 19's erythromycin should not have been crushed. *UAP C should not have taken the glass that had contained the polyethylene glycol and water from resident 19 before she had finished drinking it. *The orders for resident 20's eye drops had not been completed and accurate. *UAP B had instilled resident 17's eye drops incorrectly. Review of the provider's 2007 PharMerica Corporation Medication Administration General Guidelines revealed: *Medications were to have been administered in accordance with the written orders of the prescriber. *Prior to administration the medication and dosage schedule on the resident's MAR was to have been compared with the medication label. *If the label and the MAR had been different the prescriber's orders were to have been checked. *The need for crushing medication was to have been listed on the resident's orders so all personnel administering medications had been aware. | F 332 | The DON or designee will complete written audits on proper administration of 'do not crush' medications, correct dosage of polyethylene glycol is administered, proper procedure of eye drop administration is being followed and ensuring medication labels reflect physician orders accurately. Audits will be completed weekly x 1 month then monthly x 3 months and a minimum of 3 observations will be completed for each audit. The audit results will be reported to the QA committee by the DON or designee monthly for review and recommendation. | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS | F 431 | All residents potentially at risk. | 7/19/13 | |

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| F 431 | <p>Continued From page 8</p> <p>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.</p> <p>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.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, interview,</p> | F 431 | <p>1. As of June 13, 2013 all narcotic storage cupboard keys have been revoked from licensed nursing personnel. The DON now holds the only narcotic storage key. A licensed nurse and the DON will place and log the narcotics into the storage cabinet. The DON and Pharmacist will destroy the medications.</p> <p>The DON will educate all licensed nursing staff and contracted Pharmacist on new narcotic locking procedure on or before July 19, 2013.</p> <p>*The DON or designee will complete written audits weekly for one month then monthly for three months to ensure the log for narcotics awaiting destruction has been completed and is accurate. Those audits will also ensure the DON is the only person with the keys to that cupboard. The audit results will be reported to the QA committee by the DON or designee monthly for review and recommendation.</p> <p style="text-align: right;">MP/SDDOH/JJ</p> | | |

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| F 431 | Continued From page 9 and policy review, the provider failed to ensure a process was in place to ensure controlled medications awaiting destruction were accurately accounted for in one of one medication room. Findings include: 1. Observation on 5/30/13 at 10:00 a.m. of the medication room revealed there had been a double-locked secured cupboard for medications awaiting destruction. That cupboard had contained schedule II and III narcotics (pain medications). The charge nurses on duty had keys to that cupboard. There had not been a record of accountability of those narcotics in that cupboard. Interview with the interim director of nurses on 5/30/13 at 11:00 a.m. confirmed there had not been a way to know what medications had been placed in the double-locked cupboard waiting for destruction. Those medications had not been stored in an accountable way. Review of the provider's 2007 PharMerica Corporation Controlled Medication Storage policy revealed the accountability of the schedule II and III medications waiting to be destroyed had not been addressed. | 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 | F 441 | All residents potentially at risk. A. 1. The above mentioned observation of laundry being delivered during this survey is unable to be corrected but 1:1 education was provided to laundry personnel D on May 29, 2013 by the Environmental Services Director. | 7/19/13 | |

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| NAME OF PROVIDER OR SUPPLIER BELLE FOURCHE HEALTHCARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2200 13TH AVE BELLE FOURCHE, SD 57717 | | |
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| F 441 | <p>Continued From page 10</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 A. Based on random observation and interview the provider failed to ensure: *Residents' personal laundry remained covered during laundry delivery on two of three halls, (200 and 400).</p> | F 441 | <p>2. The above mentioned washing machines will be free of chipped paint and rust by June 20, 2013. Ceilings and walls will be sheet rocked and painted directly above the washing machine no later than July 19, 2013. The laundry cart cleaning room flooring will be completely replaced by July 19, 2013.</p> <p>3. The urinal and basin in the solarium bathroom was removed on May 30, 2013.</p> <p>4. The resident use items were removed from under the sink on June 19, 2013; the two balancing mats mentioned above have been thrown away and as of June 19, 2013 two new balancing mats have been received. No later than July 19, 2013 the therapy stair steps will be sanded, painted and a new anti-skid strip will be installed.</p> <p>5. The incontinence briefs, dry wipes and poly-file jackets were removed from the storage room on May 30, 2013.</p> <p>6. Resident #21 side rails have been removed from room on June 19, 2013. Resident was re evaluated for need for device on June 19, 2013 and it was found that resident no longer required this equipment.</p> | | |

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| F 441 | <p>Continued From page 11</p> <p>*Two of two washing machines used for residents' items remained free of chipped paint and rust.</p> <p>*Resident use items had been stored in a sanitary manner.</p> <p>*Resident use items in the therapy room were not stored under the sink.</p> <p>*Two of two balancing mats in the therapy room were free from cracks and tears. Creating uncleanable surfaces.</p> <p>*Clean resident use items were stored off the floor in the 200 hall storage room.</p> <p>*Half side rail padding in one resident's room (408A) was free of cracks and tears.</p> <p>Findings include:</p> <p>1. Observation on 5/29/13 at 2:35 p.m. of laundry staff D while she delivered residents' personal laundry down hall 200 and 400 revealed she had parked the laundry cart in each resident hallway. She had opened the cover on the laundry cart and had left it open while she delivered laundry to residents' rooms down each hallway. The laundry had been exposed to other residents, staff, and visitors walking by it.</p> <p>Interview on 5/30/13 at 11:40 a.m. with the infection control nurse confirmed she would have expected the laundry carts to have been covered during laundry delivery to residents' rooms.</p> <p>Review of the provider's undated Linen Handling Policy revealed "All linen must be delivered to the resident units maintaining the cleanliness of the laundry."</p> <p>2. Observation on 5/29/13 at 2:45 p.m. of the laundry room revealed:</p> | F 441 | <p>All staff will be educated by the Environmental Services Director or designee or before July 19, 2013. Policies and education to be covered include 1) proper storage of laundry while being transferred, 2) writing work orders on the maintenance log for the maintenance department when equipment does not have a cleanable service and 3) proper storage of resident use items.</p> <p>The Environmental Services Director or designee will complete written audits on the proper transportation of laundry and the proper storage of resident use items. Audits will be completed weekly x 1 month then monthly x 3 months and a minimum of 3 observations will be completed for each audit. The Environmental Services Director will also complete written audits on the washing machines being free from chipped paint and rust. Audits will be completed monthly x 3 months. The audit results will be reported to the QA committee by the Environmental Services Director or designee monthly for review and recommendation.</p> | | |

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| F 441 | <p>Continued From page 12</p> <p>*A washing machine used for residents' laundry had chipped paint and rust inside of the lid (photo 17).</p> <p>*A commercial washing machine had chipped paint and rust on the front of it (photo 19).</p> <p>*Part of the ceiling and walls had no sheet-rock. Clean residents' laundry had been hanging from the ceiling (photo 21 and 22).</p> <p>*The laundry cart cleaning room had soiled uneven caulking and patched grout in the floor tiles that created uncleanable surfaces (photo 20).</p> <p>3. Random observation on 5/29/13 of the dayroom bathroom revealed a basin with a soiled urinal laying inside of it on the floor next to the toilet (photo 9).</p> <p>4. Observation on 5/29/13 at 3:15 p.m. of the therapy room revealed: *Resident use items stored under the sink (photo 16). *Two balancing mats had multiple cracks and tears making them an uncleanable surface (photo 18). *A stair step with two stairs for therapy use with an approximate two-inch raw wood uncleanable surface (photo 15).</p> <p>Interview on 5/30/13 at 12:55 p.m. with the director of the therapy department confirmed: *Cracked and torn mats and raw wood created uncleanable surfaces. *Resident use items should not have been stored underneath the sink.</p> <p>5. Random observation of the 200 hall clean supply closet revealed:</p> | F 441 | <p>B.</p> <p>1. Resident #6 personal care dressing changes; the technique noted during this survey is unable to be corrected but 1:1 education was provided on May 29, 2013 to LPN A after interim DON was notified by surveyors.</p> <p>2. Resident #17 administration of eye drops; the technique noted during this survey is unable to be corrected but 1:1 education was provided on May 29, 2013 to UAP B after interim DON was notified by surveyors.</p> <p>All nursing staff will be educated by the DON or designee on or before July 19, 2013 regarding the following infection control procedures which include 1) proper care and maintenance of items/tools used in care procedures and 2) proper hand hygiene techniques.</p> | |

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| F 441 | <p>Continued From page 13</p> <p>*Three boxes of size extra large adult incontinence briefs were stored on the floor (photo 4).</p> <p>*One box of poly-file jackets was stored on the floor.</p> <p>*One box of dry-wipes was stored on the floor (photo 5).</p> <p>Interview on 5/29/13 at 3:00 p.m. with the director of environmental services revealed the above items should not have been stored on the floor.</p> <p>6. Random observation on 5/29/13 of resident 21's side rail covers revealed they were cracked and torn creating the potential for skin tears and an uncleanable surface (photo 14).</p> <p>Surveyor: 26632</p> <p>B. Based on observation, interview, and policy review, the provider failed to ensure:</p> <p>*One of one resident's (6) dressing change followed appropriate infection control procedures.</p> <p>*Handwashing and glove use was performed correctly by one unlicensed assistive personnel (UAP) (B) during the administration of eye drops to one of one (17) resident.</p> <p>1. Observation on 5/29/13 at 2:30 p.m. revealed licensed practical nurse A removed a pair of scissors from her uniform pocket, cut a piece of gauze that was used to pack resident 6's wound, and then returned those scissors to her uniform pocket. She did not sanitize the scissors before or after she had used them.</p> <p>Surveyor: 29162</p> | F 441 | <p>The DON or designee will complete written audits on proper disinfecting of items/tools used during personal cares and proper hand hygiene techniques before and after eye drop administration. Audits will be completed weekly x 1 month then monthly x 3 months and a minimum of 3 observations will be completed for each audit. The audit results will be reported to the QA committee by the DON or designee monthly for review and recommendation.</p> | |

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| F 441 | Continued From page 14 2. Observation on 5/29/13 at 10:05 a.m. of UAP B while she had administered eye drops to resident 17 revealed she wore gloves when she had administered those eye drops. She had not sanitized her hands before she had donned gloves or after she had removed them. Interview with the interim director of nurses on 5/29/13 at 11:00 a.m. confirmed UAP B should have sanitized her hands before she had donned gloves and after she had removed them. Review of the provider's undated Handwashing in the Healthcare Setting policy confirmed handwashing should have been completed before applying gloves and after removing them. | F 441 | | | |
| 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. This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, record review, interview, | F 514 | All residents potentially at risk. 1. Physician documentation received on June 25, 2013 regarding rationale for Resident #1 foley catheter. 2. The observed undocumented medications noted during this survey are unable to be corrected but education and audits will be conducted. 3a. Please refer to F281 plan of correction* regarding resident 11. <i>mp sdooh JJ</i> | 7/19/13 | |

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| F 514 | <p>Continued From page 15</p> <p>and policy review, the provider failed to ensure documentation was complete and accurate for medication administration records (MAR), treatment administration records (TAR), and nurses' and physicians' progress notes for 7 of 13 sampled residents (1, 3, 6, 7, 8, 11, and 12). Findings include:</p> <p>1. Observation of resident 1 beginning at 7:30 a.m. on 5/29/13 and throughout the survey until noon on 5/30/13 revealed she had a Foley catheter (cath) (urine collection tube).</p> <p>Review of the nurse's notes for resident 1 on 3/13/13 revealed she had not urinated during the night or in the morning. Review of her 3/13/13 physician's orders revealed an order to "Straight cath (remove urine by inserting a tube into the bladder). If over 200 ml (milliliter) leave cath in." Review of the above nurses' notes revealed 250 ml of urine had been obtained after the catheterization. The catheter had been left in per physician's orders. There was no documentation of urinary retention concerns prior to that one episode.</p> <p>Review of the physician's 4/30/13 progress notes for resident 1 revealed no mention of rationale for continued use of the catheter. Those progress notes did not state urinary retention as a diagnosis or as an area had been assessed.</p> <p>Interview on 5/29/13 at 2:45 p.m. with the interim director of nursing (DON) regarding resident 1 revealed there had been no discussion with the physician regarding the need or rationale for the continued use of the Foley catheter.</p> | F 514 | <p>3b. The observed undocumented medications and treatments noted during this survey are unable to be corrected but education and audits will be conducted.</p> <p>4. On June 24, 2013 a request to change medication administration time to 4:00PM was sent to the physician regarding Resident #7 Aricept.</p> <p>5. On June 24, 2013 resident #8 Citalopram order was clarified with an order of 'daily.'</p> <p>6. The observed undocumented medications and failure to obtain vital signs noted during this survey is unable to be corrected but education and audits will be conducted.</p> <p>7. Resident #3 guaifenesin order has been corrected to reflect current standing order as of June 24, 2013.</p> <p>All licensed nursing staff and health unit coordinator will be educated by the DON or designee on or before July 19, 2013 regarding the following accuracy of orders which include 1) physician's documented rationale for continued use for catheters,</p> | | |

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| F 514 | <p>Continued From page 16</p> <p>Interview on 5/29/13 at 2:50 p.m. with licensed practical nurse E revealed she was not sure why the Foley catheter had been continued. She stated she was sure no one had questioned whether or not a trial without the catheter should have been attempted.</p> <p>Interview on 5/29/13/ at 3:40 p.m with resident 1's physician revealed she had taken over the resident's care after the Foley catheter had been inserted. She stated she thought the reason the resident continued to have the catheter was for urinary retention. She confirmed that had not been addressed in her 4/30/13 progress note.</p> <p>Interview at 3:50 p.m. on 5/29/13 with the interim DON and nurse consultant confirmed there was no documentation regarding the need for the continued use of the Foley catheter for resident 1. They also confirmed there was only one entry found in the nurses' notes regarding any problems with urinary retention for her.</p> <p>2. Review of resident 1's 3/8/13 physician's orders revealed an order for Bisacodyl rectal suppository (for constipation) to have been given every other day.</p> <p>Review of her March, April, and May 2013 MARs revealed six of forty-one entries for the administration of the above medication had been left blank.</p> <p>Interview on 5/29/13 at 2:45 p.m. with the interim DON revealed she was unsure why those areas on the MAR had been left blank. She stated if a medication had not been given the reason for it should have been documented.</p> | F 514 | <p>2) complete and accurate medication administration records and 3) administering medications in accordance to the physician's orders.</p> <p>The DON or designee will complete written audits on documentation regarding the need for continued use for foley catheters, complete documentation with medication administration and treatments, correct time of administering medications per physician order and documentation of heart rate prior to administering amlodipine besylate. Audits will be completed weekly x 1 month then monthly x 3 months and a minimum of 3 observations will be completed for each audit. The audit results will be reported to the QA committee by the DON or designee monthly for review and recommendation.</p> | | |

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| F 514 | Continued From page 17 3. Review of resident 11's nurses' and physician's progress notes revealed no mention of the resident's pacemaker. Refer to 281, finding 2. Surveyor: 26632 3. Review of resident 6's May 2013 MAR and TAR revealed: *Oxycodone (pain medication) 5 mg had not been documented as given on 5/8/13 at 5:00 a.m. and on 5/15/13 at 5:00 a.m. *Her nebulizer mask had not been documented as changed on 5/12/13. *Her oxygen concentrator filter had not been documented as cleaned on 5/12/13. *Her coccyx (tailbone) wound dressing had not been documented as having been done on 5/9/13 for the evening shift. *Calazime (protective ointment) had not been documented as having been applied on 5/6/13 for the day shift and on 5/9/13 for the evening shift. Surveyor: 29162 4. Review of resident 7's MAR revealed an order for Aricept 5 mg (for Alzheimer's) everyday at bedtime. From 5/1/13 through 5/28/13 the time the medication had been documented as administered at 4:00 p.m. 5. Review of resident 8's MAR revealed an order for citalopram (for depression) 20 mg everyday at 8:00 p.m. From 5/1/13 through 5/28/13 the medication had been documented as administered at 5:00 p.m. 6. Interview on 5/30/13 at 11:00 a.m. with the interim director of nurses revealed the | F 514 | | | |

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| F 514 | <p>Continued From page 18</p> <p>medications that had been administered to residents 7 and 8 (above findings 4 and 5) should have been given at the time they had been ordered.</p> <p>Review of the provider's 2007 PharMerica Corporation Medication Administration General Guidelines revealed medications were to have been administered in accordance to the prescriber's orders.</p> <p>Surveyor: 32572 Preceptor: 23059</p> <p>8. Review of resident 12's May 2013 MAR revealed: *Heart rates had not been recorded for the medication amlodipine besylate (for high blood pressure) for six times as directed on the medication administration record (MAR). *The results of the as needed (PRN) pain medication (Norco) that had been administered had not been documented on 5/8/13 and on 5/15/13 at 4:00 a.m.</p> <p>Interview on 5/30/13 at 7:50 a.m. with the interim DON confirmed she would have expected the pulse to have been recorded when the amlodipine besylate had been given. She also confirmed she would have expected documentation code to have been entered on the dates with unsigned spaces.</p> <p>9. Review of resident 3's May 2013 MAR and physician's orders revealed: *On 4/16/13 guaifenesin (cough medication) had been ordered as needed (PRN) for ten days. *On 4/29/13 guaifenesin had been ordered PRN</p> | F 514 | | |

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| F 514 | Continued From page 19 for ten days. *Both orders had remained on the May 2013 MAR as active orders. *Both orders had remained on the May 2013 signed physician's orders. Interview on 5/30/13 at 7:50 a.m. with interim DON and the nurse consultant confirmed there had been duplication of orders. | F 514 | | |

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| K 000 | INITIAL COMMENTS Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/30/13. Belle Fourche Healthcare Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K018 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | | |
| K 018 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. | K 018 | All residents potentially at risk. 1. The above mentioned observation during this survey is unable to be corrected. The Environmental Services Director will determine a safe dimension for medication carts to be parked allowing the doors to latch. This dimension will be identified by using safety tape placed on the floor. All staff will be educated by the Environmental Services Director or designee on or before July 19, 2013 on maintaining an obstruction free doorway. | 7/19/13 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE ADMINISTRATOR (X6) DATE 06/25/2013

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.

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

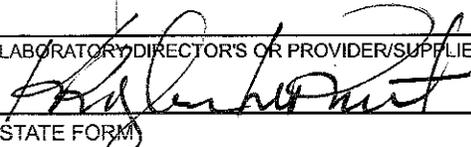
PRINTED: 06/10/2013
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435035 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 05/30/2013 |
|--|--|---|--|---|
| NAME OF PROVIDER OR SUPPLIER BELLE FOURCHE HEALTHCARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2200 13TH AVE BELLE FOURCHE, SD 57717 | |
| (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 018 | Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain the smoke tight rating of corridor door assemblies for one of two randomly observed doors (west door to the solarium). Findings include: 1. Observation and testing at 10:00 a.m. and again at 2:00 p.m. on 5/30/13 revealed the west door to the solarium could not close and latch. That door was blocked by a medication cart both times. Interview with the maintenance supervisor at the time of the observations confirmed those findings. He stated he had not placed those doors on a preventative maintenance checklist for latching. They had just started to park the carts in that room to charge the laptops. | K 018 | The Environmental Services Director or designee will complete written audits to ensure doorways are not being obstructed by medication carts. Audits will be completed weekly x1 month then monthly x3 month and a minimum of 3 observations will be completed for each audit. The audit results will be reported to the QA committee by the Environmental Services Director or designee monthly for review and recommendations. | |

ORIGINAL

SOUTH DAKOTA DEPARTMENT OF HEALTH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10594 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/30/2013 |
|--|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER BELLE FOURCHE HEALTHCARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 2200 13TH AVENUE BELLE FOURCHE, SD 57717 | | |
| (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 Surveyor: 29162 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 5/28/13 through 5/30/13. Belle Fourche Healthcare Center was found in compliance. | S 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
 Administrator 06/25/2013
 STATE FORM 021199 VNBG11 If continuation sheet 1 of 1

JUN 28 2013