



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435035</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/28/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BELLE FOURCHE HEALTHCARE COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 13TH AVE BELLE FOURCHE, SD 57717</b>		
(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	<p>Continued From page 1</p> <p>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: 33488 Based on observation, interview, manufacturers' guideline review, and policy review, the provider failed to appropriately label insulin pens with use-by-dates located in one of three medication carts. Findings include:</p> <p>1. Observation and interview on 10/27/15 at 9:45 a.m. of the medication cart with licensed practical nurse (LPN) A revealed: *Three insulin pens. *Two of those insulin pens were Novolog flex-pens (rapid-acting insulin) and one was Lantus (long-acting insulin). *All three pens were labeled with opened dates, but none were labeled with use-by-dates. *Insulin pens were not routinely labeled with use-by-dates. *She was unaware when exactly the insulin pens would be out-dated. *She assumed they were good to use for thirty days.</p> <p>Review of the Novolog manufacturer's instructions, <a href="http://www.novo-pi.com/novolog.pdf">http://www.novo-pi.com/novolog.pdf</a>, page 9, accessed on 10/29/15, revealed "The NovoLog® FlexPen® you are using should be thrown away after 28 days, even if it still has insulin left in it."</p>	F 431	<p>The Director of Nursing or Designee will complete written audits to ensure the appropriate 'use-by-date' is on all insulin pens. Written audits will be completed weekly x 1 month then monthly x 3 months with a minimum of 3 examples per audit. The DON or Designee will report monthly to the QAPI (Quality Assurance Process Improvement) committee for review and recommendations.</p>		

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

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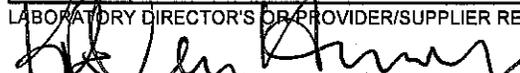
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435035</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/28/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BELLE FOURCHE HEALTHCARE COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 13TH AVE BELLE FOURCHE, SD 57717</b>		
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F 431	<p>Continued From page 2</p> <p>Review of the Lantus manufacturer's instructions, <a href="http://products.sanofi.us/lantus/lantus.html">http://products.sanofi.us/lantus/lantus.html</a>, How should I store Lantus-open (in-use) SoloStar, page 9, revealed Lantus "must be discarded after 28 days."</p> <p>Interview on 10/27/15 at 11:00 a.m. with the director of nursing (DON) regarding the above insulin pens revealed it was her expectation all insulin pens should be labeled with a use-by-date per manufacturer's guidelines.</p> <p>Review of the provider's 2015 Injectable Medications policy provided by the consulting pharmacy revealed manufacturer's recommendations were to have been followed.</p>	F 431			

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NAME OF PROVIDER OR SUPPLIER  <b>BELLE FOURCHE HEALTHCARE COMMUNITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 13TH AVE BELLE FOURCHE, SD 57717</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/27/15. Belle Fourche Healthcare Community was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K047, K069, and K076 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>*Addendums noted with an asterisk per 12/07/15 per telephone with facility administrator. CH/SDDO/H/EL</p>	
K 069 SS=C	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to maintain a connection for the kitchen range hood extinguishing system to the building fire alarm system in accordance with National Fire Protection Association 96. Findings include:</p> <p>1. Record review at 1:30 p.m. on 10/27/15 of the range hood extinguishing system inspection reports dated 03/16/15 and 9/15/15 revealed there was no documentation showing the range hood's system activated the building fire alarm system. Review at 1:40 p.m. on 10/27/15 of the building fire alarm annual inspection dated 2/17/15 revealed there was no documentation</p>	K 069	<p>All residents potentially at risk.</p> <p>1. The kitchen range hood system will be tied into the building fire alarm system no later than December 17, 2015.</p> <p>*Amick sound will perform the work. The environmental services director will verify the work is done and report to QA. CH/SDDO/H/EL</p>	12/17/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>11-19-2015</b>
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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.

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NAME OF PROVIDER OR SUPPLIER  <b>BELLE FOURCHE HEALTHCARE COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 13TH AVE BELLE FOURCHE, SD 57717</b>	
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K 069	Continued From page 1 showing the range hood's system activated the building fire alarm system. The activation of the range hood fire suppression system must activate the building fire alarm system.	K 069		
K 076 SS=C	Interview with the maintenance supervisor at the time of the record review revealed he was unaware if the suppression system activated the building fire alarm system.  This deficiency could potentially affect all eighty-three residents of the facility. <b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain storage requirements for oxygen storage over 3000 cubic feet capacity (unsealed penetrations of the one hour room, storage of combustibile items within five feet of oxygen cylinders, electrical receptacles and	K 076	All residents potentially at risk.  1. The identified unsealed openings in the oxygen room has been sealed up as of November 18, 2015.  The Environmental Services Director (ESD) or Designee will complete written audits of other hazardous areas throughout the building to ensure no unsealed openings are present. These audits will be completed weekly x 1 month then monthly x 3 months with a minimum of 3 examples per audit. The ESD or Designee will report monthly to the QAPI committee for review and recommendations.	12/17/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435035</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/27/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BELLE FOURCHE HEALTHCARE COMMUNITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 13TH AVE BELLE FOURCHE, SD 57717</b>		
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K 076	<p>Continued From page 2</p> <p>switches less than sixty inches above the floor, and storage of oxygen cylinders in a secured position) for the liquid oxygen transferring room adjacent to resident room 311. The oxygen transferring room had three liquid oxygen dewars in it. The provider must comply with the National Fire Protection Association (NFPA 99), Standard for Health Care Facilities, section 8-3.1.11 Storage Requirements. (See Attachment.) Findings include:</p> <ol style="list-style-type: none"> <li>1. Observation at 2:10 p.m. revealed unsealed openings for radiant heater tubing and electrical wiring above the lay-in ceiling through the oxygen transferring room into resident room 311.</li> <li>2. Observation at 2:13 p.m. revealed three walls with shelving with numerous amounts of plastic bags filled with soft plastic personal care items (combustible items) for oxygen breathing equipment use.</li> <li>3. Observation at 2:15 p.m. revealed the electrical receptacles and light switch were less than 60 inches above the floor in the oxygen transferring room. The light switch (highest electrical item) was located approximately 42 inches above the floor.</li> <li>4. Observation at 2:17 p.m. revealed one compressed gas oxygen 'e' sized cylinder laying on its side on the floor in the oxygen transferring room. The cylinder was not secured.</li> <li>5. Interview with the maintenance supervisor at the time of the above observations confirmed those findings.</li> </ol>	K 076	<ol style="list-style-type: none"> <li>2. All combustible items will be removed from the liquid oxygen transferring room no later than December 17, 2015.</li> </ol> <p>All staff will be educated on the proper storage and location of oxygen breathing equipment no later than December 17, 2015. The ESD or Designee will complete written audits to ensure there are no combustible items stored in the oxygen transferring room. These audits will be completed weekly x 1 month then monthly x 3 months. The ESD or Designee will report monthly to the QAPI committee for review and recommendations.</p> <ol style="list-style-type: none"> <li>3. The electrical receptacles and light switches have been removed as of November 18, 2015.</li> <li>4. The identified compressed oxygen 'e' sized cylinder has been removed as of November 18, 2015.</li> </ol> <p>All staff will be educated no later than December 17, 2015 regarding the proper and safe storage of oxygen 'e' cylinders. The ESD or Designee will complete written audits on the proper storage of 'e' cylinders weekly x 1 month then monthly x 3 months. The ESD or Designee will report monthly to the QAPI committee for review and recommendations.</p>	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>435035</b>	MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - MAIN BUILDING 01</b> B. WING _____	DATE SURVEY COMPLETE:  <b>10/27/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BELLE FOURCHE HEALTHCARE COMMUNITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 13TH AVE BELLE FOURCHE, SD</b>	

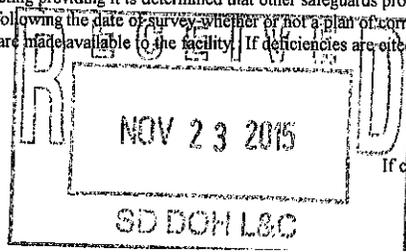
**ORIGINAL**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<b>K 047</b>	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain exit lighting for two (east exit door from the resident dining room and corridor exit sign outside of the dining room) of numerous exit signs. Findings include:</p> <p>1. Observation beginning at 11:30 a.m. on 10/27/15 revealed the east door from the resident dining room had one LED lamp in place of the original two incandescent lamps for the fixture. The LED lamp had approximately half of the light emitting diodes that were not illuminated. Further observation of the lighted exit sign outside of the resident dining room revealed the same condition existed. Interview with the maintenance supervisor at the time of the observations confirmed those conditions. He stated he had been replacing older (incandescent lamp) style exit signs with full LED fixtures.</p> <p>The deficiency affected two locations required to be provided with a marked and identifiable path of egress.</p> <p>All residents potentially risk.</p> <p>1. The two identified LED exit signs have been replaced with new LED fixtures as of November 18, 2015.</p> <p>The ESD or Designee will complete written audits weekly x 1 month and monthly x3 months of all current exit signs and will replace all retrofitted fixtures with new LED fixtures. The ESD or Designee will report monthly to the QAPI committee for review and recommendations.</p>
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The above isolated deficiencies pose no actual harm to the residents



ORIGINAL

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10594</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/28/2015</b>
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

**BELLE FOURCHE HEALTHCARE COMMUNITY** **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
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S 000	Compliance/Noncompliance Statement	S 000		
	<p>Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/26/15 through 10/28/15. Belle Fourche Healthcare Community was found in compliance.</p>			

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

TITLE

(X6) DATE

STATE FORM

6899

QRSN11

If continuation sheet 1 of 1

*[Handwritten Signature]*

*Administrator*

*11-19-15*

