STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

BELL FOURCHE HEALTHCARE COMMUNITY

NAME OF PROVIDER OR SUPPLIER

BELL FOURCHE, SD 57717

STREET ADDRESS, CITY, STATE, ZIP CODE

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-REFERENCES TO THE APPROPRIATE DEFICIENCY)

C 03/01/2018

E 000

Initial Comments

Surveyor: 32355
An initial survey for compliance with all Federal emergency preparedness requirements was conducted from 2/27/18 through 3/1/18. Belle Fourche Healthcare Community was found in compliance with 42 CFR Part 483.73 requirements.

F 000

INITIAL COMMENTS

Surveyor: 28162
A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/27/18 through 3/1/18. Belle Fourche Healthcare Center was found not in compliance with the following requirements: F580, F600, F610, F657, F659, F679, F688, F689, F725, F798, F800, F909, and F919.

A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/27/18 through 3/1/18. Areas surveyed included nursing services. Belle Fourche Healthcare Community was found not in compliance with the following associated requirements: F600, F688, and F725.

F 560

Notify of Changes (injury/Decline/Room, etc.)

CFR(e): 483.10(g)(14)(i)-(iv)(15)

§483.10(g)(14) Notification of Changes.
(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is:
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

1. Resident 47 has received an order for an inhaler as needed for shortness of breath. All residents are at risk.
2. Administrator and Director or Nursing (DON) will educate all licensed nurses on the facility's Resident, Physician, and Resident Representative(s) Notification policy to ensure the facility will immediately inform the resident; consult

LAbORATORY DIRECTORS OR PROVIDERS/SUPPLIER REPRESENTATIVE SIGNATURE

ADMINISTRATOR 3/22/2018

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 patient. For nursing homes, the findings stated above are disclosable 30 days following the date of survey whether or not the facility is found in non-compliance. For other settings, 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.

FORM CNS-2567(03-99) Previous Version Available
Event ID: 2008-4 Facility ID: 8012

If continuation sheet Page 1 of 3

SD DOH-OLOC

MAR 2 3 2018
F 580 Continued From page 1

(B) A significant change in the resident’s physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.16(c)(1)l(i).
   (i) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.16(c)(2) is available and provided upon request to the physician.
   (ii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
       (A) A change in room or roommate assignment as specified in §483.10(e)(6); or
       (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
   (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations

with the Physician/PA/NP; and inform the resident representative(s) when there is a change in condition no later than 3/26/2018. Those who have not received the education by 3/26/2018 will be educated prior to their first shift worked.

3. Administrator or designee will complete audits weekly x 4 weeks then monthly x 3 months of 4 residents, to include Resident 47, to ensure notification to the physician had occurred with a change in condition. Results of the audits will be reported by the Administrator or designee at the monthly QAIP meeting for review and recommendations for continuation or discontinuation of audit.
Continued From page 2 under §483.15(c)(8).
This REQUIREMENT is not met as evidenced by:
Surveyor: 32335
Based on interview, record review, and policy review, the provider failed to ensure notification to the physician had occurred with a change in condition for one of two sampled residents (47) who had shortness of breath. Findings include:

1. Interview on 2/27/18 at 2:30 p.m. with resident 47 and her power of attorney (POA) during the resident council meeting revealed:
   *She had felt short of breath last night (2/26/18) and thought she had an order to have her inhaler more than one time per day.
   *She asked the nurse when she had gotten her inhaler last and told her she needed it again, but the nurse would not give it to her.
   *The nurse had told her she did not have an order to have it more than one time per day.
   *It had made her "feel bad" that she could not have her inhaler.
   *The POA stated he had spoken with a staff member today, and they stated they were not able to find the order she could have the inhaler more than one time per day.

Review of resident 47's 2/28/18 Minimum Data Set (MDS) assessment revealed:
   *Her Brief Interview for Mental Status score was fourteen indicating she had no cognitive impairment.
   *She had been independent with transfers, walking, and personal hygiene.
   *Her diagnoses had included:
      -Anemia.
      -Atrial fibrillation.
      -Heart failure.
**F 580**

Continued From page 3

- Hypertension.
- Hypertension.
- Arthritis.
- Parkinson's disease.
- Depression.
- Asthma.

*Section J revealed her health conditions included shortness of breath with exertion.*

Phone interview on 3/01/18 at 10:30 a.m. with resident 47's POA revealed:

*He thought she had an order prior to entering the facility to get the inhaler more than one time per day.*

*But when she had been admitted to the facility they had switched her physician, and he was not aware of what changes they had made to her medications.*

*The staff member he had spoken to on 2/27/18 had been the director of nursing (DON).*

*She could not find the order for an inhaler for more than one time per day.*

*She had scheduled the resident to meet with the physician on 3/1/18.*

*He had not been able to connect with the physician to discuss the resident's medical issues.*

Interview on 3/01/18 at 10:51 a.m. with resident 47 revealed:

*She could not remember the name of the nurse working the night she had felt short of breath.*

*The nurse was not a new nurse to the facility.*

*She stated the nurse could not find the inhaler order and had not done anything to assist her.*

Review of resident 47's medical record revealed:

*She had been admitted on 10/30/17.*

*There had been no:
**NAME OF PROVIDER OR SUPPLIER**

BELLE FOURCHE HEALTHCARE COMMUNITY

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<td>2200 13TH AVE BELLE FOURCHE, SD 57717</td>
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| F 580 | F 580 | Continued From page 4  
-Nursing progress notes regarding the situation described above.  
-Documentation of the assessment completed by the nurse regarding the resident's shortness of breath.  
-Documentation the physician had been notified regarding the resident's change in condition.  

Review of the nursing schedule revealed registered nurse (RN) K had been the nurse working 6:00 p.m. to 6:30 p.m. on 2/28/18.  

A phone interview had been attempted on 3/01/18 at 11:16 a.m. with RN K, but she had not answered.  

Interview on 3/01/18 at 2:37 p.m. with the DON regarding resident 47 revealed:  
*She had spoken to the POA on 2/27/18 regarding the resident's inhaler order.  
*She had not documented her discussion with the POA.  
*She had not been aware of the incident with the resident having shortness of breath on 2/28/17.  
*She had not been aware there was no documentation regarding the incident.  
*She would have expected the nurse to contact the physician if the resident had been experiencing shortness of breath.  

Review of the provider's November 2016  
Resident, Physician, and Resident Representative(s) Notification policy revealed:  
**The facility will immediately inform the resident; consult with the Physician/ PANP; and inform the Resident Representative(s) when there is a change in condition such as but not limited to:  
-A significant change in the resident's physical, mental, or psychosocial status; deterioration in...**
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<td>F 580</td>
<td>Continued From page 5 health, mental or psychosocial status in either life-threatening conditions or clinical complications. A need to alter treatment significantly, such as discontinuing an existing treatment or commence a new treatment.</td>
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<td>F 600</td>
<td>Free from Abuse and Neglect CFR(6): 483.12(a)(1)</td>
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<td>§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</td>
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<td>§483.12(a)(1) The facility must-</td>
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<td>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:</td>
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<td>Surveyor: 37545 Based on interview, observation, record review, and policy review, the provider failed to ensure one of one sampled resident (43) who was dependent upon the staff for all activities of daily living (ADL) was not left on a toileting device for an extended period of time resulting in bruising to the skin. Findings Include:</td>
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<td>1. Record review for resident 43 revealed: *She was admitted on 8/27/18. *Her Brief Interview for Mental Status score was</td>
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<td>1. No immediate corrective action can be taken for resident 43 incident on 2/18/2018. Resident 43 care plan was updated on 3/20/2018 with current bed pan usage procedure to ensure safe use of a bed pan. All residents that utilize a bed pan for toileting are at risk.</td>
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<td>2. All staff will be educated by Administrator, DON on the Bedpan, Urinal, Offering or Removal policy and procedure, the Abuse Prevention Plan, and educated on current QAPI minutes with emphasis on ensuring safe use of a bed pan, no later than 3/26/2018. Those who have not received the education by 3/28/2018 will be educated prior to their first shift worked.</td>
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<td>3. Administrator or designee will complete audits of 4 residents, to include resident 43, that utilize bed pans to ensure they are removed timely per appropriate procedure weekly x 4 weeks then monthly x 3 months. Results of the audits will be reported by the Administrator or designee at the monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.</td>
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NAME OF PROVIDER OR SUPPLIER: BELLE FOURCHE HEALTHCARE COMMUNITY

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<td>eleven indicating she had moderate impairment.</td>
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<td>*Her diagnoses had included:</td>
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<td>-Depressive disorders.</td>
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<td>-Hypertension.</td>
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<td>-Deep vein thrombosis.</td>
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<td>-Hypothyroidism.</td>
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<td>*She was dependent upon the staff for all her ADL.</td>
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<td>Record review of a 2/18/18 incident regarding resident 43. revealed:</td>
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<td>*CNAs W and V had assisted her onto a bedpan on 2/18/18 at 5:08 p.m.</td>
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<td>*CNA W did not check back on her.</td>
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<td>*She was left on the bedpan for over an hour.</td>
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<td>-Call Light report showed her call light had been on for twenty one minutes prior to being answered at 8:48 p.m.</td>
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<td>*CNA R had answered her call light and discovered she was on the bedpan.</td>
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<td>-Resident stated her hip hurt.</td>
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<td>-Cleaned her up and went to get the nurse.</td>
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<td>*RN K assessed her and found a 1.5 inch by 6 inch bruise in the shape of the bedpan on her left hip/buttock area.</td>
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<td>*Resident had been interviewed by RN K and the administrator by phone.</td>
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<td>-She had not remembered being on the bedpan.</td>
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<td>-She had not used the call light for assistance off the bedpan.</td>
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<td>-She had put her call light on when she noticed her hip hurt.</td>
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<td>*Both CNAs were suspended pending the investigation.</td>
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<td>-CNA V had returned to work the next day, 2/19/18.</td>
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<td>-CNA V was educated on the new bedpan use.</td>
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<td>-CNA W resigned without notice.</td>
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**Summary Statement of Deficiencies**

"Findings were substantiated. QAPI with immediate education began 2/18/18.

Interview on 2/27/18 at 1:00 p.m. with registered nurse (RN) regarding resident 43 care revealed:
- She needed total assistance of two staff with a Hoyer lift for transfers.
- She used a bed pan for her bladder and bowel needs.
- She did not have use of her extremities.
- She had the potential for skin break down.
- She was able to move her head up and down.
- She used a soft touch pendent for her call light.

Interview and observation on 02/27/18 at 4:00 p.m. with resident 43 regarding the call lights and the 2/18/18 incident revealed she:
- Acknowledged the 2/18/18 incident had occurred.
- Had been placed on the bedpan.
- Had not been taken off the bedpan for over an hour.
- Had made her upset and uncomfortable.
- Put on her call light when her hip started to hurt.
- Stated CNA R had come to help her off the bedpan.
- Needed total assistance of two staff with a Hoyer lift for transfers.
- Used a bedpan for her bladder and bowel needs.
- Was now checked on frequently when put on the bedpan.
- Had no use of her extremities.
- Was able to move her head up and down.
- Used a soft touch pendent for her call light.
- She would depress the call light with her chin.
- Staff attached the call light to the bed sheet or her clothing.
- That prevented the call light from falling or..."
**NAME OF PROVIDER OR SUPPLIER**
BELLE FOURCHE HEALTHCARE COMMUNITY

**STREET ADDRESS, CITY, STATE, ZIP CODE**
2200 13TH AVE
BELLE FOURCHE, SD 57717

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<tr>
<td>F 600</td>
<td>Continued From page 8 slipping. *She stated &quot;Since the bedpan incident they check on me frequently.&quot; *She stated her call light was answered quickly since the 2/18/18 incident. Interview on 2/28/18 at 2:30 p.m. with CNA T regarding resident 43's care and the call light revealed: *She stated &quot;Since the incident where the resident was left on the bed pan and forgotten:&quot; *She was watched closely throughout the day. *Used a bedpan for her bladder and bowel needs. *She was checked every five minutes while on the bedpan. *The staff had been educated to get a nurse: *If she requested to be on the bedpan longer than twenty minutes. *Nurse would educate her on the potential for skin breakdown. *The digital board at the end of the hallway would light up when a call light was pressed. *It would display the resident's room number. *The resident's room number would be displayed on the computer screen at the nurses station. *To her knowledge that was the only way to know if the resident had put on their call light. *There was no alarm system alerting them of a call light being on. *Staff had walkie-talkies to use if they needed assistance from other staff. Interview on 2/28/18 at 2:40 p.m. with CNA R regarding the care of resident 43 revealed she: *Had a diagnosis of multiple sclerosis (MS). *Needed total assistance of two staff with a Hoyer lift for transfers. *Was checked on every two hours. *Was a vulnerable resident.</td>
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**BELLE FOURCHE HEALTHCARE COMMUNITY**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

220 12TH AVE

BELLE FOURCHE, SD 57717

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<td>F 600</td>
<td>Continued From page 9 *She had no use of her extremities. *Used a bedpan for her bladder and bowel needs. *Staff had been educated to check residents every five minutes when on the bed pan. *Acknowledged an incident where the resident had been placed on the bedpan and forgotten. -She was not sure how long the resident had been on the bedpan *An incident report had been filled out. Interview on 2/28/18 at 3:55 with the director of social services regarding resident 43 revealed: *She was a vulnerable resident. *Facility had a new bedpan usage policy in place. *Staff had been educated on the new bedpan usage policy. Interview on 2/28/18 at 10:00 with the director of nursing regarding the 2/18/18 incident with resident 43 revealed: *She acknowledged the incident had taken place. *It was reported to the local law enforcement. *It was reported to the state. *She provided copies of the: -Incident report filed with the state. -Informal investigation form. *They had procedures in place to prevent that from happening in the future such as: -Quality assurance performance improvement (QAPI) plan for bedpan usage. -Check resident every five minutes while on the bedpan. -After twenty minutes get the nurse. -Nurse to educate resident on the risk. -Reposition resident and check every five minutes. -Staff were educated on the new procedures. *Her care plan had been updated after the incident to reflect her current bladder and bowel</td>
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F 600 Continued From page 10 needs.

Record review of the 2/18/18 QAPI meeting minutes interventions revealed:

**"Immediate education was given to all staff to check on all residents who are put on a bed pan every 5 mins [minutes] to see if they are ready to be taken off the bed pan. If they are not taken off after 20 mins [minutes], the nurse needs to explain the risks to the resident and if they still request to stay on the bed pan, the resident should be repositioned on the bed pan and checked again every 5 mins [minutes], and nurse assessment every 20 minutes."**

**"Audit x [times] 4 weeks and reviewed for continuation at QAPI."**

Record review of the 2/18/18 incident regarding resident 43, revealed:

*CNA W and V had assisted her onto a bedpan on 2/18/18 at 5:08 p.m.
*CNA W did not check back on her.
*She was left on the bedpan for over an hour.
-Call Light report showed her call light had been on for twenty one minutes prior to being answered at 6:48 p.m.
*CNA R had answered her call light and discovered she was on the bedpan.
-Resident stated hip hurt.
-Cleaned her up and went to get the nurse.
*RN K assessed her and found a 1.5 inch by 6 inch bruise in the shape of the bedpan on her left hip/Buttock area.
*Resident had been interviewed by RN K and the administrator by phone.
-She had not remembered being on the bedpan.
-She had not used the call light for assistance off the bedpan.
-She had put her call light on when she noticed...
Continued From page 11

her hip hurt.

-Call Light report showed her call light had been on for twenty one minutes prior to being answered at 6:48 p.m.
*Both CNAs were suspended pending the investigation.

-CNA V had returned to work the next day, 2/19/18.
-CNA V was educated on the new bedpan use.
-CNA W resigned without notice.
*Findings were substantiated.
*QAPI with immediate education began 2/18/18.

Review of the following device activity report (call light report) for resident 43 revealed:
*On 2/16/18 at 8:39 p.m. call light was on for sixty-four minutes and fifty-five seconds before being turned off.
*On 2/18/18 at 10:35 a.m. call light was on for thirty-two minutes and fifty-seven seconds before being turned off.
*On 2/18/18 at 6:48 p.m. call light was on for twenty-one minutes and twenty-six seconds before being turned off.

Review of the revised 2/21/18 care plan for resident 43 revealed:
*Her current bladder and bowel needs had been updated on 2/19/18.
*I have a history of pushing my call light after I am done using the bed pan, but am not frequently doing so anymore and would like staff to check frequently on me while I am on the bed pan.*
*The new bedpan usage policy for checking resident every five minutes while on the bedpan, was not on her care plan.

Review of the revised January 2014 Bedpan Urinal, Offering or Removal policy and procedure
F 600  Continued From page 12
  revealed: "Do not allow the resident to sit on a bedpan for extended periods. (Note: This is not only uncomfortable to the resident, it also causes skin breakdown.)"

Review of the revised October 2017 Abuse Prevention plan-South Dakota revealed:
"
"In accordance with the Vulnerable Adult Law of the State and the Centers for Medicare and Medicaid, (CMS), it is our policy that all residents residing in the facility will be protected from abuse, neglect, and that interventions are implemented to provide the vulnerable adult with a safe living environment."

"All residents have the right to be free of abuse and neglect."

"A vulnerable adult means any resident receiving services from this facility who may be unable to report maltreatment without assistance due to physical or mental impairment."

"Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress."

"(CMS Definition) Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress."

F 610  Investigate/Prevent/Correct Alleged Violation
  CFR(5): 483.12(c)(2)-(4)

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must;

§483.12(c)(2) Have evidence that all alleged

F 610  1. No immediate corrective action can be taken at this time to complete a thorough investigation of the previous falls that Resident 41 incurred since her admission. Resident 41 previous falls will be reviewed to determine a root cause for the falls and a comprehensive care plan will be developed with appropriate
<table>
<thead>
<tr>
<th>(X4) ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 810</td>
<td>F 810</td>
<td>Interventions to assist in the prevention of falls no later than 3/26/2018.</td>
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</table>

2. Administrator or Director of Nursing will educate all nursing staff on the facility Abuse Prevention Plan with focus on completing a thorough investigation of all resident falls to develop an appropriate care plan to prevent additional incidents of falls. This education will be completed no later than 3/26/2018. Those who have not received the education by 3/26/2018 will be educated prior to their first shift worked.

3. Administrator or designee will complete audits of 4 residents with falls, to include resident 41, to ensure completion of a thorough investigation with appropriate care plan interventions to prevent additional incidents of falls. Audits will be weekly x 4 weeks then monthly x 3 months. Results of the audits will be reported by the Administrator or designee at the monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.

---

**F 810** Continued From page 13 violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

Surveyor: 32335
Based on review, interview, and policy review, the provider failed to thoroughly investigate twenty-four falls for one of five sampled residents (41). Findings include:

1a. Review of resident 41's medical record revealed:
   *She had been admitted on 12/19/17.  
   *She had twenty-four falls since her admission date of 12/19/17.  
   *Two of those falls resulted in major injury.

Review of resident 41's 12/28/17 Minimum Data Set (MDS) assessment revealed her Brief Interview for Mental Status (BIMS) score was zero indicating she had severe cognitive impairment.

Review of resident 41's 12/19/17 fall scene investigation reports revealed:
   *She had been found on the floor of the bathroom at 9:00 p.m.  
   *She crawled out of bed and got to the bathroom.
**F 610** Continued From page 14

-She urinated on bathroom floor and had a large round BM [bowel movement] which she was holding in her left hand.
-She moved all extremities and tried to crawl back to her bed during assessment.*
-What appeared to be the root cause of the fall had been "Needing to toilet."
--At 4:00 a.m. "Res [resident] has been caught 6x's [times] trying to crawl out of bed. She needed and voided in toilet each time."
-They had added one hour checks to her care plan.
*There had been no documentation regarding the following investigation areas:
-Interviews conducted with staff members who had been working.
-Where the call light had been located.
-What level of assistance she required.
-If the care plan had been followed.
-What the environment looked like upon entering the room.
-Who had last worked with her.
-If there had been any medication changes.

b. Review of resident 41's 12/29/17 fall scene investigation reports revealed:
*She was found on the floor at 10:30 a.m. in the resident's room by the bathroom door.
-She had been alone and unattended.
-Resident stated she was trying to get to the bathroom.
-Last time she had been toileted was at 8:30 a.m.
--She had been dry but "Had a BM right away."
-The root cause had been "Resident has unsteady gait."
-Initial interventions to prevent future falls had been "Educated staff to sue resident to toilet every 2 hours and PRN [as needed]."
-Summary of falls team meeting had been...
**NAME OF PROVIDER OR SUPPLIER**
BELLE FOURCHE HEALTHCARE COMMUNITY

<table>
<thead>
<tr>
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<td>F 610</td>
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<td>&quot;Resident attempted to toilet self after breakfast.&quot;</td>
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<td>-There had been no conclusion or additional care plan updates documented.</td>
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<td>*She had been found on the floor in the resident's room in the doorway at 8:50 a.m.</td>
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<td>-She had been alone and unattended.</td>
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<td>-Staff were unsure if she had been crawling, but her bed had been in low position.</td>
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<td>-The last time toilet had been marked &quot;unsure.&quot;</td>
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<td>-Conclusion had been &quot;Cont with low bed/mat. She continues to crawl out of bed.&quot;</td>
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<td>d. Review of resident 41's 1/3/18 fall scene investigation reports revealed:</td>
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**Statement of Deficiencies and Plan of Correction**

<table>
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<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
</table>
| F 610 | Continued from page 16 | "She had been found sitting on the mat next to her bed at 2:20 a.m.  
- Last time toileted had been at 12:10 a.m., and she had been dry.  
- Root cause had been "Cont to crawl out of bed, Toileting."  
- Initial interventions to prevent future falls had been "Cont with low bed/mat. Cont with toileting upon rising, before and after meals, before bed and PRN."  
- Conclusion had been "Cont with frequent toileting, checks and low bed/mat."  
*There had been no documentation regarding the following investigation areas:  
- Interviews conducted with staff members who had been working.  
- Where the call light had been located.  
- What level of assistance she required.  
- If the care plan had been followed.  
- What the environment looked like upon entering the room.  
- Who had last worked with her.  
- If there had been any medication changes.  

- Review of resident 4/1's 1/3/18 fall scene investigation reports revealed:  
*She had been found on the floor at 6:30 a.m. by the bathroom door.  
*She had been alone and unattended.  
- When the resident was asked what she was doing just before the fall she "Kept requesting to go to the BR [bathroom]."  
- The last time toileted had not been completed.  
- Root cause had been "Resident got up per self to go to the BR - too unsteady to stand per self."  
- Conclusion had been change care plan to toilet every two hours.  
*There had been no documentation regarding the following investigation areas: | | | |
**F 810** Continued From page 17

- Interviews conducted with staff members who had been working.
- Where the call light had been located.
- What level of assistance she required.
- If the care plan had been followed.
- What the environment looked like upon entering the room.
- Who had last worked with her.
- If there had been any medication changes.

f. Review of resident 41's 1/10/18 fall scene investigation reports revealed:

"The resident had been found on the floor in her room by the recliner at 1:45 p.m."
- She had been alone and unattended.
- When asked what she was doing prior to the fall she said, "I have to go to the BR.
- She had been toileted at 12:30 p.m."
- She had been wet and had a BM.
- She had been at the hospital prior to this fall, so no medications had been given to her.
- Root cause had been "Resident attempted to get up from recliner chair - had to go to the BR."

- Initial interventions to prevent future falls had been "Initiate hourly checks."
- There had been no documentation regarding the following investigation areas:
  - Interviews conducted with staff members who had been working.
  - Where the call light had been located.
  - What level of assistance she required.
  - If the care plan had been followed.
  - What the environment looked like upon entering the room.
  - Who had last worked with her.
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<td><strong>STREET ADDRESS, CITY, STATE, ZIP CODE</strong></td>
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<tr>
<td>BELLE FOURCHE HEALTHCARE COMMUNITY</td>
<td>2200 13TH AVE</td>
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*FORM CM-2067(92-98) Previous Version Obsolete*

Event ID: 2669011 Facility ID: 0512

If continuation sheet Page 18 of 92
F 610 Continued from page 18
Department of Health report revealed:
*She had been found on the floor in front of the recliner by three certified nursing assistants (CNA).
*Two of the CNAs had used a gait belt to lift her off the floor prior to notifying the nurse.
*She had been sent to the emergency room and was found to have a left hip fracture.
*There had been no fall scene investigation completed.
*There had been no documentation regarding the following investigation areas:
  - Where the call light had been located.
  - What level of assistance she required.
  - If the care plan had been followed.
  - What the environment looked like upon entering the room.
  - Who had last assisted her.
  - If there had been any medication changes.

h. Review of resident 41’s 2/22/18 fall scene investigation reports revealed:
*She fell forward out of her wheelchair (w/c) and hit her head on the floor at 11:20 a.m.
*She had been alone and unattended.
*She had last been toileted at 9:00 a.m. and had been wet.
*Root cause had been “Resident leaned forward too far in w/c and fell out.”
*Initial intervention to prevent future falls had been “Resident in w/c only for transportation.”
*Conclusion had been “Recliner or bed between meals, Leg extenders added to w/c. LCD (last completion date) was yest (yesterday) for therapy. Will set up restorative plan.”
*According to the 2/22/18 attached incident note the “Resident was incontinent of urine through her pants.”
*Per investigation staff were educated to not
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CJA
IDENTIFICATION NUMBER:
435035

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ________________
B. WING _____________________

(X3) DATE SURVEY COMPLETED
03/01/2018

NAME OF PROVIDER OR SUPPLIER
BELLE FOURCHE HEALTHCARE COMMUNITY

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 LIC IDENTIFYING INFORMATION)

ID PREFIX TAG

F 610 Continued From page 10
leave the resident alone in her wheelchair.
*There had been no documentation regarding the
following investigation areas:
- Interviews conducted with staff members who
had been working.
- What level of assistance she required.
- If the care plan had been followed.
- Why she had not been assisted to the bathroom
since 9:00 a.m.
- Who had last assisted her.
- If there had been any medication changes.

1. Review of resident 41's interdisciplinary notes
from 12/19/17 through 2/27/18 revealed:
*She had also fallen on the following dates:
-1/2/18.
-1/3/18 a third time.
-1/4/18.
-1/5/18 two times.
-1/6/17.
-1/27/18.
-1/28/18.
-2/1/18.
-2/2/18 two times.
-2/5/18.
-2/6/18.
-2/7/18.
*There had been no fall scene investigation
reports or other documentation the above falls
had been investigated.

J. Interview on 3/01/18 at 2:03 p.m. with the
director of nursing revealed she agreed the above
falls had not been thoroughly investigated.

Review of the provider's October 2017 Abuse
Prevention Plan policy revealed:
**Facility will investigate all incidences such as
falls, bruises, medication errors, resident
Continued From page 20
complaints, etc."
"Facility will identify the staff member(s) responsible for:
- The initial report.
- Initiating the investigation.
- Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.
- Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent and cause;
- Providing complete and thorough documentation of the investigation.
- Reporting the results to the proper authority within the 5-day state requirement."

Care Plan Timing and Revision
CFR(s): 483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be:
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the
**F 657** Continued From page 21

resident’s care plan.

(F) Other appropriate staff or professionals in
disciplines as determined by the resident's needs
or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary
team after each assessment, including both the
comprehensive and quarterly review
assessments.

This REQUIREMENT* is not met as evidenced by:

Surveyor: 37545

Based on observation, interview, record review,
and policy review, the provider failed to ensure
the care plan reflected physician's orders for one
of one sampled resident (40) who used oxygen
and a bilevel positive airway pressure (BiPAP)
device. Findings include:

1. Review of resident 40's medical record
revealed:

*Her Brief Interview for Mental Status score was
fifteen indicating no cognitive impairment.

*She had an above the knee amputation of the
left leg.

*Her diagnoses had included:
   - Type 2 diabetes mellitus.
   - Sleep apnea.
   - Heart failure.
   - Major depressive disorder.
   - Hypothyroidism.
   - Hyperlipidemia.
   - Gastro-esophageal reflux.
   - Abnormal posture.
   - Muscle weakness.

*Physician's orders on 4/27/17 for oxygen (02)
and BiPAP.

- Oxygen at 4 liters per minute (lpm) continuous
when BiPAP not in use.
- Oxygen at 10 lpm via BiPAP at night and during

**F 657** will be educated prior to their first shift
worked.

3. Administrator or designee will
complete audits of 4 resident care plans,
to include resident 40, weekly x 4 weeks
then monthly x 3 months to ensure care
plan reflects accurate physician orders
that are referenced on the care plan.

Results of the audits will be reported by
the Administrator or designee at the
monthly QAPI meeting for review and
recommendations for continuation or
discontinuation of audit.
### Statement of Deficiencies and Plan of Correction

**NAME OF PROVIDER OR SUPPLIER:**
Belle Fourche Healthcare Community

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
2200 13th Ave
Belle Fourche, SD 57717

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| F 657 | Continued from page 22  
naps.  
-BIPAP at 16/8 with a backup rate of 12.  
*Physician's order on 2/21/18 for oxygen.  
-Oxygen at 2 lpm continuous.  
-Continued BIPAP when sleeping.  
Observation on 2/27/18 at 3:00 p.m. with resident 40 revealed she had:  
*Been sitting up in her lift chair taking a nap.  
*Been wearing oxygen at 2 lpm.  
*A BIPAP machine on her bedside table.  
Interview on 2/27/18 at 3:00 p.m. with certified nursing assistant (CNA) R regarding resident 40 revealed she used:  
*Oxygen at 2 lpm during the day.  
*BIPAP at night.  
Interview on 2/27/18 at 3:15 p.m. with CNA S regarding resident 40 revealed:  
*She stated "I have never seen her wear her BIPAP when she takes a nap during the day."
  
*She used oxygen at 2 lpm during the day.  
Interview and observation on 2/27/18 at 3:30 p.m. with resident 40 revealed:  
*She had been sitting up in her lift chair and using her oxygen per a nasal cannula.  
*Oxygen concentrator had been set at 2 lpm.  
*She stated "I only use my oxygen at 2 lpm during the day and 6 lpm with my BIPAP."  
*"I have lost weight and my breathing is getting much better."  
*I only use my BIPAP at night."  
*She no longer took naps in her bed, as she was getting stronger.  
*She used a stand aid for transfers.  
*She took naps in her lift chair. |
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Review of resident 40's January 2018 and February 2018 treatment administration records (TAR) revealed:

*O2 at 10 lpm via BIPAP at night and during naps.
- Start date 4/27/17.
*O2 at 4 lpm per nasal cannula continuous when BIPAP not in use.
- Start date 4/27/17.
*Documentation of oxygen and BIPAP checks from 6 a.m. to 2 a.m., 2 a.m. to 1 p.m., and 10 p.m.

Review of resident 40's 2/21/18 revised care plan revealed "I USE OXYGEN AT 10 lpm AT NOC [night] with a Bi-Pap. O2 4 lpm DURING THE DAY."

Interview on 2/28/18 at 2:56 p.m. with registered nurse (RN) I regarding resident 40 revealed she:

*Used BIPAP at night with oxygen at 6 lpm bled-in.
*Used oxygen at 2 lpm continuous during the day.
* Took naps during the day.
- Had not used her BIPAP for naps.

Interview on 3/1/18 at 12:27 p.m. with the director of nursing regarding resident 40 revealed:

* Her oxygen order had been changed on 2/2/18.
- Oxygen at 2 lpm continuous.
- Continue BIPAP when sleeping.
* The new order had not been changed on the TAR or care plan.
- She agreed that should have been changed to reflect the resident's current oxygen orders.
* She had been unable to provide an order for the decrease in the oxygen bled-in with the BIPAP.
- Unsure when or why that had been changed.
*She planned on calling the pulmonary physician for clarification of the following:
| F 657 | Continued From page 24 
- Oxygen liter flow for daytime and nighttime. 
- Oxygen usage for daytime and nighttime. 
- BiPAP usage with or without naps. 

Review of the provider’s revised July 2017 
Physician Order Procedure policy revealed: 
"**To correctly and safely receive and transcribe 
physician’s orders so correct order is 
followed/administered."** 
"**A notation needs to be made in the resident’s 
medical record as to the reason for the new order 
and a brief summary of what it was."** 
"**All transcription of orders should be signed off 
by a nurse and double checked by a second 
nurse to assure that all steps have been carried 
out to avoid errors. The second nurse will run the 
Administration Record Report for the MAR/TAR to 
view for accuracy of the transcription."**

Review of the provider’s revised January 2014 
Physician Services policy revealed: "Physician 
orders and progress notes shall be maintained in 
accordance with current regulations and facility 
policy."

Review of the provider’s revised November 2017 
Care Planning policy revealed: 
"The physician’s orders were referenced in the 
resident’s care plan. 
*The DON was responsible for updating the care 
plan."

| F 658 | Services Provided Meet Professional Standards 
SS= D CFR(s): 483.21(b)(3)(i) 

§483.21(b)(3) Comprehensive Care Plans 
The services provided or arranged by the facility, 
as outlined by the comprehensive care plan, must:

---

No immediate corrective action could be 
taken for Registered Nurse (RN) that 
initiated the medication prior to 
medication administration to resident 61. 
No Immediate corrective action could be 
taken for unlicensed assistive personnel 
(UAP) that calculated medication doses
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

BELLE FOURCHE HEALTHCARE COMMUNITY

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2208 13TH AVE

BELLE FOURCHE, SD 57717

<table>
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<tr>
<th>ID</th>
<th>PREFIX</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tr>
<td>F 558</td>
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(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:

Surveyor: 29162

Based on observation, record review, interview, job description review, and policy review, the provider failed to ensure:

*Medications were initiated after being administered by one of one registered nurse (RN) (I) who administered medication to resident 81.*

*Unlicensed assistive personnel (UAP) (A) had supervision of a registered nurse (RN) to calculate medication doses for two of two sampled residents (14 and 27) who required dosage calculation.

*Physician's orders had been followed for:
- One of one sampled resident (10) with a new physician's order for heel protector boots.
- One of one sampled resident (40) who used oxygen and bilevel positive airway pressure (BIPAP) device had been followed.

Findings include:

1. Observation on 2/28/18 at 7:50 a.m. of RN I while she prepared medications for resident 61 revealed she signed the resident's medication as having been given as soon as she had finished preparing it. Interview with RN I at that time revealed she had done that because she was only going to administer medication to resident 81. She stated she did not want to have to come back to the medication cart to sign the medication administration record.

2a. Observation and interview on 2/27/18 at 9:00 a.m. of UAP A while she administered medication to resident 27 revealed:

*An order on the resident's February 2018 medication administration record (MAR) stated for residents 14 and 27. Resident 10 heel protector boots have been assessed and are appropriate to prevent pressure to his heels per physician's order. Resident 40 physician's order for BIPAP and oxygen have been clarified and updated to reflect appropriate physician's order and care plan updated to reflect current physician's orders. All residents are at risk.

2. All residents with heel protector boots will be assessed to ensure they are appropriate to prevent pressure to heels.

All residents with BIPAP/CPAP/Oxygen have been clarified and updated to reflect appropriate physician's order and care plan updated to reflect physician's order. Administrator and DON will educate all licensed nurses and UAPs on the Medication Pass Policy to ensure medications are not being initiated prior to administration. The Medication Aide policy was revised to reflect that UAPs do not calculate medication dosages for administration. Administrator and DON will educate all licensed nurses and UAPs on the Medication Aide Policy to ensure UAPs do not calculate medication dosages for administration. Administrator and DON will educate all staff on the proper positioning of heel protector boots to ensure off-loading of the heels. Administrator and DON will educate all licensed nurses on the Physician Order Procedure policy to ensure that physician's orders are correctly and safely received, and transcribed so...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<thead>
<tr>
<th>ID</th>
<th>Provider/Supplier ID Number:</th>
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<th>DATE SURVEY COMPLETED</th>
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**NAME OF PROVIDER OR SUPPLIER**

**BELLE FOURCHE HEALTHCARE COMMUNITY**

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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 658</td>
<td></td>
<td>Continued From page 26 renitadine 150 milligrams (mg) (for stomach) in the morning. There he *There had not been verification on the MAR that had indicated the correct dosage was two tablet of renitadine. *She gave the resident two 75 mg tablets of renitadine and stated: -She gave two tablets of renitadine 75 mg to the resident, because there had not been any 150 mg tablets. -There used to be 150 mg tablets. -Now the tablets were 75 mg. -She just knew two 75 mg tablets would equal 150 mg of medication for the resident. -She had not asked a licensed nurse for verification of the correct dose of medication when the tablets had changed from 150 mg to 75 mg.</td>
<td>F 658</td>
<td></td>
<td>correct order is followed and administered. This education will be provided no later than 3/26/2018. Those who have not received the education by 3/26/2018 will be educated prior to their first shift worked. 3. Administrator or designee will complete audits weekly x 4 weeks then monthly x 3 months of 4 licensed nurses or UAP's, to include RN I, during medication pass to ensure medications are not being initialed prior to administration. Administrator or designee will complete audits weekly x 4 weeks then monthly x 3 months of 4 UAPs, to include UAP A, during medication pass to ensure they do not calculate medication doses. Administrator or designee will complete audits weekly x 4 weeks then monthly x 3 months of 4 residents with heel protector boots, to include resident 10, to ensure proper positioning of heel protector boots to allow for off-loading of heels. Administrator or designee will complete audits weekly x 4 weeks then monthly x 3 months of 4 residents, to include resident 40 to ensure that physician's orders are correctly and safely received and transcribed so correct order is followed and administered. Results of the audits will be reported by the Administrator or designee at the monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.</td>
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| F 658 | Continued From page 27 revealed:  
  * He had on soft foam covered ankle boots.  
  * His right heel laid directly on the inside of the boot approximately half way up from the heel area.  
  * His right heel had not been exposed in the opened area of the boot meant for off loading.  
  * That ankle boot laid directly on the resident's bed.  
  Surveyor; 37545  
  b. Review of resident 40's medical record revealed:  
  * Her Brief Interview for Mental Status score was fifteen indicating no cognitive impairment.  
  * She had an above the knee amputation of the left leg.  
  * Her diagnoses had included:  
    - Type 2 diabetes mellitus.  
    - Sleep apnea.  
    - Heart failure.  
    - Major depressive disorder.  
    - Hypothyroidism.  
    - Hyperlipidemia.  
    - Gastro-oesophageal reflux.  
    - Abnormal posture.  
    - Muscle weakness.  
  * Physician's orders on 4/27/17 for oxygen (3L) and BIPAP:  
    - Oxygen at 4 liters per minute (lpm) continuous when BIPAP not in use.  
    - Oxygen at 10 lpm via BIPAP at night and during naps.  
    - BIPAP at 18/8 with a backup rate of 12.  
  * Physician's order on 2/2/18 for oxygen:  
    - Oxygen at 2 lpm continuous.  
    - Continue BIPAP when sleeping.  
  Observation on 2/27/18 at 3:00 p.m. of resident |
Continued From page 28

40 revealed she had:
* Been sitting up in her lift chair taking a nap.
* Been using oxygen at 2 lpm.
* A BIPAP machine on her bedside table.

Interview on 2/27/18 at 3:00 p.m. with CNA R regarding resident 40 revealed she used:
* Oxygen at 2 lpm during the day.
* BIPAP at night.

Interview on 2/27/18 at 3:15 p.m. with CNA S regarding resident 40 revealed:
* She stated "I have never seen her wear her BIPAP when she takes a nap during the day."
* She used oxygen at 2 lpm during the day.

Interview and observation on 2/27/18 at 3:30 p.m. with resident 40 revealed:
* She had been sitting up in her lift chair and using her oxygen per a nasal cannula.
* Oxygen concentrator had been set at 2 lpm.
* She stated "I only use my oxygen at 2 lpm during the day and 6 lpm with my BIPAP."
  - "I have lost weight and my breathing is getting much better." 
  - "I only use my BIPAP at night."
* She no longer took naps in her bed, since she was getting stronger.
* Used a stand aid for transfers.
* She took her naps in her lift chair.

Review of resident 40's January 2018 and February 2018 treatment administration record (TAR) revealed:
* C2 at 10 lpm via BIPAP at night and during naps.
  - Start date 4/27/17.
* C2 at 4 lpm per nasal cannula continuous when BIPAP not in use.
  - Start date 4/27/17.
Continued from page 29:

"Documentation of 02 and BiPAP checks from 6 a.m. to 2 a.m., 2 a.m. to 1 p.m., and 10 p.m."

Review of resident 40's 2/21/18 revised care plan revealed: "I USE OXYGEN AT 10 lpm AT NOC [night] with a Bi-Pap. 02 4 lpm DURING THE DAY."

Interview on 2/28/18 at 2:55 p.m. with registered nurse (RN) I regarding resident 40 revealed she:

-Used a BiPAP device at night with oxygen at 6 lpm bled-in.
-Used oxygen at 2 lpm continuous during the day.
-Took naps during the day.
-Did not use her BiPAP for naps.

4. Interview on 3/1/18 at 9:15 a.m. with the director of nurses confirmed:

-Resident 25's right heel had not been off-loaded per physician's orders.
-Both should not have pre-signed for medications. Medications were to have been signed by the RN after they had been given.
-UP A should not have calculated medication doses.
-The MAR had not indicated giving two tablets of ranitidine or acetaminophen had cleared the crocet dosage.
-Medication doses should only have been calculated by a licensed nurse.
-UP A required the supervision of an RN to pass medications.
-UP A should have verified the doses of the above mentioned medications with a RN.

Interview on 3/1/18 at 12:27 p.m. with the director of nursing regarding resident 40 revealed:

Her oxygen order had been changed on 2/2/18 to:
**NAME OF PROVIDER OR SUPPLIER**

BELLE FOURCHE HEALTHCARE COMMUNITY

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2209 13TH AVE
BELLE FOURCHE, SD 57717

**DATE SURVEY COMPLETED**

03/01/2018

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<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

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<th>ID</th>
<th>PROVIDER’S PLAN OF CORRECTION</th>
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<td>F 656</td>
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- Oxygen at 2 lpm continuous.
- Continue BiPAP when sleeping.

*The new order was not changed on the TAR or care plan.*
*She agreed that should have been changed to reflect the resident's current oxygen orders.*
*She had been unable to provide an order for the decrease in the oxygen bleed-in with the BiPAP.*
*Unclear when or why that had been changed.*
*She planned on calling the pulmonary physician for clarification of the following:*
-Oxygen liter flow for daytime and nighttime.
-Oxygen usage for daytime and nighttime.
-BiPAP usage with or without naps.

Review of the provider's last revised 1/2/18 medication aids job description revealed they were to have:
*Asked questions, so he/she could understand and support decisions having been made.*
*Kept direct supervisor informed on necessary information.*
*Strived to master the skills needed to do the best for the people they cared for.*
*Consulted with the staff nurse as needed.*
*Passed routine and as needed medications under the direction of a nurse.*

Review of provider's revised July 2017 Physician Order Procedure policy revealed:
**To correctly and safely receive and transcribe physician’s orders so correct order is followed/administered.*
**A notation needs to be made in the resident’s medical record as to the reason for the new order and a brief summary of what it was.”
*All transcription of orders should have been signed off by a nurse and double-checked by a second nurse to assure that all steps have been
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<th>(X9) COMPLETION DATE</th>
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<tr>
<td>F 658</td>
<td>Continued From page 31 carried out to avoid errors. The second nurse will run the Administration Record Report for the MAR/Tar to view for accuracy of the transcription.* Review of the provider's 2014 Medication Administration policy revealed medication should have been signed after it had been given. Review of provider's revised January 2014 Physician Services policy revealed: &quot;Physician orders and progress notes shall be maintained in accordance with current regulations and facility policy.&quot; Review of provider's revised November 2017 Care Planning policy revealed: &quot;The physician's orders were referenced in the resident's care plan. The DON was responsible for updating the care plan. Surveyor: 23162. Review of Patricia A. Potter et al., Fundamentals of Nursing, 9th Ed., Elsevier, St. Louis, Mo., 2017, page 311, revealed: &quot;The physician is responsible for directing medical treatment (311).&quot; &quot;Nurses care provider's orders unless they believe that the orders are in error, violate agency policy, or are harmful to the patient [resident] (311).&quot;</td>
<td>F 658</td>
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<td>F 679 SS=D</td>
<td>Activities Meet Interest/Needs Each Resident CFR(5): 483.24(c)(1) §483.24(c)(1) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan</td>
<td>F 679</td>
<td>An initial Activity Assessment will be completed on Resident 41. Activities will interview niece to inquire on Resident 41 41 likes and Interests. Activity Director will initiate individualized one-on-one activities with Resident 41. All residents are at risk.</td>
<td>3/25/2018</td>
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Continued From page 32
and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

This REQUIREMENT is not met as evidenced by:
Surveyor: 32335
Based on observation, record review, and interview, the provider failed to provide individualized activities to one of six sampled dependent residents (41). Findings Include:

1. Review of resident 41’s medical record revealed:
* She had been admitted on 12/19/17.
* She had been admitted from the hospital for weakness.
* She had been at home prior to that with a caregiver.
* She had twenty-four falls since her admission on 12/19/17.

Review of resident 41’s 12/20/17 Minimum Data Set (MDS) assessment revealed her Brief Interview for Mental Status (BIMS) score was zero indicating she had severe cognitive impairment.

Observation on 2/27/18 at 11:20 a.m. of resident 41 revealed:
* She was in her room sitting in her recliner watching the TV.
* Her leg was stuck in-between the foot rest of the recliner and the seat.

2. All residents have been reviewed to ensure an Initial Activity Assessment has been completed. Administrator will provide education to the Activities Director on the Role of the Activity Director/Coordinator to include completion of Initial Activity Assessment along with interviews with resident and family to determine interests and likes along with completion of an individual activity plan that reflects those activities desired by the resident no later than 3/20/2018.

3. Administrator or designee will complete audits of 4 residents, to include resident 41 weekly x 4 weeks then monthly x 3 months to ensure individualized activities are provided to residents and activity assessments are completed on admission during assessment periods to include completion of Initial Activity Assessment along with interviews with resident and family to determine interests and likes; audit care plans to ensure they reflect individualized activities. Results of the audits will be reported by the Administrator or designee at the monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.
F 679 Continued From page 33
Observation and interview on 2/27/18 at 11:45 a.m. with registered nurse (RN) I regarding resident 41 revealed:
*She was lying in her bed.
*RN I stated she was told about the resident getting her leg stuck in the recliner.
*They were going to remove the recliner from her room due to the incident.
*At that time the maintenance director came over to take the recliner out of her room.
*RN I stated the resident could not be left alone in her wheelchair without supervision, as she had fallen out of the wheelchair.
She had hit her head as a result of falling out of her wheelchair.

Observation on 2/27/18 at 2:10 p.m. of resident 41 revealed she was lying in her bed with no radio or TV on.

Observation on 2/27/18 at 4:50 p.m. of resident 41 revealed she was lying in bed with no radio or TV on. She was awake.

Observation on 2/27/18 at 8:25 p.m. of resident 41 revealed:
*She was lying in bed.
*She was attempting to get out of bed.
*Both legs were over the scooped mattress.
*She was trying to lift her body up.
*She was wide awake.
*There had been no staff around.

Observation on 2/28/18 at 7:29 a.m. of resident 41 revealed she was up in her wheelchair in the living room/common area.

Observation on 2/28/18 at 8:29 a.m. of resident 41 revealed she was up in her wheelchair in the
<table>
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<tr>
<th>ID PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tr>
<td>F 679</td>
<td>Continued From page 34 living room/common area. She was slouched over.</td>
<td>F 679</td>
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<td>Observation on 2/23/18 at 8:49 a.m. regarding resident 41 revealed:</td>
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<td>*She was slouched over in her wheelchair sleeping.</td>
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<td>*There had been no staff in the area supervising her.</td>
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<td>Observation on 2/23/18 at 9:02 a.m. of resident 41 revealed she was taken into her room and laid down.</td>
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<td>Observation on 2/23/18 at 6:27 a.m. of resident 41 revealed she was attempting to get up out of bed, There had been no staff around to witness her attempt at getting up.</td>
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<td>Interview on 2/23/18 at 9:31 a.m. with CNA N revealed:</td>
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<td>*They chacked on resident 41 every two hours to see if she needed to go to the bathroom.</td>
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<td>*They usually laid her down in between meals.</td>
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<td><em>She is the first one they lay down after breakfast, and the last one to get up before lunch.</em></td>
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<td>Observation on 2/28/18 at 10:00 a.m. of resident 41 revealed RN I had been in her room changing her dressings to her heels. She was in a sitting position with her feet hanging over the bed. She was lying back against wall.</td>
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<td>Interview on 3/01/18 at 9:49 a.m. with the social services designer regarding resident 41 revealed:</td>
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<td>*She had made a referral to the mental health services in the area.</td>
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*Her niece wanted her to be moved to another facility, and she was working on that.
*There were no other interventions she was attempting with the resident.
*There had been no documentation regarding social service interventions.

Observation on 3/01/18 at 9:58 a.m. of resident 41 revealed she was lying in bed with both feet hanging off the bed. There were no staff around to see her. The TV and radio were not on.

Observation on 3/01/18 at 10:41 a.m. of resident 41 revealed:
*She had been lying in bed.
*Both legs were hanging off the side of the bed.
*The lights were off.
*She was awake.

Observation on 3/01/18 at 1:02 p.m. of resident 41 revealed she was lying in bed with no TV or radio on.

Interview on 3/01/18 at 1:02 p.m. with the recreation services manager regarding resident 41 revealed:
*She had not done an assessment upon admission regarding her activity choices or preferences.
*Her niece thought she would like BINGO, but the recreation services manager stated she did not think she would like it.
*She had not asked the niece about any other likes of the resident.
*She thought the resident liked to people watch the most.
*She sometimes refused and had not wanted to participate in activities.
*She had not been doing one-on-ones with her.
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<td>F 679</td>
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<tr>
<td></td>
<td><em>Stated &quot;I know we need to do more with her.&quot;</em></td>
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<td><em>The music/radio/TV activity was usually in her room.</em></td>
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<td><em>The socializing with others activity was at meals.</em></td>
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<td><em>She was not sure how to print the activities logs for December 2017 or January 2018.</em></td>
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<td>Review of resident 41's February 2018 activities documentation revealed:</td>
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<td><em>Her activities included church services, radio/music/TV, friends/family visit, and socializing with others.</em></td>
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<td><em>She had attended church three times.</em></td>
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<td><em>She had family or friends visit three times.</em></td>
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<td><em>She had radio/music/TV marked twenty-five times.</em></td>
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<td><em>She had socializing with others marked twenty-five times.</em></td>
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<td><em>There were no other activities documented.</em></td>
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<td>Interview on 3/01/18 at 2:03 p.m. with the director of nursing regarding resident 41 revealed they had been laying her down in bed after meals. They had been doing that because she had to be supervised when she was in her wheelchair. She was unsure what activities they had been doing with her.*</td>
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<td>F 686</td>
<td>Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(§): 483.25(b)(1)(i)(ii)</td>
<td>3/26/2018</td>
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<td>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that: (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition</td>
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<td>1. No corrective action was taken on Resident 320 due to resident's discharge from facility on 3/10/2018. All residents with diabetic/pressure ulcers are at risk.*</td>
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<td>2. All other residents with diabetic/pressure ulcers have been reviewed to ensure nutritional assessments are completed with interventions per the RD recommendations. Administrator will educate DON, Dietary Director and</td>
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FORM CMS-2587 (02-16) Previous Versions Obsolete Event ID: 2589V11 Facility ID: 0912 If continuation sheet Page 37 of 39
F 686

Continued from page 37

demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives
necessary treatment and services, consistent
with professional standards of practice, to
promote healing, prevent infection and prevent
new ulcers from developing.
This REQUIREMENT is not met as evidenced
by:
Surveyor: 32355
Based on observation, interview, record review,
and policy review, the provider failed to ensure
one of two sampled residents (320) who had a
diabetic/pressure ulcer received appropriate
dietary interventions and services per the
physician's orders. Findings include:

1. Interview on 2/27/18 at 8:10 a.m. with licensed
practical nurse (LPN) C regarding resident 320
revealed:
*He:
- Had been admitted on 2/21/18 from an acute
care setting.
- Was diabetic and had been admitted with two
wounds.
*She stated "He has a black wound at the tip of
his right second toe and a small scrape behind
his left ankle."
- He had a daily dressing change for the wound to
his right second toe.
- The dressing on his left ankle was changed
every three days.
*She was unsure how he had gotten the wounds.

Observation and interview on 2/27/18 at 8:40
a.m. of resident 320 revealed:
*He had:
- Been in his room sitting on the edge of the bed.
- Been wearing a nasal cannula that was hooked
up to an oxygen concentrator and running at 2

F 686

Registered Dietician (RD) on the facility's
Skin Program policy to ensure residents who
have a diabetic/pressure ulcer receive appropriate dietary interventions
and services per physician's orders no
later than 3/26/2018.

3. Administrator or designee will complete
audits of 4 residents weekly x 4 weeks
then monthly x 3 months to ensure care
and services are being provided to
promote the healing of pressure
ulcers/wounds that are present. Results
of the audits will be reported by the
Administrator or designee at the monthly
QAPI meeting for review and
recommendations for continuation or
discontinuation of audit.
**Statement of Deficiencies and Plan of Correction**

| (X1) Provider/Supplier Identification Number | (X2) Multiple Construction
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**Name of Provider or Supplier:**

Belle Fourche Healthcare Community

**Street Address, City, State, Zip Code:**

2200 12th Ave

Belle Fourche, SD 57717

**Summary Statement of Deficiencies**

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Continued from page 38

- He stated:
  - "I was in really poor condition when I went to the hospital."
  - I'm a diabetic and my sugars were very high."
  - "My goal is to go home here really soon."
  - He had a wound on the tip of his right toe and left ankle.
  - He stated:
    - "I've been told my toe is a diabetic ulcer."
    - "I fell at the hospital and scraped my left ankle."

Observation on 2/27/18 at 12:46 p.m. with LPN C during a dressing change with resident 320 revealed:

- He had:
  - Prepared to change the dressing on his right second toe.
  - Removed the old dressing and exposed the wound on his toe.

- The tip of the resident's toe had been:
  - Contracted at the first joint, so the tip was in the downward position.
  - Covered with a brown colored scab.
  - That scab measured approximately 0.5 centimeters (cm) by 0.5 cm in diameter.

- She assessed, cleaned, and applied a new dressing to that wound.

- The resident stated: "I think it came from a shoe, but I'm not sure."

Review of resident 320's medical record with the Minimum Data Set (MDS) assessment coordinator revealed:

- On 2/21/18:
  - He had been readmitted to the facility from an acute care setting.
  - The staff had completed an admission physical...
F 686 Continued From page 39

assessment of his skin and documented “Small black scab to tip R [right] foot 2nd toes, black ulcer intact and dry, observing for any changes.”

*Diagnoses included: respiratory failure with hypoxia, chronic obstructive pulmonary disease, Type 2 diabetes with diabetic neuropathy, anxiety, depression, muscle weakness with falls, and chronic pain.

*He was:
-Alert, oriented, and had good memory recall.
-Working with the therapy department to improve his strength, safety, and independence with the goal to return home.

*On 2/22/18 the physician had:
-Been in the facility to assess the resident and review his orders from the hospital.
-Written orders for optifoam to be applied to his toe daily.
-Referrer the resident to the dietary department for education and nutritional support.
-Not provided a diagnosis for the wound to his right toe, but identified it as a wound.

*No documentation to support the dietary department had been notified of the wound to his right toe per physician’s orders.

Review of resident 320’s 2/21/18 through 2/28/18 daily skilled progress notes with the MDS assessment coordinator revealed:

*There was no consistent charting to identify the type of wound the resident had on his right second toe.

*The nursing staff had randomly charted the wound as:
-“Small, shallow, black scab.”
-Black ulcer.
-Pressure ulcer.
-Dark/black area/pressure sore on second toe right foot.
Continued from page 40

- Diabetic sore 2nd toe on the right.*
  *No documentation:
  - To support the dietary department had been notified of his wound.
  - By the dietary manager or the dietician to support nutritional involvement or knowledge of that wound.

Review of resident 320's 2/28/18 skilled status assessment with the MDS assessment coordinator revealed the wound to his right second toe was assessed and documented as a diabetic ulcer by the director of nursing (DON).

Review of resident 320's 2/28/18 admission care plan with the MDS assessment coordinator revealed:
  * A focus area: "I am at nutritional risk."
  * Goal:
    -- "I wish to have my nutritional and hydration needs met so that I do not suffer from dehydration, significant weight changes, and/or skin breakdown."* 
    -- *No goal identifying a wound or ulcer to his right second toe.

*There had been no nutritional interventions in place to support and promote healing of an ulcer or wound to his right toe.

Interview on 2/28/18 at 4:01 p.m. with the dietician and MDS assessment coordinator revealed:
  * He had not been aware the resident had an ulcer to his right toe until 2/27/18.
    - The director of nursing (DON) had emailed him their weekly wound report.
    - That report supported a diabetic ulcer on the resident's toe.
  * He would not have expected to be notified of a
F 686 Continued From page 41

diabetic ulcer.
-He stated:
-"There is really nothing I can do for a vascular
wound, but a stage two or greater pressure ulcer
absolutely."
-"I talked to the resident and looked at his toe, it
is deformed, and the resident said it is a diabetic
ulcer."
-He would have expected the staff to notify him of
a pressure ulcer.
-He was available to the staff and dietary
manager via email or phone on the days he was
not in the facility.

Interview on 2/28/18 from 3:37 p.m. through 4:13
p.m. with the MDS assessment coordinator after
review of resident 320's medical record revealed
she:
*Agreed the nursing staff:
-Could not diagnose a diabetic ulcer.
-Had the capability to assess, document, and
stage a pressure ulcer.
-Should have clarified with the physician what
type of ulcer the resident had on his right toe on
2/22/18.
*Agreed the physician should have documented
what type of ulcer the resident had on his toe.
*She confirmed there was no documentation to
support the dietary department had been aware
of an ulcer to his right toe.
*She confirmed:
-There was no physician progress notes located
in the resident's chart for the staff to review.
-She stated:
-"The doctor does not have progress notes in
any of the resident's charts."
-"There are some notes hand written on the
physician's order sheets."
-"The progress notes are dictated, but we have
F 686 Continued From page 42

printing issues and we can't print them."

"I believe we don't have access to their new system at the clinic."

Interview on 3/1/18 at 11:15 a.m. with the dietary manager regarding resident 320 revealed:
*She had not been aware he had an ulcer to his right toe.
*The department managers had stand-up meetings every week day morning.
- Wounds would have been discussed at that meeting.
*She:
- Would have handwritten any pertinent notes for the dietary department during those meetings.
- Had no documentation on any of her handwritten notes from the past week to support knowledge of a wound to the resident's right toe.
- Confirmed the dietitian was available via email or phone when he was not in the facility to address any nutritional concerns.
- Would not confirm whether the dietary department should have been notified of all types of wounds and ulcers to ensure adequate nutritional support.

Interview on 3/1/18 at 1:20 p.m. with the DCN and physician regarding resident 320 revealed:
*The physician confirmed her visit and assessment with the resident on 2/22/18.
*She had been aware of the wound to his right second toe.
*She agreed:
- Her assessment and documentation on the physician's orders should have identified what type of wound he had on his toe.
- The nursing staff could not diagnose a diabetic ulcer and required the support of the physician's diagnosis and assessment for a pressure ulcer.
Continued From page 43

"She stated:
- "But I don't care what type of ulcer it is the dietary department should be involved with any and all types of ulcers."
- "His toe is both a diabetic and pressure ulcer due to the deformity of it, his neuropathy problems, and possible pressure from his shoes."
- "He specifically requested dietary education and support, because he is diabetic, has neuropathy, and will be going home soon."
- "It is crucial to have that nutritional support and involvement because of his neuropathy and the potential of that wound to worsen when he goes home."
- "I expected the dietary department to have been notified per my orders."
"She confirmed:
- She wrote a brief and shorthand note on all the resident's physician's orders.
- She had dictated her progress notes and they could not be found in the residents' charts.
- She stated:
  "In October we went to a different system and the nursing home cannot access them and print them now."
  "The clinic can print them, we will have to start printing them, and getting them to the facility."
"The DON:
- Confirmed:
  - The department heads had a daily stand-up meeting on the weekdays, and wounds were discussed at that time.
  - The dietary manager would have attended all of those meetings.
- She stated:
  "We reviewed that resident in stand-up after he was admitted, and the dietary manager was there."
  "I personally myself told the dietician about it."

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NAME OF PROVIDER OR SUPPLIER

BELLE FOURCHE HEALTHCARE COMMUNITY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION |
| 435035 | A. BUILDING | B. WING |

| STREET ADDRESS, CITY, STATE, ZIP CODE |
| 2220 13TH AVE |
| BELLE FOURCHE, SD 57717 |

| (X3) DATE SURVEY COMPLETED |
| 03/01/2018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ORC#S-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 686 | Continued From page 44  
- Had a form dated 2/23/18 from that morning stand-up meeting.  
--The resident’s name had been written down on that form to review for skin concerns that day.  
- Confirmed the dietitian had emailed the weekly wound form on 2/27/18.  
- Was unable to locate any documentation to support her conversation with the dietitian regarding the resident’s ulcer prior to 2/27/18.  
Review of resident 320’s 2/22/18 physician’s visit progress note revealed:  
*He had:  
- Type 2 diabetes with multiple complications including peripheral neuropathy.  
- A right second toe shallow diabetic ulcer.  
- Been referred to dietary for nutritional education and support.  
*It was not available for review by the staff, and a part of his medical record until 3/1/18 after the surveyor requested to review it.  
Review of the provider’s December 2017 Skin Program policy revealed:  
*Policy: "To provide care and services to promote the healing of pressure ulcers/wounds that are present."
*Procedure:  
- "Nursing personnel will utilize the results of the physical exam and the Pressure Ulcer Assessment tools to determine an individualized pressure ulcer prevention program for each at-risk resident.  
- This will include interventions to encourage optimal nutrition and fluid intake."  
**When a skin ulcer is identified, This assessment will include: Type of skin ulcer (MD [medical doctor] is asked to identify type of ulcer; e.g., pressure, stasis [venous, ischemic (arterial), |
| F 686 |  |  |  |  |
Continued From page 45
or neuropathic, and provide skin treatment orders."

"Nursing personnel will develop a POC [plan of care] with interventions consistent with resident and family preferences, goals, and abilities.
-POC to include nutritional status and interventions."

Increase/Prevent Decrease in ROM/Mobility
SS=I
CFR(s): 483.25(c)(1)-(3)

§483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:

Surveyor: 38557

Based on observation, interview, record review, and policy review, the provider failed to ensure a functional restorative therapy program was in place for one of three sampled residents (61) residents who had contractures. Findings include:

1. Observation and interview on 2/27/18 at 8:05
F 688 Continued From page 46

a.m. with resident 61 revealed:
*Both hands had observable contractures.
  -Her left hand side fingers were touching the
  palms of her hand, and her wrist had contracted
  toward her forearm.
  -Her right hand and wrist were slightly less
  contracted than her left side.
  *The left arm had been tight against her chest.
  -A contracture in her left elbow made it impossible
  for her arm to be straightened.
  *Her head angled toward the right due to
  contracture.
  -She could stretch it toward the left with much
  effort.
  *Both legs were unable to lay completely straight
  due to contracture.
  *She stated she was unhappy with therapy
  services.
  -She would like to walk again but understood she
  was a long way from that.
  -She stated her contractures were getting worse.
  -Her hands, neck, and legs felt tight.
  -Stretching made it feel better.
  *She stated she would enjoy more restorative
  therapy if it were offered.

Review of the 3/1/18 physician's orders revealed:
*Diagnoses of: flaccid hemiplegia affecting
unspecified side, unspecified intracranial injury
with loss of consciousness of unspecified
duration, sequela, paraplegia, other muscle
spasm, and other chronic pain.
*Pain medications included: a fentanyl patch
every seventy-two hours, and as needed
acetaminophen suppository, acetaminophen
tablet, and hydrocortisone-acetaminophen tablets.

Review of her 2/13/18 care plan revealed:
*A focus area of: "I am at risk for contractures."
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| F 688 | Continued From page 47  
*A goal of: "I will participate with Restorative Therapy through next review to maintain ROM [range of motion] to UE's [upper extremities], LE's [lower extremities], and neck 2-3x/wk [times per week]. 5-10 reps. [repetitions] to prevent further contractures for ADL [activities of daily living] functioning."  
*Interventions of: "Passive ROM to both UE's and LE's 5-10 reps. while in supine or w/c [wheelchair]. Passive stretch to neck right side bending, 1-5 mins. 2-3x/wk."  
*A second focus area of: "I am at risk for a decline in function."  
*The goals were: "I will participate in my restorative program for PROM [passive range of motion] stretching 10-15 minutes 2-3 x a week."  
*The interventions were: "Nursing Rehab: PROM to both upper and lower extremities, passive neck stretch to right neutral 10-15 minutes 2-3 x a week."  
Review of 1/30/18 through 2/27/18 task documentation titled nursing rehab revealed:  
*Instructions had been to perform passive range of motion to both upper and lower extremities, passive neck stretch to right neutral with five to ten repetitions; two to three times a week revealed:  
-Resident had completed care/training as directed.  
Review of the 2017 quarterly physical therapy (PT) screen forms revealed:  
*A 2/13/17 order for PT to improve head position during meals.  
*A 6/26/17 screen stated no change, and that PT evaluation had not been indicated.  
*A 8/1/17 screen stated no new complaints of positioning. | F 688 | | | |
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<th><strong>MULTIPLE CONSTRUCTION</strong></th>
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### (X4) ID 
**TAG**  F 688

**SUMMARY STATEMENT OF DEFICIENCIES**

- An 11/7/17 PT evaluation stated to re-establish the restorative program after return to long term care from hospital.

- Review of the 11/7/17 occupational therapy (OT) evaluation revealed a recommendation of placing a washcloth roll in her left hand. And to resume the range of motion program for the restorative nursing program.

- Interview on 2/28/18 at 9:41 a.m. with the director of nursing (DON) revealed:
  - The current process for placing a resident on a restorative nursing program consisted of the OT and the PT completing an initial evaluation.
  - Each therapist would then create recommendations for a restorative nursing program.
  - Those recommendations would be discussed with the restorative supervisor who was a certified nursing assistant (CNA).
  - The restorative supervisor would discuss the recommendations with the DON to determine a realistic individualized restorative nursing program.
  - She would review the restorative supervisor's monthly program review for each resident and decide if the resident's restorative program should be changed or stay the same.
  - Review of resident 81's program revealed no changes had been made.
  - She had not been told that resident felt her contractures had gotten worse.
  - She felt the resident's contractures had remained the same and had not worsened.
  - There was only one restorative aide, so they had to consider that when creating each restorative program.
  - She did not feel CNA's could provide passive
**F 688** Continued From page 49

range of motion stretches due to time constraints.

Interview on 2/28/18 at 2:10 p.m. with resident 61 revealed:

*She had been lying down in bed with a rolled washcloth partially in her hand.
*According to her:
  - That was to prevent her fingernails from pushing into the palm of her hand.
  - It was also to prevent her contracture from getting worse.
*She said she used to wear a brace.
*She stated she did not always get therapy two to three times a week.
*It was usually in the mornings.
*If there were not enough staff she might not get therapy.
*She sometimes tried to do her own stretches.
  - Using her right hand she demonstrated by pushing her left hand and arm to stretch it herself.
  -- Her ability to do that had been very limited.

Interview on 2/28/18 at 2:15 p.m. with restorative supervisor/CNA C revealed:

*She did passive range of motion exercises with resident 61 three to four times per week.
*Her day started at 4:00 a.m. to get everyone done per their preferences.
*Resident 61 had not complained to her about pain or contractures worsening.
*If she had known that she would have reported it to her supervisor for an evaluation.
*She was the only restorative aide.
*Her schedule was four days per week.
*There were forty residents on her caseload.
*She did not feel resident 61's contractures had worsened.
*Her supervisor, the DON, had completed monthly reviews of all residents on her caseload.
**BELLE FOURCHE HEALTHCARE COMMUNITY**

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<td>Continued From page 50 for appropriateness on the restorative therapy program. The resident was feeling better.</td>
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<td>If a resident needed more days of restorative therapy she would have needed to work longer days to get everything done.</td>
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<td>Interview on 2/28/18 at 2:20 p.m. with PT revealed:</td>
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<td>* He completed a screen with each quarterly MDS.</td>
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<td>* He would get information from residents when possible and from staff.</td>
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<td>* If a resident was worsening or had a change of condition they could screen any time, they did not need to wait until the quarterly screen.</td>
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<td>* He would then decide if he could work with her on the physical therapy program, or if he would recommend her for the restorative therapy program.</td>
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<td>* He worked closely with the restorative aide and nursing to set recommendations.</td>
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<td>* He agreed that current restorative aide had a large caseload.</td>
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<td>* He had not heard that resident 61 had a concern.</td>
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<td>* He would talk to her.</td>
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<td>* He had seen her twice during the past year.</td>
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<td>* He had completed an evaluation after her last hospitalization that had been from 10/20/17 to 11/8/17.</td>
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<td>Interview on 3/01/18 at 3:21 p.m. with the DON and the medical consultant revealed:</td>
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<td>* They had been unaware of resident 61’s wish to receive more restorative therapy.</td>
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<td>* They were unaware that she had any concerns regarding her restorative therapy program or her contractures.</td>
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<td>* The DON completed monthly reviews of all</td>
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<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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</table>
| F 688               | Continued From page 51 residents on the restorative therapy program caseload for appropriateness. *
|                     | Both acknowledged that if the resident were to request more services they would need to review
|                     | her current services for appropriateness. Review of January 2018 Restorative Nursing Program policy revealed:
|                     | “The concept “actively focuses on achieving and maintaining optimal physical, mental, and
|                     | psychosocial functioning.”
| F 689               | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)
| SS=G               | §483.25(d) Accidents. The facility must ensure that -
|                     | §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and
|                     | §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent
|                     | accidents. This REQUIREMENT is not met as evidenced by:
|                     | Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to have adequate supervision and interventions in place for one of one sampled resident (41) with multiple falls occurring in the facility and resulting in two major injuries. Findings Include:
|                     | 1. Review of resident 41’s medical record revealed:
|                     | *She had been admitted on 12/19/17.
|                     | *She had been admitted for weakness from the hospital.
|                     | *She had been at home prior to that with a care resident 41 previous falls will be reviewed to determine potential root cause for the falls. A comprehensive fall care plan has been developed to address her fall with hip fracture and fall with head laceration. Appropriate interventions have been identified and implemented with review of her toileting practices, positioning, pain assessment, bed placement, assistive devices, apparel and use of glasses and/or hearing aides. All residents are at risk.
|                     | 2. All other residents fall care plans will be reviewed for effectiveness of current interventions to ensure appropriate interventions have been implemented to provide adequate supervision. Administrator will provide education to all staff on the Fall Prevention policy and Resident Incident Reporting policy and informed them of their roles and responsibilities for all residents identified at risk for falls.
|                     | 3. Administrator or designee will audit 4
F 689 Continued from page 52.

- The resident's care plans weekly x 4 weeks and monthly x 3 months to ensure necessary care interventions are identified and implemented and have been reviewed for effectiveness.

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<tr>
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<tbody>
<tr>
<td>F 689</td>
<td>*She had been identified at risk for falls during her admission assessment.</td>
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<td>*The 12/19/17 fall risk assessment score was twenty-one.</td>
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<td>-A score of ten or above indicated a risk of falling.</td>
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<td>-They were to implement the fall prevention protocol and place approaches in the plan of care.</td>
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<td>--The fall prevention protocol initiated had been:</td>
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<td>&quot;Resident is very confused. She was orientated to call light but does not appear to know how to use this. She will be working with therapy. Will initiate low bed mat.&quot;</td>
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<td>*She had twenty-four falls since her admission on 12/19/17.</td>
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<td></td>
<td>-Two of those falls had resulted in major injury: a fractured hip on 1/14/18 and a head injury on 2/22/18.</td>
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</table>

Review of resident 41's 12/26/17 Minimum Data Set (MDS) assessment revealed:

*Her Brief Interview for Mental Status (BIMS) score was zero indicating she has severe cognitive impairment.

*She had verbal behaviors that had occurred one-to-three days during the assessment period.

*She had not rejected care during the assessment period.

*She required assistance of one staff member for the following:
  - Bed mobility,
  - Transferring from one location to another,
  - Locomotion on the unit,
  - Locomotion off the unit,
  - Toilet use,
  - Dressing,
  - Personal hygiene.

*Her diagnoses had included:
**F 689**

Continued From page 53
- Cancer.
- Hypertension.
- Diabetes.
- Hyponatremia.

She had a fall prior to admission.
She had one fall with no injury since admission.

Review of resident 41’s 1/29/18 MDS assessment revealed:
- Her BIMS score was zero indicating she had severe cognitive impairment.
- She had no behaviors.
- She had rejected care one-to-three days during the assessment period.
- She required extensive assistance of two staff members for the following:
  - Bed mobility.
  - Transferring from one location to another.
  - Locomotion on the unit.
  - Toilet use.
- She required assistance of one staff member for the following:
  - Locomotion off the unit.
  - Dressing.
  - Personal hygiene.
- Her diagnosis had included:
  - Cancer.
  - Hypertension.
  - Peripheral vascular disease (PVD).
  - Diabetes.
  - Hyponatremia.
  - Hip fracture.
- They had documented no falls since admission or prior assessment.

Review of resident 41’s fall scene investigation reports from 12/19/17 through 2/28/18 revealed she had eight un witnessed falls. Refer to F610, finding 1.
Review of resident 41's fall scene investigation reports revealed the following witnessed falls:
*On 12/23/17 she had a witnessed fall at 2:30 p.m. that stated "resident lost balance."
*She had been alone and unattended.
*The last time toileted had a question mark in the box.
*Conclusion had been "Is working with therapy cont [continue] with hourly checks. Ensure call light is within reach."
*There had been no additional care plan updates documented.
*On 12/31/17 she had a fall in the open court area at 9:30 a.m.
*She had been sitting in her wheelchair.
*"She stated her butt keeps sliding to edge of wheelchair."
*Root cause: "Cushion in wheelchair slick. Resident keeps sliding to edge of wheelchair seat."
*Initial interventions to prevent future falls had been "Staff to monitor positioning."
*Additional care plan updates had been "Ensure cushion has cover and is hooked to wheelchair. Therapy looking to adjust w/c [wheelchair]."

Review of resident 41's interdisciplinary notes from 12/19/17 through 2/27/18 revealed:
*She had also fallen on the following dates:
-1/2/18.
-1/3/18 a third time.
-1/4/18.
-1/5/18 two times.
-1/6/18.
-1/27/18.
-1/28/18.
-2/1/18.
-2/2/18 two times.
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<tr>
<th>(X4) ID PRE/SUFFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 689</td>
<td>Continued From page 55 - 2/5/18. - 2/6/18. - 2/7/18. *There had been no fall scene investigation reports for the above falls. Review of resident 41's current undated care plan revealed: *There had been no intervention to check on her hourly per the above 1/10/18 intervention. *Her toileting plan had been to toilet every two hours. *There had been no interventions regarding an individualized toileting plan. *Interventions in place were initiated after the falls had occurred and not prior. Observation and interview on 2/27/18 at 11:20 a.m. of resident 41 revealed: *She had been sitting in her recliner in her room with the TV on. *She had a green/yellow bruise under her right eye and a two-inch bandage on her forehead. *Her left leg was stuck in-between the recliner seat and the foot rest. *The gap between the two areas had been approximately four inches. *She asked to have her slipper put on. *She seemed unaware her leg was stuck. *She was told her leg needed to be unstuck from the chair. *She stated &quot;Oh no can you put on my slipper.&quot; *She attempted to pull her leg out from between the gap but was not successful. *She could not pull her call light on when asked to, and she just looked at it. *The surveyor put her call light on. *The resident grimaced when she attempted to move her leg.</td>
<td>F 689</td>
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</table>
F 689 Continued From page 56

*No one had come to her room.

-An unidentified activities staff member was doing an activity in the common area and was asked if there were staff around who could assist the resident.

*She stated she was not sure and looked around the area.

*She then pointed out a certified nursing assistant (CNA) on the south end of the common area.

*The staff member was asked if she had gotten a page for room 307.

*She stated she was not wearing a pager.

*She came to assist resident 41, and when she saw the resident's leg stuck stated "Oh wow!"

*She then used her walkie talkie to call another CNA as her partner on that hall had been on break.

-The CNA she called stated she would be down after she helped another resident.

*The CNA in resident 41's room assisted the resident by herself and pulled her leg out of the gap.

*She then left the room.

Observation and interview on 2/27/18 at 11:45 a.m. with registered nurse (RN) regarding resident 41 revealed:

*The resident was lying in her bed.

*RN stated she was told about the resident getting her leg stuck in the recliner.

*They were going to remove the recliner from her room due to the incident.

*At that time the maintenance director came over to take the recliner out of her room.

*RN stated the resident can not be left alone in her wheelchair without supervision, as she had fallen out of the wheelchair.

-She had hit her head as a result of falling out of her wheelchair.
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<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F 689</td>
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<td>Continued From page 57</td>
<td>F 689</td>
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<td>Observation on 2/27/18 at 12:30 p.m. of resident 41 in the dining room revealed:</td>
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<td>*She had been pushed up to the table.</td>
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<td>*Her foot pedals had been angled up.</td>
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<td>*She had not been able to get up to the table due to the foot pedals being angled up.</td>
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<td></td>
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<td>*The foot pedals hit the tablкомate to her right when she was pushed closer to the table.</td>
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<td>Interview on 2/27/18 at 12:40 p.m. with CNA P revealed:</td>
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<td>*They had tried to put the foot pedals down in her wheelchair, but she was not sure why they left them up.</td>
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<td>*She went over and took the pedaп off and pushed her closer to the table.</td>
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<td>*Recreation services aide Q stated she had not known the foot pedals were to come off.</td>
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<td>Observation on 2/27/18 at 2:10 p.m. and again at 4:50 p.m. of resident 41 revealed she was lying in bed. The recliner had been taken out of her room and not replaced.</td>
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<td>Observation on 2/27/18 at 6:25 p.m. of resident 41 revealed:</td>
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<td>*She had been lying in bed.</td>
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<td>*She was attempting to get out of bed.</td>
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<td>*Both her legs were over the scooped mattress.</td>
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<td></td>
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<td>*She was trying to lift her body up to get out of bed.</td>
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<td></td>
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<td>*She was wide awake.</td>
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<td>*There were no CNAs in the area.</td>
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<td>-The director of nursing (DON) was found and the above situation was explained to her.</td>
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<td>Observation on 2/28/18 at 7:20 a.m. of resident 41 revealed she was up in her wheelchair in the living room/common area. There were no staff in</td>
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| F 889         | Continued From page 58 the common area. Observation on 2/28/18 at 8:29 a.m. of resident 41 revealed she was up in her wheelchair in the living room/common area. She was slouched over. The leg pedals were angled up. Observation on 2/28/18 at 8:49 a.m. regarding resident 41 revealed: *She was slouched over in her wheelchair sleeping. *There had been no staff in the area supervising her. *The leg pedals were angled up. Observation on 2/28/18 at 9:02 a.m. of resident 41 revealed she was taken into her room and laid down. Observation on 2/28/18 at 9:27 a.m. of resident 41 revealed she was attempting to get up out of bed. There had been no staff around to witness her attempt at getting up. Interview on 2/28/18 at 9:31 a.m. with CNA N revealed: *They checked on resident 41 every two hours to see if she needed to go to the bathroom. *They usually laid her down in between meals. **She is the first one they lay down after breakfast, and the last one to get up before lunch. *She had been the only CNA on the 300 hall at that time due to her partner being on break. Observation on 2/28/18 at 10:00 a.m. of resident 41 revealed RN I had been in her room changing her dressings to her heels. She was in a sitting position with her feet hanging over the bed. She
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<tbody>
<tr>
<td>F 689</td>
<td>Continued From page 59 was lying back against wall. Observation on 3/01/18 at 8:56 a.m. of resident 41 revealed she was lying in bed with both feet hanging off the bed and heel protectors on. There were no staff around to observe her. Observation on 3/01/18 at 10:41 a.m. of resident 41 revealed she had been lying in bed. Both legs were hanging off the side of the bed. The lights were off. She was awake. Interview on 3/01/18 at 2:03 p.m. with the DON regarding resident 41 revealed: <em>They were putting her in bed between meals, because she had to be supervised if she was up in her chair.</em> <em>They had not attempted an individualized bathing schedule for her.</em> <em>The CNAs only documented one time per shift that they toileted the resident.</em> <em>The fall interventions had been implemented after falls had occurred and not before for her.</em> Review of the provider's March 2017 Fall Prevention policy revealed: <strong>A fall risk assessment will be completed at the following times:</strong> - Upon admission/re-admission to the facility. - Quarterly - can complete a quarterly review instead of full assessment if no change since previous assessment. - Prior to the annual MDS. - Change of condition. <em>Fall precautions will be reviewed and appropriate precautions will be implemented after a fall occurs and as needed.</em> <em>Incident report and a fall scene investigation form will be completed after fall.</em></td>
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<td>ID</td>
<td>Provider/Supplier Identification Number</td>
<td>X2) Multiple Construction</td>
<td>X3) Date Survey Completed</td>
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<td>F 689</td>
<td>Continued From page 60</td>
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<td>F 725</td>
<td>Sufficient Nursing Staff</td>
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**Continued From page 60**

"Falls will automatically be logged through completion of Incident Report in PCC [point click care]."

**Sufficient Nursing Staff**

CFR(e): 483.35(a)(1)(2)

§483.35(a) Sufficient Staff.
The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:
Surveyor: 32335
Based on observation, interview, and record review, the provider failed to ensure sufficient

**1. Resident 61 has been referred to physical therapy on 3/19/2018 related to complaints of neck pain and currently awaiting orders for physical therapy, upon completion of physical therapy, resident will be referred to the restorative therapy program with recommendations and appropriate program per the Physical Therapist that will meet her needs. Resident 41 has had an activity assessment completed on 3/22/2018 and interview with family to determine her previous activity interests and her fall care plan has been revised with interventions to assist in prevention of falls. No immediate action can be made for call light response concerns expressed at resident council during survey. All residents are at risk.**

**2. Call lights are being discussed monthly at resident council and call light response times are being monitored daily at Quality Conference and weekly interviews with 4 residents will be done to ensure call lights are answered timely and resident needs are being met. Administrator will educate Human Resources Director and DON on sufficient staffing needs of the facility to ensure there is appropriate staffing to meet the needs of each resident in a timely manner. Staffing schedule and daily assignment will be reviewed**
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</table>
| F 725 | Continued From page 61 | nursing staff were available to ensure:  
*One of three sampled residents (81) received restorative therapy.  
*One of one sampled resident (41) with multiple falls had been supervised.  
*Call lights were answered timely to ensure resident needs were met.  
Findings include:  
1. Interview with resident 61 revealed the facility failed to provide her with restorative therapy on a regular basis. Refer to F688, finding 1.  
2. Review of resident 41's medical record revealed she had twenty-four falls since her admission on 12/19/17. Refer to F689, finding 1.  
3. Resident council meeting on 2/27/18 at 2:25 p.m. with a group of residents and two family members revealed:  
*They had concerns with the call light wait times.  
*Staff would come in the room, turn off the call light, and say they would come back later.  
-They would not always come back.  
*The wait times got better for a little while but had gotten bad again.  
Review of the October 2017, November 2017, and January 2018 resident council minutes revealed concerns had been brought up about long call light wait times. Refer to F919, finding 3. | F 725 | and discussed at Quality Conference daily. All direct care staff and managers will be required to carry pagers and walkie-talkies to ensure call lights are answered timely to meet the needs of the resident. Education will be provided no later than 3/26/2018. Those who have not received the education by 3/26/2018 will be educated prior to their first shift worked. | | | |
<p>| F 759 | Free of Medication Error Rts 5 Pront or More CFR(s): 483.45(t)(1) | | F 759 | §483.45(t) Medication Errors. The facility must ensure that its- | | | |</p>
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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Precised by Full Regulatory or LSC Identifying Information)</th>
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<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced To The Appropriate Deficiency)</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>F 759</td>
<td>Continued From page 62</td>
<td>§483.45(b)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Surveyor: 28162 Based on observation, interview, and policy review, the provider failed to ensure two of two randomly observed residents' (40 and 56) insulin had been administered according to policy and procedure by one of one licensed practical nurse (LPN) (B). Those observations created a medication error rate of 12.9%. Findings include:</td>
<td>F 759</td>
<td></td>
<td></td>
<td>1. No immediate corrective action could be made for the inappropriate insulin administrations to residents 40 and 56 by LPN B. All residents that receive insulins via insulin pen are at risk. 2. DON will educate all licensed nurses on the Insulin and Non-Insulin Pen Delivery Systems policy to ensure the needle remains in the resident's skin for at least 10 seconds before withdrawing the needle to assure the full dose is delivered. This education will include review of the insulin table that indicates the length of injection time for all types of insulin pen injections. This table will be available on all medication cards and medication storage rooms. 3. DON or MDS Coordinator will complete audits of 4 Nurses to include LPN B, administering insulin per pen method to ensure the needle remains in the resident's skin for at least 10 seconds before withdrawing the needle to assure the full dose is delivered. Results of the audits will be reported by the Administrator or designee at the monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.</td>
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F 750 | Continued From page G3
*Insulin injection pens should have remained inserted in the skin for at least five seconds.
Review of the provider's last revised March 2016 Insulin and Non-Insulin Pen Delivery Systems policy and procedure revealed:
*The length of insulin injection times to have been:
    -Levemir "6 seconds."
    -Vioza "6 seconds."
    -Novolog "6 seconds."
"Dose buttons should be pressed down and needle kept under the skin for a full count of seconds to insure the full dose is injected."

F 880 | 483.80 | Infection Prevention & Control
SS=E CFR(e): 483.80a(1)(2)(4)(e)(f)

1. The Hoyer lift on the 200 hall has been taken out of service until the blue fabric padding can be replaced. Resident 10's heel protectors have been replaced. The bed pan in room 216 has been placed in a plastic bag and stored on a hook in the bathroom. The graduated pitcher in room 216 has been placed in a plastic bag and stored on a hook in the bathroom.
The bathroom on the Transitional Care Unit has been designated as an Occupational Therapy training bathroom and the resident use equipment has been removed from the bathroom or stored in a sanitary condition. Resident 320 has discharged so unable to complete corrective action. Resident 321 has discharged so unable to complete corrective action. The placement of resident personal care products in room 110 and 113 have been separated and stored appropriately to maintain a sanitary condition.
**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/Clinical Identification Number:** 435035

**Building:**

- **B. Wing:**

**Name of Provider or Supplier:**

**Belleville Healthcare Community**

**Street Address, City, State, Zip Code:**

2200 13th Ave

Belleville, SD 67717

**Date Survey Completed:** 03/01/2018

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>Provider's Plan of Correction</th>
</tr>
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<tbody>
<tr>
<td>F 880</td>
<td>Continued From page 64</td>
<td></td>
<td>accepted national standards;</td>
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§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which 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; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

The kitchenette in the Transitional Care Unit that stores the juice containers has been cleaned and put on a cleaning schedule to ensure it is maintained in a sanitary condition. The filters in the five hairdryers have been cleaned and added to the preventative maintenance program. The 400 wing storage room walls will be repaired and painted no later than 3/28/2018. The door to the housekeeping supply room in the 400 wing storage room will be repaired no later than 3/28/2018.

2. All resident rooms have been reviewed to ensure all personal care items are kept clean and stored in a sanitary condition. Administrator will educate all staff on the Infection Prevention and Control Program Overview to include their role and responsibility for their assigned tasks for infection control and prevention. Administrator will educate Maintenance Director on the preventative maintenance program to include lifts, walls and doors are repaired or replaced and the hair dryer filters will be cleaned to ensure a sanitary condition is maintained. Administrator will educate all staff to include therapy staff that the bathroom on the Transitional Care Unit will be used as an Occupational Therapy training bathroom and therapy items stored in bathroom will be stored and maintained in a sanitary condition. Administrator will educate nursing staff on the Care and Storage of Resident Personal Care items policy to include...
Continued From page 65

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

Surveyor: 29182
Based on observation, interview, and policy review, the provider failed to ensure:
* The Hoyer lift on the 200 hall had cleanable surfaces.
* One of one randomly observed resident (10) had clean and unworn heel protector boots.
* A bedpan and graduate pitcher in room 216 had been stored in a sanitary manner.
* A sanitary environment was maintained for:
  - The storage of resident use equipment in one of one bathroom located on the Transitional Care Unit (TCU).
  - One of two sampled resident's (320) oxygen tubing when not in use.
  - The placement of a urinal after it was used for one of one sampled resident (321).
  - The placement of resident personal care products in two of five randomly observed resident's rooms (110 and 113).
  - The storage of juice containers in one of one kitchenette on the TCU for one of one juice machine.
  - The filters in five of five hairdryers located in the main sitting/visiting area on the 300 wing.
  - One storage room on the 400 wing.

Findings include:

1. Observation on 2/27/18 at 11:27 a.m. of the 200 hall Hoyer lift revealed it had a blue fabric and foam covering over the bar where the slings hooked. That covering was opened approximately six inches and had exposed yellow foam poking.

3. Administrator or designee will complete audits of 4 lifts and 4 rooms to ensure appropriate cleanable surfaces are maintained; audits of 4 resident's personal care items, to include Resident 10, to ensure resident care items are kept clean and stored in a sanitary condition and no worn with holes items are in use; audits of 4 residents' use oxygen to ensure oxygen tubing is stored appropriately in a bag attached to the concentrator when not in use; audits of the Transitional Care Unit to ensure the kitchenette is clean and maintained in a sanitary condition; audits of hairdryer filters to ensure filters are clean and...
F 880 Continued From page 66

out. That foam would be uncleanable.

2. Observation on 2/27/26 at 11:35 a.m. of resident 10 revealed she had on heel protector boots. Those boots had Velcro closures. The fabric around the Velcro and on the top and sides of those boots was torn and worn. It was an uncleanable surface.

3. Observation on 3/1/18 at 8:15 a.m. of the bathroom in resident room 216 revealed a wash basin and bedpan sitting on the floor directly below the sink. There had been no covering or barriers in place to protect those items from contamination from the floor.

4. Interview on 3/1/18 at 8:45 a.m. with the director of nurses (DON) revealed she agreed:
"The padding on the Hoyer lift bar needed replacing and had been an uncleanable surface. Resident 10's heel protector boots needed to be replaced and had been uncleanable.
"The wash basin and bedpan should not have been on the floor in resident room 216's bathroom."

Review of the provider's last revised September 2015 Laundry and Linen policy revealed all washable residents' personal equipment would be laundered if soiled.

Surveyor: 32355

5. Observation on 2/27/18 at 11:05 a.m. of a bathroom on the TCU located across from the therapy department revealed:
"The bathroom with a toilet, sink, and bathtub had been identified as a shared female/male bathroom by a sign attached to the door."

maintained in a sanitary condition; and audit of the Occupational Therapy training bathroom to ensure items stored in bathroom are stored and maintained in a sanitary condition. All audits will be done weekly x 4 weeks then monthly x 3 months. Results of the audits will be reported by the Administrator or designee at the monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.
F 880  Continued From page 67

-There had been several types of resident use equipment stored in that bathroom such as:
  -A wheelchair (w/c) weighing scale.
  -A large wooden mirror that had wheels on the bottom of it for movability.
  -Two small plastic bins sitting directly on the floor next to the bathtub.
  -A shower chair.
  -W/c.
  -Several walkers hanging on hooks.
  -A red therapy bolster sitting directly on the floor.
  -Two large bouncy balls located on a shelf above the walkers.

Interview on 2/27/18 at 11:10 a.m. with speech therapist (T) regarding the above observation revealed she:
*Had been unsure:
-What the bathroom was used for.
-If the bathroom was used for storage or not.
*Stated "But I know the visitors use that for a bathroom."

Observation and interview on 2/27/18 at 11:44 a.m. with the administrator regarding the TCU bathroom revealed she:
*Had been unaware that:
-Visitors had been using that bathroom.
-The staff had been storing resident use equipment in that bathroom.
*Stated:
-"Visitors should not be using that bathroom."
-"Staff shouldn't be storing equipment in there."
-"That bathroom is to be used by therapy with the residents for training purposes only."
*Agreed with visitors using the bathroom they could not guarantee the equipment that was stored in there was kept clean.
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<th>ID</th>
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<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
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<tr>
<td>F 880</td>
<td>F 880</td>
<td>Each corrective action should be cross-referenced to the appropriate deficiency.</td>
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</table>

**Summary Statement of Deficiencies**

Each deficiency must be preceded by full regulatory or LSC identifying information.

**F 880**

Continued from page 68.

Observation and interview on 2/27/18 at 2:00 p.m. with physical therapist (PT) G regarding the TCU bathroom revealed he:

*Had been aware that visitors used that bathroom.*

*Had been aware resident equipment was stored in that bathroom.*

*Stated:

- "The staff use it as well. It's the only bathroom close to this area.
- "We mostly use the bathtub when working with residents who are going home and have a bathtub."

*He agreed:

- The equipment was not stored in a clean environment.
- That process had created the potential for bacteria to spread from one person to another.

6. Random observations on 2/27/18 from 8:00 a.m. through 3:13 p.m. of resident 320's oxygen tubing revealed:

*The resident had been observed using:

- His oxygen continuously throughout the day.
- An oxygen concentrator when he was in his room.
- A portable oxygen tank when not in his room.*

*At 8:46 a.m. the:

- Resident had been in his room and was using the oxygen concentrator.
- Portable oxygen tank had been hanging from his walker.
- The oxygen tubing attached to that portable tank was on the floor and underneath his bed.

*At 12:51 p.m. revealed the same observation as above.

*At 3:03 p.m. the:

- Resident had been in the therapy room and was using his portable oxygen tank.
Continued From page 69

-Oxygen tubing attached to the concentrator in his room was lying directly on the floor.

Observation and interview on 2/23/18 at 8:35 a.m. with certified nursing assistant (CNA) (D) regarding resident 320's oxygen tubing revealed:

*She had not been aware the resident was leaving his oxygen tubing on the floor when not in use.

*She stated "They usually have a bag attached to the walker and concentrator to put them in." The concentrator had a bag attached to it, but the walker did not.

*The resident had been in the room, and he:

*Was not aware that storing the oxygen tubing on the floor when not in use was unsanitary.

*Had never been educated by the staff of a different process.

*She agreed the process above:

*Was not completed in a sanitary manner.

*Created the potential for the spread of bacteria to the resident.

7. Random observations on 2/27/18 from 7:55 a.m. through 4:27 p.m. of resident 321 revealed:

*He had:

*Been admitted from the hospital after having a stroke.

*That stroke had caused him to have hemiparesis on the right side of his body.

*Required staff assistance with all activities of daily living (ADL).

*Remained continent of urine with the use of a urinal.

*Been able to use that urinal independently.

*Stored the urinal on his bedside table by his water glass, Kleenex, and other various personal items.

*Required the staff to empty the urinal for him.
F 880 Continued From page 70

after he had used it.
  *During the above time frame the resident had
used the urinal twice.
  *Both of those times he had:
  --Filled the urinal a quarter full of urine and placed it
on the bedside table for the staff to empty.
  --Not called the staff to empty the urinal after he
used it.
  *At 4:27 p.m.:
  -Licensed practical nurse (LPN) C had
administered medication to the resident in his
room.
  -He had recently used the urinal, and it was a
quarter full of urine.
  -He had placed the urinal on his bedside table by
his water glasses and Kleenex.
  -LPN C administered him the medication and left
the room without emptying his urinal.

Interview on 2/28/18 at 8:32 a.m. with CNA D
regarding resident 321’s urinal revealed:
  *She had been aware the resident placed his
urinal on the bedside table.
  *She confirmed the resident:
  -Was dependant upon the staff to empty his
urinal.
  -Would not call the staff to empty it after he had
used it.
  -Was alert, oriented, and capable of being
educated on a better process for placing/storing
his urinal.
  *The staff had not worked with the resident to see
where he could have placed the urinal and still
have access to it without difficulty.
  *She agreed the placement of his urinal was not
considered a sanitary process.

8. Random observations on 2/27/18 from 10:36
a.m. through 10:48 a.m. of resident rooms 110
<table>
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<tr>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| F880 |       |     | Continued From page 71 and 113 revealed:  
*Both rooms had large plastic containers sitting on top of the counters by the sinks.*  
*Those containers had various personal healthcare products inside of them such as:*  
  - Open bars of soap.  
  - Combs and brushes with hair inside of them.  
  - Packages of wet wipes.  
  - A plastic bag containing used roll of tape inside of it.  
  - Tubes of toothpaste.  
  - Toothbrushes with their bristles unprotected and resting right next to the above items.  
Observation and interview on 2/23/18 at 8:40 a.m. with CNA D regarding the plastic containers in residents' rooms 110 and 113 revealed also:  
*Confirmed there were personal care products mixed together inside of those plastic containers.*  
*Agreed:*  
  - The personal care products should not have been stored together like that.  
  - Mixing those personal care products together had not been a sanitary process.  
*Stated "The toothbrushes should not be stored in there with all of this stuff."  
9. Observation on 2/27/18 at 12:15 p.m. of the kitchenette area in the TCU revealed:  
*There was a juice machine sitting on top of the counter.*  
*Above and below the juice machine was cabinetry with several drawers and doors.*  
*The juice containers that were connected to the juice machine for dispensing were located on a shelf inside of the cabinet below the machine.*  
*The shelf the juice containers were stored on was covered and dirty with thick/grey colored lint particles. | F880 |     |
**Continued From page 72**

Interview on 2/27/18 at the time of the above observation with CNA D revealed:

*The staff who worked in the TCU were responsible for the cleaning of the kitchenette area.*

*There was no specific cleaning schedule for them to follow.*

*The juice machine had been purchased less than a week ago.*

*The storing of the containers in the cabinet below was a new process for them.*

*She agreed that:
- Shelf was dirty, and it would have taken longer than a week for that amount of lint build-up.
- Placement of those juice containers had not been done in a sanitary manner.
- Kitchenette area was to have been as clean as possible to ensure the delivery of food/drinks was done in a safe and sanitary manner.*

10. Observation on 2/28/18 at 7:55 a.m. In the sitting area of the 300 wing revealed:

*There had been several recliners/chairs located in that area.*

*Mixed in between those recliners/chairs were five hairdryers.*

*All five of those hairdryers had lint filters attached to the back of them.*

*Those filters had:
- Been full of a grayish/white colored particle.
- Created a small dust ball in the air when pulled out of the hairdryers.*

11. Interview on 3/1/18 at 9:41 a.m. with the director of nursing and administrator revealed:

*They had not been aware of all the concerns and break in sanitary processes identified above.*

*They were not sure:*
Continued From page 73
-If the hairdryers belonged to the beautician or were owned by the facility.
-Who should have been responsible to ensure the filters on the hairdryers had been kept clean.
*They agreed the processes above were unsanitary and created the potential for bacteria to have spread to the residents.

Review of the provider's December 2013 Care and Storage of Resident Personal Care Items policy revealed:
*Policy: "To assist in the prevention of the spread of infection by assuming resident personal care items are kept clean and stored in the resident's personal area."
*Procedures:
-*Personal care items will be stored in non-communal area. E.G. such as a toothbrush in a holder.*
-*Items will be placed in a drawer resident's bedside table in a basin, or in a plastic bag away from other personal care items.*
-*If a personal care item is found to be left out in the resident's bathroom or on top of a nightstand or other area where the sanitation is questionable, it will be discarded and replaced with a new one, or if cleanable, will be disinfected prior to return to storage area.*

On 2/28/18 at 2:00 p.m., a list of policies and procedures were given to the administrative department and had been requested:
*Use of a urinal.
*Storage of resident use equipment.
*TCU kitchenette cleaning of cabinets/area.
*Oxygen tubing placement when attached to concentrators/portable oxygen canisters and not in use.
*Those above policies were not provided to the
Surveyor: 38557
Observation on 2/27/18 at 8:30 a.m. of the storage room located on the 400 wing revealed:
*The room had been used for mechanical lift storage, five oxygen concentrators, four lift batteries were located on a shelf, one electric scooter with a liquid oxygen cylinder attached, a shower bench, a commode, and other miscellaneous items. *Each wall had chipped paint with the highest concentration being along the bottom of each wall.
*There had been scuff marks on all lower walls.
*A crack in the exterior wall had been visible under the lower left corner of the window.
*There was a door inside this storage room that stated housekeeping supplies.
*The door had four areas along the edge which had the top layer of wood missing.
**These areas were approximately a quarter in diameter each.
*The lower area of the door had two holes.
**Each of these holes were approximately the size of a quarter.

Interview on 2/28/18 at 9:41 a.m. with the director of nursing revealed:
*The storage room walls and door to housekeeping supply area were in need repair.
*She agreed they would be considered unable to be cleaned.
*She stated it would be maintenance's responsibility to complete these repairs.

Observation and interview on 3/01/18 at 3:05
<table>
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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F80</td>
<td></td>
<td></td>
<td>Continued From page 76 p.m. with</td>
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<td></td>
<td></td>
<td></td>
<td>the maintenance director revealed:</td>
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<td></td>
<td>The storage room down the 400 wing</td>
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<td></td>
<td></td>
<td></td>
<td>*The storage room down the 400 wing was in need of a new door for the housekeeping supply area.</td>
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<td></td>
<td></td>
<td>was in need of repair and paint.</td>
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<td>*He stated they repair and/or paint four to five rooms per year and prioritize resident rooms before other areas.</td>
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<td>*He does not want other rooms to be neglected but always tries to do resident rooms first.</td>
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<td></td>
<td></td>
<td></td>
<td>*He does not have any type of policy regarding when to repair or paint rooms.</td>
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<td>*Both agreed it would be considered unable to be cleaned.</td>
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<td>Observation and interview on 3/01/18 at 3:20 p.m. with the administrator and the medical consultant revealed:</td>
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<td>*A walk through inspection of the storage room located on the 400 wing had chipped paint on every wall.</td>
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<td></td>
<td>*The housekeeping storage door located inside the storage room had gouges in the wood.</td>
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<td></td>
<td>*The room was in need of paint and repair.</td>
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<tr>
<td>F909</td>
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<td></td>
<td>Resident Bed</td>
<td>F909</td>
<td></td>
<td></td>
<td>1. Resident 320 has discharged so no immediate corrective action was taken. All residents are at risk.</td>
<td>3/26/2018</td>
</tr>
<tr>
<td>SS-D</td>
<td>CFR(s): 483.80(d)(3)</td>
<td>§483.80(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased</td>
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<td>2. Administrator will provide education to the Maintenance Director to review bed manufacturer's Instructions for the safety brackets. The Maintenance Director has</td>
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</table>
F 906 Continued From page 76

separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.

This REQUIREMENT is not met as evidenced by:

Surveyor: 32355

Based on observation, interview, and manufacturer's manual review, revealed the provider failed to assess the safety for one of one sampled resident's (320) mattress to ensure it was secured to the bed frame and free from unsafe movement. Findings include:

1. Observation and interview on 2/27/18 at 8:57 a.m. with resident 320 revealed:
   - He had been:
     - Located in the transitional care unit (TCU).
     - Sitting on the edge of his bed.
     - The repositioning bar had been in the down position on the right side of his bed.
     - The left side of his bed had been placed against the wall.
   - The bed frame had:
     - Been exposed underneath of his right leg.
     - Long metal brackets attached to each end of it.
     - Those metal brackets were used to secure the mattress in place.
   - His mattress was not secured in place by those brackets and had shifted sideways on the bed frame.
   - That movement had created the bed frame to be exposed underneath of his leg by approximately 2 to 3 inches in width.
   - He confirmed:
     - He was independent in his room and could transfer himself on and off the bed.
     - The mattress had shifted and moved around on the bed frame since he was admitted on 2/1/18.
   - He stated "They did offer me another bed," but I

F 906 evaluated all the beds and made adjustments to the brackets to fit the mattresses of the beds when necessary in the Translational Care Unit and all other beds have been assessed for properly sized mattresses and secured to the beds to ensure the safety of the mattress and/or bed use. Administrator will provide education to all staff to report to Maintenance Director or administrator if mattresses are not fitting and moving on the beds and other safety risks are identified. Education will be provided no later than 3/29/2018. Those who have not received the education by 3/29/2018 will be educated prior to their first shift worked.

3. Administrator or designee will complete audits of 4 beds weekly x 4 weeks then monthly x 3 months to ensure mattresses are properly sized and secured on the bed. Results of the audits will be reported by the Administrator or designee at the monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.
### NAME OF PROVIDER OR SUPPLIER
BELLE FOURCHIE HEALTHCARE COMMUNITY

### SUMMARY STATEMENT OF DEFICIENCIES
(FILL IN EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LGD IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID NUMBER</th>
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<th>SUMMARY</th>
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<tbody>
<tr>
<td>F 909</td>
<td></td>
<td>Continued From page 77 refused it as I didn't want to cause any problems.&quot; He denied any injury from the exposed bed frame. Observation on 2/27/18 at 11:50 a.m. of resident 320 revealed: *The resident had just returned from working with therapy and was sitting on the edge of the bed. *The mattress continued to be: -In the same position as observed above. -Not secured in place by the metal brackets. Observation on 2/27/18 at 3:07 p.m. of resident 320 revealed: *He had been lying on his bed resting. *The mattress: -Continued to be not secured in place by the metal brackets. -Had shifted further to the left and moved down towards the foot of the bed. --That movement had exposed a larger portion of the bed frame. *The head of the mattress had moved down to expose approximately 3 inches of the bed frame. *The side of the mattress had shifted further to the left and exposed approximately 4 to 5 inches of the bed frame. Observation and interview on 2/28/18 at 8:45 a.m. with certified nursing assistant (CNA) D regarding resident 320's bed revealed: *The resident's bed had been made, and the fitted sheet had been placed over the metal brackets. *The mattress had been secured to the bed frame with the fitted sheet over those brackets. *CNA D: -Was not aware what the metal brackets were used for.</td>
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<tr>
<td>F 909</td>
<td>Continued From page 78</td>
<td>- Had always made the resident's beds that way.</td>
<td>F 909</td>
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<td>- Could not remember being trained on the proper use for the metal brackets.</td>
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<td>- Confirmed the resident was independent in his room and had been able to transfer himself in/out of the bed.</td>
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<td>- Agreed the:</td>
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<td>--Position of the mattress as observed above was a safety concern for the resident.</td>
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<td>- Resident could have acquired a skin injury from the bed frame or fallen when transferring.</td>
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<td>Interview on 3/1/18 at 7:57 a.m. with the maintenance supervisor revealed:</td>
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<tr>
<td></td>
<td></td>
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<td>*He had not been aware of what the facility was</td>
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</tbody>
</table>
Continued From page 79

using for bed frames, mattresses, and safety brackets in the TCU.

*The only time he had checked the beds for proper placement of the mattresses was when he was asked to replace it with an air mattress.

*He was not sure who should be checking to make sure the safety brackets were in place and had been used properly by the staff.

*The maintenance department had not placed the safety brackets on a preventative maintenance program to routinely check for proper use and safety.

*He agreed if they were not used properly any resident would have been at risk for injuries.

Interview on 3/1/18 at 8:15 a.m. with registered nurse (RN) F and CNA J who worked on the TCU revealed:

*They:

- Had not been educated on the proper use for the safety brackets attached to the bed frames.

-Agreed there was potential for any resident to have obtained an injury if the brackets were not used properly.

Interview on 3/1/18 at 10:15 a.m. with the director of nursing (DON) and administrator revealed:

*The DON was aware the mattresses in the TCU had not been the correct size for those bed frames.

*The current bed frames and safety brackets had been ordered over a year ago when the TCU first opened.

*The original mattresses that came with those beds and had concaved edges.

*The maintenance department had reordered mattresses for those beds, and they came to small.

*No one had ordered proper fitting mattresses for
Continued From page 80
those beds to ensure safety of the residents.
*The administrator had not been:
- Aware of the above concern.
- Sure who should be responsible for the routine checking for the proper use of the safety brackets and security of the mattresses.

Review of the provider's May 2015 Zenith 5,000 Manufacturer's Instructions for use revealed:
"The safety brackets, or retainers, could be positioned for an eighty inch or seventy-six inch mattress.
*The the instructions on how to insert properly into the bed frame.
*Important:
"Be sure to use a mattress that is properly sized to fit the sleep deck, which will remain centered on the deck relative to State and Federal Guidelines.
Use of an improperly fitted mattress could result in injury or death."

Resident Call System
CFR(5): 483.90(g)(2)
§483.90(g) Resident Call System
The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area.

§483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:
Surveyor: 32355
Based on observation, interview, record review, manufacturer's review, and policy review, the provider failed to ensure a consistent process

Administrator and Maintenance Director have reviewed the manufacturers' instructions and safe guards for the facility call light system and will order pagers and walkie-talkies to ensure each direct care staff have a pager and walkie-talkie at all times, and managers will have pagers and walkie-talkies. All residents at risk.

Administrator will educate all staff on the Answering Call Light policy and the facility requirement of carrying a pager and walkie-talkie and their role and responsibility at all times to ensure the resident's needs are met in a timely and efficient manner. Call light response time
 Continued From page 81

F 919

was in place for a multi-use call light system to support the resident's needs had been met in a timely and efficient manner. Findings include:

1. Random observations on 2/27/18 from 8:00 a.m. through 9:50 a.m. in the Transitional Care Unit (TCU) revealed:
   * Most of the residents were out in the dining room eating their breakfast or exercising with the therapists.
   * The residents observed in the dining room wore a long necklace with a square pendant attached to it.
   * The center of the pendant contained a rubber type material.
   * The residents' rooms all had call lights located by their beds and in the bathrooms.
   * There were no lights above the residents' doors to notify the staff when a resident had turned on their call light.
   * There was a digital board located at the south end of the hall attached to the wall above the exit door.
   * The digital board:
     - Was approximately 20 feet from the dining room area and the nurses' station.
     - Made a loud beeping noise whenever a resident would push their call light for assistance.
     - Would only beep once for each call light.
     - Had large red digital numbers that would run across the board to indicate which resident's room had their call light on.
     - The room numbers on the board would keep running until staff answered the resident's call light.

Interview on 2/27/18 at 8:53 a.m. with resident 320 revealed:
* He had been in his room sitting on the bed.

F 919 will be monitored daily at Quality Conference meetings, and follow up with individual residents when issues are identified. Education will be provided no later than 3/26/2018. Those who have not received the education by 3/26/2018 will be educated prior to their first shift worked.

3. Administrator or designee will complete audits/interview of 4 staff members, weekly x 4 weeks then monthly x 3 months to ensure staff members are carrying pager and walkie-talkies; interview 4 residents to discuss any potential concerns with call light response and if their needs are being met timely; audits to ensure resident council is discussing call lights and if indicated, grievances are addressed and followed up on to confirm resolution. Results of the audits will be reported by the Administrator or designee at the monthly QAPI meeting for review and recommendations for continuation or discontinuation of audit.
**NAME OF PROVIDER OR SUPPLIER**

BELLE FOURCHE HEALTHCARE COMMUNITY

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2200 13TH AVE

BELLE FOURCHE, SD 57717

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDENTIFICATION NUMBER:</td>
<td></td>
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<tr>
<td>435035</td>
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</table>

**DATE OF SURVEY COMPLETED**

03/01/2018

<table>
<thead>
<tr>
<th>(X3) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 919</td>
<td>Continued From page 62</td>
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</table>

*His call light had been clipped to the cord and was hanging against the wall behind the bed's headboard.*

*That call light was not within his reach.*

*He had worn a pendant around his neck as observed on the other residents in the dining room.*

*He stated:*

*"I've lost two already from being cut."*

*"I would rather use this than the regular call light."*

*"We can use both, but I prefer to use this one, & I wear it all the time."*

Interview on 2/27/18 at 1:13 p.m. with CNAs D and E regarding the call light system revealed:

*They confirmed most of the residents preferred to use the pendants on their necks versus (vs) the regular call light.*

*The staff wore pagers at all times to alert them of call lights that were on.*

*Those pagers would have revealed the resident's room number when they had put on their call light.*

*The digital board was another system in place for the staff to use to when checking the residents' call lights.*

*During the day shift:*

*Only the CNAs wore a pager.*

*The charge nurse would not have worn a pager to alert her when a resident put on their call light.*

*During the night shift there was only one CNA and the charge nurse.*

*Both the CNA and charge nurse wore the pagers during that shift.*

*They were not sure why the day shift charge nurse would not have worn a pager.*

*The CNAs pushed resident 321's pendant to demonstrate how they worked in conjunction with...*
F 919 Continued From page 83

the pagers and the digital board.
- The pagers made a vibrating noise, and the resident's room number appeared on it.
- The digital board made a beeping noise and revealed the resident's room that needed assistance.
*They had:
- Demonstrated how to clear the resident's pendant.
- To manually clear their pagers after they cleared the resident's pendant.

Interview on 2/27/18 at 1:20 p.m. with licensed practical nurse (LPN) C regarding the call light system revealed:
*She confirmed the interviews with CNAs D and E.
*She did not know why the day shift charge nurses were not required to wear a pager.
*She stated:
- "It's always been that way."
- "We don't even have another one down here. All we have are two pagers."
*She confirmed the digital monitor:
- Could not have been heard when she was down the hall or in another resident's room.
- Would have only made one sound for each call light.
*Unless she had heard the digital monitor or randomly checked if she had no way of knowing when a resident had their call light on and for how long.
*She agreed that was not a safe process for the residents.

Observation on 2/27/18 at 1:30 p.m. with CNA D and resident 320 revealed:
*The CNA had the resident put his call light in his room.
**F 919** Continued From page 84

- The CNAs pager vibrated and his number appeared on her pager.
- When he had put his call light on the digital monitor made a loud beeping noise, and his room number was shown on the monitor.
- His room number had continued to show on the digital monitor until she cleared his call light.
- The resident's room number continued to show on her pager until she manually cleared it.

Interview on 3/1/18 at 9:13 a.m. with registered nurse (RN) F revealed she:
- *Had not been wearing a pager.*
- *Confirmed the above interview with LPN C.*

Interview on 3/1/18 at 10:50 a.m. with the administrator and the DON regarding the call light system in the TCU revealed:
- *The administrator had not been aware:*
  - The charge nurse was not wearing a pager during the day shift.
  - There were only two pagers for the staff to use in the TCU.
  - That had always been their process.
- *The DON:*
  - Had been aware there were only two pagers for the staff to use in the TCU.
  - Stated:
    - "I never wear one myself when I work down there during the day."
    - "I check with the staff and the digital monitor to see if they need help."
    - "I have never had any problems."
  - Agreed she could not guarantee all the day shift charge nurses would have checked with the staff or digital monitor to ensure there were no call lights that needed answering.
  - They would not comment on whether the day shift charge nurse should wear a pager to ensure:
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

433035

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING __________________________

B. WING __________________________

**(X3) DATE SURVEY COMPLETED**

C. 03/01/2018

**NAME OF PROVIDER OR SUPPLIER**

BELLE FOURCHE HEALTHCARE COMMUNITY

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2208 13TH AVE

BELLE FOURCHE, SD 57717

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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</table>
| F 919  | Continued From page 85 -The safety and well being for the residents. -The personal and care needs for the residents had been met in a timely manner. *The DON stated "I don't like that call system. Its not very effective. The pager doesn't clear the room number off of it when you answer the call lights. You have to manually remove the number."

Surveyor: 37545  
2. Random observations on 2/27/18 from 1:00 p.m. through 4:00 p.m. on the 200 wing revealed:

*There were no lights above the resident's doors to notify the staff when a resident had pushed their call light.

*There was a digital board located at the end of the hallway above the exit door.

*The digital board:

-Had large red digital numbers that would run across the board to indicate which resident's room had their call light on.

-The room numbers on the board would keep running until the staff answered the resident's call light.

Interview on 2/27/18 at 1:00 p.m. with registered nurse (RN) I regarding resident 43's use of her call light revealed:

*She had a diagnoses of multiple sclerosis (MS).

*She needed assistance of two staff with a Hoyer lift for transfers.

*She used a bed pan for her bladder and bowel needs.

-She was watched closely when on the bed pan.

-She had the potential for skin break down.

*She had no use of her extremities.

*She was able to move her head up and down.

*She used a soft touch pendant for her call light.

*She would depress the call light with her chin. | F 919 |
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<th>(X5) ID</th>
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<th>(X6) COMPLETION DATE</th>
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<td>435635</td>
<td>Continued From page 86</td>
<td>F 818</td>
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- Staff would attach the call light to the bed sheet or her clothing.
- That would prevent the call light from falling or slipping.
- When her call light was pushed it would be:
  - Displayed on the digital board located at the end of the hallway.
  - The room numbers on the board would keep running until the staff answered the resident's call light.
  - Displayed on the computer screen at the nurses station located at the beginning of the hallway.

Interview and observation on 2/27/18 at 1:50 p.m. with certified nursing assistant (CNA) R regarding the call lights on the 200 wing revealed:
- That two CNAs were assigned to the 200 wing.
- When a resident had their call light on the room number would be displayed on the:
  - Digital board located at the end of the wing above the exit sign.
  - The room numbers on the board would keep running until the staff answered the resident's call light.
  - Computer screen at the nurses station located at the beginning of the wing.
- There had been no alarm or beeping system to alert them of a call light being on.
- She stated “Since we do not have an alarm system we look at the digital board and computer screen frequently.”

Interview on 2/27/18 at 2:05 p.m. with CNA S regarding call lights on the 200 wing revealed:
- She was covering on the 200 wing for the CNA’s break.
- She was one of the CNAs assigned to the 400 wing.
- When a resident put their call light on:
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLIANCE DATE</th>
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|    | 919    |     | **F 919** Continued From page 87  
*It showed up on the screen at the end of the hallway.  
*Staff had walkie-talkies to use if they needed assistance from other staff.  
*Interview and observation on 02/27/18 at 4:00 p.m. with resident 43 regarding the call lights revealed:  
*She had a diagnosis of multiple sclerosis (MS).  
*She needed total assistance of two staff with a Hoyer lift for transfers.  
*She used a bed pan for her bladder and bowel needs.  
*She was checked on frequently when put on the bed pan.  
*She did not have use of her extremities.  
*She was able to move her head up and down.  
*She used a soft touch pendant for her call light.  
*She would depress the call light with her chin.  
*Staff would attach the call light to the bed sheet or her clothing.  
*That would prevent the call light from failing or slipping.  
*Interview on 02/28/18 at 2:30 p.m. with CNA T regarding the call lights on the 200 wing revealed:  
*The digital board at the end of the hallway lit up when a call light was pressed.  
*It would display the resident's room number.  
*The resident's room number would be displayed on the computer screen at the nurses station.  
*To her knowledge that was the only way to know if the resident had put on their call light.  
*There was no alarm system alerting them of a call light being on.  
*Staff had walkie-talkies to use if they needed assistance from other staff.  
*Interview on 02/28/18 at 2:40 p.m. with CNA R |    | 919    |     |                                                                                                                                |     |         |     |                                                                                                                                |                 |
Continued From page 88 regarding the 200 wing call lights revealed:

* The digital board at the end of the hallway light up when:
  - A resident pushed their call light and stays lite up until the resident's call light was turned on or turned off.
* The resident's room number would be displayed across the computer screen at the nurses station.
* She stated she checked the computer screen at the nurses station frequently.
* To her knowledge that was the only way to know if the resident's puts on their call lights.
* If she needed help then she had a walkie-talkie to radio for assistance.
  - She stated one CNA stayed on the hallway at all times.
* To her knowledge that was the only call system available at the facility.

Surveyor: 32335
3. Observation and Interview on 2/27/18 at 11:20 a.m. with resident 41 revealed:
* She had been sitting in her recliner in her room with the TV on.
* Her left leg was stuck in-between the recliner seat and the foot rest.
* The gap between the two areas had been approximately four inches.
* She could not put her call light on when asked to, and she just looked at it.
* The surveyor put her call light on.
* The resident grimaced when she attempted to move her leg.
* No one had come to her room.
- An unidentified activities staff member was doing an activity in the common area and was asked if there were staff around who could assist the resident.
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<th>ID</th>
<th>PREVIOUS STATEMENT OF DEFICIENCIES</th>
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<td>F 919</td>
<td>Continued From page 89</td>
<td>F 919</td>
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</table>
Statement of Deficiencies and Plan of Correction

(X1) Provider/Supplier/LICA Identification Number:
435036

(X2) Multiple Construction
A. Building
B. Wang

(X3) Date Survey Completed
03/01/2018

Name of provider or supplier:
BELLE FOURCHE HEALTHCARE COMMUNITY

Street Address, City, State, Zip Code:
2203 13TH AVE
BELLE FOURCHE, SD 57717

ID: Prefix Tag
F 919

Summary Statement of Deficiencies:
Each deficiency must be preceded by full regulatory or LSC identifying information

F 919
Continued From page 90

Resident council meeting on 2/27/18 at 2:25 p.m. with a group of residents and two family members revealed:
*They had concerns with the call light wait times.
*Staff would come in the room, turn off the call light, and say they would come back later.
*They would not always come back.
*The wait times got better for a little while but had gotten bad again.

Interview on 2/28/18 at 6:31 a.m. with CNA N revealed:
*She had been employed for one year and had a pager on her person.
*She was asked to demonstrate how she knows what room was needing assistance.
*She stated "Bear with me as this is new to me."
*She had only had the pager a few days.
*They had not had enough pagers for everyone, and they would run out.
*The other CNA on the 300 hall was currently on break.
*There were only two CNAs on that hall.
*When the other CNA went on break they would have to call over the walkie-talkies to get another CNA from a different hall to help them.

Interview on 2/28/18 at 2:25 p.m. with the DON revealed:
*It was not a requirement to carry pagers.
*The pagers were old and did not work the best.
*The room number would not clear off the pager unless it was manually reset on each individual pager.
*The CNAs would not know if the resident had already been helped so they would have to take the time to go to the room and check.
*"Pagers are not the problem" regarding the call
**F 919**: Continued From page 91

*light wait times.*

*She did not like the pagers.*

*They had not looked at pagers or staffing as being a problem with the call light wait times.*

Interview on 2/28/18 at 3:10 p.m. with the human resources director regarding the call light system revealed:

*She was responsible for running the call light log reports.*

*The residents could use to use a pendant call light.*

*If the resident was in the living room or open court area and pushed the pendant the staff would probably check the resident's room first.*

*There was no way to know where the resident was if they pushed the pendant.*

Interview on 3/01/18 at 3:13 p.m. with the DON revealed:

*She was not sure if they had the correct pagers that went along with the call light system.*

*She had asked a CNA to bring over their pager to look at.*

*That pager the CNA was carrying was an Apollo AL-624L with a digital paging company label.*

*She again stated she did not like the pagers.*

Review of the Aerial Wireless Communication Systems Installation Manual revealed:

**"The Aerial system uses wireless transmitting devices to notify staff members of an incident within the facility."**

**"If the paging system is being used, staff members carrying the pagers are automatically notified of the call, without having to return to the Aerial CMS."**

*The pager model number was 52105.*

*The paging option allows staff members to be
**Continued From page 92**

"Notified of a potential emergency anywhere within the coverage area."

"The pager informs staff of calls for help and when those calls have been cleared."

Review of the provider's June 2015 Answering the Call Light policy revealed:

*Staff were to answer the resident's call light as soon as possible.
*It had not addressed the use of the call light system and pagers.
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td>Surveyor: 20031</td>
<td>A recertification survey for compliance with all applicable Federal, State, and local Emergency Preparedness requirements was conducted on 2/27/18. Belle Fourche Healthcare Community was found in compliance with 42 CFR Part 483.73 requirements for emergency preparedness.</td>
<td>E 000</td>
<td>Submission of this Response and Plan of correction is not a legal admission 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 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.</td>
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<tr>
<td>K 000</td>
<td>INITIAL COMMENTS</td>
<td>Surveyor: 20031</td>
<td>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/27/18. Belle Fourche Healthcare Community was found not in compliance with 42 CFR 483.70 (e) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for Existing Health Care Occupancies upon correction of the deficiencies identified below.</td>
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<tr>
<td>K 324</td>
<td>Cooking Facilities</td>
<td>SS=D CFR(e): NFPA 101</td>
<td>Cooking Facilities</td>
<td>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * * residential cooking equipment (i.e., small</td>
<td>1. The required semi-annual commercial kitchen hood was inspected on 3/7/2018, by Armstrong Extinguisher Services. All Residents are at risk</td>
<td>3/26/2018</td>
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</table>
### K 324

Continued From page 1

- Appliances such as microwaves, hot plates, toasters are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2
- Cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or
- Cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.

Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.

18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2

This REQUIREMENT is not met as evidenced by:

Surveyor: 20031

Based on document review and interview, the provider failed to ensure required semi-annual maintenance, inspection, and testing were provided for one of one commercial kitchen hood. Findings include:

1. Document review at 10:30 a.m. on 2/27/18 revealed missing required semi-annual commercial kitchen hood inspection documentation for the second half of 2017. The latest inspection documentation provided was dated 4/25/17. An inspection should have been conducted in October 2017, but no documentation could be provided indicating that inspection had been conducted.

2. This required semi-annual maintenance, inspection, and testing of commercial kitchen hood has been added to the facility preventative maintenance program to be done every 6 months. Administrator will educate the Maintenance Director on the requirement to ensure cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations no later than 3/26/2018. Administrator will educate Maintenance Director to follow the preventative maintenance program and notify the Administrator if there is an issue with timely completion of this requirement no later than 3/26/2018.

3. Results of the semi-annual maintenance, inspection and testing of the commercial kitchen hood will be reviewed at the next month QAPI meeting following the inspection.
**BELLE FOURCHE HEALTHCARE COMMUNITY**

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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>COMPLETION DATE</th>
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</table>
| K 324 | C  | Continued From page 2  
Interview with the environmental services director 
at the time of the above document review 
revealed he was unaware that inspection had not 
been conducted. He believed all required 
inspection had been conducted.  
The deficiency affected one of one required test 
on the commercial hood system. 
No policy was given by the end of survey to 
indicate how many or how often the commerical 
hood inspections must be completed. | K 324 | C  | 1. The required sprinkler system five year 
internal inspection is scheduled to be 
done on 3/29/2018 by Rapid Fire 
Protection Inc. The required sprinkler 
system annual back-flow inspection is 
scheduled to be completed on 3/29/2018 
by Rapid Fire Protection Inc. All 
residents are at risk. 
2. The five year inspection has been 
added to the preventative maintenance 
schedule to be done at least every five 
years. The annual back-flow inspection 
has been added to the preventative 
maintenance program to be done yearly. 
Administrator will educate the 
Maintenance Director on the requirement 
to ensure that the facility continuously 
maintain automatic sprinklers in reliable 
operating condition to include 5 year 
internal automatic sprinkler inspection 
and annual back flow inspection no later 
than 3/26/2018. | 3/26/2018 |
| K 352 | E  | Sprinkler System - Supervisory Signals  
Sprinkler System - Supervisory Signals  
Automatic sprinkler system supervisory 
attachments are installed and monitored for 
integrity in accordance with NFPA 72, National 
Fire Alarm and Signaling Code, and provide a 
signal that sounds and is displayed at a 
continuously attended location or approved 
remote facility when sprinkler operation is 
impaired. 
9.7.2.1, NFPA 72 
This REQUIREMENT is not met as evidenced 
by: 
Surveyor: 20031 
Based on record review and interview, the 
provider failed to continuously maintain automatic 
sprinklers in reliable operating condition (five year 
internal and back-flow inspections were not 
completed in 2017). Findings include: 
1. Record review on 2/27/18 at 10:30 a.m. 
revealed the required five year internal and the 
annual back-flow inspections had not been 
performed in the past year. The five year Internal | K 352 | E  | 1. The required sprinkler system five year 
internal inspection is scheduled to be 
done on 3/29/2018 by Rapid Fire 
Protection Inc. The required sprinkler 
system annual back-flow inspection is 
scheduled to be completed on 3/29/2018 
by Rapid Fire Protection Inc. All 
residents are at risk. 
2. The five year inspection has been 
added to the preventative maintenance 
schedule to be done at least every five 
years. The annual back-flow inspection 
has been added to the preventative 
maintenance program to be done yearly. 
Administrator will educate the 
Maintenance Director on the requirement 
to ensure that the facility continuously 
maintain automatic sprinklers in reliable 
operating condition to include 5 year 
internal automatic sprinkler inspection 
and annual back flow inspection no later 
than 3/26/2018. | 3/26/2018 |
**K 352** Continued From page 3

Inspection had last been completed on 1/27/12. There were no reports when a back-flow inspection had been completed.

Interview with the environmental services director at the time of the record review confirmed those findings.

Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire.

The deficiency affected one of numerous required tests on the automatic sprinkler system.

No policy was given by the end of the survey to indicate how many or how often automatic sprinkler inspections must be completed.

**K 352** Administrator will educate Maintenance Director to follow the preventative maintenance program and notify the Administrator if there is an issue with timely completion of this requirement. This education will be provided no later than 3/26/2018.

3. Results of the five year internal and the annual back-flow inspections will be reviewed at the next month QAPI meeting following the inspection.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETE DATE</th>
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</thead>
<tbody>
<tr>
<td>S 000</td>
<td>Compliance/Noncompliance Statement</td>
<td>S 000</td>
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</table>

Surveyor: 36413
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/27/18 through 3/1/18. Belle Fourche Healthcare Community was found in compliance.

Surveyor: 36413
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 2/27/18 through 3/1/18. Belle Fourche Healthcare Community was found in compliance.