**Statement of Deficiencies and Plan of Correction**

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

**Street Address, City, State, Zip Code:** 2200 13th Ave, Belle Fourche, SD 57717

<table>
<thead>
<tr>
<th>(X4) ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full, regulatory or local identifying information)</th>
<th>(X4) ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>(X5) Completion Date</th>
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<tbody>
<tr>
<td>F 000</td>
<td><strong>INITIAL COMMENTS</strong></td>
<td>F 000</td>
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</tbody>
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Surveyor: 16385  
A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/20/18 through 8/21/18. Areas surveyed included resident assessment and resident abuse. Belle Fourche Healthcare Community was found in compliance.

**Laboratory Director's or Provider/Supplier Representative's Signature:**

**Title:** Administrator

**Date:** 8/23/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
August 22, 2018
Sent to facility via email.

CMS Certification No. 435035

Tracy Harwood, Administrator
Belle Fourche Healthcare Community
2200 13th Ave
Belle Fourche, SD 57717

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Dear Ms. Harwood:

On August 21, 2018, a Complaint Health Survey was conducted at Belle Fourche Healthcare Community by the South Dakota Department of Health, Office of Health Care Facilities Licensure & Certification, to determine if your facility was in compliance with Federal participation requirements for nursing facilities participating in Medicare/Medicaid. This survey found the facility in compliance with federal participation requirements with NO deficiencies cited. Please sign and date the CMS-2567 Form and return it to the following email address: DOHOLCPoC@state.sd.us, no later than September 1, 2018.

The Office of Health Care Facilities Licensure and Certification will recommend continued certification of your facility for Medicare/Medicaid.

If you have any questions, please contact Diana Weiland, Office of Health Care Facilities Licensure & Certification, 605-995-8057.

Sincerely,

Chris Qualm, Administrator
OFFICE OF HEALTH CARE FACILITIES LICENSURE & CERTIFICATION
CQ:jjj

Enclosures: CMS 2567

cc: Greg Evans and Darin Ries, Provider Reimbursement and Audits, Office of State Medicaid Agency (via email)
    Beth Dokken and Donna Fischer, DSS, Office of Adult Services and Aging (via email)
    Yvette Thomas, Division Director, DHS, Long Term Care Services and Supports (via email)