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 _____	05/08/2025

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 5/5/25 through 5/8/25. Highmore Health was found not in compliance with the following requirements: F583, F610, F812, and F880.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws.	F 583	1. Social Services reviewed facility's Resident's Rights in a Nursing Home and CMS's document "Your Rights and Protections as a Nursing Home Resident." 2. All residents have the right to privacy and are potentially affected. 3. Residents were moved to different rooms and a "family room" was then reestablished on 5/29/25. All residents or their representatives as appropriate were notified of the family room's existence and their right to use it as needed on 5/29/25. All staff were educated on the family room and the residents' right to privacy at the all staff meeting on 5/29/25. 4. Social Services Director or designee will audit all new admits to make sure that all are aware of the family room and its availability to them and their family weekly for 4 weeks and then monthly for the next two months. Social Services Director or designee will audit the family room to ensure that no residents are placed to live in the room weekly for 4 weeks and then monthly for the next two months. The audits will ensure that no residents have been missed for this issue. The Social Services Director or designee will report results of audits at monthly QAPI meetings for review.	6/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Knox	Administrator	6/3/2025

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 583	Continued From page 1 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and grievance review, the provider failed to ensure a private area was available for residents and families to meet. This concern was identified by four residents (6, 13, 17, and 22). Findings include: 1. Interview on 5/5/25 at 4:06 p.m. with resident 6 in his room revealed: *He resided in a shared room with another resident. *He had concerns about not having privacy when visitors were there. *He did not like his room full of visitors who visited his roommate. *He stated he had expressed his concerns about privacy to social services director (SSD) C and administrator A. *He stated, "I guess I just have to live with it." 2. Interview on 5/5/25 at 4:19 p.m. with resident 22 and her family in her room revealed: *Resident 22 stated there was no private space for a family to meet in the facility. *Her family stated they would like to have a space where the family could gather when they visited the resident that was private. 3. Interview on 5/5/25 at 4:25 p.m. with resident 17 in her room revealed she wished there was a space in the facility where residents and visitors could meet privately.	F 583		

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F 583	Continued From page 2	F 583		

4. Interview on 5/7/25 at 12:34 p.m. with SSD C revealed:
*There were a couple of residents' families that had complained to her about the lack of a private space to meet with residents in the facility.
*The previous owner had decided to turn the "Family Room" into a resident room for financial reasons.
*There had been a 4/28/25 grievance filed by a family member about that issue.

5. Interview on 5/7/25 at 12:42 p.m. with director of nursing (DON) B revealed:
*They used to have a "Family Room" that residents and their visitors could use.
*It was the previous owner's decision to turn it into a resident room.
*They tried to make accommodations for families to meet with residents in the dining room when meals were not being served and activities were not scheduled.
*One resident had complained to her about the lack of a private space.
*They were planning to eventually get the "Family Room" back so that residents and their families could have a private space to meet.
*She confirmed that there was currently no space available for residents to meet with visitors privately if they shared a room with another resident.

6. Interview on 5/7/25 at 12:49 p.m. with administrator A revealed:
*One resident's family member had complained about the lack of a private space for residents and their visitors to meet in the facility.
*She had received "the go-ahead" from current ownership to return that room to the "Family

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F 583	Continued From page 3 Room." *They had not made that change. *She confirmed that there currently was no available space for residents and their visitors to meet privately. 7. Review of the 4/28/25 grievance filed by the family member of resident 13 revealed: *He was very frustrated by having no private space for families to gather. *He offered to go to the board to explain why they needed the space. *Administrator A had written on the bottom of the grievance form, "I am going to bring it to the nursing home board at the next meeting on 5/20/25." 8. Review of the provider's undated "Resident's Rights in a Nursing Home" revealed that residents have a right to have proper privacy, property, and living arrangements.	F 583		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 610	1. Resident Incident Policy, Resident Accident Prevention Policy, and Abuse, Neglect, Misappropriation Policy were reviewed & updated by the Director of Nursing. Re-education will be provided regarding investigation procedures for incidents and accidents with any bodily injury. Care plan was updated on resident 26. 2. All residents are vulnerable adults and are potentially affected. 3. All staff were educated on the changes to the Resident Incident Policy and Resident Accident Prevention Policy on 5/29/25 by the Administrator. Investigations, root cause analysis, and reporting to State DOH was reviewed with all staff at the meeting on 5/29/25. 4. The Administrator or designee will audit al l investigations (including falls) in Risk Management to discern if proper procedure was followed in investigation and documentation weekly for 4 weeks and then monthly for the next two months. The audits will ensure that no residents have been missed for this issue. The Administrator or designee will report results of audits at monthly QAPI meetings for review.	6/13/2025

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F 610	Continued From page 4	F 610		

accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, interview, and policy review, the provider failed to ensure an investigation had been conducted and documented to rule out abuse and neglect for one of one sampled resident (26) who had sustained a skin laceration while being transferred to the bath chair by staff with the use of a total mechanical lift.
Findings include:

1. Observation and interview on 5/6/25 at 8:53 a.m. of resident 26 in his room while he was seated in his Geri-chair (a high-backed padded wheelchair with reclining capabilities) revealed:
*He had been reclined back in his Geri-chair.
*He was non-verbal during the interview.
*A total mechanical lift (lift and sling used to lift a person's full body) had been in his room.

2. Record review of resident 26's electronic medical record (EMR) revealed:
*He had a diagnosis of Alzheimer's disease and dementia and had been receiving hospice services.
*His 3/4/25 Brief Interview for Mental Status (BIMS) assessment score was 99 (which indicated the interview was not completed successfully).
*On 3/8/25 at 3:58 p.m. a progress note entered by licensed practical nurse (LPN) J revealed:
-"Resident has approximately a 2.5-inch laceration on the tip of his penis from the bath sling."

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F 610	Continued From page 5 -"Area was cleaned due to the location it's very difficult to apply a bandage." -"Skin protectant applied to the area; MD notified as well as POA." -There we no additional notes to determine how the injury was caused specifically due to the transfer or the bath sling, which staff were involved, or if the transfer was done safely. *On 3/10/25, 3/11/25, and 3/13/25 the laceration had been assessed for healing. *Resident 26 was dependent on staff for mobility and required assistance for: -Transferring with the use of two staff and the total mechanical lift. -Toileting due to him being incontinent of bowel and bladder. -He was not able to communicate his needs consistently. 3. Interview on 5/7/25 at 2:00 p.m. with director of nursing (DON) B regarding resident 26's 3/8/25 injury investigation revealed: *She did not think that she had needed to investigate the acquired injury. *She agreed that an investigation of the incident could have ruled out resident abuse or neglect. *She had not interviewed the staff involved in the incident because she did not think it was a potential abuse or neglect. *An incident report and investigation had not been completed by the nurse who had assessed resident 26's laceration at the time of the event. 4. Interview on 5/7/25 at 3:10 p.m. with DON B regarding her 5/7/25 investigation of resident 26's incident from 3/8/25 revealed: *She had been able to interview the certified nursing assistants (CNAs) who had been involved with the 3/8/25 incident that caused resident 26	F 610		

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F 610	Continued From page 6	F 610		

skin laceration.
*DON B had interviewed licensed practical nurse (LPN) J that had assessed resident 26's skin laceration.
*LPN J informed her that the injured area was more of an abrasion than a laceration.
*DON B had thought that the words abrasion and laceration were interchangeable.
*She had stated that both CNAs involved had been competent to use the full body lift.
-No documentation of competencies of the CNA's lift use had been provided.

5. Interview on 5/7/25 at 3:30 p.m. with CNA H who had witnessed the incident on 3/8/25 involving resident 26 revealed:
*She was behind the bath chair to assist in guiding him onto the bath chair using the total lift.
*She helped to assist him to the back of the chair while he was lowered down by the total mechanical lift by another CNA.
*While he was lowered onto the bath chair he said "ouch", and they had stopped and noticed he was bleeding from his penis.
*They notified the nurse immediately.

7. Review of the provider's November 2018 Abuse and Neglect Policy revealed:
*What injuries to report: Injuries investigated and not witnessed. For example, bruises or abrasions, skin tears or lacerations.

8. Review of the provider's November 2018 Abuse, Neglect, and Misappropriation of Property Prevention Policy:
*Abuse: Physical harm, bodily injury, or attempt to cause harm or injury, or the infliction or fear of imminent physical harm or bodily injury on an elder of disabled person.

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F 610	Continued From page 7 9. Review of the provider's undated Resident Accident Prevention Policy and Procedures revealed: *"In the event an accident does occur, the appropriate incident report is completed, depending on the accident." *"All reports are reviewed by Administration and Director of Nursing."	F 610		
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 follow standard food safety practices for: *One of one cook (G) who had not changed her gloves or washed her hands while serving	F 812	1. The food safety requirements for food procurement, storage and sanitation was reviewed by the Dietary Director. The Dietary Department Infection Control Policies & Procedures was reviewed by the Dietary Director. The Glove Use and Hand Hygiene in the Kitchen Policy was reviewed and revised by the Dietary Director. 2. All residents who eat facility food are potentially affected. 3. Dietary Director reviewed proper procedures for glove use, The Glove Use and Hand Hygiene in the Kitchen policy changes for glove use, proper cleaning procedures, and the cleaning schedules with dietary staff on 5/29/25. 4. Dietary Director or designee will do audits on glove use, cleaning schedules as it pertains to the prep table, lower shelf of the prep table, steam table and storage shelf at least twice weekly for 4 weeks and then weekly for 4 weeks, then monthly for the next 2 months. Dietary Director or designee will report results from audits at the monthly QAPI meetings for review.	6/13/2025

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F 812	Continued From page 8	F 812		

resident food items to prevent potential contamination.
*Kitchen equipment that had not been cleaned to maintain a sanitary environment.
Findings include:

1. Observation on 5/5/25 at 5:28 p.m. of cook G during a meal service revealed with her gloved hands she:
*Removed the lids from the covered food items on the steam table.
*Touched a ladle and then grabbed the handle of a cart.
*Organized resident meal cards and opened the microwave door to heat up the pureed food.
*Used a sanitizer wipe to clean the serving ledge of the steam table.
*Used a thermometer to check the temperature of the sloppy joe meat.
*Opened a drawer and retrieved a spoon to stir the microwaved pureed food.
*Opened the microwave door and placed a bowl of potato soup in it.
*Retrieved the bowl of potato soup from the microwave.
*Retrieved a roast beef and cheese sandwich from a Ziplock bag and potato chips from a bag and placed them on a serving plate.
*Checked the temperature of the potato soup and placed the bowl of soup on a tray to be served to residents.
*Retrieved hamburger buns from a package sliced the buns into pieces and then put sloppy joe meat on the buns.
*Tore up another bun, placed meat on it, and sent it to be served to residents.
*Used those same gloves throughout the observed meal service.

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F 812	Continued From page 9 2. Interview on 5/6/25 with cook G immediately after the above observation revealed: *She stated it was her normal practice to not change her gloves during food service. *She agreed she should have used tongs to retrieve the buns and the sandwiches from the packages. 3. Observation on 5/6/25 at 11:25 a.m. of the prep table in the kitchen across from the stove revealed: *A 9 by 13 (9x13) inch pan had food spatter and debris on the inside of the pan. *Lids for pans had food spatter and debris on them. *The lower shelf of the prep table had food spatter and debris on it. 4. Observation on 5/6/25 at 11:35 a.m. of the steam table revealed: *The wooden surface had bare wood exposed, making it an uncleanable surface. *The front of the steam table had food spatter and stains on it. *The storage shelf had food stains and debris on it. 5. Interview on 5/6/25 at 11:42 a.m. with dietary manager (DM) F regarding the cleaning of the shelves and the steam table revealed: *The prep table shelf had not been cleaned in a while. *She had a weekly and monthly cleaning schedule posted for staff to follow. *She agreed that those cleaning schedules had not been followed. *She thought that cook D had cleaned the steam table two weeks ago, but food would get spilled on it, and the staff sometimes would not clean the	F 812		

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F 812	Continued From page 10 spilled food off the steam table. 6. Interview on 5/6/25 at 11:50 a.m. with cook I regarding the cleaning of the steam table revealed: *He had cleaned the steam table about two weeks ago. *He agreed the steam table needed to be cleaned again. 7. Interview on 5/8/25 at 10:35 a.m. with DM F regarding the observation with cook C revealed: *She had agreed that cook C should have changed her gloves after touching multiple surfaces. *She agreed Cook c should not have worn the same pair of gloves when she touched multiple surfaces and then continued to plate and serve food. *Staff should have only worn gloves when preparing ready to eat food items. *DM B agreed that wearing gloves and touching multiple surfaces and then handling ready to eat food items with those same gloves would have been an infection control concern that created the potential for cross-contamination. Review of the provider's cleaning schedule revealed: *The steam table had been signed-off as having been cleaned on 2/11/25, 2/25/25, and 3/4/25. *There was no area to sign-off the completion of cleaning the prep table shelves. Review of the provider's October 2014 Dietary Department Infection Control Policies and Procedures revealed: *"Clean and sanitize work surfaces, utensils, and equipment after each use."	F 812		

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F 812	Continued From page 11 Review of the provider's undated Use of Gloves and Washing Hands policy revealed: *"Only single-use gloves will be used." *"Hands must be washed before putting on gloves and when changing to a new pair." *Food handlers will change gloves when: -Gloves become soiled or torn. -Before beginning a different task. -At least every four hours during continual use, and more often as necessary. -After handling raw meat, seafood, or poultry and before handling ready-to-eat foods.	F 812		
F 880 SS=F	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 §483.71 and following accepted national standards;	F 880	1. The following policies were reviewed and revised as necessary: Respiratory Equipment Cleaning Instructions, General Cleaning and Maintenance of Equipment, Linen Handling, Water Management Program by the Director of Nursing, Administrator and Environmental Services Officer. Additional instructions added to Post-Neb Assessments in MARs on residents 6, 10, and 18 as well as all other residents with respiratory equipment to remind staff to clean neb equipment. Additional instructions reviewed on BIPAP cleaning on resident 10's MAR as well as all other residents with BIPAPs and CPAPs MARs. All unlabeled, shared personal care items were removed from whirlpool room that could potentially be used for multiple residents on 5/8/25. All items that may potentially contaminate clean linen were removed from clean linen storage rooms on 5/8/25. New part has been ordered for the bath chair to replace the rusted, uncleanable part and will be placed as soon as it arrives from manufacturer. Download and implement CDC toolkit. 2. All residents and all staff have the potential to be impacted. 3. All staff were educated on the changes to the policies and procedures of Respiratory Equipment Cleaning Instructions, General Cleaning and Maintenance of Equipment, Linen Handling, Water Management Program on 5/29/25. Additional instructions for Post-Neb Assessments and BiPAP and CPAP cleaning are built into the facility's computer program now to remind staff about proper cleaning of respiratory equipment. Implementation of the CDC toolkit will be done by the Environmental Services Officer and the Administrator. 4. Director of Nursing or designee will audit nebulizer and BIPAP cleaning, cleanable surfaces on whirlpool equipment, linen room cleanliness, and personal care items in the whirlpool room 4 times a week for 4 weeks and then monthly for the next 2 months. Director of Nursing or designee will report results from audits at the monthly QAPI meetings for review. Environmental Services Officer or designee will audit water management weekly for 4 weeks and then monthly for the next 2 months. Environmental Services Officer or designee will report results from audits at the monthly QAPI meetings for review.	

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	435092	A. BUILDING _____ B. WING _____	05/08/2025

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

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F 880	Continued From page 12 §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 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.	F 880		

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F 880	Continued From page 13 §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, record review, and policy review, the provider failed to ensure proper infection control practices were followed regarding: *The cleaning and storage of nebulizer machines and equipment (a device that converts liquid medication into an inhalable mist) for three of three sampled residents (6, 10, 18) who used a nebulizer machine. *The cleaning and storage of a BiPAP machine (device that pushes pressurized air into your lungs) and equipment for one of one sampled resident (10) who used a BiPAP machine. *The maintenance of one of one whirlpool bath chairs in a safe and cleanable condition. *The cleaning, storage, and use of shared personal care items found in one of one whirlpool room. *The storage of items in two of two designated clean linen closets. *The assessment for the risk of Legionella, the implementation of measures to prevent the growth of Legionella, and the establishment of testing protocols for Legionella. Findings include: 1. Observation on 5/5/25 at 3:41 p.m. in resident 6's room revealed there was an oxygen concentrator in his room with a nasal canula (flexible tubing that delivers oxygen through the nose) attached. The nasal canula was draped over the concentrator and was not covered. There was a nebulizer machine on a table. The tubing and the mask were attached to it, and the	F 880		

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F 880	Continued From page 14	F 880		

medication chamber was wet. The mask was sitting on the table, uncovered.

Observation and interview on 5/6/25 at 9:19 a.m. with resident 6 in his room revealed that his nebulizer was in the same condition as observed on 5/5/25. The resident stated he used the nebulizer three times per day. He also stated that the staff changed the tubing every week.

Observation and interview on 5/7/25 at 9:16 a.m. with resident 6 in his room revealed the nebulizer was in the same condition as observed on the previous two days. He stated that the staff does not disconnect the medication chamber from the nebulizer, rinse it out, and let it dry between treatments. The nasal cannula remained draped over the oxygen concentrator as observed on 5/5/25.

Observation on 5/7/25 at 4:12 p.m. and 5/8/25 at 8:32 a.m. of resident 6's room revealed the nebulizer remained in the same condition as previously observed.

Review of resident 6's electronic medical record (EMR) revealed:
*He had a diagnosis of chronic obstructive pulmonary disease (COPD) (lung disease that makes breathing difficult).
*He received nebulizer medication treatments three times a day.
*His breathing was to be assessed by a nurse after each nebulizer treatment was completed.
*There was an order to change the nebulizer mask and tubing once per week.
*There was no documentation or anything in his care plan that addressed the cleaning and storage of his respiratory devices.

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F 880	Continued From page 15 2. Observation and interview on 5/6/25 at 10:16 a.m. with resident 10 in his room revealed he had a nebulizer machine on his bedside table, with the tubing and mask attached. The mask was on the table, uncovered, and the medication chamber was wet. Resident 10 stated he used the nebulizer daily. Observation on 5/7/25 at 9:16 a.m. in resident 10's room revealed the nebulizer was in the same condition as observed on 5/6/25. There was a BiPAP machine with the tubing and mask connected to it. The mask was resting in a pink basin on the floor next to the bed, uncovered. There was also a towel and a plastic grocery bag in the basin. Observation on 5/8/25 at 8:33 a.m. revealed the BiPAP and neb machines were in the same condition as observed on 5/7/25. Review of resident 10's EMR revealed: *He had a diagnosis of COPD and emphysema (a lung condition that causes shortness of breath). *He received nebulizer (neb) treatments twice a day. *His breathing was to be assessed by a nurse after each nebulizer treatment was completed. *There was a physician's order to clean the BiPAP daily with soap and water. *There was a 1/20/25 care plan intervention to "Administer nebulizer treatments as ordered. Clean and replace equipment and supplies per protocol/as ordered." *There were 12/27/24 care plan interventions to "Change BiPAP and oxygen tubing and supplies as ordered" and "Clean BiPAP and equipment as ordered."	F 880		

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F 880	Continued From page 16 *There was no order or anything written in his care plan that addressed the storage of his respiratory devices. 3. Observation on 5/7/25 at 4:12 p.m. of resident 18's in his room revealed: *A neb machine was on resident 18's bedside table with the mask, reservoir cup, and tubing unassembled lying on a dry washcloth. -The washcloth was folded in half and draped over the neb mask and reservoir cup. *Resident 18 could not verify if he had washed the neb mask, reservoir cup, and neb tubing. Observation on 5/8/25 at 9:15 a.m. of resident 18's room revealed: *The neb machine remained on resident 18's bedside table with the mask, reservoir cup, and tubing all assembled. -There was a small amount of clear liquid that remained in the reservoir cup. Interview on 5/8/25 at 9:21 a.m. with registered nurse (RN) D regarding resident 18's nebulizer equipment revealed: *She stated she does not wash out the neb mask, reservoir cup, or tubing. *She indicated that the resident washes out neb mask, reservoir cup and tubing himself after the treatment. Review of resident 18's electronic medical record (EMR) revealed: *He was admitted on 3/19/24. *He had a Brief Interview for Mental Status (BIMS) assessment score of 10, which indicated he was moderately cognitively impaired. *He had a diagnosis of chronic obstructive pulmonary disease (COPD).	F 880		

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F 880	Continued From page 17 *A physician's order on 10/29/24 for ipratropium and albuterol (med to relax muscles in the airways and increase air flow to the lungs) inhalation suspension to be given four times a day by neb for COPD. *A physician's order on 10/29/24 for albuterol (med to reduce inflammation) inhalation suspension 0.083% to be given four times a day by neb for shortness of breath (SOB). *His care plan did not include that he washes the neb mask, reservoir cup, and tubing himself. Interview on 5/8/25 at 10:41 a.m. with director of nursing (DON) B revealed: *Nurses were responsible for cleaning the nebulizers and storing them appropriately as part of the post-treatment assessment, and it was her expectation that they were doing that. *It was her expectation that the BiPAP was being cleaned daily, stored, and the daily cleaning of the BiPAP was documented on the MAR. Interview on 5/8/25 at 11:13 a.m. with registered nurse (RN)/infection control preventionist E revealed: *It would be a concern if nebulizer tubing and BiPAP machines were not being cleaned and stored to dry. *She stated they were supposed to be cleaned, left to dry, and stored after each use. 4. Observation and interview on 5/8/25 at 9:34 a.m. with certified nursing assistant (CNA) K in the shower/tub room revealed: *Several containers of partially used and unlabeled soap, shampoo, and lotion next to the whirlpool tub. -She stated those items were shared and used for residents who did not have their own caddy of	F 880		

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F 880	Continued From page 18 personal hygiene items available in the shower/tub room. -She agreed that each resident should have had their own personal hygiene products to limit the potential for cross-contamination. *The arm of the bath chair had several areas of rust and areas that were cracked and bubbled. -She agreed that those were not cleanable surfaces. Observation and interview on 5/8/25 at 12:04 p.m. in the shower/tub room with RN/infection control preventionist E revealed: *They had experienced similar issues in the past with the bath chair and had repaired it. -She stated it was not a cleanable surface in that condition and was a risk for possible infection control concerns. Interview on 5/8/25 at 1:10 p.m. with DON B and RN/infection control preventionist E revealed: *They did not have a policy on shared use of personal hygiene products. *It was their expectation that personal hygiene products were not shared between residents to limit the potential for cross-contamination and infection control concerns. *They expected staff to bring each resident's own caddy of personal hygiene products from the resident's room to the shower/tub room and to only use those products for each resident. 5. Observation and interview on 5/7/25 that began at 3:04 p.m. with laundry assistant L of the clean linen closets revealed: *There were two clean linen storage closets with a coded keypads on the doors. *Items other than clean linens were stored in the first closet, including the following unclean items:	F 880		

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F 880	Continued From page 19 -A rolling rack that held packages of disposable bathing cloths, a stack of individual disposable briefs, and towels. -A resident's walker with a quilted basket on it that contained a gait belt. -A pair of shoes. -A single shoe. -An open package of heel protectors. -A wheelchair foot pedal. -Opened packages of disposable briefs. -Various cushions, pillows, and wheelchair cushions. *The second clean linen closet had unclean items stored, including: -Opened packages of briefs. -A gait belt. -A blue plastic basket that contained a resident's open and labeled personal care items, including deodorant, lotion, denture care tablets, and lotion. -Packages of disposable bathing cloths. -Christmas decorations. -Wheelchair cushions. *She stated that because linen was not covered in the closet, only clean linen should have been stored there to prevent potential contamination of the linen. Interview on 5/8/25 at 10:41 a.m. with DON B revealed: *It was her expectation that only clean linen be stored in linen closets. *She expected unclean items like wheelchair foot pedals and personal care items to be stored in the storage room. Interview on 5/8/25 at 11:13 a.m. with RN/infection control preventionist E revealed: *She expected linen closets to contain only clean linen.	F 880		

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F 880	Continued From page 20 *Unclean items stored with clean linens could result in contamination of clean linens. 6. Interview on 5/8/25 at 12:15 p.m. with administrator A about their water management plan to prevent waterborne pathogens revealed: *They had not assessed their water systems to determine where Legionella (a bacteria that can grow in water and cause serious illness) or other opportunistic pathogens could grow. *They had not implemented any measures to prevent the growth of Legionella in their facility. *They had not established any testing protocols to monitor for the presence of Legionella in their water system. *She stated they did not have a policy related to Legionella. 7. Review of the provider's 12/24 "Respiratory Equipment Cleaning Instructions" revealed: *Purpose: -To provide proper cleaning of respiratory equipment to maintain proper working order of equipment and to ensure proper infection control methods are adhered to. *Hand Held and Mask Nebulizers: -Clean after each treatment. --Disassemble nebulizer pieces. --Rinse thoroughly with distilled water. --Allow to dry on a clean paper towel or cloth. *CPAP or BiPAP Machine/Equipment: -Daily: --Remove headgear and any other pieces that will detach from the mask. --Remove tubing from any connectors, the humidifier or machine. --Fill a small sink, tub, or basin with warm water. Add a small amount of gentle dish soap. --Submerge the mask, headgear, tubing and	F 880		

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F 880	Continued From page 21 connectors in the warm soapy water. Allow to soak for a short period of time (about 20-30 minutes). Rinse. --Allow everything to air dry on a towel. Review of the provider's 1/10 Handling Clean Linen Policy and Procedure revealed: *Purpose: -To prevent contamination of clean linen. *Procedure -Linen must remain covered at all times until it is placed in the resident's room. -This reduces the potential for mishandling linen causing cross-contamination.	F 880		

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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 on 5/13/25. Highmore Health was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at E0034 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	E 000		
E 034 SS=E	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.542(c)(7), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of	E 034	1. Emergency Preparedness Plan (EPP) reviewed and revised with verbiage and specifics added regarding communication plan in the case of emergencies. 2. All residents, residents' family members, staff, this community, and the surrounding communities included in the facility's EPP are potentially affected. 3. All staff were educated on the changes to the EPP on 5/29/25. The new EPP was made available for all current residents or representatives as appropriate to review on 5/29/25. All new admissions will be given a copy of the new EPP. All new hires will be given a copy of the new EPP. 4. Administrator or designee will audit all new admissions and all new hires to make sure that they are given a copy of the new EPP when they are educated on the EPP weekly for 4 weeks and then monthly for the next two months. The audits will ensure that no residents have been missed for this issue. The Administrator or designee will report results of audits at monthly QAPI meetings for review.	6/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Knox	Administrator	5/30/2025

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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E 034	Continued From page 1 providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on policy review and interview, the provider failed to develop and maintain an emergency preparedness communication plan. Findings include: 1. Review of the provider's emergency preparedness policies revealed there was no emergency preparedness communication plan. 2. Interview and policy review with the administrator on 5/13/25 at 2:30 p.m. revealed she confirmed there was no written emergency preparedness communication plan in the emergency preparedness policies.	E 034		

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 _____	**05/13/2025**

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 was conducted on 5/13/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Highmore Health was found in compliance.	K 000		

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

Kim Knox | Administrator | 5/30/2025

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.

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 _____	05/08/2025

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 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 5/5/25 through 5/8/25. 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 44:73, Nursing Facilities, was conducted from 5/5/25 through 5/8/25 and then on 5/13/25. Highmore Health was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim Knox
TITLE: Administrator
(X6) DATE: 5/30/2025