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 _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHMORE HEALTH	410 8TH STREET 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) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/25/24 through 2/28/24. Highmore Health was found not in compliance with the following requirements: F565, F584, F655, F657, F661, F689, F700, F761, F812, F851, and F880.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to	F 565	1. Activity Program Policy reviewed and revised. Grievance Policy reviewed. The Activity Director was educated on the revision to the Activity Program Policy and grievance procedure within the resident council meeting on 3/18/2024. 2. All residents who attend resident council meetings are potentially affected. All grievances resulting from resident council meetings will be written and reviewed by appropriate staff. All Staff were re-educated on the grievance policy on 3/25/24. At the next resident council meeting on 4/9/2024, residents will be instructed to report any unresolved concerns from previous meetings to the Administrator. 3. Activity Director or designee will write up any and allresident grievances that result from resident council meetings and bring them to the appropriate staff member after the meeting. 4. Administrator or designee will audit all residentd council meeting notes and grievance forms and follow up after each resident meeting to make sure they are properly written up and also given to the appropriate staff member monthly for 3 months. Administrator or designee will report results of audits at monthly QAPI meetings for review.	3/18/2024

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

Kim Knox | Administrator | 3/27/2024

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 565	Continued From page 1 participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, resident council meeting minutes review, and policy review, the provider failed to ensure: *Resident council meetings were conducted on a monthly basis. *Residents were notified of the time and place of the resident council meetings. *There was an investigation, follow-up, and documented responses to resident council grievances brought forward by an undisclosed number of residents identified in three of five monthly meeting minutes sampled (September 2023, December 2023, and January 2024). Findings include: 1. Resident council interview on 2/27/24 at 10:30 a.m. revealed: *There were twelve residents in attendance. *Three anonymous residents stated that grievances were not followed up by staff and communicated with the residents. *Two anonymous residents stated they did not know how to file a grievance. *One anonymous resident stated they were not aware that there was a resident council and that the council met monthly. Review of resident council minutes from September 2023 through January 2024 revealed: *In September 2023 an undisclosed number of	F 565		

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F 565	Continued From page 2 residents met with activity director L individually: -An undisclosed number of residents requested an activity called "Balloon Act" more often. --The response documented in the September 2023 minutes included, "Planning on putting it into the calendars more but that doing this my [may] lessen other things or move them around a bit." -There was no resolution that concern. *The 10/16/23 meeting minutes included a meeting that was held with 17 residents in attendance. -Activity director L included, "I am going to be moving these meetings to a Tuesday morning at the beginning of each month at 10:30 a.m. This will start in December ..." *The 12/12/23 the meeting minutes included a meeting that was held with four residents in attendance. -One resident stated she does not like it when a certain resident was allowed to sit beside her because that resident touched things that she should not. --The minutes included, "I told her I would talk to the nurse to relay to the CNA's, and I would talk to the Activity staff." -One resident stated that the stop sign in place at her door does not stop a resident from wandering into her room and that resident breaks things in her room. --The minutes included, "I told her I would put on [maintenance director D's] clipboard to maybe lower the Velcro [for the stop sign placement] to se if that may help with that resident going under it." -One resident stated that sometimes there was water on her bathroom floor that she had to wipe up before she could use it safely. She thought that was from staff members not wringing out the	F 565		

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F 565	Continued From page 3 mop head and other times it was from the toilet leaking. --The minutes included, "I let her know I would also put this on his clipboard [maintenance director D] and talk to him about it. She explained that she has talked to him personally about it before and he is aware." -An undisclosed number of residents stated that they "get a lot of fruit and is always has a lot of syrup in it." --The minutes included, "I let them all know there are state guidelines that we have to follow but I would talk to ...[the dietary manager M] about the syrup." -Two residents expressed concerns that their bathroom garbage was not removed as often as it should have been and it was getting too full. --The minutes included, "I let them know I will talk to ...[maintenance director D] about this and see if he can talk to his staff." -One resident stated she needed extra help in the morning and to be woken up. --The minutes included, "I will talk to the DON [director of nursing B] and charge Nurse to talk with CNAs about her needing more help." ---There was no resolutions to the above resident concerns. *On 1/9/24 the meeting minutes included a meeting was held with seven residents in attendance. -An undisclosed number of residents expressed a concern as to why "are we short of help around here lately?" --The minutes included, "I let them know that sense [census] is down and that we must cut some hours. That is why they do not see as many staff on the floor." ---There was no resolution to the concern.	F 565		

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F 565	Continued From page 4 Interview on 2/28/24 at 3:00 p.m. with activity director L regarding resident council grievances revealed: *Resident council meetings should have been held on a monthly basis. -Some months she visited residents individually for their input rather than have a meeting. *When a grievance was received during a meeting she: -Would speak to the department head that the grievance pertained to. -For the maintenance department she would write it on his clipboard and maybe speak to him. --He would write his initial next to the grievance on the clipboard when he resolved the concern. -For the social service department, she would fill out a form, talk to registered nurse (RN)/social service designee (SSD) H. *Asked the residents in the next resident council meeting if they wanted to revisit their concern or if it was resolved. -She thought she documented that in the minutes. *She would fill out a formal grievance form, "but there hasn't been anything lately that I felt I needed to fill out right away for them." *She had received a grievance from a resident a while ago regarding a nursing concern, she was not certain of how long ago. -For that grievance, she had talked to a certified nursing assistant and a charge nurse. --She had not followed up with the resident to ensure the grievance was resolved. Interview on 2/28/24 at 3:17 p.m. with director of nursing B regarding resident council grievances revealed: *She has never received a grievance from the resident council.	F 565		

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F 565	Continued From page 5 *The process for resident council grievances was for a concern specific to a department to be given to that department head to resolve. Interview on 2/28/24 at 3:34 p.m. with administrator A regarding resident council grievances revealed: *Activity director L has never filled out a grievance form from a grievance expressed during a resident council meeting. -Activity director L would speak to administrator A if there was a concern and she would then go talk to the resident to, "determine what was going on". --Administrator A would try to resolve the issue, but would not write up a grievance. *Administrator A confirmed a grievance form should have been completed, investigated, and a resolution reviewed with the residents. Review of the provider's undated Grievance Policy revealed: *"Policy: -It is the policy of...[provider] to have accessible, responsive grievance procedure which protects residents and their families' ability to report any grievances with this facility. Complaints will be addressed promptly and fairly. *Procedure: -1. Residents and their families have the following rights: --a. To voice concerns and complaints, either orally or in writing, relating to the treatment or care we provide or the behavior of other residents. --b. To receive a timely response by us in which we agree to consider the issue or issues you raise and to act upon them. --c. To be free from any pressure intended to discourage you from voicing your concerns and	F 565		

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F 565	Continued From page 6 complaints. -2. Any grievance of a resident or someone acting on behalf of a resident should be directed to our Administrator, the Director of Nursing, or appropriate department head. Details concerning time, place[,] nature of occurrence or condition, persons involved, and other pertinent facts should be included in order to facilitate the investigation and follow-up action. -3. When we receive a grievance, we will: --a. Promptly investigate. --b. Correct any condition found to be inconsistent with our policies and procedures and the rights and responsibilities of our residents."	F 565		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584	1. Floors in the dining room and by the nurses station will be repaired and contractor notified to see what the best option is. The floor in resident room 106 was repaired on 2/27/2024. 2. Maintenance Director or designee will inspect the floors in the dining room, by the nurses station and in all resident rooms to ensure floors are in proper repair. 3. Maintenance Director or designee will add inspecting the flooring to his monthly checks. 4. Maintenance Director or designee will report findings to monthly QAPI meetings for review for 3 months.	3/20/2024

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F 584	Continued From page 7 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure a safe environment, free from potential accident hazards for all residents who may be at risk for falls or other injury. Findings include: 1. Observation on 2/27/24 at 9:47 a.m. in the dining room revealed: *The laminate flooring in the doorway in the area that transitioned from the front room to the back room had a patch of torn flooring. -That area was approximately three inches by fifteen inches long. -The edges were rough and raised and the underflooring was exposed. 2. Observation on 2/27/24 at 11:31 a.m. in the dining room revealed: *An unidentified dining room staff member had	F 584		

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F 584	Continued From page 8 been pushing a metal cart towards the kitchen. *The cart had been unable to avoid the torn flooring and the wheel caught on the upward peeling edges. 3. Observation on 2/28/24 at 1:45 p.m. in the lobby revealed: *The carpeted flooring had a tear that extended from the front of the nurses' station into the 100 hallway over six feet long and approximately two to three inches wide. *Residents had to move through that area to access the dining room and the front door. 4. Interview on 2/28/24 at 1:37 p.m. with administrator (ADM) A regarding the flooring in the dining room and the lobby revealed: *She was aware of issues with flooring. *The facility was "going through a sale and being bought by the city." *It was her expectation that the flooring was to have been repaired at that time. *She stated "that the new company will put in new flooring once the sale is complete." *She moved resident 32's recliner and exposed additional areas of torn flooring. *After she observed resident 32's floor she stated, "I guess it's getting really bad." *She proceeded to peel back sections of the flooring with her foot. Refer to F689	F 584		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans	F 655	1. The Baseline Care Plan regulation was reviewed. The Care Plan policy was reviewed and revised. No corrective action was taken for resident 90's Baseline Care Plan because it was past the 48 hour window for completion. 2. All new residents must have a Baseline Care Plan done within 48 hours of admission. And any resident admitted since this survey will be audited to ensure Baseline Care Plan is complete. 3. All staff resposible for the Baseline Care Plan have been re-educated on the Baseline Care Plan revisions on 3/25/2024. MDS Coordinator or designee will be responsible for completing the Baseline Care Plan, reviewing it with the resident/representative, having them sign it, and placing it in the resident's chart so that it is accessible to staff. MDS Coordinator or designee will continue yearly education for staff which is documented in the All-Staff meetings binder. 4. Director of Nursing or designee will audit all new residents' Baseline Care Plans for accuracy weekly for 4 weeks and then monthly for the next 2 months. The audits will ensure that no residents have been missed for this issue. Director of Nursing or designee will report results of the audits at monthly QAPI meetings for review.	3/25/2024

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F 655	Continued From page 9 §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details	F 655		

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F 655	Continued From page 10 of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure a baseline care plan accurately reflected the resident's care needs for one of one sampled newly admitted resident (90). Findings include: 1. Observation and interview on 2/26/24 at 3:07 p.m. with resident 90 and his spouse revealed he had: *Recently been admitted following a hospital stay. *Was sitting in a wheelchair *Had a urinary catheter in place. *Had an open area to his heel and to his coccyx (tailbone) area. 2. Review of resident 90's medical record revealed: *He was admitted on 2/16/24. *At the time of his admission, he had the following: -A blister on his heel and an open wound to his coccyx area. -A catheter was in place. -He used a wheelchair for mobility. 3. Review of resident 90's baseline care plan revealed it indicated: *He did not: -Have a catheter. -Use a wheelchair. -Have any current skin issues. *The "Signatures of Staff Completing Baseline Care Plan" area indicated it had been completed by registered nurse(RN)/Minimum Data Set coordinator (MDS) G and the RN/social services designee (SSD) H.	F 655		

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F 655	Continued From page 11 4. Interview on 2/28/24 at 8:59 a.m. with director of nursing (DON) B regarding resident 90's baseline care plan revealed she: *Agreed he had a blister on his heel, an open wound to his coccyx, a catheter, and he used a wheelchair at the time of his admission. *Confirmed those areas were not indicated on his baseline care plan. *Would have expected those areas to be addressed on his baseline care plan. 5. Review of the provider's 3/23 "Care Plan Policy and Procedure" revealed: *It was the responsibility of the MDS coordinator or designee. *"Care plans include active and historical diagnoses, goals and/or expected outcomes, specific nursing interventions so that any nursing staff member is able to quickly identify a resident's individual needs and to decrease the risk of incomplete, incorrect, or inaccurate care, and to enhance continuity of nursing care." *"Upon admission, resident will be assessed by the MDS Coordinator or designee and a baseline care plan will be developed with information gathered from the resident and resident's family within 48 hours."	F 655		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657	1. Care Plan policy reviewed and revised. Care Plans were updated and revised on residents 2, 11, 31, and 189. 2. All residents require care plans and are potentially affected by the failure to update care plans. 3. Care plan timing and revision and Care Plan policy updates have been reviewed with all staff responsible for care planning on 3/25/24. MDS Coordinator or designee will ensure that care plans are updated with changes upon admission, quarterly, annually, and with significant changes. Significant changes and/or new care concerns and possible interventions will be discussed at daily stand up meetings. MDS Coordinator or designee will ensure that changes discussed will be implemented. 4. MDS Coordinator or designee will audit at least 3 residents weekly until all residents have had care plans reviewed. The audits will ensure that no residents have been missed for this issue. MDS Coordinator or designee will report results of audits at monthly QAPI meetings for review.	3/25/2024

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F 657	Continued From page 12 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure resident care plans were updated to accurately reflect the current care needs of four of five sampled residents (2, 11, 31, and 189) including fall interventions, code status, and assist bars. Findings include: 1. Observation on 2/26/24 at 10:01 a.m. of resident 189's room revealed there were two fall mats on the floor and a twin-sized bed mattress up against a wall. Observation of resident 189 on the following dates and times revealed: *On 2/26/24 at 10:58 a.m. he had been standing with the right side of his body leaned up against	F 657		

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	435092	A. BUILDING _____ B. WING _____	02/28/2024

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F 657	Continued From page 13 the doorframe. *On 2/26/24 at 2:10 p.m. and again at 3:10 p.m. he was asleep in his bed that was in a low position with another bed mattress on the floor next to his bed. *On 2/27/24 at 11:20 a.m. he had been sitting on his bed with his back against the wall and his feet were rested on the fall mat that was on the floor next to his bed. *On 2/28/24 at 1:58 p.m. he had been resting in his bed on his back and there was a fall mat on the floor next to his bed. Review of resident 189's electronic medical record revealed he was: *Admitted on 2/12/24. *Diagnoses included Wernicke's encephalopathy (a brain disorder affecting memory), mild cognitive impairment, and repeated falls. *A fall risk assessment was completed on 2/16/2024 that indicated he was at a high risk for falling. *A care plan area goal that he "Will not sustain serious injury through the review date." *Care plan interventions included: -"A wheelchair is his primary mode of transportation." -"Be sure call light is within reach and encourage to use it for assistance as needed." -"Coordinate with appropriate staff to ensure a safe environment with: Floors even and free from spills or clutter, Adequate, glare-free light, Call light, Bed in low position at night, Handrails on walls, Personal items within reach." Interview on 2/28/24 at 2:03 p.m. with director of nursing (DON) B regarding the use of fall mats, the bed mattress on the floor, fall risks, and the	F 657		

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F 657	Continued From page 14 care plan for resident 189 revealed: *She confirmed resident 189 had fallen multiple times since his admission. *She was aware a fall mat had been used as an intervention and had thought it was on his care plan. *She then reviewed his care plan and agreed it: -Had an intervention "to ensure a safe environment with: Floors even and free from spills or clutter." -Did not include the use of a fall mat or the bed mattress. *She stated the use of a bed mattress on the floor was not a typical intervention, but she felt it was acceptable for staff to use a mattress if they were not able to find a fall mat. *She would have expected the use of the fall mats to have been included in resident 189's care plan. 2. Review of resident 2's medical record revealed: *Her 1/9/24 signed CPR (Cardiopulmonary resuscitation) Statement of Decision (code status) form indicated she did not wish CPR to be performed. *Her 2/25/24 care plan indicated she wanted CPR to be performed in the event of a cardiac event. 3. Review of resident 31's medical record revealed: *Her 2/8/23 signed CPR Statement of Decision indicated she wanted to have CPR initiated in the event of cardiac arrest. *Her 2/25/24 care plan indicated she did not want CPR performed. Interview on 2/28/24 at 12:56 p.m. with registered nurse/social service designee (RN/SSD) H	F 657		

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F 657	Continued From page 15 regarding code status care planning revealed: *She obtained a resident's preference of code status when they were admitted. *She would add the code status to the care plan at that time. *The interdisciplinary team would review the code status with the resident or their representative at each care conference. *Resident 2's care plan was not updated when her code status changed from CPR to do not resuscitate (DNR) on 1/9/24. -She was not certain why the care plan had not been updated to reflect the DNR code status on 1/9/24. *She confirmed the care plan should have been updated when the resident's code status changed. Review of the provider's undated Health Advance Directive Policy and Procedure revealed the following: *"Objective of Advance Directive Policy and Procedure" -"E. Resident wishes will be communicated to the staff via the care plan and (identify facility protocol for communication of advance directives either in written or oral format) and to the resident physician." -G. During the quarterly RAI (Resident Assessment Instrument) process and with any significant changes of condition, facility staff will:" --"v. Changes to the resident choices for advance directives will be documented, included in the resident plan of care, State specific documents will be updated as necessary, physician orders will be obtained to reflect new choices as applicable and all items will be communicated to staff providing resident care".	F 657		

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F 657	Continued From page 16 4. Observation on 2/25/24 at 4:49 p.m. of resident 11's room revealed bilateral assist bars attached to the bed and they were in the upright position. Observation and interview on 2/26/24 at 11:07 a.m. with resident 11 revealed: *He was admitted from a hospital "two or three weeks ago". -He had broken a bone close to his tailbone. *The bilateral assist bars on his bed were in the upright position. -He used those bars to assist him in getting in and out of bed. Review of resident 11's 2/25/24 care plan revealed the use of the bilateral assist bars were not included in his care plan. Interview on 2/28/24 at 2:37 p.m. with RN/Minimum Data Set G regarding resident care plans revealed she was not aware that resident 11 used bed assist bars so she had not added that to his care plan. Review of the provider's updated March 2023 Care Plan policy and procedure revealed: *"Basic Responsibility: -MDS Coordinator or designee -Purpose: --Care plans will be developed by an interdisciplinary team with participation of the resident, family, and/or representative (when available). Care plans include active and historical diagnoses, goals and/or expected outcomes, specific nursing interventions so that any nursing staff member is able to quickly identify a resident's individual needs and to decrease the risk of incomplete, incorrect, or inaccurate care, and to enhance continuity of	F 657		

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F 657	Continued From page 17 nursing care." *"General instructions:" -"5. Care Plans will be reviewed quarterly, annually and with any significant change in resident condition. Changes that may involve updating the care plan will be discussed and implemented during daily IDT meetings. -6. Care Conferences are offered/scheduled on admission, quarterly, with significant change, and at the request of residents, families, or staff."	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §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 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). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements	F 661	1. Recapitulation by a nurse will be done on every resident discharged from the facility beginning on our next discharged resident. 2. After discharge, each resident's chart will be given to the MDS Coordinator or designee to include a recapitulation of each resident's stay. All staff members responsible for discharge summary have been re-educated on 3/19/2024. 3. Director of Nursing or designee will audit recapitulation of discharged residents monthly for 3 months. 4. Findings will be reported to monthly QAPI committee meetings with further follow-up as recommended by committee.	3/20/2024

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F 661	Continued From page 18 that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on closed medical record review and interview the provider failed to ensure one of one sampled resident's (37) closed record included a recapitulation (a summary of the resident's nursing home stay). Findings include: 1. Review of resident 37's closed medical record revealed: *She was admitted on 9/25/23. *She was discharged to her home on 12/15/23. *A discharge summary was completed. *There was no documented recapitulation of her stay. Interview on 2/28/24 at 5:31 p.m. with director of nursing B revealed: *Registered nurse/Minimum Data Set G was responsible for completing a discharge summary to include the recapitulation of a resident's stay when they discharged. *Her expectation was for the discharge summary to also include the recapitulation. *She confirmed there was no recapitulation of resident 37's stay in the facility. *There was no policy for a discharge summary or recapitulation of a resident's stay upon their discharge from the facility.	F 661		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689	1. Floors in the dining room and by the nurses station will be repaired and contractor notified to see what the best option is. The floor in resident room 106 was repaired on 2/27/2024. 2. Maintenance Director or designee will inspect the floors in the dining room, by the nurses station and in all resident rooms to ensure floors are in proper repair. 3. Mainnance Director or designee will add inspecting the flooring to his monthly checks. 4. Maintenance Director or designee will report findings to monthly QAPI meetings for review for 3 months.	3/20/2024

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F 689	Continued From page 19 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the provider failed to ensure a safe environment, free from potential accident hazards in the room of one of one sampled resident (32) with a history of multiple falls. Findings Include: 1. Observation on 2/26/24 at 11:22 a.m. of resident 32 while in his room revealed: *He had been asleep, seated in his wheelchair, with his feet on the floor, next to his bed, facing his recliner. *There were four areas of flooring around and his recliner that had peeled up and had visible underflooring. -Those areas ranged in size from approximately three inches by four inches to approximately five inches by six inches. *He moved his feet and revealed another area of exposed underflooring and flooring with peeled edges. *He then moved his wheelchair back and the wheel caught on one of the exposed edges. 2. Observation on 2/27/24 at 11:19 a.m. of resident 32's room revealed additional areas of peeled flooring and exposed underflooring beside his bed, in front of his recliner. 3. Review of resident 32's electronic medical record revealed: *He had impaired mobility and cognition. *A wheelchair was his primary mode of	F 689		

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F 689	Continued From page 20 transportation. *He had fallen on 08/21/23, 10/29/23, 11/19/23, 11/26/23, 12/8/2023, 12/25/23 and 12/29/23. *He was assessed and found to be at a high risk for falls. *His care plan indicated staff were to coordinate with appropriate staff to ensure a safe environment, that included even floors. 4. Interview on 2/28/24 at 1:37 p.m. with administrator (ADM) A regarding the flooring in resident 32's room revealed: *She was aware of issues with flooring. *The facility was "going through a sale and being bought by the city." *It was her expectation that the flooring was to have been repaired at that time. *She stated "that the new company will put in new flooring once the sale is complete." *She moved resident 32's recliner and exposed additional areas of torn flooring. *After she observed resident 32's floor she stated, "I guess it's getting really bad." *She proceeded to peel back sections of the flooring with her foot.	F 689		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. 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. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 700	1. Reviewed Bed Assist Bar policy and procedure. The Interdisciplinary Team discussed bed assist bar appropriateness for resident 11 and proper protocol was then followed. MDS Coordinator or designee will check all residents' beds and compare with all assessments on file for accuracy. 2. All staff responsible for bedrails will be educated on bed assist bar installation protocol on 3/25/2024. 3. MDS Coordinator or designee will ensure that bed assist bar assessment and consents are completed on all residents determined to need a bed assist bar. Maintenance Director will ensure that bed assist bars are removed when residents using them are dischrged. 4. MDS Coordinator or designee will audit all residents requiring a bed assist bar for assessments amd consents monthly for 3 months. MDS Coordinator or designee will report results of audits at the monthly QAPI meetings.	3/20/2024

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F 700	Continued From page 21 §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. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and policy review, the provider failed to ensure one of five sampled residents (11) received benefits of use versus the risks of use for bilateral bed assist bars on his bed, had an informed consent signed, and had alternatives attempted before installation and use of those bilateral bed assist bars on his bed. Findings include: 1. Observation on 2/25/24 at 4:49 p.m. of resident 11's room revealed his bed had bilateral bed assist bars attached to the bed in the upright position. Observation and interview on 2/26/24 at 11:07 a.m. with resident 11 revealed: *He was admitted to the facility from a hospital "two or three weeks ago". -He had broken a bone close to his tailbone from a fall at home. *The bilateral assist bars on his bed were in the up position. -He did not remember: --Receiving education on benefits of use versus	F 700		

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F 700	Continued From page 22 the risk of use for those assist bars. --Signing an informed consent. Review of resident 11's medical record regarding the bilateral assist bars revealed: *There was no documented education for benefits of use versus the risks of use of those assist bars. *There was no signed informed consent. *There was no safety assessment completed for use of those assist bars. *His care plan had not included the use of those assist bars. Interview on 2/27/24 at 2:12 p.m. with certified nursing assistant (CNA) E regarding resident 11's use of the bilateral assist bars revealed that he used those assist bars on the right side of the bed to turn when staff members provided care to him, but he did not use the assist bar on the left side of the bed. Continued interview on 2/28/24 at 9:52 a.m. with CNA E revealed she clarified resident 11 used both assist bars during the night when staff members assisted with his care. Interview on 2/28/24 at 2:03 p.m. with director of nursing B regarding the use of the bilateral assist bars used by resident 11 revealed: *She thought he used the assist bars to get in and out of bed, due to his shoulder pain. *Registered nurse (RN)/Minimum Data Set (MDS) G was responsible for completing the assist bars education, obtaining the informed consent, and completing the assessments. Interview on 2/28/24 at 2:37 p.m. with RN/MDS G regarding the bilateral assist bars used by	F 700		3/2/2024

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F 700	Continued From page 23 resident 11 revealed: *She was responsible for assessing residents for safe use of the assist bars. *She was not aware that resident 11 had used bilateral assist bars on his bed. *The process for determining the use of assist bars was for: -The interdisciplinary team to discuss the resident's need for the use of the assist bars. --She was part of the interdisciplinary team. --There was no discussion by the team regarding resident 11's use of those assist bars on his bed. Review of the provider's revised March 2023 Bed Assist Bar Policy and Procedure revealed: *"Policy: -Use bed assist bars to enhance resident mobility and independence. -Make resident and/or representative aware of risks of bed assist bars. -Ensure ongoing assessment and maintenance of resident bed assist bar use. *Procedure: -1. Prior to installation of bed assist bar: --a. Alternative must be attempted (i.e. adjusting bed height, raising head of bed, trapeze, concave mattress, bed wedges/bumpers) and reason alternative did not work. --b. MDS Coordinator or designee must complete Bed Assist Bar User Defined Assessment (UDA) in...[electronic medical record program] to determine appropriateness of using it. -2. Decision to install bed assist bar should be made based on the following information assessed in the Bed Assist Bar UDA: --a. Determine the reason for the bed assist bar and if it is likely to the resident meet his or her needs. --b. Evaluation of any bed assist bar alternatives	F 700		

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F 700	Continued From page 24 attempted that failed to meet the resident's needs prior to use and installation and alternatives considered but not attempted because they were considered inappropriate. --c. Assess the resident for safety with use of bed assist bar including cognition, mobility, communication, etc. --d. Risk for resident to suffer from entrapment and how the risks will be mitigated. -3. Obtain informed consent of the safety risks after reviewing those potential risks with resident and/or resident representative."	F 700		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761	1. Director of Nursing or designee will review and revise as necessary policy and procedure regarding medication storage in the facility specifically controlled substance storage. 2. The controlled substance storage cupboard will be locked by DON with a second nurse as a signing witness. All staff responsible for controlled substance storage have been re-educated on policy. 3. Administrator or designee will audit the form signed by DON and a second nurse witness weekly for 4 weeks and then monthly for 2 more months. Findings will be reported to monthly QAPI committee meetings with further follow-up as recommended by committee. 4. Director of Nursing will be responsible for this area of compliance.	3/20/2024

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	435092	A. BUILDING _____ B. WING _____	02/28/2024

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(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
F 761	Continued From page 25 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure controlled medications (drugs easily diverted by staff) were securely stored for one of one observed medication rooms. Findings include: 1. Observation and interview on 2/27/24 at 2:40 p.m. of the medication room with registered nurse (RN) K revealed: *The cupboard used to store controlled medications that were to have been destroyed was not locked and had several medications placed inside of it. *She stated the director of nursing (DON) B was the only one who had a key for that cupboard. *She immediately requested the DON B to the medication room. 2. Observation and interview on 2/27/24 at 2:44 p.m. with the DON B regarding the controlled medication cupboard revealed she: *Confirmed the cupboard was unlocked and had several controlled medications inside it. *Stated the last time she had accessed that cupboard was to put resident 195's bottle of morphine in it because it did not fit in the slot in the cupboard door. *A count of the medications inside that cupboard and it contained the following controlled medications: -One bottle of liquid morphine sulfate containing one milliliter (ml). -One bottle of liquid morphine sulfate containing 15 mls. -193 tablets of 50 milligrams (mg) of tramadol.	F 761		

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F 761	Continued From page 26 -68 doses of 0.5 mg of lorazepam. -43 half-tablets of 5 mg of oxycodone. -56 tablets of 5 mg of hydrocodone and 325 mg of acetaminophen. -86 capsules of 75 mg of pregabalin. -45 tablets of 200 mg of Modafinil. -31 tablets of 2.5 mg of Lomotil. *The count was correct. 3. Observation and interview on 2/27/24 at 2:54 p.m. and again at 3:22 p.m. with the DON B revealed: *Controlled medications would routinely be destroyed about once a month by herself and another RN. *She kept the originals count sheets (controlled drug receipt/record/disposition forms) in her office and would place a copy of the count sheets with the controlled medications and place them in the locked cupboard in the medication room. *She then completed a comparison of those count sheets and the controlled medications amounts on hand, with no missing medications found. *She stated resident 195 had passed away on 2/17/23. His two bottles of morphine sulfate had been kept in the locked box in the locked medication cart and counted by two nurses at each shift change until she was able to place them in the controlled medications cupboard on 2/19/24. *She stated she must not have locked that cupboard door and that it had remained unlocked until it was discovered on 2/27/24, that was 9 days. 4. Interview on 2/27/23 at 3:24 p.m. with RN K revealed she confirmed the controlled medication counting process at each shift change as stated	F 761		

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F 761	Continued From page 27 by DON B. 5. Review of the February 2024 narcotic count signature sheet (shift change count sheet) and interview with the DON B on 2/27/24 at 3:33 p.m. and again at 3:54 p.m. revealed: *One missing nurse signature on that narcotic count sheet as follows: -2/6/24 at 7:00 p.m. -2/16/24 at 7:00 p.m. -2/18/24 at 7:00 a.m. and 7:00 p.m. *She identified the two nurses that were on duty during those times as and provided them re-educated them on the controlled medications counting process on 2/27/24. 6. Review of the provider's 2006 Medication Storage In The Facility Controlled Substance Storage policy revealed: *"Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances re subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations." *"The director of nursing, in collaboration with the consultant pharmacist, maintains the facility's compliance with federal and state laws and regulations in the handling of controlled substances. Only authorized licensed nursing and pharmacy personnel have access to controlled substances." *"At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented." *"Controlled substances remaining in the facility after the order has been discontinued or the	F 761		

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F 761	Continued From page 28 resident has been discharged are retained in the facility in a securely locked area with restricted access until destroyed. Accountability records for discontinued controlled substances are maintained with the unused supply until it is destroyed or disposed of."	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure food items were appropriately stored in a safe and sanitary manner in one of one observed kitchen for the following: *One of one commercial refrigerator that contained food items that were not labeled, dated, or discarded by the use by date, and staff	F 812	1. The food safety requirements for food procurement, storage and sanitation was reviewed. 2. Dietary Director or designee reviewed proper procedures for dating, labeling, personal food storage, storage of scoops and temps of freezers with dietary staff on 3/25/2024. 3. Dietary Director or designee will do audits on dating, labeling, personal food storage, storage of scoops, and temps of freezers weekly for 4 weeks and then monthly for the next 2 months. 4. Dietary Director or designee will report results from audits at the monthly QAPI meetings for review.	3/25/2024

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F 812	Continued From page 29 items were stored where resident food items were stored. *One of one upright freezer contained food items that were not labeled or dated. *One of two small chest freezers that did not have a functioning thermometer to ensure foods were stored at a safe temperature. *One of one commercial freezer contained food items that were not stored, labeled or dated. *Two of two containers of a food thickening product had scoops stored in them. *One of one container of powdered milk had a scoop stored in it. *Staff food items were being stored where resident food items were blended. Findings include: 1. Observation of the kitchen on 2/25/24 at 3:20 p.m. revealed: *A commercial refrigerator contained: -One opened container of half and half that had a use by date of 2/4/24. -One lidded cup of red liquid that was not labeled or dated. -One covered cup of white liquid that was not labeled or dated. -One Ziploc bag of shredded cheese was not labeled or dated. -One Ziploc bag of diced ham was not labeled or dated. -One plastic grocery bag containing a burrito and a snack-sized package of cheese that belonged to a staff member. *An upright freezer contained two covered cups that were not labeled or dated. *An opened container of powdered milk that had a scoop stored inside of it. *Two opened containers of a food-thickening product that had scoops stored inside of them.	F 812		

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F 812	Continued From page 30 *A small chest freezer had a thermometer inside of it that had frozen and was not functioning. *A commercial freezer had a plastic bin that contained two pancakes that were not packaged or labeled. *An opened can of Red Bull that belonged to a staff member placed on the windowsill above the area where residents' food was blended. 2. Observation on 2/25/24 at 5:37 p.m. of the kitchen revealed two outdoor jackets were on the counter where staff would blend residents' food. 3. Observation and interview on 2/26/24 at 5:14 p.m. with dietary manager (DM) M in the kitchen revealed: *Two uncovered slices of pumpkin pie and one and one-half doughnuts placed on Styrofoam plates on counter where resident food items were being blended. *DM M stated they were from lunch for staff and then covered them. 4. Interview and observation on 2/28/24 at 9:49 a.m. with DM M in the kitchen regarding the above observations revealed: *The commercial freezer contained the same unpackaged, unlabeled items as observed on 2/25/24. *She was not aware of the undated, unlabeled, stored food items, or that the freezer thermometer had not been functional. *She felt that staff items could be stored in the kitchen if they were not in direct contact with food items. *She would have expected the following: -All food items should been stored in containers, labeled and dated. -Staff food items should have been stored	F 812		

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F 812	Continued From page 31 separately from the resident food items. -She should have been notified by staff of any non-functioning thermometers for replacement. 5. Review of the provider's undated (food) storage policy and procedures revealed: *"All perishable foods are refrigerated at the appropriate temperature and in an orderly and sanitary manner. Thermometers are provided in all refrigerators and freezers. Refrigerators are kept at temperatures of 35-45 degrees F and freezers are kept at 0 degrees or less." *"All refrigerated left over food is labeled and dated and discarded if not used in 72 hours."	F 812		3/2024
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).	F 851	1. Payroll-Based Journal submission has been corrected. 2. Business Office Manager corrected the Payroll-Based Journal entry process by manually entering the data rather than importing data from the timeclock. BOM will then print the report confirming successful submission to keep on file. 3. Administrator or designee will check to make sure the Payroll-Based Journal submission was successful by auditing PBJ submission monthly for 3 months. 4. Findings will be reported at monthly QAPI meetings and followed up on as necessary.	3/20/2024

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

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F 851	Continued From page 32 §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on the Payroll Based Journal (PBJ) record	F 851		

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F 851	Continued From page 33 review and interview, the provider failed to submit PBJ data accurately for three of four federal fiscal quarters (Quarter 1, 2023; Quarter 3, 2023; and Quarter 4, 2023). Findings include: 1. Review of PBJ records submitted to the Center for Medicaid and Medicare (CMS) services revealed the PBJ report for the provider for the three quarters listed above included: *The following items were triggered: -Failure to submit data for the quarter. -One-star staffing rating. *The following metrics were suppressed for invalid data: -Excessively low weekend staffing. -No registered nurse hours worked. -Failure to have licensed nursing coverage 24 hours per day. Interview on 2/25/24 at 3:45 p.m. with administrator A regarding the PBJ reporting information revealed: *She was aware there were issues with the correct reporting of staff member's hours worked. -She thought that was related to incomplete reporting of agency nursing staff member's hours worked. --Each agency staff member had their own number and would clock in and out using the electronic time clock system. *Business office manager (BOM) N was responsible for the coding of all staff hours for the PBJ report. -BOM N would monitor the hours worked on a regular basis and adjust them as needed, rather than waiting until the end of the calendar quarter to fix any identified issues. *Administrator A thought they had resolved issues related to inaccurate PBJ reporting.	F 851		

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F 851	Continued From page 34 BOM N was not available for an interview during the survey period.	F 851		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880	1. For the identification of lack of appropriate: Cleaning and maintenance of whirlpool tub. The Administrator, DON, infection control nurse and/or designee, maintenance director in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. Please do read 2567 findings. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 3/25/2024, by Administrator or designee. 2. Individual residents and other residents as well as staff have potential to be impacted. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 3/25/2024, by Administrator or designee. 3. Root cause analysis conducted answered the 5 Whys: After answering the 5 whys, the reason the tub has an uncleanable surface is because of incomplete staff knowledge in the tub cleaning process. Administrator, DON, maintenance director, medical director, and/or any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. DON contacted the South Dakota Quality Improvement Organization (QIO) on 3/19/2024 and discussed findings of the 5 Whys self-assessment and planned response to findings including staff re-education and audit plan. 4. Administrator, DON, and/or designee, maintenance director will conduct auditing and monitoring of above identified items 2-3 times weekly over all shifts where whirlpool bathing is done. monitoring for determined approaches to ensure effective implementation and ongooing sustainment. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for 1 month. Monthly monitoring will continue at a minimum for 2 months. 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.	3/25/2024

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F 880	Continued From page 35 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure one of one whirlpool (WP) tub was cared for in a manner that maintained the quality of the WP tub's interior surface. Findings include:	F 880		3/

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F 880	Continued From page 36 Observation on 2/27/24 at 1:50 p.m. of the shower room on the 100-hallway revealed: *The WP tub had: -Rust-colored areas on the interior bottom of the WP tub around the power jets. -Lime build-up and what appeared to have been grime covering the bottom one-fourth of the interior walls and extending from the waterspout to the drain. -Several areas of paint, on the edge of the WP tub, that were missing exposing the underlying material, the largest area measuring approximately two inches by one inch. *There was a scrub brush for cleaning the WP tub that had bristles that appeared frayed from over-use. Interview on 2/27/24 at 3:43 p.m. with registered nurse/infection control preventionist C regarding the WP tub revealed she: *Agreed the WP tub had lime build-up and what appeared to be grime on the interior walls. -She used her fingernail to scrape off an area of the grime. *Stated the WP tub was disinfected after each resident use but needed a thorough cleaning. -"Maybe it is just time for a new one." *Agreed the scrub brush was frayed. *Confirmed the chipped areas on the WP tub made it a non-cleanable surface Observation and interview on 2/28/24 at 8:18 a.m. with certified nursing assistant F regarding the WP tub cleaning and disinfecting revealed: *She disinfected the WP tub according to the instructions that she was provided. -She stated the WP tub was disinfected after each resident use. -The WP tub appeared to be in the same	F 880		3/25/2024

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HIGHMORE HEALTH	410 8TH STREET 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) COMPLETION DATE
F 880	Continued From page 37 condition as detailed above, after the disinfecting process. *Maintenance director D descaled the WP tub once a month. -She was not sure when that was last done. Interview and review of the maintenance monthly log 2/28/24 at 8:32 a.m. with maintenance director D and director of nursing B regarding cleanliness of the WP tub revealed: *The monthly log included a one-page checklist by month of various items, including "Whirlpool Tub". *The month of January 2024 had a check mark by each of the items that were listed. *Maintenance Director D stated he cleaned the WP tub once a month. -He was not sure which day in the month of January 2024 he had cleaned the tub. -He had not cleaned the WP tub in the month of February 2024. -He stated he used "LSR (Lime Scale Remover, a potent acid-based compound that dissolved stains and deposits). -He sprayed the LSR on the interior of the WP tub, left the LSR on for ten minutes, then used a power scrub brush to clean it. *DON B stated, "It could be better" (referring to the cleanliness of the WP tub). *Maintenance director D indicated he "might try" to clean it more often. Interview on 2/28/24 at 3:35 p.m. with administrator A regarding the WP tub revealed she confirmed the interior surface of the tub was deteriorated, possibly from too strong of a cleaning chemical, and that made it an un-cleanable surface.	F 880		

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 _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHMORE HEALTH	410 8TH STREET 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) COMPLETION DATE
F 880	Continued From page 38 Review of the provider's updated 11/16/21 Whirlpool Cleaning policy and procedure revealed it did not reference using LSR as a cleaning product.	F 880		

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

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	435092	A. BUILDING _____ B. WING _____	02/28/2024

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

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E 000	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 from 2/25/24 through 2/28/24. Highmore Health was found in compliance.	E 000		

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

Kim Knox | Administrator | 3/20/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435092	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHMORE HEALTH	**410 8TH STREET 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) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/29/24. Highmore Health was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to conduct fire drills as required during the overnight shift. Findings include: Record review conducted 2/29/24 at noon showed documentation of fire drills all occurring during the afternoon shift change, between 1:30	K 712	1. Fire drill form was reviewed. 2. Maintenance staff will verify fire drills are held once per shift each quarter. 3. Staff will be re-educated on correct times fire drills are held and proper completion of fire drill forms on 3/25/2024. Forms will be audited once a month for three months and annually thereafter. Findings will be reported at monthly QAPI meetings. 4. Maintenance staff or designee is responsible for this area of compliance.	3/25/2024

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

Kim Knox | Administrator | 3/20/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435092	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHMORE HEALTH	**410 8TH STREET 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) COMPLETION DATE
K 712	Continued From page 1 p.m. and 3:00 p.m. Fire drills are required to be conducted quarterly on each shift under varied conditions. Time of day was one of the conditions that must be varied. Ref: 2012 NFPA 101 Section 19.7.1.6 Interview on 2/29/24 at 1:00 p.m. with the environmental services director revealed fire drills were conducted to maximize the number of staff present for the drills. He was not aware silent drills with later activation of the alarm system was a possibility. Failure to conduct fire drills as required increases the risk of death or injury due to fire. The deficiency affected one of three shifts.	K 712		

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 _____	02/28/2024

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 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/25/24 through 2/28/24. Highmore Health was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 2/25/24 through 2/28/24. Highmore Health was found in compliance.	S 000		

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

TITLE: Administrator

(X6) DATE: 3/20/2024