

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 68823	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/10/2026
NAME OF PROVIDER OR SUPPLIER HIGHMORE HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 410 8TH ST SE HIGHMORE, SD 57345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 9/8/26 through 9/10/26. Highmore Health was found not in compliance with the following requirements: S632 and S685.	S 000		
S 632	44:70:07:04 Storage And Labeling of Medications The medications or drugs of each resident for whom a medication is facility-administered must be stored in the container in which it was originally received and may not be transferred to another container. Single dose medication received by a resident from a physician, physician assistant, or nurse practitioner must be identified as single dose. Each prescription medication container, including manufacturer's complimentary samples, must be labeled with the resident's name; the name of the resident's physician, physician assistant, or nurse practitioner; medication name and strength; directions for use; and prescription date. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure there were pharmacy labels on a bottle of Dorzol/Timol solution (an eye drop to lower pressure in the eye), a Lantus insulin (a long acting insulin used to lower blood sugar levels in the blood) pen, and a Novolog (short-acting insulin) insulin pen to indicate whose medications they were, directions for use, and the prescriber's	S 632	1. The improperly labeled medications identified from Resident 1 were destroyed and immediately replaced with properly pharmacy-labeled medications. The resident's current medications were reviewed to ensure appropriate labeling. 2. The facility's Medication Labels and Medications Brought to Facility by Resident/Responsible Party policies were reviewed and revised. Medications brought into the facility will not be accepted or administered unless appropriately labeled and meeting facility requirements. Staff was educated on medication labeling requirements and the process for addressing improperly labeled medications on 9/28/26. 3. The Director of Nursing or designee will audit 3–5 residents weekly until all residents have been reviewed, including medications currently in use and medication labels, to ensure compliance with labeling requirements. Any concerns identified will be corrected promptly and reported through QAPI until all residents have been reviewed for 4 months. 4. Completion Date: 10/02/2026.	10/02/2026

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

Kin Knox

TITLE

Administrator

(X6) DATE

10/8/2026

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S 632	Continued From page 1 name, for one of one sampled resident (1). Findings include: 1.Observation on 9/9/26 at 8:20 a.m. of certified nursing assistant (CNA)/certified medication aide (CMA) D administering medications to resident 1 revealed that CNA/CMA D prepared resident 1's medications at the medication cart outside resident 1's room. CNA/CMA D removed a bottle of Dorzol/Timol eye drops from the top drawer of the medication cart. The bottle of Dorzol/Timol was labeled with resident 1's initials and had 9/4/26 written on it. CNA/CMA D took a medication cup of pills, an inhaler, and the Dorzol/Timol eye drops into resident 1's room and placed them on her bedside table. CNA/CMA D gave resident 1 the medication cup of pills, and she swallowed them with water. After resident 1 self-administered her inhaler and her eye drops, CNA/CMA D took the eye drops and the inhaler out of resident 1's room and placed them back in the medication cart. 2. Interview on 9/9/26 at 8:25 a.m. with CNA/CMA D revealed she acknowledged that the bottle of Dorzol/Timol did not have a label on it that indicated whose eye drops they were, but stated there were no other residents with those initials in the facility, so the eye drops had to belong to resident 1. She acknowledged that if there was another resident with those initials, she would not have known whose eye drops those were without a pharmacy label. She also acknowledged she could not compare the directions for use for the Dorzol/Timol eye drops to the resident's medication administration record (MAR) to be sure the medication was being administered according to physician's orders. CNA/CMA D stated she would put a sticker on the bottle of	S 632	Type text here	

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S 632	Continued From page 2 Dorzol/Timol eye drops to indicate that they were resident 1's eye drops. 3. Observation and interview on 9/9/26 at 8:38 a.m. with contracted travel licensed practical nurse (LPN) C administering resident 1's insulin revealed that he removed a plastic bag with resident 1's first name on it from the top drawer of the medication cart. From the plastic bag, he removed a Lantus insulin pen and a Novolog insulin pen. He primed both pens with a two-unit dose of each insulin and then dialed the Lantus pen to 6 units and the Novolog pen to 4 units. He stated that resident 1 received 6 units of Lantus insulin every morning, and she would get 4 units of Novolog insulin with her breakfast because her blood sugar was 167 milligrams (mg) per deciliter (dl). There was no pharmacy label on the Lantus insulin pen or the Novolog insulin pen. Contracted travel LPN C was entering resident 1's room when the surveyor stopped the insulin administration process and asked contracted travel LPN C how he knew those insulin pens belonged to resident 1 with no pharmacy label on them to indicate whose insulin pens they were. Contracted travel LPN C looked at the pens and acknowledged there were no labels on the Lantus or Novolog insulin pens to verify they were resident 1's pens. He stated he should not administer insulin to resident 1 with those pens because he could not verify those were resident 1's insulin pens. Contracted travel LPN C discarded the unlabeled Lantus and Novolog pens and entered the medication room, and removed a Lantus insulin pen that was labeled with a pharmacy label. He removed a Novolog insulin pen from a box in the refrigerator that was labeled with a pharmacy	S 632		

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S 632	Continued From page 3 label. When he removed the Novolog pen, he indicated there was no label on the pen, but he verified that they were resident 1's Novolog pens because of the pharmacy label on the box in the refrigerator. He stated he would place a sticker on the Novolog pen that indicated it was resident 1's Novolog insulin pen and the date he opened the insulin pen. Contracted travel LPN C primed both the Novolog insulin pen and the Lantus insulin pen with two units of insulin, and then dialed up the Lantus to 6 units and the Novolog to 4 units. He entered resident 1's room, administered the Lantus and Novolog insulin into resident 1's right upper arm, and exited her room. When he returned to the medication cart, he labeled the Novolog insulin pen with a sticker that had resident 1's name and date of birth on it. Contracted travel LPN C stated the pharmacy usually labeled the residents' medications. Resident 1 admitted to the facility from her home and brought her medications with her, so not all the medications were labeled with a pharmacy label. He would call the pharmacy to get labels for resident 1's Novolog insulin and her Dorzol/Timol eye drops. He acknowledged that if resident 1 had brought the Lantus insulin, Novolog insulin, or Dorzol/Timol eye drops from home, there would not have been a label on those medications to indicate whose medications they were or how they were to be administered. Those medications were documented by the staff as having been administered since she admitted to the facility. 4. Review of resident 1's electronic medical record (EMR) revealed resident 1 admitted to the facility on 8/21/26. She had an 8/21/26 physician's order for Dorzol/Timol solution, one drop to be administered in both eyes two times a	S 632		

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S 632	Continued From page 4 day, a 8/25/26 physician's order for Lantus insulin 6 units to be administered subcutaneously (in the fatty tissue) every morning, and an 8/21/26 physician's order for Novolog insulin to be administered subcutaneously according to sliding scale parameters. 5. Interview and EMR review on 9/10/26 at 9:43 a.m. with director of nursing (DON) B revealed that she expected all resident medications to be labeled with a pharmacy label. She stated resident 1 admitted to the facility from her home and brought her medications with her. She acknowledged that the staff were to check the medications before they were administered to the residents, which could not be completed if the medication was not labeled. She acknowledged the insulin could have potentially been given to the wrong resident if the insulin pen was not labeled with the resident's name. She acknowledged the Dorzol/Timol eye drops could have potentially been given to the wrong resident if there was another resident with the same initials as resident 1. DON B was not aware there was specific information that was to be included on the medication labels. She was aware that the labeling of medications was to be completed by a pharmacist. 6. Review of the provider's November 2011 Provider Pharmacy Requirements policy revealed, "The provider pharmacy agrees to perform the following pharmaceutical services, including but not limited to: ...Labeling all medications dispensed in accordance with the medication labeling policy (See IC10: MEDICATION LABELS) and with state and	S 632		

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S 632	Continued From page 5 federal requirements." 7. Review of the provider's November 2011 Medication Labels policy revealed, "Medications are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy/registered pharmacist can modify, change, or attach prescription labels." "Each prescription medication label includes: Resident's name, Specific directions for use, including route of administration ... Medication name ...Strength of medication ...Prescriber's name, Date dispensed, Quantity of medication, 'Beyond use' (or expiration) date of medication, Name, address, and telephone number of the of the dispensing pharmacy, DEA number of the dispensing pharmacy, if required, and Prescription number."	S 632		
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely	S 685		

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S 685	Continued From page 6 perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure residents had a physician's order and were assessed by the staff to safely self-administer their medications regarding one of one sampled resident (1) who self-administered her eye drops and did not have a physician's order or a medication self-administration assessment completed. Findings include: 1. Observation on 9/9/26 at 8:20 a.m. of certified nursing assistant (CNA)/certified medication aide (CMA) D administering medications to resident 1 revealed that CNA/CMA D prepared resident 1's medications at the medication cart outside resident 1's room. She brought a medicine cup of	S 685	1. Resident 1's ability to self-administer her eye drops was assessed. A provider order allowing self-administration of the eye drops was obtained. All residents were reviewed regarding self-administration; no other residents initially were found to desire to self-administer medications. 2. The Self-Administration of Medications policy was reviewed and revised. All staff were educated on 9/28/26 by Administrator and DON to notify the DON or designee if a resident expresses a desire to self-administer any medication so that an appropriate assessment and provider order can be obtained prior to self-administration. 3. The Director of Nursing or designee will audit 3–5 residents weekly until all residents have been reviewed to identify any residents self-administering medications and verify that the appropriate assessment, provider order, and documentation are in place. Any concerns identified will be corrected promptly and reported through QAPI until all residents have been reviewed for 4 months. 4. Completion date: 10/2/26	10/02/2026

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S 685	Continued From page 7 pills, an inhaler, and a bottle of eye drops into resident 1's room and placed them on the bedside table. CNA/CMA D handed resident 1 the medication cup with the pills in it. Resident 1 put the medications in her mouth and swallowed them with a drink of water. CNA/CMA D was preparing resident 1's inhaler for administration when resident 1 stated that CNA/CMA D should let residents administer their own inhaler. CNA/CMA D handed the inhaler to resident 1 who then opened the inhaler, administered one inhalation to herself, and closed the inhaler. She then handed the inhaler back to CNA/CMA D. CNA/CMA D told resident 1 that CNA/CMA D needed to put on gloves to give resident 1 her eye drops. As CNA/CMA D was getting the gloves out of resident 1's bathroom, resident 1 asked if she could give herself the eye drops. CNA/CMA D hesitated and then asked if resident 1 was able to put the eye drops in her eyes. Resident 1 stated she was able to. CNA/CMA D handed the bottle of eye drops to resident 1. Resident 1 placed one drop of the eye drops in each of her eyes and handed the bottle to CNA/CMA D. CNA/CMA D washed her hands, and left the room with resident 1's inhaler and eye drops, then placed them into the medication cart outside resident 1's room. 2. Interview on 9/9/26 at 8:25 a.m. with CNA/CMA D revealed that she was not sure whether resident 1 was assessed to safely administer her inhaler or her eye drops. 3. Review of resident 1's electronic medical record (EMR) revealed resident 1 admitted to the facility on 8/21/26. She had an 8/21/26 physician's order for Trelegy Ellipta (an inhaler used to treat chronic obstructive pulmonary	S 685		

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S 685	Continued From page 8 disease (COPD; a group of lung diseases that block airflow and can make it difficult to breathe) one puff to be administered by mouth once daily. She had an 8/27/26 physician's order to self-administer her nebulizer (a device that converts liquid medication into an inhalable mist) treatments after it was set up by a staff member. She had an 8/21/26 physician's order for Dorzol/Timol solution (an eye drop to lower pressure in the eye) one drop to be administered in both eyes two times a day. She did not have a physician's order to self-administer her eye drops. Resident 1 had an 8/27/26 self-administration of nebulizer assessment that indicated she could safely self-administer her nebulizer treatment. There was no assessment completed that indicated resident 1 was able to safely self-administer her eye drops. 4. Interview and EMR review on 9/10/26 at 8:33 a.m. with contracted travel licensed practical nurse (LPN) C revealed that resident 1 had a self-administration assessment that indicated she was able to safely self-administer her nebulizer. She did not have a self-administration assessment completed to self-administer her eye drops. Contracted travel LPN C verified that the assessment to safely self-administer a nebulizer treatment did not cover other forms of medication administration such as eye drops. 5. Interview and EMR review on 9/10/26 at 9:43 am. with director of nursing (DON) B revealed that the provider's policy indicated that the self-administration of the inhaler was covered under the self-administration of nebulizer assessment. She verified resident 1 did not have an assessment completed to determine if she could safely self-administer her eye drops and there was no physician's order for resident 1 to	S 685		

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S 685	Continued From page 9 self-administer her eye drops. 6. Review of the provider's November 2011 Self-Administration of Medications policy revealed, "In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer." "For each medication authorized for self-administration, the label contains a notation that it may be self-administered." "An order to self-administer nebulizer treatments may also extend to other respiratory treatments such as inhalers and nasal sprays."	S 685		