STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435092	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHMORE HEALTH	**410 8TH STREET SE , HIGHMORE, South Dakota, 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) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/8/26 through 9/10/26. Highmore Health was found not in compliance with the following requirements: F605, F628, and F658.	F0000	Type text here	
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . .	F0605	1. Medication Management Policy reviewed regarding psychotropic medication use, including identification of indications/target symptoms, non-pharmacological interventions, care planning, monitoring, and GDR requirements. Resident 12's clinical record, assessments, and care plan were reviewed and updated to reflect current diagnoses, behaviors/symptoms, interventions, and continued need for quetiapine. The prescribing practitioner evaluated Resident 12 on 9/16/26 and documented the continued clinical need for the medication and rationale regarding GDR. All residents receiving psychotropic medications or with behaviors are at risk. 2. All staff educated by Administrator and DON on psychotropic medication management, including appropriate interventions, care plan implementation, reporting of behaviors/ symptoms, documentation, and monitoring of medication effectiveness and adverse consequences on 9/28/26. New staff will receive education during orientation. 3. Social Services Director or designee will audit 3-5 residents receiving psychotropic medications weekly until all residents have been reviewed to ensure appropriate indications, interventions, care planning, monitoring/ documentation, and GDR requirements are addressed. Then any new admissions will be audited for one more month after that. Any identified concerns will be corrected as appropriate and education provided as indicated. Results will be reported to the QAPI for review for 4 months. 4. Completion date: 10/2/2026.	10/02/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kin Knox	Administrator	10/08/2026

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F0605 SS = D	Continued from page 1 . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F0605		

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F0605 SS = D	Continued from page 2 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the facility failed to protect the residents' rights to be free of unnecessary medications, for one of one sampled resident (12) who was administered quetiapine, an antipsychotic medication (a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) and did not have documentation in the resident's electronic medical record (EMR) to support the identified target behavior for the resident's use of that medication, non-pharmacological (any medical treatment or health care approach that does not use drugs or medication) interventions for the staff to implement to manage that behavior or alternative treatment options were identified and offered for the use of the quetiapine. Findings include: 1. Review of resident 12's electronic medical record (EMR) revealed she admitted to the facility on 4/1/26. She discharged from the facility on 6/29/26 and admitted to the facility again on 8/24/26. Her	F0605		

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F0605 SS = D	Continued from page 3 8/30/26 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated her cognition was moderately impaired. Her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) with behavioral disturbances, major depressive disorder (a mood disorder that causes low mood and loss of interest in normal activities), adjustment disorder (an emotional or behavioral reaction to a stressful life change or event that causes more distress and disruption than normally expected), and anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). She had an 8/27/26 physician's order for quetiapine 25 milligrams (mg) to be administered once daily for dementia with other behavioral disturbances. Her 4/6/26 and 8/27/26 consent for the administration of the quetiapine did not indicate if alternative treatment options were identified and offered to the resident or the resident's representative before the quetiapine was administered to the resident. Her 9/9/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated she was on quetiapine for dementia. It did not indicate what behavior the quetiapine was prescribed to treat, or non-pharmacological interventions that the staff could attempt to manage her behaviors. Her certified nursing assistant (CNA) behavior documentation from 8/27/26 through 9/10/26 did not indicate if she exhibited any behaviors. There was no documentation in her progress notes of behaviors or attempted non-pharmacological interventions for the staff to implement to manage those behaviors since she readmitted to the facility on 8/24/26. 2. Interview on 9/10/26 at 8:17 a.m. with CNA L revealed that resident 12 was emotional, depressed, and wandered. When resident 12 exhibited those symptoms CNA L would visit with her and try to distract her from her feelings. The CNAs documented resident 12's behaviors under "tasks", within her EMR and they would notify the nurse of the behavior. CNA L referred to the resident's care plan to identify a behavior that a resident may exhibit and the non-pharmacological interventions for the staff to implement to manage that behavior. 3. Interview and EMR review on 9/10/26 at 8:25 a.m.	F0605		

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F0605 SS = D	Continued from page 4 with contracted travel licensed practical nurse (LPN) H revealed that resident 12 became verbally and physically aggressive with the staff and had periods of feeling anxious. Contracted travel LPN H stated he would try to redirect the resident to an activity, talk with her, or encourage her to watch television but he felt those non-pharmacological interventions were only effective about 50 percent of the time. He expected the residents' behaviors to be identified in the resident's care plan as well as the non-pharmacological interventions for their behaviors. Contracted travel LPN verified resident 12's behaviors were not identified in her care plan and there were no non-pharmacological interventions for the staff to try to manage her behaviors in her care plan. 4. Interview and EMR review on 9/10/26 at 9:34 a.m. with director of nursing (DON) B revealed resident 12 was aggressive with the staff at times. She verified resident 12 had ongoing anxiousness, and aggression towards the staff. DON B expected resident 12's behaviors and the non-pharmacological interventions that were attempted by the staff to be documented in her EMR. DON B verified that resident 12's EMR had no behaviors documented by the CNAs and no progress notes of her behaviors and non-pharmacological interventions attempted by the staff. DON B acknowledged that if resident 12's behaviors were not documented, it was difficult to determine if the quetiapine was effective or if a gradual dose reduction (GDR(systematic dose reduction over time to determine if the condition could be managed with a lower dose or discontinuation of the medication)), of that medication should be attempted. DON B expected resident behaviors and the non-pharmacological interventions for those behaviors to be identified in the resident's care plan. Social Service Designee (SSD) C was responsible for documenting the resident's behaviors and non-pharmacological interventions for those behaviors in the resident's care plan. DON B acknowledged there was no documentation in resident 12's EMR to support what target behavior she received the quetiapine for. 5. Interview on 9/10/26 at 10:37 a.m. with SSD C revealed she was responsible for updating the residents' care plans related to the residents' psychotropic (drugs that affect brain activities associated with mental processes and behavior)	F0605		

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F0605 SS = D	Continued from page 5 medication use. She was not aware that a target behavior needed to be identified for the use of those medications and that the non-pharmacological interventions that the staff may attempt to manage those behaviors, needed to be identified. She did not know that the staff expected to find a resident's behaviors and non-pharmacological interventions for those behaviors in the resident's care plan. 6. Review of the provider's November 2011 Medication Management policy revealed, "When selecting medications and non-pharmacological interventions, members of the interdisciplinary team participate in the care process to identify, assess, address, advocate for, monitor, and communicate the resident's needs and changes in condition." "When possible, non-pharmacological interventions are considered before initiating a new medication." "When a resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing symptoms, the resident is evaluated for the appropriateness of a taper or gradual dose reduction (GDR) of the medication."	F0605	Type text here	
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate.	F0628	1. The facility reviewed and revised its discharge, transfer, and death notification process to ensure that required notifications are completed timely and accurately. All new discharges, transfers, and deaths have since been submitted since survey starting 9/10/26. 2. Upon a resident discharge, transfer, or death, the Social Services Director or designee will ensure that the required information is submitted through the South Dakota Department of Human Services Long Term Care Ombudsman reporting process at least monthly starting 9/10/26. All staff were educated by Administrator and SSD on the reporting requirements and the facility's procedure on 9/28/26. Nursing staff were instructed to complete the Resident Transfer Form for each encounter as a reminder for SSD. 3. Social Services Director or designee will be responsible for auditing weekly for 4 weeks and then monthly for 3 more months that each applicable report has been submitted and that confirmation of submission is maintained in the facility's reporting records. Results will be reported to QAPI for review. 4. Completion Date: 10/2/26.	10/02/2026

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F0628 SS = D	Continued from page 6 (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F0628		

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F0628 SS = D	Continued from page 7 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure	F0628		

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F0628 SS = D	Continued from page 8 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to	F0628		

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F0628 SS = D	Continued from page 9 include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider failed to ensure notification was provided to the Office of State Long-Term Care Ombudsman (a designated state entity mandated by the federal Older Americans Act to advocate for the rights, health, safety, and welfare of residents living in long-term care facilities) when a resident transferred to the hospital and discharged from the facility for one of one sampled resident (38) who transferred to the hospital and then discharged to her home. Findings include: 1. Review of resident 38's electronic medical record (EMR) revealed that she admitted to the facility on 2/17/26. On 3/13/26, she had a follow-up appointment with her surgeon. During that appointment, the surgeon decided to transfer her to a hospital. Resident 38 did not return to the facility after that hospitalization and discharged to her home. There was no documentation that the Office of State Long-Term Care Ombudsman was notified of resident 38's transfer to the hospital or her discharge to home. 2. Interview on 9/9/26 at 4:05 p.m. with social services designee (SSD) C revealed she was responsible for notifying the Office of State Long-Term Care Ombudsman of resident discharges, hospitalizations, or transfers. She would verbally inform the Ombudsman about the resident discharges, transfers, and hospitalizations every couple of months when the Ombudsman visited the facility. SSD C did not document which resident discharges, transfers, or hospitalizations she told the Ombudsman about. SSD C was not aware that the Office of State Long-Term Care Ombudsman had an online portal for her to submit the resident discharges, transfers, or hospitalizations. 3. The provider did not have a policy related to the notification of the Office of State Long-Term Care	F0628		

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F0628 SS = D	Continued from page 10 Ombudsman of resident discharges, transfers, or hospitalizations.	F0628	Type text here	
F0658 SS = D	Services Provided Meet Professional Standards 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- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure staff members followed nursing professional standards for obtaining a physician's order for the use of Circaid compression wraps (a brand of low-stretch fabric wraps that provide increased pressure to muscles during movement and can be adjusted to decrease pressure as swelling fluctuates) and ensuring that the staff applied them according to the manufacturer's instructions for one of one sampled resident (19) with edema (swelling) who used Circaid compression wraps to his foot and lower leg. Findings include: 1. Observation on 9/8/26 at 11:40 a.m. of resident 19 in his room revealed he was sitting in his recliner with his feet elevated. He had a shoe on his right foot and a gripper sock on his left foot. He was wearing black compression socks on both lower legs. He was Circaid compression wraps on his left lower leg and foot. 2. Interview on 9/9/26 at 12:53 p.m. with resident 19 revealed he wore compression socks on both legs and a "wrap" (Circaid compression wrap) on his left foot and lower leg because he had a lot of swelling in his feet and legs. The physician did not want him to be on anymore "water pills [medications that help the body shed excess fluids]." Resident 19 stated the certified nursing assistants (CNAs) put the compression socks and Circaid wraps on his foot and lower leg every morning and took them off every night. He thought he had worn the Circaid compression wraps for about one week. 3. Interview on 9/9/26 at 1:00 p.m. with CNA M	F0658	1. Resident 19's physician order for compression wraps was obtained and clarified for application to both lower extremities. Resident 19's care plan was reviewed and updated. Therapy reviewed all other residents for use of specialized compression wraps or treatments and no additional residents were identified. 2. Compression Wrap policy reviewed and revised regarding specialized compression wraps, including orders, staff competency, and application/documentation requirements. Therapy will provide appropriate training and competency validation for specialized compression wraps and similar therapy skills and will notify nursing when a physician's order is needed. All staff were educated on the procedure by Administrator and DON on 9/28/26. Necessary staff that were not present at meeting on 9/28/26 will go to the therapy department for education/training/ competency evaluation prior to performing the skill with a resident. 3. Director of Nursing or designee will audit residents using specialized compression wraps three times per week for 4 weeks, weekly for 4 weeks, and monthly for 3 additional months to ensure appropriate orders, care plan interventions, training/competency, and application/documentation. Results will be reported to QAPI for review. 4. Completion Date: 10/2/26.	10/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435092	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHMORE HEALTH	**410 8TH STREET SE , HIGHMORE, South Dakota, 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) COMPLETION DATE
F0658 SS = D	Continued from page 11 revealed that the CNAs put resident 19's compression socks and Circaid compression wraps on his lower extremities (legs) every morning and took them off at bedtime. She thought resident 19 had the Circaid compression wraps in use for about six months. She received training on how to put the Circaid compression wraps on by the physical therapist. The foot Circaid was put on first and then the lower leg Circaid was put on. She would pull on the Circaid straps, so they were secure on resident 19's leg but were not "too tight." She was not aware that there was a measuring device that was to be used to determine the amount of pressure the Circaid compression wraps applied to the area they covered. 4. Review of resident 19's electronic medical record (EMR) revealed he admitted to the facility on 3/19/24. He was discharged from the facility on 6/29/26 and readmitted to the facility on 8/17/26. He had an 8/27/26 Brief Interview for Mental Status (BIMS) assessment score of 14, which indicated his cognition was intact. His diagnoses included edema and heart failure. There was no physician's order for the use of the Circaid compression wraps or what the Circaid compression wraps pressure measurement should have been. His 9/9/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) did not indicate he wore Circaid compression wraps or compression socks. The CNA task documentation indicated they were to, "Apply black compression socks. Then wraps to cover bilaterally [both legs]. On in [the] AM [morning] and off in HS [bedtime]. 5. Interview on 9/9/26 at 1:21 p.m. with physical therapist (PT) E revealed she did not train the nursing staff about the use of resident 19's Circaid compression wraps but there was documentation that they had received training in August 2026. She did not know if the training included how to use the Circaid measuring device to determine the pressure the Circaid compression wraps were applying to resident 19's lower leg and foot. She stated there were times the Circaid compression wraps were just applied securely but not so tight they caused discomfort for the resident. The Circaid measuring device was not used. She stated resident 19 had a Circaid compression wrap on his foot and his lower leg. She did not know when his Circaid compression wraps were first prescribed or how long he had had them. The PT would recommend the use of the Circaid	F0658		

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F0658 SS = D	Continued from page 12 compression wraps for a resident and then the nursing staff would obtain a physician's order for them. The PT would measure the girth of the resident's legs to determine the size of Circaid compression wrap that resident required. 6. Review of the physical therapy documentation revealed that on 8/18/26 physical therapy aide (PTA) R obtained proper fitting compression socks for both of resident 19's lower legs. She applied edema wraps to resident 19's left lower extremity from his toes to his knee. She applied a Circaid compression wrap to resident 19's right lower leg. PTA R indicated in her note that the nursing staff was given instructions for wrapping resident 19's left lower leg with edema wraps and that resident 19 was to wear the edema wrap overnight and the edema wrap was to be removed by the staff in the morning to let his leg "breathe" and then the staff were to again wrap his legs and feet. On 8/20/26 PT S documented that she educated the staff on putting on "lymphedema [swelling caused by fluid in body tissue] wraps" to resident 19's left lower leg and foot. On 8/25/26 PTA R measured resident 19's left lower leg to monitor his edema. After she discussed her findings with the nursing staff she switched to the use of the "daily compression wraps" on resident 19's left foot and lower leg and "monitor if this works as well as [the] wraps." The physical therapy documentation was not clear which types of wraps that the PT staff were referring to in each their documented notes. 7. Interview on 9/10/26 at 8:20 a.m. with CNA L revealed that the physical therapy staff verbally communicated with the nursing staff which of resident 19's legs they were supposed to put the Circaid compression wraps on. She put the Circaid compression wraps on the foot and leg that were the most swollen. 8. Interview on 9/10/26 at 9:39 a.m. with contracted travel licensed practical nurse (LPN) H revealed that he received training from the physical therapy department about resident 19's Circaid compression wraps. He did not know how long resident 19 wore the Circaid compression wraps, but knew he wore them in June and every day since he readmitted to the facility on 8/17/26. When he put the Circaid	F0658		

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F0658 SS = D	Continued from page 13 compression wraps on resident 19's leg and foot, he pulled the Circaid's straps, so they were stretched about 50 percent, and then wrapped them around resident 19's leg and foot. He would make sure the wraps were not so tight that they caused resident 19 discomfort. He expected there was a physician's order for the use of the Circaid compression wraps, but did not think resident 19 had a physician's order for them. 9. Interview and EMR review on 9/10/26 at 9:39 a.m. with director of nursing (DON) B revealed that she did not know how the staff knew which leg and foot resident 19's Circaid compression wraps were to be put on other than the physical therapy staff's verbal communication with the nursing staff. She was not aware there was a Circaid measurement device to determine the amount of pressure the Circaid compression wraps put on the resident's leg and foot. She thought resident 19 started wearing the Circaid compression wraps about one week after he readmitted to the facility on 8/17/26. In the past, the staff did not obtain a physician's order for the use of Circaid compression wraps they just followed the physical therapist's recommendations for use. DON B reviewed the CNAs "tasks" documentation in resident 19's EMR and stated the CNAs documented that resident 19's compression socks and ace wraps were put on both of his legs. She stated that was his order before the Circaid compression wraps were used, and the CNAs task documentation was not updated to reflect his current treatment. She verified resident 19 did not have a physician's order for the Circaid compression wraps. She acknowledged that inconsistent or incorrect application of Circaid compression wraps had the potential to cause the Circaid compression wraps to be ineffective for reducing edema, or they could injure a resident if they were applied too tightly. 10. Review of the provider's undated Circaid manufacturer's instructions manual revealed, "Apply circaid compressive undersock. Position component & [and] loosely fasten [the] bottom two bands. Apply bands. Adjust compression level. Repeat for all bands. Each band should be independently measured for correct compression level."	F0658		

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	435092	A. BUILDING **01 - MAIN BUILD...** B. WING	**09/08/2026**

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HIGHMORE HEALTH	**410 8TH STREET SE , HIGHMORE, South Dakota, 57345**

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 9/8/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Highmore Health was found in compliance.	K0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Knox	Administrator	09/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435092	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/08/2026

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 9/8/26. Highmore Health was found in compliance.	E0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Knox	Administrator	09/30/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10628	A. BUILDING: _____ B. WING _____	09/10/2026

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HIGHMORE HEALTH	410 8TH ST SE HIGHMORE, SD 57345

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted on 9/8/26 through 9/10/26. Highmore Health was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim Knox — TITLE: Administrator — (X6) DATE: 09/30/2026