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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435092 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 09/25/2014 |
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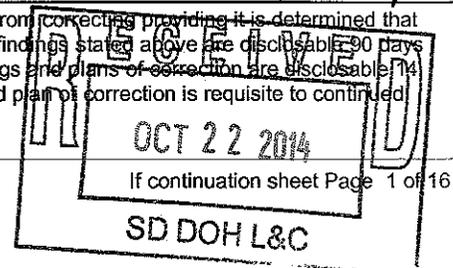
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| NAME OF PROVIDER OR SUPPLIER HIGHMORE HEALTH | STREET ADDRESS, CITY, STATE, ZIP CODE 410 8TH STREET SE HIGHMORE, SD 57345 |
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| F 000 | <p><i>Addendums noted with an asterisk per 10/20/14 telephone to facility administrator.</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 32333</p> <p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/23/14 through 9/25/14. Highmore Health was found not in compliance with the following requirements: F281, F323, 364, 371, and F441.</p> | F 000 | <p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> | |
| F 281 SS=E | <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on interview, record review, and policy review, the provider failed to ensure appropriate fall follow-up protocol had been followed per facility policy for five of ten sampled residents (1, 3, 5, 9, and 10). Findings include:</p> <p>1. Review of resident 10's medical record revealed: *He had the diagnoses of chronic obstructive pulmonary disease (difficulty breathing) (COPD), diabetic (unable to control blood sugar levels in the blood), and atrial fibrillation (AFIB) (irregular heart rate). *He had been at risk for falls and had fallen from his bed on 7/10/14 resulting in an injury to his head.</p> <p>Review of the provider's investigation report from 7/10/14 through 7/12/14 regarding resident 10 revealed:</p> | F 281 | | <p>F 281</p> <p>1) Director of Nursing, Administrator, and interdisciplinary team will review other policies related to resident assessment and will revise and re-educate as necessary regarding follow-up after a fall.</p> <p>* See page 2 * 2 All staff responsible for the tasks of follow-up on resident falls were reeducated October 21st 2014 regarding the Fall policy and appropriate follow-up protocol.</p> <p>* 4 The Director of Nursing or designee will review all falls weekly for 4 weeks and then monthly for 2 more months for appropriate charting and follow-up. The Director of Nursing or designee will bring the results of the findings to share at the monthly QAPI committee with further follow-up as recommended by the committee.</p> |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Neil Bedue</i> | TITLE <i>Administrator</i> | (X6) DATE <i>10-20-14</i> |
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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 281 | Continued From page 1 *On 7/10/14 at 11:00 p.m. he had been found lying on the floor. *He was sitting on the edge of his bed and had been trying to reach for an item on his dresser. *He had received a 4 inch laceration (cut) to the top of his head. *The nursing staff had been unable to stop the bleeding to his laceration. He had been sent to the hospital for an evaluation. *On 7/11/14 at 5:00 a.m. he returned from the hospital with staples to his wound. *On 7/12/14 at: -8:00 p.m. he had been requiring more staff assistance due to an increase in shortness of breath (SOB). The staff had administered a nebulizer treatment to help him breathe better. He had been very pale. -9:00 p.m. he had been resting with oxygen on, and the head of bed elevated. -10:00 p.m. {Resident yelling out "help me" resident color dusky with increase in SOB.} Physician had been notified and the ambulance called. -10:30 p.m. "Resident went unresponsive, ambulance crew started CPR (cardiopulmonary resuscitation)." Review of the hospital's 7/11/14 patient information and instructions form revealed: *The staff were to have "Watched for any new symptoms such as change in mental status." *Follow-up with his primary physician as scheduled or sooner if needed. **"Return immediately to the emergency department for any new symptoms or worsening of your current symptom." Review of resident 10's vital sign (blood pressure [b/p], pulse, and respirations) record report from | F 281 | *5 JD/SDDO4/MF The Director of Nursing or designee will be responsible for this area of compliance. *2. All residents including residents 1, 3, 5 and 9 will have the appropriate fall follow-up documentation per facility protocol and policy. JD/SDDO4/MF | 11/14/14 |

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| F 281 | <p>Continued From page 2</p> <p>2/12/14 through 7/10/14 revealed his b/p ranged from 110/50 to 140/70.</p> <p>Review of resident 10's the nurses' notes from 7/10/14 through 7/12/14 revealed on:</p> <p>*7/10/14 at 11:30 p.m.:</p> <ul style="list-style-type: none"> -He had been found on the floor and sent to the hospital as stated in the above report. -Neurological (neuro) checks (a test to check for responsiveness and pupil (dark center of eye) reaction had been done along with vital signs by the staff. -The physician had been notified by fax on the following: <p>*7/11/14 at 4:00 a.m. revealed:</p> <ul style="list-style-type: none"> -They had received a call from the hospital and he was returning to the facility. -His b/p done earlier had been 94/49. -A CT (computerized tomography) was done, and no internal injury of the head had been viewed. <p>*7/11/14 at 5:00 a.m. revealed:</p> <ul style="list-style-type: none"> -He had returned to the facility. -He had been alert and responsive. -His b/p had been 90/60. <p>*7/11/14 at 8:00 a.m. the physician had been notified of his return to the facility.</p> <p>*7/11/14 at 8:50 p.m. revealed:</p> <ul style="list-style-type: none"> -His b/p was 98/54 and he had been complaining of a headache. An as needed order for Tylenol 650 milligrams (mg) had been received from the physician and given with relief. -No documentation had been found to support if neuro checks (eye responsiveness, strength testing, and level of alertness) had been done upon his return from the hospital. <p>*7/12/14 at 5:00 a.m. revealed he had received pain medication at bedtime for complaints of pain all over. No vital signs or neuro checks had been documented.</p> | F 281 | | | |

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| F 281 | <p>Continued From page 3</p> <p>*7/12/14 at 5:15 p.m. revealed: -"Resident had been very sleepy today." -No documentation to support neuro checks and vital signs had been completed.</p> <p>*7/12/14 at 8:00 p.m. revealed he had an increase in SOB with a nebulizer treatment given. His color was pale with abnormal sounds heard in his lungs. His continuous positive airway pressure (C-PAP) (keeps the airways in the lungs open) had been applied.</p> <p>*7/12/14 at 9:00 p.m. he had been resting soundly with oxygen on at 2 liters per nasal cannula (n/c). He was complaining of SOB and had requested his C-PAP to be applied.</p> <p>*7/12/14 at 10:00 p.m. he had been yelling out "help me." His color was poor with vital signs checked and b/p 80/40 with a temperature of 99.9 degrees Fahrenheit. His oxygen levels were low at 72% (normal is 90% to 100%). The physician had been notified, and the staff was given orders to transport him by ambulance to the hospital.</p> <p>*7/12/14 at 10:30 p.m. he became unresponsive while the staff had been assisting him to get ready to go to the hospital. The ambulance had arrived, initiated CPR, and left with the resident.</p> <p>*7/12/14 at 11:20 p.m. the hospital called to inform the facility that he had passed away.</p> <p>*No documentation had been found to support the nursing staff had been monitoring his neuro checks per facility policy.</p> <p>Review of the provider's November 2002 Falls policy revealed: **Nurse performs range of motion (ROM), neuro checks, (if there is a head injury) assessment for rotation and vital signs." **Neuro checks consist of vital signs, level of consciousness, motor function, pupil response, and pain response."</p> | F 281 | | | |

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| F 281 | <p>Continued From page 4</p> <p>**Neuro's done when any resident suspected of hitting head:</p> <ul style="list-style-type: none"> -Every fifteen minutes times (x) four. -Every thirty minutes x four. -Every hour x four. -Every four hours x four. -Every eight hours x four. <p>Interview on 9/25/14 at 12:20 p.m. with the director of nurses (DON) regarding resident 10 revealed she would have expected to see a minimum of 32 hours of documentation by the nursing staff in his nurses' notes. The staff had not assessed and documented per the facility falls policy for a resident who had sustained a head injury. She would have expected the nursing staff to have documented and informed the physician more than they had on his condition.</p> <p>2. Review of resident 9's medical record revealed:</p> <ul style="list-style-type: none"> *On 9/22/14 at 1:00 a.m. she had been found sitting on the floor next to the toilet. *The toilet had broken free from the wall and fell over. *No injuries had been found during the initial nursing assessment. *On 9/25/14 at 11:30 a.m. no further documentation was found to support the nursing staff had been assessing the resident per the facility policy. <p>Review of the provider's November 2002 fall policy revealed:</p> <ul style="list-style-type: none"> *Purpose "To ensure that all residents are evaluated for injuries after a fall." **Follow through consists of (if there is no head injury): -Monitoring vital signs as indicated by | F 281 | | |

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| F 281 | <p>Continued From page 5 assessment."</p> <p>-"Assessment of pain, discomfort, rotation, and bruising or abrasions every 8 hours for minimum of 24 hours."</p> <p>Interview on 9/25/14 at 12:30 p.m. with the DON revealed: *She confirmed the nursing staff should have documented on resident 9 for 24 hours. *She agreed the nursing staff needed to be more pro-active with using the provider's fall policy.</p> <p>Surveyor 23059 3. Review of resident 3's 2/22/14 nurse's notes revealed at 7:30 p.m. he had fallen in his bathroom doorway. A large amount of blood was noted coming from his left ear. His face had started to swell. The resident was transported by ambulance to the emergency room at 8:15 p.m. that day. He returned to the facility on 2/23/14 at 1:30 a.m. He had a large pressure dressing to the left side of his head. He had a laceration on his left ear that had required stitches. No vital signs or neurological checks were found documented at the time of his return from the hospital.</p> <p>Review of resident 3's 2/23/14 nurses notes revealed an entry at 5:00 a.m. that stated "neuros WNL [within normal limits]". At 10:00 a.m. his vital signs had been taken and recorded. No further vital signs or neurological checks had been found documented in those nurses notes.</p> <p>Review of the 2/23/14 emergency room discharge orders revealed the physician was to have been notified if there had been any neurological changes.</p> <p>Interview on 9/25/14 at 12:25 p.m. with the DON</p> | F 281 | | | |

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| F 281 | <p>Continued From page 6 revealed she would have expected neurological checks and vital signs to have been documented on resident 3 according to their policy.</p> <p>Surveyor: 32333 4. Review of resident 1's complete medical record revealed: *She had been admitted on 11/2/12. *She had medical diagnoses that included but not limited to dementia (altered mental status), diabetes, and high blood pressure. *She had been on psychotropic medication (alters mental thinking).</p> <p>Review of resident 1's nursing notes from 6/23/14 through 9/24/14 revealed: *On 6/24/14 at 1:05 a.m. the resident was sitting on the floor beside her bed. *At 8:00 a.m. on the same date as above she was found on the floor lying next to her bed. *On 7/6/14 she was found on the floor in front of her wheelchair. *On 7/14/14 she had rolled out of her bed onto the floor. *There had been no further follow-up documented regarding the resident's falls.</p> <p>5. Review of resident 5's complete medical record revealed: *She had been admitted on 8/19/09. *She had medical diagnoses that included but not limited to mild dementia, high blood pressure, and congestive heart failure. *She had been on psychotropic medication.</p> <p>Review of resident 5's nursing notes from 5/28/14 through 9/24/14 revealed on 6/17/14 the resident had been found sitting on the floor. There had been no further follow-up documented regarding</p> | F 281 | | | |

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| F 281 | Continued From page 7 her fall. Surveyor: 23059 6. Interview on 9/25/14 at 12:25 p.m. with the DON revealed she would have expected the Falls policy would have been followed after every resident's fall. Review of the provider's November 2002 Falls policy revealed: *Purpose "To ensure that all residents are evaluated for injuries after a fall." **Follow through consists of (if there is no head injury): -"Monitoring vital signs as indicated by assessment." -"Assessment of pain, discomfort, rotation, and bruising or abrasions every 8 hours for minimum of 24 hours." ***Nurse performs range of motion (ROM), neuro checks, (if there is a head injury) assessment for rotation and vital signs." ***Neuro checks consist of vital signs, level of consciousness, motor function, pupil response and pain response." ***Neuro's done when any resident suspected of hitting head: -Every fifteen minutes times (x) four. -Every thirty minutes x four. -Every hour x four. -Every four hours x four. -Every eight hours x four. | F 281 | | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives | F 323 | | | |

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| F 323 | <p>Continued From page 8</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, testing, interview, and policy review, the provider failed to ensure water temperatures were maintained at a safe level throughout the facility. Findings include:</p> <p>1. Observation and testing of water temperatures on 9/23/14 beginning at 1:30 p.m. in three randomly tested resident rooms (205, 212, and 111) on two of two hallways revealed water temperatures from the bathroom faucets ranged from 125 degrees to 127.4 degrees Fahrenheit (F).</p> <p>Interview on 9/23/14 at 2:00 p.m. with the maintenance supervisor revealed he thought water temperatures were being monitored by the laundry staff. He could not produce documentation testing had been done. He stated he used to check water temperatures at least monthly but had not done that on a regular basis for over two years. When asked to use the facility's thermometer to check the temperature of the water he stated that thermometer had not been used "in quite some time." The thermometer case was covered with a thick layer of dust. When tested that thermometer did not work and would not register a temperature.</p> <p>Review of the last water temperature log revealed it had been completed in February 2012. No</p> | F 323 | <p>F 323</p> <p>1.) The Administrator, Maintenance Supervisor, and interdisciplinary team will review and revise as necessary the policy and procedure about monitoring and responding to elevated water temperatures.</p> <p>2.)  JD/SDBO/HMF</p> <p>3.) Maintenance Director or designee will audit water temperatures weekly for 3 months and monthly thereafter. The Maintenance Director or designee will report findings to monthly QAPI Committee meetings with further follow-up as recommended by the committee.</p> <p>4.) Maintenance Director or designee is responsible for this area of compliance.</p> <p>Water temperatures have been lowered to be maintained between 100 degrees to 120 degrees Fahrenheit. A contractor was obtained to install a new temperature control unit. Resident rooms 205, 212 and 111 were tested and in the appropriate temperature range as listed above. JD/SDBO/HMF</p> | 11/4/14 |

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| F 323 | Continued From page 9 record of water temperature recordings since that time were found. Phone call to the Department of Health deputy administrator on 9/23/14 at 2:05 p.m. revealed this surveyor was to advise administrative and maintenance staff to immediately turn down the temperature on the hot water heater. Temperature testing at 6:30 p.m. on that same day revealed temperatures still ranged from 127.8 degrees F to 129.4 degrees F in two randomly tested rooms (202 and 101). Interview with the administrator on 9/23/14 at 6:30 p.m. revealed it would take some time for all of the hot water to run through the lines. He confirmed the water temperature on the hot water heater had been lowered considerably. Review of water temperatures on 9/24/14 at 8:10 a.m. revealed they ranged from 108.4 degrees F to 113.4 degrees F. Review of the provider's undated Resident Accident Prevention policy revealed: **"Resident lavatories have water temperatures not exceeding 125 degrees." *Water temperatures were to have been monitored by maintenance on a regular schedule. | F 323 | | | |
| F 364 SS=D | 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. | F 364 | | | |

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| F 364 | Continued From page 10 This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure a liquid with nutritive value had been added to thin the pureed foods for one of two observed meal services (supper) for six residents who were on pureed foods. Findings include: 1. Observation of the supper meal preparation and service on 9/23/14 from 5:20 p.m. through 6:30 p.m. revealed cook F: *Placed several cooked egg rolls in the food processor. *Retrieved a coffee cup and filled it with hot water from the coffee machine. *Added the hot water to the egg rolls. *She pureed those egg rolls and placed them in a portable steam table well. *She also pureed rice with hot water and placed it in a portable steam table well. *She had served the above pureed foods to the six residents who required blended foods. Interview on 9/23/14 at the time of the above observation with cook F revealed: *She would have used hot water to liquify the foods. This had been her normal practice. *She might have used cold milk or water to puree desserts. Interview on 9/24/14 at 2:05 p.m. with the dietary manager revealed: *She had been unaware that cook F had been using water to liquify and puree foods. *She agreed using hot water did not add any nutritive value to the pureed food. | F 364 | F 364 1) Dietary Manager met with dietician and reviewed policies and procedures. They developed a Pureed Foods policy. All staff responsible for the tasks of preparing pureed foods were educated on the new policy. 2) All other similar dietary policies and procedures related to nutritional value of foods were reviewed and revised as necessary to ensure nutritional value of foods. 3) Dietary Manager or designee will audit random puree/blending of foods weekly for 1 month and then monthly for 2 more months. Dietary Manager or designee will report findings to monthly QAPI Committee meetings with further follow-up and recommendation by committee. 4) The Dietary Manager or designee is responsible for this area of compliance. <i>*including cook F JDD/DH/MF</i> | 11/14/14 |

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| F 364 | Continued From page 11 Review of the provider's undated Food Preparation and Serving policy revealed no procedure to follow for pureeing foods. Lisa Eckstein and Katheryn Adams, Pocket Resource for Nutritional Assessment, 2013 Ed., Chicago, IL., 2013, pp. 103 and 106, revealed dysphagia (problems with swallowing) can result in serious health consequences as it can interfere with adequate nutrition and hydration. To minimize swallowing problems, and maximize nutrition, hydration, and quality of life for the resident dietary modifications involve changes in food and/or liquid texture to help compensate for loss of function, to maintain appropriate nutritional and hydration status, and to reduce the risk of aspiration. Those might include temperature changes and order of food/liquid presentation changes such as moistening and providing a cohesive bolus (to hold an amount together) by adding gravy or sauce. | F 364 | | |
| F 371 SS=D | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: | F 371 | | |

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| F 371 | <p>Continued From page 12 Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure appropriate handwashing, glove use, and handling of ready-to-eat food items had been done by one of two observed cooks (F) while preparing and serving one of two meals (supper). Findings include:</p> <p>1. Observation on 9/23/14 from 5:20 p.m. through 6:30 p.m. of cook F while preparing and serving the supper meal revealed: *She had washed her hands and put on a pair of gloves. With those gloved hands she had performed the following multiple tasks: -Puree foods. -Handled multiple kitchen equipment such as blenders, food processor, pans, cups, plates, bowls, and serving utensils. -Opened cupboard doors and retrieved bowls and cups. -Opened drawers and retrieved serving utensils. -Checked the temperature of multiple foods. -Touched ready-to-eat food items (cut-up several egg rolls) with her soiled gloves. *She had not been observed washing her hands or changing her gloves between any of the above tasks.</p> <p>Observation on 9/23/14 at 6:00 p.m. of cook F while checking the temperature of the food revealed she had not consistently cleansed the thermometer. She had not used an alcohol wipe six times between testing of the foods.</p> <p>Observation on 9/23/14 from 6:05 p.m. through 6:30 p.m. of cook F while serving the supper meal revealed she had laid the serving utensils on top of the well lids of the rice and egg rolls.</p> | F 371 | <p>F 371</p> <p>1) Dietary Manager reviewed and revised Food Handling policy with the dietician. Re-educated employee F and all other dietary employees on Food Handling, Sanitation, and Handwashing policy.</p> <p>2) All other similar dietary policies and procedures related to food handling, sanitation, and handwashing were reviewed and revised as necessary.</p> <p>3) Dietary Manager or designee will audit food handling, sanitation, and handwashing weekly for 1 month and then monthly for 2 more months and report findings to monthly QAPI Committee meetings with further follow-up as recommended by the committee.</p> <p>4) Dietary Manager or designee is responsible for this area of compliance.</p> | 11/14/14 | |

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| F 371 | Continued From page 13 That had been observed during the entire serving process. Interview on 9/24/14 at 2:10 p.m. with the dietary manager revealed: *She had not done any audits of the cook during the pureeing and serving of food processes. *She would have expected cook F to have performed one task with one set of gloves. *Cook F should have: -Changed her gloves and washed her hands between each task. -Cleansed the thermometer between each food that had been tested for the proper temperature. -Not left any serving utensils on top of the serving well lids. Review of the provider's undated Food Preparation and Serving policy revealed no procedure in place for preparing and serving food. Review of the provider's January 2010 Handwashing policy and procedure revealed only the proper way to wash hands. There was no process specific to the dietary department. | F 371 | | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - | F 441 | | | |

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| F 441 | Continued From page 14 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, and policy review, the provider failed to ensure a multiple-resident use blood glucose meter (device to check a blood sugar) had been disinfected after each use by two of two observed registered nurses (RN) (A and B). Findings include: 1. Observation on 9/23/14 at 4:50 p.m. with RN A | F 441 | <i>F 441 including RNs A and B, JBS/DMF</i> 1.) <u>All staff responsible for the task of disinfecting the blood glucose meter</u> were re-educated on the policy and procedure for proper cleaning of the glucometer between residents. 2.) Director of Nursing will review and revise the policy for the blood glucometers as necessary related to the appropriate cleaning and disinfecting of nursing equipment. 3.) The Director of Nursing or designee will do glucometer cleaning checks weekly for 4 weeks and monthly for 2 more months for appropriate cleaning of the glucometer between residents. The Director of Nursing or designee will bring the results of the findings to the monthly QAPI Committee meetings with further follow-up as recommended by the committee. 4.) The Director of Nursing or designee will be responsible for this area of compliance. | 11/14/14 |

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| F 441 | <p>Continued From page 15</p> <p>after she had checked resident 2's blood sugar revealed she: *Wiped the blood glucose meter with a Gluco-Chlor wipe. *Immediately put the blood glucose meter back into its case.</p> <p>Observation on 9/24/14 at 4:00 p.m. with RN B after she had checked resident 2's blood sugar revealed she: *Wiped the blood glucose meter with a Gluco-Chlor wipe. *Set the blood glucose meter on top of the medication cart to dry.</p> <p>Review of the Gluco-chlor wipe manufacturer's label revealed to allow the surface to remain wet for five minutes. A five minute contact time was required for disinfection.</p> <p>Interview on 9/25/14 at 9:00 a.m. with the director of nursing revealed she agreed the blood glucose meter should have been properly disinfected after each resident's use per the manufacturers's label.</p> <p>Review the provider's Blood Glucose Meter Cleaning and Disinfection policy and procedure revealed to "Clean and disinfect meter between residents and any time contamination with blood or body fluid occurs or is suspected."</p> | F 441 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435092 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 09/23/2014 |
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| K 000 | INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/23/14. Highmore Health was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiency identified at K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | | |
| K 144 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 18087 A. Based on observation and interview, the provider failed to maintain the generator as required. A remote stop for the generator was not installed. Findings include: 1. Observation at 2:15 p.m. on 9/23/14 revealed the generator providing power for emergency | K 144 | | |

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

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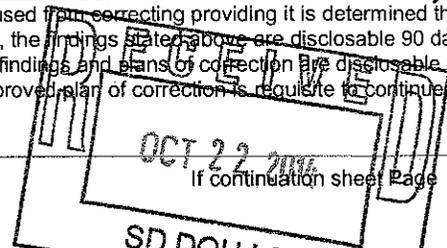
TITLE

Administrator

(X6) DATE

10-20-14

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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| K 144 | <p>Continued From page 1</p> <p>lighting was found to be lacking a remote manual stop station as required. That should have been mounted outside of the all-weather enclosure when the prime mover was located outside of the building. Interview with the maintenance supervisor confirmed that condition.</p> <p>This deficiency affected a single location required to be equipped with remote emergency stops.</p> <p>B. Based on observation and interview, the provider failed to install a remote alarm (annunciator) in a continuously occupied location to indicate when the generator system was in a trouble status. Findings include:</p> <p>1. Observation at 2:30 p.m. on 9/23/14 revealed the generator annunciator was installed in the boiler room which was not a continuously occupied space. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He acknowledged technical assistance had noted that condition had existed during the previous survey dated 10/29/13.</p> <p>The deficiency affected one of numerous generator installation requirements.</p> <p>C. Based on observation and interview, the provider failed to cover the battery terminals for the generator. Findings include:</p> <p>1. Observation at 2:45 p.m. on 9/23/14 revealed the generator battery did not have the terminals protected/covered. Interview with the maintenance supervisor at the time of the observation confirmed that finding.</p> | K 144 | <p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <p>K 144</p> <ol style="list-style-type: none"> 1.) Facility will have electrician install a remote stop button for the generator in a continuously occupied location. Generator battery terminals have been covered. 2.) Maintenance Director or designee will inspect other areas of generator to ensure compliance. 3.) Maintenance Director or designee will audit battery terminals once a month for three months and yearly thereafter. Maintenance Director or designee will inspect remote stop for generator after installation by electricians and will report findings to monthly QAPI Committee with further follow-up as recommended by the committee. 4.) Maintenance Director or designee will be responsible for this area of compliance. | 11/14/14 |

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| K 144 | Continued From page 2 The deficiency affected one of numerous generator maintenance requirements. | K 144 | | | |

South Dakota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10628 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 09/25/2014 |
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| S 000 | Initial Comments Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/23/14 through 9/25/14. Highmore Health was found not in compliance with the following requirement: S236. | S 000 | The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: | |
| S 236 | 44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32355 Based on employee file review, interview, and policy review, the provider failed to ensure three of five newly hired sampled employees (C, D, and E) received the two-step Tuberculin (TB) | S 236 | S 236 1.) Employee E was terminated 8-29-14. Employee C will be given two step TB test. Employee D has completed two step TB test. The Director of Nursing or designee will review all employee files to ensure that each employee had received a two step TB test. ✖ 2.) The policy for Tuberculin screening was reviewed and revised as necessary by the Director of Nursing and interdisciplinary team. 2A.) Staff responsible for ensuring the TB screens are delivered as per policy were re-educated on proper protocol. <i>Employee C will be given a two step TB test on 10/21/14 & completed on 10/28/14 to be read on 10/30/14. Employee D completed a two step TB test on 10/31/14.</i> | |

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

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Administrator

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South Dakota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10628 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 09/25/2014 |
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| S 236 | Continued From page 1 screening within two weeks of employment. Findings include: 1. Review of employee C's file revealed she had: *Been hired on 4/28/14. *Not received the two-step TB screening upon being hired. Review of employee D's file revealed she had: *Been hired on 5/27/14. *Just started the two-step TB screening on 9/24/14. Review of employee E's file revealed she had: *Been hired on 6/5/14. *Not received the two-step TB screening upon being hired. Interview on 9/24/14 at 4:30 p.m. with the director of nurses revealed she had: *Been responsible for the two-step TB screening on all new hires. The social worker was a licensed practical nurse and had been her back-up for the TB screening tests when she was not in the facility. *Confirmed the above findings and agreed the two-step TB screening was not completed within the two week requirement. Review of the provider's undated Tuberculosis Testing of Healthcare Workers policy revealed: *"It is the policy of this facility that all healthcare workers be tested for tuberculosis (TB) upon hire." *"Initial testing will be a two-step procedure, with the first dose given as soon as possible and the second "booster dose" given 1 to 3 weeks after the first." | S 236 | 3.) The Director of Nursing or designee will review all new hires weekly for 4 weeks and then monthly for 2 more months for appropriate TB testing. The Director of Nursing or designee will bring the results of the findings to share at the monthly QAPI Committee meetings with further follow-up as recommended by the committee. 4.) The Director of Nursing or designee will be responsible for this area of compliance | 11/14/14 |