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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435092 | A. BUILDING _____ B. WING _____ | 12/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HIGHMORE HEALTH | 410 8TH STREET SE HIGHMORE, SD 57345 |

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| F 000 | INITIAL COMMENTS<br><br>Surveyor: 41895<br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 12/19/21 through 12/21/21. Highmore Health was found not in compliance with the following requirements: F582, F686, F700, F812, and F880. | F 000 | | |
| F 582 SS=E | Medicaid/Medicare Coverage/Liability Notice<br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the | F 582 | 1.) Director of Nursing, MDS Coordinator, and/or designee will develop a policy and procedure for Medicaid/Medicare Coverage/Liability Notices.<br>2.) On 12/22/2021 education was provided to the staff responsible for the Skilled Nursing Facility Advance Beneficiary Notices by the administrator. The MDS Coordinator or designee will ensure that the date and time of phone calls are documented on the SNF ABN and in resident's chart if not availble to sign within timeframe required. All other SNF ABNs will be signed 3 days prior to end of Medicare stay.<br>3.) The MDS Coordinator or designee will audit all Notices of Medicare Non-Coverage once a month for three months to ensure all dates and times are correct going forward.<br>4.) The MDS Coordinator or designee will report results of audits at the monthly QAPI meetings fo review. | 1/19/2022 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Kim Knox | Administrator | 1/13/2022 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 582 | Continued From page 1<br>Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 43844<br><br>Surveyor: 41895<br>Based on record review and interview, the provider failed to ensure the appropriate Medicare notice was provided for:<br>*Two of two sampled residents (10 and 28) who had remained in the facility following their discharge from skilled services.<br>*One of one sampled resident (201) who had discharged to home following their discharge from skilled services.<br>Findings include: | F 582 | | |

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| F 582 | Continued From page 2<br><br>1. Review of resident 10's medical record revealed:<br>*Her last day of Medicare Part A services was 10/28/21.<br>*The Medicare Part A services being provided had concluded and there should have been notice prior to the conclusion of the service.<br>*The Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) was signed on 11/24/21.<br>-This notification was not provided timely.<br>-This standardized notice allows Medicare beneficiaries to make informed decisions about whether to receive certain Medicare services and accept financial responsibility for those services if Medicare does not pay.<br><br>2. Review of resident 28's medical record revealed:<br>*His last day of Medicare Part A services was 10/20/21.<br>*The Medicare Part A services being provided had concluded and there should have been notice prior to the conclusion of the service.<br>*The Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) was signed on 11/20/21.<br>-This notification was not provided timely.<br>-This standardized notice allows Medicare beneficiaries to make informed decisions about whether to receive certain Medicare services and accept financial responsibility for those services if Medicare does not pay.<br><br>3. Review of resident 201 medical record revealed:<br>*Her last day of Medicare Part A services was 7/9/21.<br>*She had covered days remaining and discharged to a lower level of care/home. | F 582 | | |

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| F 582 | Continued From page 3<br>*The Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) was signed on 7/9/21.<br>-This notification was provided on the day she discharged home.<br>-This notification was not provided timely, and should have been provided before the day of discharge.<br>-This standardized notice allows Medicare beneficiaries to make informed decisions about whether to receive certain Medicare services and accept financial responsibility for those services if Medicare does not pay.<br><br>4. Interview on 12/21/21 at 11:31 a.m. with minimum data set (MDS) coordinator C regarding beneficiary notifications revealed she had:<br>*Not been aware the NOMNC and SNFABN needed to be signed prior to discharge from Medicare A services.<br>*Called the residents power of attorney (POA) about one week to three days before discharge from Medicare A services.<br>-She had not documented those conversations.<br>*Mailed the NOMNC and SNFABN forms to the POA to be signed and returned to the facility.<br>*A log of who she notified about the discharge from Medicare A services.<br>-The log had not included a date or time of notification.<br><br>Interview on 12/21/21 at 3:05 p.m. with administrator A regarding beneficiary notification revealed:<br>*There was no policy for NOMNC and SNFABN notices.<br>*The MDS coordinator was responsible for the beneficiary notifications.<br>*Her expectation was for the notices to be provided two days prior to discharging from | F 582 | | |

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| F 582 | Continued From page 4<br>Medicare A:<br>*When a resident had a representative, documentation of date and notification to their representative should have been completed.<br><br>5. On 12/21/21 at 1:33 p.m. a policy for NOMNC and SNFABN notification was requested from administrator A, the provider did not have a policy. | F 582 | | |
| F 686 SS=G | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(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 demonstrates that they were unavoidable; and<br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 41895<br>Based on observation, interview, record review, and policy review, the provider failed to ensure one of one resident (25) with a facility acquired pressure ulcer had received necessary care and interventions to prevent her wound from developing and worsening. Findings include:<br><br>1. Review of resident 25's medical record revealed: | F 686 | 1.) Reviewed and updated with current pressure injury intervention(s) resident 25's care plan. All residents are at risk of developing a pressure injury and will be monitored by MDS Coordinator or designee as necessary and at least quarterly during assessment. Residents with diabetes, previous pressure injuries, or poor nutrition are at greater risk of developing a pressure injury.<br>2.) All staff will be educated on the prevention of skin breakdown and pressure injuries and appropriate interventions on January 17, 2022. Residents that utilize a wheelchair all have pressure redistribution cushions in them. All residents have a pressure redistribution mattress on their beds. Residents that cannot reposition themselves will be on a turning and repositioning schedule for every 2-3 hours and as needed. Residents that cannot take themselves to the bathroom or that are often incontinent will be on a toileting schedule for every 2-3 hours and as needed. All residents will have daily skin checks done routinely by CNAs and at least weekly by licensed nursing staff. Nutrition and weight loss will be monitored by Registered Dietician for all residents.<br>3.) Staff will be educated on 1/17/2022 at all staff meeting regarding communication including shift to shift reporting. Root cause analysis conducted to answer the 5 Whys: It was found that staff do not always remember to remove footwear while residents are resting in bed or recliners during the day. Staff does not always remember to relay new skin care treatments to oncoming staff. Staff do not receive formal training on pressure injury prevention upon hiring. Staff will remove consenting residents' shoes while they are in bed or recliners to relieve pressure risk to feet. On 1/17/2022 at all staff meeting staff will be trained to edit care plans immediately with changes in skin interventions to facilitate communication on interventions. Training about prevention of skin breakdown and pressure injuries will be added to the new hire training checklist. DON or designee will ensure ALL facility staff responsible for the assigned task has received education upon hiring and yearly at scheduled skin care in-services. | 1/17/2022 |

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| F 686 | Continued From page 5<br>*She had been admitted on 12/7/19.<br>*Her diagnoses included: heart disease, chronic kidney disease, dementia, stage three pressure ulcer to right heel, personality disorder, and delusional disorder.<br>*Her 11/9/21 Braden scale for predicting pressure sore risk was 19 indicating she was low risk for developing a pressure ulcer.<br>*She had skin assessments completed on 11/8/21, 11/15/21, 11/22/21, 11/29/21, 12/6/21, 12/13/21, and 12/20/21.<br>*On 11/28/21 a calloused area had been noted to be pulling away from the skin bed on her right heel.<br>*On 11/30/21 the nurse practitioner had seen her and assessed the right heel.<br>*On 12/2/21 an order had been received to apply bacitracin to the callous area on her right heel. The area was to be left open to air during the day and covered with an adhesive foam pad at bedtime.<br>*On 12/3/21 a nurse note revealed the right heel was a stage II pressure ulcer.<br>-The heel was dressed as ordered with the adhesive foam pad and elevated on a pillow.<br>-She did not have complaints of pain.<br>*On 12/5/21 she was noted to have pain in the right heel.<br>*On 12/14/21:<br>-She had an appointment with a podiatrist:<br>--The wound to her right heel was a stage III pressure ulcer.<br>--The wound treatment order had been changed.<br>--A Multi Podus [is made of firm plastic and thick foam or sheepskin and intended to protect the heel from pressure and friction] boot was ordered.<br>-Her son had been notified of the stage III pressure ulcer and updated on the treatment | F 686 | 4.) Director of Nursing or designee will audit care plans and skin assessments of at least 3 residents weekly until all residents have been reviewed. The DON or designee will audit 3 residents weekly while they are in their recliner or bed between meals to make sure pressure has been reduced to heels by removing shoes or other appropriate interventions. The audits will ensure that no residents have been missed for this issue. Director of Nursing or designee will report results of audits at monthly QAPI meetings for review. | |

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| F 686 | Continued From page 6 | F 686 | | |

plan.
-She had been noted to have complaints of pain in the right heel.
-Was the first time a weekly wound user-defined assessment had been completed to document the size and appearance of the wound.

Observation on 12/19/21 at 3:55 p.m. of resident 25 on her back in bed revealed she had a pair of shoes on, her right heel was flat on the bed, and her left foot was hanging off the left side of the bed.

Observation on 12/19/21 at 4:30 p.m. of resident 25 sitting up in her wheelchair revealed she was wearing a pair of shoes.

Observation on 12/20/21 at 9:02 a.m. of resident 25 sitting in her wheelchair at a table in the dining room revealed she was wearing gripper socks.

Observation on 12/20/21 at 9:31 a.m. of resident 25 sitting in her wheelchair in her room revealed she was wearing gripper socks and there had been a pair of foam heel protectors on the foot of her bed.

Observation on 12/20/21 at 10:28 a.m. of resident 25 sitting in her recliner with the footrest in the up position revealed:
*She was wearing gripper socks.
*Her heels had been resting on the footrest.
*A pair of foam protectors had been on the foot of the bed.

Observation on 12/20/21 at 12:31 p.m. of resident 25 sitting in her wheelchair at a table in the dining room revealed she had been wearing gripper socks.

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| F 686 | Continued From page 7<br><br>Observation on 12/20/21 at 1:53 p.m. of resident 25's pressure ulcer during wound care treatment by registered nurse (RN) G revealed:<br>*The pressure ulcer was to the back of the right heel.<br>-The center of the wound bed was black and the size of a nickel.<br>-The edges of the wound were moist and white.<br><br>Interview on 12/20/21 at 2:00 p.m. with RN G regarding resident 25 revealed:<br>*The wound on the right heel appeared as a callous.<br>*When resident returned from her appointment with the podiatrist the podiatrist had diagnosed it as a stage III pressure ulcer.<br>*She had agreed that because the wound bed was black it should have been an unstageable pressure ulcer.<br><br>Observation on 12/20/21 at 2:30 p.m. of resident 25 revealed she had been assisted with a bath and was sitting in her wheelchair with a pair of shoes on.<br><br>Interview on 12/20/21 at 3:30 p.m. with certified nursing assistant (CNA) J regarding resident 25 revealed:<br>*She had given her a bath and the dressing on her right heel had fallen off.<br>*She had told the nurse and the nurse was going to redress the wound.<br>*She did not know if the resident should have been wearing her shoes or not.<br><br>Observation on 12/20/21 at 4:45 p.m. of resident 25 revealed:<br>*Her right shoe had been removed and she was | F 686 | | |

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| F 686 | Continued From page 8<br>wearing a Multi Podus boot.<br>-A Multi Podus boot is used to eliminate pressure or friction on the heel and increase blood flow to the area.<br>*She was still wearing her left shoe.<br><br>Interview on 12/20/21 at 4:50 p.m. with RN G revealed the Multi Podus boot had just been delivered and initiated.<br><br>Observation on 12/21/21 at 8:15 a.m. of resident 25 sitting at a table in the dining room revealed she was wearing a gripper sock on her left foot and a Multi Podus boot on her right foot.<br><br>Observation on 12/21/21 at 10:03 a.m. of resident 25 revealed she had been:<br>*On her back in her bed.<br>*Wearing the Multi Podus boot on her right foot.<br>*Wearing a gripper sock on her left foot.<br>-The left heel was flat on the bed and not elevated to relieve pressure to the heel.<br><br>Observation on 12/21/21 at 1:09 p.m. of resident 25 revealed she:<br>*Had been on her back in her bed.<br>*Had been wearing the Multi Podus boot on her right foot.<br>*Had been wearing a gripper sock on her left foot.<br>-The left heel was flat on the bed and not elevated to relieve pressure to the heel.<br>*Had a small blanket folded up, a comforter, and the sheets between her heels and the bed.<br><br>Review of the progress notes from resident 25's 12/14/21 podiatry appointment revealed:<br>*She had a stage II pressure ulcer.<br>*It was "imperative they offload the heel."<br>*A Multi Podus boot was recommended. | F 686 | | |

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| F 686 | Continued From page 9 | F 686 | | |

Review of resident 25's doctor order sheet revealed on 12/14/21 a verbal order had been received to:
*Order a Multi Podus boot for right heel and to use the foam heel protectors until it had arrived.
*Apply iodine gauze to pressure ulcer, cover with dry gauze, and tape in place daily.
*Have a follow-up appointment in one month.

Review of resident 25's turning and repositioning documentation revealed:
*It had been added to the CNA's task list on 12/20/21.
*She had been turned and repositioned on:
-12/20/21 at 1:33 p.m. and 9:54 p.m.
-12/21/21 at 4:50 a.m. and 1:50 p.m.
*Staff had not documented turning and repositioning prior to 12/20/21.

Review of resident 25's 11/10/21 care plan revealed:
*She had a focus area related to risk for pressure ulcer development due to impaired mobility and incontinence.
*She had a goal revised on 12/14/21 for the "pressure ulcer to show signs of healing and remain free from infection..."
*Interventions included:
-To provide treatments as ordered.
-A pressure redistributing mattress had been initiated on 5/28/21.
-Licensed staff to perform weekly skin assessments.
-Assist rails allowed her to turn side to side independently.
*It had not included the foam heel protectors, Multi Podus boot, turning and repositioning, or off-loading of her heels.

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| F 686 | Continued From page 10<br>*It had not included the location of the pressure ulcer.<br><br>Review of resident 25's Weekly Wound Documentation User Defined Assessments revealed:<br>*The first one had been completed on 12/14/21 and it had indicated:<br>-The onset date of the wound was 11/30/21.<br>-The wound was a stage III pressure ulcer on the right heel and measured 2 centimeters (cm) x 1 cm.<br>--There had been no depth to the wound.<br>--The wound was not open.<br>--The wound had a scant amount of bleeding.<br>--The edges of the wound had been macerated.<br>-There was pain noted to the pressure ulcer that had been managed with scheduled doses of Tylenol.<br>-Heel protectors had been worn at night.<br>-A pressure-relieving mattress on the bed and pressure-relieving cushion in the wheelchair.<br>*On 12/21/21:<br>-The wound was an unstageable pressure ulcer to the right heel that measured 2 cm x 1.2 cm.<br>-There was no depth to the wound.<br>-The wound had a scant amount of bleeding.<br>-The wound was covered with 90 percent dead tissue and 10 percent new tissue.<br>-Pain was noted to the pressure ulcer and was managed with scheduled doses of Tylenol and a Duragesic patch.<br><br>Interview on 12/21/21 at 8:13 a.m. with CNA E about resident 25's pressure ulcer revealed:<br>*She was not to be wearing her shoes because it caused her to have pain.<br>*Staff should have been putting on the foam heel protectors and floating the right heel when she | F 686 | | |

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| F 686 | Continued From page 11<br>was in bed.<br>*The Multi Podus boot had just been put into place.<br><br>Interview on 12/21/21 at 11:03 a.m. with MDS coordinator C regarding resident 25's pressure ulcer revealed:<br>*She had agreed the location of the pressure ulcer should have been on the care plan.<br>*When asked what interventions had been put into place after the pressure ulcer was discovered she had indicated they had done daily dressing changes.<br>*All wounds were discussed at the interdisciplinary team (IDT) meeting on Mondays.<br>*When a new wound was found she would hear about it from the charge nurse.<br>*She had not read the resident's progress notes daily and did not know that it had been called a stage II pressure ulcer on 12/3/21.<br>*She agreed no other interventions were care planned after the discovery of the pressure ulcer.<br>*She stated a dressing had been ordered, the doctor was called, and the doctors order had been followed.<br>-She did not think there needed to be any further interventions.<br>*She agreed that shoes could have caused pressure on the heels.<br><br>Interview on 12/21/21 at 1:13 p.m. with director of nursing (DON) B regarding resident 25's pressure ulcer revealed:<br>*Resident 25 had been mobile and able to move herself so she did not know how the pressure ulcer had developed.<br>*Before the podiatrist appointment the right heel was not open, it had been covered with a white callous. | F 686 | | |

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| F 686 | Continued From page 12<br>*She had not been aware that a nurse had documented the wound on the right heel as a stage II pressure ulcer on 12/3/21.<br>*She had not seen the pressure ulcer since the podiatrist appointment, but had been told the podiatrist had debrided the wound.<br>*She had expected the staff to put on the foam heel protectors when she was in bed.<br>*The foam heel protectors had been put into place prior to the podiatrist appointment.<br>-This had not been documented, so she had not known when they were implemented.<br>*She agreed interventions after the pressure ulcer had developed had not been documented.<br>*The pressure ulcer had been discussed during interdisciplinary team (IDT) meetings on Mondays, with a discussion about using the stand lift as needed and doing the dressing changes.<br>-No other interventions had been discussed.<br>-IDT notes had been copied and given to all departments and CNAs.<br>*She agreed the turning and repositioning task had just been added to CNA's documentation on 12/20/21, so there had been no documentation of resident being turned or repositioned prior to that.<br>*She agreed the care plan should have included interventions such as the Multi Podus boot, foam heel protectors, not to put her shoes on, and to elevate her feet on a pillow when in bed.<br>*She agreed that having a folded-up blanket and a comforter under the resident's feet while in bed could have affected the pressure reducing function of the mattress.<br><br>Review of the provider's updated 7/24/20 Skin and Wound Management Policy and Procedure revealed:<br>*"Wounds are identified as avoidable or unavoidable | F 686 | | |

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| F 686 | Continued From page 13<br>-If unavoidable, documentation in the medical record includes assessments, interventions, re-assessments and additional interventions, as well as the identification of the resident's medical diagnosis and complication factors that lead to the conclusion that the wound is unavoidable."<br>*Care plans were to be individualized and updated on an ongoing basis.<br>*"In the event of eschar or necrotic tissue [dead tissue] the facility typically regards this wound as "unstageable." A fundamental requirement of staging is the ability to visualize the base of the wound, which is not possible when eschar or necrotic tissue is present." | F 686 | | |
| F 700 SS=E | Bedrails<br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing | F 700 | 1.) MDS Coordinator, DON, and/or designee will review and revise as necessary the bedrail and assist rail policy and procedure.<br>2.) All staff will be educated on the risk versus benefits of bedrails/assist rails on 1/17/2022. MDS Coordinator will ensure that all residents requiring a bedrail/assist rail will have a completed consent on file including educating them on the risks versus benefits.<br>3.) MDS Coordinator or designee will audit all residents requiring a bedrail/assist rail for consents including the education on the risks versus benefits monthly for three months.<br>4.) MDS Coordinator or designee will report results of audits at the monthly QAPI meetings. | 1/19/2022 |

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| F 700 | Continued From page 14<br>and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 41895<br><br>Based on observation, interview, record review, and policy review, the provider failed to ensure:<br>*Ten of ten sampled residents (5, 6, 7, 10, 15, 17, 20, 25, 81, and 131) in a census of thirty-seven had:<br>-Received risks versus benefits education for side rail use.<br>-Obtained signed informed consent forms for side rail use.<br>*Three of ten sampled residents (7, 15, and 131) had quarterly assistive device assessments completed.<br>Findings include:<br><br>1. Observation and interview on 12/20/21 at 12:17 p.m. with resident 5 revealed she:<br>*Had been sitting in her chair in her room.<br>*Had bilateral side rails on the upper part of her bed which were in the upright position.<br>*She stated she used the rails to move in bed and to get in and out of the bed.<br><br>Review of resident 5's medical record revealed:<br>*She had been admitted on 10/20/20.<br>*Her 10/12/21 brief interview for mental status (BIMS) score was a three, indicating severely impaired cognition.<br>*Her diagnoses included: traumatic brain injury, arthritis, chronic pain, and dementia.<br>*Assistive device assessments had been completed quarterly.<br>*The side rail had been used for positioning and comfort.<br>*No documentation that the resident or her | F 700 | | |

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| F 700 | Continued From page 15 | F 700 | | |

representative had been provided education on risks and or benefits of the side rail.
*No documentation of informed consent prior to installation of the side rail.

2. Observation on 12/20/21 at 10:30 a.m. of resident 6 in her bed revealed she had:
*Bilateral side rails on the upper part of her bed which were in the upright position.
*Used them to roll over in the bed while staff were performing cares.

Review of resident 6's medical record revealed:
*She had been admitted on 8/4/20.
*Her 10/16/21 BIMS score was 14, indicating her cognition was intact.
*Her diagnoses included: right sided weakness secondary to a stroke, morbid obesity, and diabetes.
*Assistive device assessments had been completed quarterly.
*The side rail had been used for positioning and comfort.
*No documentation that resident or her representative had been provided education on risks and or benefits of the side rail.
*No documentation of informed consent prior to installation of the side rail.

3. Observation on 12/19/21 3:55 p.m. and on 12/20/21 at 1:53 p.m. of resident 25 in her bed revealed she had a side rail on the upper part of her bed which was in the up position.

Review of resident 25's medical record revealed:
*She had been admitted on 12/7/12.
*She had short and long-term memory problems.
*Her diagnoses included: dementia, personality disorder, osteoarthritis, history of falls, anxiety,

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| F 700 | Continued From page 16 | F 700 | | |

pain in left knee, and stage three pressure ulcer to right heel.
*Assistive device assessments had been completed quarterly.
*The side rail had been used for positioning and comfort.
*No documentation that resident or her representative had been provided education on risks verses benefits of the side rail.
*No documentation of informed consent prior to installation of the side rail.

4. Observation and interview on 12/20/21 at 10:43 a.m. with resident 81 while she was sitting in a chair in her room revealed she:
*Had bilateral side rails on the upper part of her bed which were in the upright position which she used to maneuver in her bed.
*Stated the rails had been on the bed since she was admitted.
*She had not requested the side rails or received education on the risks verses benefits of the side rails.

Review of resident 81's medical record revealed:
*She had been admitted on 11/9/21.
*Her admission BIMS score was 13, indicating her cognition was intact.
*Her diagnosis included: abscess of bursa, diabetes, pain, neuropathy, and bladder-neck obstruction.
*Assistive device assessment had been completed on 12/14/21.
*The side rail was used for positioning and comfort.
*No documentation that resident or her representative had been provided education on risks and or benefits of the side rail.
*No documentation of informed consent prior to

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installation of the side rail.

Surveyor: 45683
5. Observation on 12/20/21 at 8:54 a.m. of resident 10 in her room revealed:
*She had been in bed sleeping.
*There had been two side rails near the head of the bed in the upright position.

Interview on 12/20/21 at 8:55 a.m. with resident 10 revealed she had:
*Used the side rails when she dressed.
*Not recalled getting an education on the risks and benefits of side rail use.

Review of resident 10's medical record revealed:
*She was admitted on 1/28/11.
*Her BIMS score was 15, indicating cognition was intact.
*Her diagnoses included: multiple sclerosis, bipolar disorder, unspecified and unspecified dementia without behavioral disturbance.
*Her care plan dated 9/22/21 stated she used assist rails to aid in turning and repositioning.
*There had been no documentation of:
-The resident or her representative having been provided education on risk of use or benefits of use for the side rail.
-Informed consent prior to installation of the side rail had been obtained.

Surveyor: 43844
6. Observation on 12/20/21 at 8:39 a.m. of resident 7 revealed:
*He had been sitting on the edge of his bed.
*There had been bilateral side rails attached to his bed, in the up position.

Interview on 12/21/21 at 10:09 a.m. with

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| F 700 | Continued From page 18<br>registered nurse (RN) D revealed resident 7 had used his side rails to reposition and to pull himself up to sit on the edge of the bed.<br><br>Review of resident 7's medical record revealed:<br>*He had been admitted on 5/2/18.<br>*He had short and long-term memory problems.<br>*His diagnoses included: dementia, muscle weakness, and pain.<br>*Assistive device assessments had been completed on 8/4/20, 2/2/21, 5/4/21, 7/19/21, and 10/19/21.<br>-No assistive device assessments had been completed from 8/4/20 to 2/2/21.<br>-Two additional quarterly assistive device assessments should have been completed during this time.<br>*The side rails were used for positioning and comfort.<br>*There had been no documentation of:<br>-The resident or his representative receiving education on the risk of use or benefits of use for the side rail.<br>-Informed consent before installation of the side rail had been obtained.<br><br>7. Observation on 12/20/21 at 2:55 p.m. revealed resident 15 had been sleeping in his bed, and there had been bilateral side rails attached to his bed, in the up position.<br><br>Interview on 12/21/21 at 10:07 a.m. with resident 15 revealed he used the side rails to reposition while in bed.<br><br>Review of resident 15's medical record revealed:<br>*He had been admitted on 3/27/12.<br>*He had short and long-term memory problems.<br>*His diagnoses included: Parkinson's, dementia, | F 700 | | |

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pain, restless leg syndrome, and insomnia.
*Assistive device assessments had been completed on completed on 6/30/20, 9/22/20, 6/22/21, 9/21/21, 12/14/21.
-No assistive device assessment had been completed from 9/22/20 to 6/22/21.
--Two additional quarterly assistive device assessments should have been completed during this time.
*The side rail had been used by him for positioning and comfort.
*There had been no documentation of:
-The resident or his representative receiving education on the risk of use or benefits of use for the side rail.
-Informed consent before installation of the side rail had been obtained.

8. Observation on 12/20/21 at 2:58 p.m. of resident 17 in her room revealed:
*She had been sitting in her recliner.
*Bilateral side rails had been installed on her bed and were in the up position.

Review of resident 17's medical record revealed:
*She had been admitted on 10/26/16.
*She had short and long-term memory problems.
*Her diagnoses included: dementia, weakness, falls.
*Assistive device assessments had been completed quarterly.
*The side rail had been used for positioning and comfort.
*There had been no documentation that:
-The resident or her representative receiving education on the risk of use or benefits of use for the side rail.
-Informed consent prior to installation of the side rail had been obtained.

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| F 700 | Continued From page 20<br><br>9. Observation on 12/19/21 at 4:01 p.m. of resident 20 revealed he had been sleeping in his bed, and there had been a side rail attached to the right side of his bed, in the up position.<br><br>Interview on 12/20/21 at 9:04 a.m. with resident 20 revealed he had used the side rail to get in and out of bed.<br><br>Review of resident 20's medical record revealed:<br>*He had been admitted on 11/11/21.<br>*He had short and long-term memory problems.<br>*His diagnoses included: Parkinson's, dementia, pain, restless leg syndrome, and insomnia.<br>*The side rail was used by him for positioning and comfort.<br>*There had been no documentation of:<br>-The resident or his representative receiving education on the risk of use or benefits of use for the side rail.<br>-Informed consent prior to installation of the side rail had been obtained.<br><br>10. Observation on 12/20/21 at 9:40 a.m. of resident 131 revealed there had been a side rail attached to the left side of her bed, in the up position.<br><br>Interview on 12/20/21 at 3:00 p.m. with resident 131 regarding the side rail revealed she used it to turnover in bed.<br><br>Review of resident 131's medical record revealed:<br>*She had been admitted on 2/11/20.<br>*Her diagnoses included: pain, osteoporosis, and dementia.<br>*Assistive device assessments had been | F 700 | | |

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| F 700 | Continued From page 21<br>completed on completed on 8/4/20, 7/6/21, and 10/20/21.<br>-No assistive device assessment had been completed from 8/4/20 to 7/6/21.<br>--Two additional quarterly assistive device assessments should have been completed during this time.<br>*The side rail had been used for positioning and comfort.<br>*There had been no documentation that:<br>-The resident or her representative receiving education on the risk of use or benefits of use for the side rail.<br>-Informed consent prior to installation of the side rail had been obtained.<br><br>11. Interview on 12/20/21 at 8:33 a.m. with director of nursing (DON) B regarding bed side rails revealed:<br>*The minimum data set coordinator (MDS) C was responsible to complete the assessments.<br>*All assistive device assessments were documented in the residents electronic medical record.<br><br>Surveyor: 41895<br>Interview on 12/20/21 at 2:38 p.m. minimum data set (MDS) coordinator C revealed<br>*Residents were not given risks versus benefits education on side rail use.<br>*Informed consents were not obtained prior to side rail use.<br>*She had not been aware it was required to provide education and obtain the consent prior to side rail use.<br><br>Interview on 12/20/21 at 2:51 p.m. with director of nursing (DON) B revealed:<br>*Informed consents were not signed prior to side | F 700 | | |

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| F 700 | Continued From page 22<br>rail use.<br>*Risk versus benefits education for side rail use may have been given verbally but it had not been documented.<br>*She had expected assistive device assessments to be completed quarterly by MDS coordinator C.<br>*She had not been aware education and consents were required for side rails.<br><br>Surveyor: 43844<br>Interview on 12/21/21 at 10:45 a.m. with MDS coordinator C regarding assistive device assessments revealed she:<br>*Had been responsible to complete the assessments on a quarterly basis or with a residents change of condition.<br>*Stated she should have double checked her work to ensure the assessments had been completed.<br><br>Surveyor: 41895<br>12. A side rail policy had been requested from administrator A on 12/20/21 at 5:40 p.m.<br>*DON B had indicated on 12/21/21 the policy for side rails was included in the providers Resident Accident Prevention Policy and Procedures policy.<br><br>Review of the provider's updated April 2020 Resident Accident Prevention Policy and Procedure's policy revealed:<br>* "7) All residents are assessed quarterly for their risk of accidents and fall, and receive individualized care planning related to their individual needs.<br>-a. Assistive Device Assessment is completed initially, quarterly, and with significant changes to determine resident safety in using devices such as assist bars, geri-chairs, and recliners." | F 700 | | |

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| | 435092 | A. BUILDING _____ B. WING _____ | 12/21/2021 |

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| HIGHMORE HEALTH | 410 8TH STREET SE HIGHMORE, SD 57345 |

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| F 700 | Continued From page 23<br>*It had not included education on risks versus benefits or signed informed consent for the use of side rails. | F 700 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 45683<br><br>Surveyor: 43844<br>Based on observation, interview, and policy review, the provider failed to maintain appropriate hand hygiene and glove use during one of one observed meal service by one of one employee (H). Findings include:<br><br>1. Observation on 12/19/21 at 5:20 p.m. of the evening meal service revealed cook H: | F 812 | 1.) The food safety requirements for food procurement, storage and sanitation was reviewed. The Certified Dietary Manager and Registered Dietician held an inservice on 12/28/2021regarding handwashing, glove use, dating and storing food.<br>2.) The CDM and RD held a mandatory inservice, which included employee H, to go over proper handwashing, glove use, and proper dating and storage of food on December 28, 2021. There were two videoes that were watched:-Proper Handwashing and Glove Use and -Food Safety is in Your Hands.<br>3.) All staff will be educated on proper handwashing and glove use at all staff meeting on 1/17/2022.<br>4.) The CDM or designee will audit glove use, handwashing, and dating and storing of food weekly for four weeks and then monthly for the next two months. CDM or designee will report results of audits at monthly QAPI meetings for review. | 1/19/2022 |

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| F 812 | Continued From page 24<br>*Had been wearing plastic gloves.<br>-While wearing those gloves she had:<br>--Taken the sandwich trays out of the refrigerator.<br>--Obtained a serving spoon out of a drawer.<br>--Obtained a thermometer out of another drawer to take the temperature of the soup.<br>--Picked up two potholders and used them to get a pan of carrots out of the oven, and placed the pan in the steam table.<br>--Lifted the edge of a slice of bread to obtain the temperature of the ground meat sandwich.<br>--Picked up a dietary tray card.<br>--Used utensils to plate the soup and carrots, and used her gloved hand to put the ready-to-eat sandwich and saltine crackers on a plate.<br>--Put a container of food in the microwave, and touched the control panel to start it.<br>--Picked up a sandwich, cut it into quarters, and placed it on a plate.<br>--Touched a pair of eyeglasses that had been on the counter.<br>--Picked up two visibly soiled potholders, and placed them on the counter.<br>--Adjusted her face mask.<br>--Picked up a plate.<br>--Touched dietary meal tray cards.<br>*Continued to serve the meal, touching each sandwich and crackers with her contaminated gloved hands before putting them on the plates.<br>-She missed 14 opportunities for hand hygiene.<br><br>Interview on 12/19/21 at 5:37 p.m. with cook H revealed she:<br>*Agreed she had touched soiled items and then ready to eat food with her gloved hands.<br>*Had thought because she had on gloves, she had not needed to perform hand hygiene when touching a soiled item and then touching ready to eat foods. | F 812 | | |

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| F 812 | Continued From page 25 | F 812 | | |

Interview on 12/21/21 at 10:28 a.m. with dietary manager I revealed:
*She had educated kitchen staff for glove use and hand hygiene when preparing raw meats, fruits and vegetables, and while preparing food.
*She acknowledged that cook H was not following their policy by not using tongs to pick up the sandwiches and saltine crackers.
*Cook H should have changed her gloves and washed her hands after touching contaminated surfaces.

Interview on 12/21/21 at 11:27 a.m. with administrator A regarding the use of gloves in the dietary department revealed she agreed cook H should have performed hand hygiene before touching ready-to-eat foods.

Review of the September 2014 provider's handwashing policy revealed:
*"Policy: Employees will wash hands frequently and always after using the restroom, touching hair, face, nose, and before touching food, clean utensils, pans, etc."
*"Procedure:"
-"6. Wash hands before beginning work; handling or serving food; and after using the restroom, coughing, sneezing, handling hair, face, raw poultry or meat, picking things up off the floor, handling or scraping soiled dishes, and handling money.
-7. Hand contact with food should be avoided as much as possible. Plastic gloves and appropriate utensils are available for use...."

Review of the undated provider's use of gloves and washing of hands policy revealed:
*"Policy: Dietary Employees will use gloves as

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| F 812 | Continued From page 26<br>needed and with all ready to eat foods. Correct hand washing techniques will be followed when gloves are used.<br>-Procedure: 1. Only single use gloves will be used."<br>--"4. Food handlers will change gloves when[.]<br>--a. Gloves become soiled or torn[.]<br>--b. Before beginning a different task[,]"<br>--"d. After handling raw meat, seafood, or poultry and before handling ready-to-eat foods." | F 812 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, | F 880 | 1.) For the identification of lack of:<br>*Appropriate hand hygiene and glove uses during personal cares and wound dressing change.<br>*Appropriate screening of surveyors following facility COVID-19 response plan.<br>The Administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for:<br>a.) Appropriate hand hygiene and glove use for personal cares and wound dressing change.<br>b.) Ensuring appropriate screening for COVID-19 of all who enter facility.<br>All facility staff who provide or are responsible for the above cares and services will be educated /re-educated on 1/17/2022 by Director of Nursing.<br>2.) ALL residents and staff have the potential to be affected if:<br>*appropriate hand hygiene and glove use are not adhered to.<br>*all who enter facility are not appropriately screened for COVID-19.<br>Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided on 1/17/2022 by Director of Nursing.<br>3.) Root cause analysis conducted answered the 5 Whys: During procedures there is a knowledge deficit on when to wash hands and change gloves. Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsilble for the assigned task(s) have received education/training with demonstrated competency and documentation. Administrator, DON, and Infection Preventionist contacted the South Dakota Quality Improvement Organization (QIN) on 12/21/2021. The SD QIO provided us with resources on hand hygiene and a performance tracker. The SD QIO also helped identify the root cause. | 1/19/2022 |

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| F 880 | Continued From page 27<br>but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | F 880 | 4.) Administrator, DON and/or designee will conduct auditing and monitoring to ensure appropriate hand hygiene and glove use for the assigned task(s) and screening for all who enter the facility are practiced by all staff monitoring for determined approaches to ensure effective implementation and ongoing sustainment.<br>*Staff compliance in the above identified areas. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months.<br>Monitoring results will be reported by administrator, DON, and/or designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee. | |

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| F 880 | Continued From page 28<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 41895<br>Based on observation, interview, and policy review, the provider failed to ensure appropriate infection control techniques and practices had been followed for:<br>*Hand hygiene and glove use by one of one certified nursing assistant (CNA) F during personal care for one of one resident (6).<br>*Hand hygiene and glove use by one of one registered nurse (RN) G during a dressing change for one of one resident (25).<br>*Screening of surveyors for signs and symptoms of COVID-19 upon entrance to the facility on 12/19/21.<br><br>1. Observation on 12/20/21 at 8:26 a.m. of CNA F while performing personal care for resident 6 revealed:<br>*CNA F was wearing a pair of gloves and performed perineal care for resident 6.<br>*CNA F had not removed those gloves or performed hand hygiene after performing the perineal care.<br>*With those now contaminated gloves CNA F:<br>-She assisted CNA K to put a mechanical lift sling under resident 6 and used the mechanical lift to transfer her to a bath chair.<br>-She had touched the mechanical lift and the handles of the bath chair.<br>*CNA F then removed her gloves and performed hand hygiene.<br>-She then had touched the contaminated lift and bath chair where she had with her contaminated gloves.<br>*Without performing hand hygiene CNA F assisted CNA K to take the resident to the whirlpool room. | F 880 | | |

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| F 880 | Continued From page 29<br><br>Interview on 12/20/21 at 8:50 a.m. with CNA F regarding the above observation confirmed:<br>*She should have removed her gloves and performed hand hygiene after she performed perineal care.<br>*Her gloves would have been contaminated and would have contaminated the other surfaces in the room she had touched.<br><br>Interview on 12/21/21 1:49 p.m. with director of nursing (DON) B regarding the above observation confirmed CNA F should have performed hand hygiene after performing perineal care and before moving on to a clean task.<br><br>2. Observation on 12/20/21 at 1:53 p.m. of RN G during a dressing change for resident 25 revealed:<br>*RN G was wearing a pair of gloves and removed a dressing from resident 25's right heel.<br>*With those same now contaminated gloves she:<br>-Reached into an open package of gauze pads, removed a few of them, wet them, and cleaned the wound on the heel.<br>-Removed more gauze pads from the package, applied betadine to them, and applied them to the wound.<br>-Removed more gauze pads from the package, applied them over the betadine-soaked gauze pads, and taped them in place.<br>*She removed her gloves, performed hand hygiene, put on another pair of gloves, applied another piece of tape to the dressing.<br>*She removed her gloves and performed hand hygiene.<br><br>Interview on 12/20/21 at 2:00 p.m. with RN G regarding the above observation confirmed she: | F 880 | | |

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| F 880 | Continued From page 30<br>*Should have removed gloves and performed hand hygiene after removing the dressing and after cleansing the wound.<br>*Could have contaminated the wound by continuing to wear the contaminated gloves.<br>*Agreed by reaching into the open package of gauze pads with her contaminated gloves could have contaminated the rest of the package.<br><br>Interview on 12/21/21 at 1:39 p.m. with DON B regarding the above observation confirmed RN G should have changed gloves and performed hand hygiene after removing the dressing from the wound, after cleaning the wound, and after applying the new dressing.<br><br>3. Review of the provider's updated 11/9/21 Hand Hygiene Policy and Procedure revealed:<br>*"General Instructions<br>-Perform hand hygiene before and after any resident care/contact."<br>-[Perform hand hygiene] before putting on and taking off gloves.<br>-"Wash hands after any personal hygiene cares.<br>-Wash hands with soap and water whenever visibly soiled."<br><br>4. Observation on 12/19/21 at 2:00 p.m. when the surveyors entered the facility:<br>*There had been a sign on the entry door that instructed visitors to:<br>-"Please register, take your temperature, and answer the 2 questions on the clipboard.<br>-Please wear your mask unless you are in the room with the resident.<br>-Sanitize your hands after filling out the Visitor Registration."<br>*There was not a clipboard or thermometer in the entryway. | F 880 | | |

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| F 880 | Continued From page 31<br>*The sign did not indicate where to find the clip board.<br>*Surveyors were directed to a family room by unlicensed assistive personnel (UAP) L.<br>*Staff had not screened surveyors for signs and symptoms of COVID-19 upon entrance.<br><br>Observation and interview on 12/19/21 at 2:50 p.m. with administrator A about the visitor screening process for COVID-19 revealed:<br>*The provider had changed their policy to have visitors screen themselves when they entered the building.<br>*There had been a sign on the entrance door (see above observation) and a sign on top of the nurses station instructing visitors to screen themselves.<br>-The sign on top of the nurses station directed visitors to "Please complete the "Visitor Registration" before entering - Thanks!"<br>*There was a clipboard with a paper log and thermometer on the nurses station for visitors.<br>*Agreed that staff should have ensured surveyors were screened when entering the building.<br>*Confirmed that a visitor who had not visited before may not know the provider's procedure to screen themselves for signs and symptoms of COVID-19.<br>*All staff should have known to screen the surveyors when they entered the building.<br>*She had the surveyors return to the nurses' station and screened them.<br><br>Observation on 12/20/21 at 8:00 a.m. upon entrance to the facility the clipboard with the screening log and thermometer had been moved into the entry way for visitors to screen themselves. | F 880 | | |

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| F 880 | Continued From page 32<br>Review of the provider's September 2021 COVID-19 Infection Prevention and Control Guidance Policy and Procedure revealed:<br>*"2. Universal Screening: ALL entrants to facility including staff will be screened upon entry (limit and monitor points of entry to facility) and only admitted entry if criteria are met including:<br>-a. Actively taking temperature."<br>-"b. Questionnaire about signs, symptoms, and potential exposure to COVID-19.<br>-c. Observation of any signs or symptoms.<br>-d. Must attest to any close contact with someone with COVID-19 in the prior 14 days (regardless of visitor's vaccination status).<br>-e. Ask visitors to inform facility if they develop fever or symptoms consistent within 14 days of visiting the facility.<br>-f. Must attest to their COVID-19 status (testing results). If they have had COVID-19 in the prior 10 days, they will not be allowed.<br>-g. Comply with testing based on facility's most current COVID-19 Testing Policy and Procedure if required and provided by the facility." | F 880 | | |

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

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| E 000 | Initial Comments<br><br>Surveyor: 41895<br>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 from 12/19/21 through 12/21/21. Highmore Health was found in compliance. | E 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kim Knox | Administrator | 1/13/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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|---|---|---|---|
| | 435092 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **12/21/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **HIGHMORE HEALTH** | **410 8TH STREET SE**<br>**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) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 12/21/21. Highmore Health was found in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kim Knox | Administrator | 1/13/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JAN 13 2021

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 _____ | 12/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HIGHMORE HEALTH | 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/Noncompliance Statement<br><br>Surveyor: 41895<br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/19/21 through 12/21/21. Highmore Health was found in compliance. | S 000 | | |
| S 000 | Compliance/Noncompliance Statement<br><br>Surveyor: 41895<br>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 12/19/21 through 12/21/21. Highmore Health was found in compliance. | S 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim Knox

TITLE: Administrator

(X6) DATE: 1/13/2022

STATE FORM 6899 DPWD11 If continuation sheet 1 of 1