

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

PRINTED: 06/28/2016  
FORM APPROVED  
OMB NO. 0938-0391

**ORIGINAL**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435092</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/15/2016</b>
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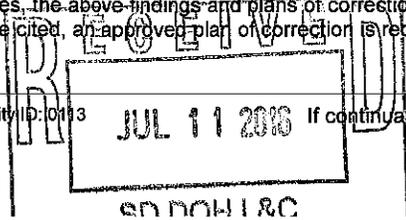
NAME OF PROVIDER OR SUPPLIER  <b>HIGHMORE HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 8TH STREET SE HIGHMORE, SD 57345</b>
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F 000	<p><i>*Addendums noted with an asterisk per 7/25/16 F 000 Per telephone with facility's emergency permit holder. MDS/DHCL</i></p> <p>Surveyor: 29162</p> <p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/13/16 through 6/15/16. Highmore Health was found not in compliance with the following requirements: F156, F242, F253, F274, F280, F281, F283, F323, F371, F441, and F514.</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 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p>	F 156	<p>F156</p> <ol style="list-style-type: none"> <li>1.) The Notice of Medicare Non-Coverage was updated to include the name and number of the Quality Improvement Organization(QIO) on the form.</li> <li>2.) Residents' 13, 14 &amp; 15 forms were left as is since these happened in the past.</li> <li>3.) The MDS Coordinator or designee will audit all Notices of Medicare Non-Coverage once a month for three months to ensure forms include the Quality Improvement Organization(QIO) name and number.</li> <li>4.) The MDS Coordinator or designee will report results of audits at the monthly QAPI meetings for review.</li> </ol>	8/4/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kim Knox</i>	TITLE <i>Emergency Permit Holder</i>	(X6) DATE <i>7/8/16</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 156	Continued From page 1  The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.  The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;  A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.  A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156			

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F 156	<p>Continued From page 2</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review and interview, the provider failed to ensure the liability notification of the Medicare denial process was accurately presented to three of three randomly selected residents (13, 14, and 15) who had received Medicare services. Findings include:</p> <p>1a. Review of resident 13's Notice of Medicare Non-Coverage form revealed the provider had failed to include the name and number of the quality improvement organization (QIO) on the form. The resident was not provided with the name or telephone number of the QIO. The resident's representative had signed the form on 4/25/16.</p> <p>b. Review of resident 14's Notice of Medicare Non-Coverage form revealed the provider had failed to include the name and number of the QIO on the form. The resident's representative had signed the form on 3/21/16.</p>	F 156			

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F 156	Continued From page 3 c. Review of resident 15's Notice of Medicare Non-Coverage form revealed the provider had failed to include the name and number of the QIO on the form. The resident had signed the form on 2/11/16.  d. Interview on 6/15/16 at 2:15 p.m. with the Minimum Data Set assessment coordinator revealed she presented the residents with the Notice of Medicare Non-Coverage. She agreed she had not provided the above residents with all the required information on the non-coverage notice.  A policy for Medicare denial notices was requested on 6/15/16. The emergency permit holder stated they did not have a policy for that.	F 156	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:	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 36413  Based on observation and interview, the provider failed to ensure resident requests were honored for food choices at meal time for one of one sampled residents (11) who had special requests. Findings include:	F 242	F242  1.) Resident #11's food preferences were reviewed with the resident by the Dietary Director to ensure the food preferences are noted. Also, all other residents' food preferences were reviewed with each resident by the Dietary Director to ensure their food preferences were noted. 2.) Handling of resident food preferences were reviewed with the dietary staff and all other employees responsible for these tasks. 3.) Dietary Director or designee will audit 5 residents' food preferences once per month for three months to ensure food preferences are being met. 4.) Dietary Director or designee will report findings from audits at the monthly QAPI meetings for review.	8/4/16

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F 242	Continued From page 4  1. Observation on 6/14/16 at 8:15 a.m. in the kitchen revealed a request for poached eggs from resident 11 was not honored. *Cook C had received the request and proceeded to make and serve a fried egg.  Interview on 6/14/16 at 8:25 a.m. with cook C regarding resident 11 revealed: *That resident was hard to please. **"If I would have made her a poached egg, she would have wanted a fried egg."  Interview on 6/14/16 at 11:00 a.m. with the dietary manager revealed poached eggs were an available choice for breakfast.  Interview on 6/15/16 at 11:00 a.m. with cook D revealed she did not know how to make a poached egg. She was not aware they were supposed to make that choice available for residents.  A policy for food choices was requested from the dietary manager but was not provided prior to the end of the survey.	F 242	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:  <i>→ *This will include painting of the wooden base under the recliner of resident 3. MP/SDDO/H/L</i>	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, interview, testing, and	F 253	F253  1.) Maintenance Supervisor has painted over all uncleanable wood surfaces and areas where paint was peeling. Whirlpool tub will be repaired and contractor notified to see what the best option is. Concrete slab will be replaced. 2.) Maintenance Supervisor or designee will inspect the facility for exposed wood, peeling paint, cracked concrete and will also inspect the whirlpool tub. 3.) Maintenance Supervisor or designee will add to his monthly preventative maintenance checklist to check the facility for exposed wood, peeling paint, the whirlpool tub and the outside concrete. 4.) Maintenance Supervisor or designee will report findings to monthly QAPI meetings for review.	8/4/16

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F 253	<p>Continued From page 5</p> <p>checklist review, the provider failed to ensure maintenance services were maintained to keep the facility environment in a safe and sanitary manner for:</p> <ul style="list-style-type: none"> <li>*Two of two wooden trim pieces with large scraped areas of exposed wood and splinters in two of two hallways .</li> <li>*One of one recliner that was resting on raw wood planks in one of seven sampled resident's (3) rooms .</li> <li>*One of two hallways (west wing) with missing and peeling paint.</li> <li>*Two of two foam arm rests with pieces missing on one of one whirlpool tub chair.</li> <li>*One of one whirlpool base with chips in the epoxy base making it an uncleanable surface.</li> <li>*One of one concrete loading pad with large cracks and crevices creating a trip hazard.</li> </ul> <p>Findings include:</p> <p>1. Random observations throughout the survey from 3:30 p.m. to 6:30 p.m. on 6/13/16, 8:00 a.m. to 6:00 p.m. on 6/14/16, and 8:00 a.m. through 3:30 p.m. on 6/15/16 revealed two wooden wall trim pieces in the west and north hallways that had large areas of scraped and exposed wood. Those areas of scraped wood:</p> <ul style="list-style-type: none"> <li>*In the west hallway revealed: <ul style="list-style-type: none"> <li>-There were three scraped and exposed wood areas that measured three inches by one-half inch wide, four inches by one inch wide, and four inches by one-half inch wide. Those areas were at heights easily accessible by residents when they were passing by.</li> <li>-Testing by running the finger across those areas revealed sharp splinters of wood. Some of those splinters of wood were easily removable with limited touching by a finger.</li> </ul> </li> <li>*In the north hallway revealed:</li> </ul>	F 253		

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F 253	<p>Continued From page 6</p> <p>-There was one area of scraped and exposed wood area that measured five inches long by one inch wide on the lower end of that trim piece.</p> <p>-Testing of that area revealed splinters of wood were easily rubbed off by touching it with a finger. That area was easily accessible to residents' lower legs when they were passing by.</p> <p>2. Observation on 6/13/15 at 3:45 p.m. revealed two raw wooden two by two inch planks were under a recliner in resident 3's room. Those wood planks were being used to raise the seat height of that recliner. Those wood pieces had not been painted or sealed and presented an uncleanable surface.</p> <p>3. Observation at 9:30 a.m. on 6/14/15 revealed a five and one-half inch by two and one-half inch area where paint had peeled off the wall. Testing of that area at that time revealed a one inch by two inch piece was easily removed by touching it.</p> <p>4. Observation on 6/14/15 at 4:50 p.m. revealed the two foam arm rests on the whirlpool tub chair had areas that were cracked and missing. Testing of those areas revealed they were sharp and ragged. That created an uncleanable area and safety hazard for resident's skin.</p> <p>5. Observation on 6/14/15 at 4:52 p.m. revealed two one-half inch open areas in the epoxy base of the whirlpool tub. Those areas exposed raw metal underneath and presented both a safety and health hazard for residents.</p> <p>6. Observation and interview on 6/15/16 from 9:30 a.m. to 10:00 a.m. with the maintenance supervisor confirmed the areas in need or repair: *Those planks had not been sealed or painted.</p>	F 253		

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F 253	<p>Continued From page 7</p> <p>He stated he was not aware those planks were under the resident's chair.</p> <p>*The area of missing and peeling paint on the west wing. He stated he was not aware that area was in need of repair.</p> <p>*The open areas in the whirlpool tub exposing raw metal. He stated he was not aware those areas in the tub needed repair</p> <p>*The open and cracked whirlpool tub arm rests. He stated he was not aware those arm rests needed to have been replaced.</p> <p>He agreed the above conditions created unsafe and unsanitary conditions for residents.</p> <p>7. Observation and interview on 6/15/16 at 10:07 a.m. with the housekeeping supervisor revealed a large gaping area in the concrete loading ramp outside the back (east) entrance. That area of missing concrete was approximately ten feet long by one foot wide. The gap created uneven surfaces that could become a trip hazard. That ramp was used to load and unload residents coming and going from the facility in vehicles. The housekeeping supervisor confirmed that area posed a safety concern for residents as they were entering and exiting vehicles.</p> <p>8. Review of the provider's preventative maintenance checklist revealed all of the above areas except for the whirlpool tub were on that checklist. Items were scheduled to have been reviewed daily, weekly, monthly, quarterly, semi-annually, and annually. Items noted by staff as needing repair were placed on a maintenance clipboard that was reviewed daily. None of the above items were on that clipboard as in need of repair.</p> <p>The provider did not have a maintenance policy</p>	F 253			

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F 253 F 274 SS=D	Continued From page 8 upon request. 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE  A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)  This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review and interview, the provider failed to determine a significant change in condition had been coded on the Minimum Data Set (MDS) assessment for one of nine sampled residents (2) who had MDS assessments completed. Findings include:  1. Review of resident 2's medical record revealed: *MDS assessments had been completed on the following dates: -1/28/16, an annual assessment. -4/19/16, a quarterly assessment. *He had been hospitalized on 2/13/16 and returned to the nursing home on 2/14/16.	F 253 F 274	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:  F274  1.) The policy for a significant change MDS was reviewed. 2.) Resident 2's MDSs will be left as is since they are in the past. 3.) The MDS Coordinator or designee will audit all residents' MDSs for a significant change that return from the hospital monthly for the next three months. 4.) The MDS Coordinator or designee will report results of audit at the monthly QAPI meetings for review.	8/4/16

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F 274	Continued From page 9 *That hospitalization had been related to: --A moderate to severe fecal retention. --Severe urinary retention. *A significant change in condition MDS had not been completed after that hospitalization.  Interview on 6/15/16 at 2:15 p.m. with the MDS coordinator regarding resident 2 revealed: *Fecal retention identified at the hospital had been a concern and change in condition for the resident. *The indwelling catheter had been a change in urinary elimination for the resident.  Review of the October 2015 RAI (Resident Assessment Instrument) manual online, Chapter 2.5, Assessment types and Definitions, revealed: "A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting' (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan."	F 274	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:	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the	F 280	F280  1.) Resident 2's care plan was reviewed and updated as necessary. 2.) The MDS Coordinator will review all other resident care plans and will update care plans as necessary. 3.) The MDS Coordinator will audit all care plans of residents returning from the hospital once a month for three months. 4.) The MDS Coordinator or designee will report results of audits at monthly QAPI meetings for review.	8/4/16

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F 280	<p>Continued From page 10</p> <p>comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review, interview, and policy review, the provider failed to ensure a care plan had been updated and revised to reflect the resident's current needs for one of one sampled resident (2) who had been hospitalized. Findings include:</p> <p>1. Review of resident 2's medical record revealed he had: *Been transferred to the hospital on 2/13/16 at 11:35 a.m. *Returned to the facility on 2/14/16 at 4:00 p.m. *Been diagnosed with urinary retention and constipation during that hospitalization. *An indwelling catheter inserted into his urinary bladder while he had been at the hospital. **"Moderate to severe fecal distention within the proximal colon." *Medications added or adjusted related to constipation while at the hospital. Those were -A bisacodyl 10 milligram suppository as needed for constipation.</p>	F 280		

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F 280	Continued From page 11 -Senokot 8.6-50 milligrams for constipation. -Polyethylene glycol 17 grams increased from once to twice a day.  Review of resident 2's undated care plan printed on 6/14/16 revealed: *No mention of constipation as a focus area. *A focus area for "Indwelling Foley (brand name) Catheter" that had not been initiated until 5/4/16. That had been three months after the catheter had been inserted.  Interview on 6/15/16 at 2:15 p.m. with the Minimum Data Set assessment coordinator revealed she agreed: *Constipation had not been added as a focus area to resident 2's care plan but should have been. *The focus area for the indwelling catheter had not been added timely to the above resident's care plan.  Review of the provider's Care Plan Policy and Procedure revealed: *The purpose was to be able to quickly identify a resident's individual needs. *Decrease the risk of incomplete, incorrect, or inaccurate care, and to enhance continuity of nursing care. *Care plans were to have been reviewed with any significant change in resident condition.	F 280	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:  <i>*this will include review of resident's 2 and 16. MP/SDDO/HJL</i>	
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.	F 281	1.) Director of Nursing will review and revise as necessary policies and procedures about resident changes of condition, insulin pen injections, and secure medication storage. 2.) Appropriate assessment and documentation for resident changes of condition, correct insulin pen injections, and secure medication storage mandatory in-service was held and included LPN (F) and other staff involved in these procedures. 3.) Director of Nursing or designee will audit charting on residents for changes in condition, insulin pen administration, and medication storage weekly for 4 weeks and monthly for 2 more months. <i>*five charts for MP/SDDO/HJL</i> 4.) Findings will be reported to monthly QAPI committee meetings with further follow-up as recommended by committee. <i>*The DON or designee will report to QAPI. MP/SDDO/HJL</i>	8/4/16

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F 281	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162</p> <p>Based on record review, observation, interview, and policy review, the provider failed to ensure:</p> <ul style="list-style-type: none"> <li>*One of one resident (2) who had been hospitalized for fecal retention and urinary retention had his condition assessed and documented prior to hospitalization.</li> <li>*Insulin administered per injection pen for one of one randomly observed resident (16) had been done correctly by one of one observed licensed practical nurse (LPN) (F).</li> <li>*Medication had been stored securely from residents, staff, and visitors during one of two observed medication passes.</li> </ul> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of resident 2's medical record revealed: <ul style="list-style-type: none"> <li>*An admission date of 1/21/16.</li> <li>*Admitting diagnoses that included: <ul style="list-style-type: none"> <li>-Rheumatoid arthritis.</li> <li>-Chronic pain.</li> <li>-Dorsalgia.</li> <li>-Weakness.</li> <li>-Constipation.</li> <li>-Gastritis.</li> <li>-Moderate protein calorie malnutrition.</li> <li>-Depression.</li> <li>-High blood pressure.</li> <li>-Peripheral vascular disease.</li> <li>-Right below-the-knee amputation.</li> <li>-Pressure ulcer of the right and left buttocks.</li> </ul> </li> </ul> </li> </ol> <p>*Review of the hospital admission notes from a 2/13/16 hospitalization revealed: -CT scan of the abdomen and pelvis at the time of that admission revealed "Severe distention of</p>	F 281		

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F 281	<p>Continued From page 13</p> <p>urinary bladder. Mild hydronephrosis of bilateral kidney which is secondary to the bladder distention. Moderate to severe fecal retention within the proximal colon."</p> <p>-Hospital emergency room (ER) physician's assessment revealed:</p> <p>--Abdominal pain secondary to the bladder distention.</p> <p>--Constipation.</p> <p>--Dehydration with hyponatremia.</p> <p>-Hospital ER physician's plan for treatment included:</p> <p>--Foley catheter inserted with "almost 1700 [cubic centimeters] [56.6 ounces] urine output."</p> <p>--Magnesium citrate administered for constipation.</p> <p>--Severe dehydration and hyponatremia treated with intravenous therapy and monitoring of the patient's sodium, blood urea nitrogen, and creatinine.</p> <p>*Review of the resident's hospital admission assessment by the ER physician revealed:</p> <p>- "No BM (bowel movement) for several days and some nausea."</p> <p>-Chronic constipation.</p> <p>-Bowel sounds present, Distended (Mildly tympanic), Soft.</p> <p>-Urinary outlet obstruction."</p> <p>Review of the provider's Nurse's Notes for the following dates revealed:</p> <p>*On 2/11/16 at 2:40 p.m., "Resident up @ 0730 when this nurse got on shift. Went to therapy shortly after. @0830 he left therapy." "Staff told me he was requesting a sleeping pill and to be put back into bed." "Staff put him back into bed."</p> <p>-Resident complained he was so sick and nauseated and had diarrhea all night and today.</p>	F 281		

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F 281	<p>Continued From page 14</p> <p>His pain was 9.5 so he received requested MS IR (morphine, strong opiate narcotic). His temperature was 99.9 so he received ES (extra strength) Tylenol.</p> <p>- At 10:45 a.m. his pain was unchanged and his temperature was 98.6. He still complained of nausea so Mylanta was given. At 11:00 he had no relief. Staff reports that he had had no loose BM's today. Will continue to monitor. That note had been signed by LPN F.</p> <p>*No further nurses' notes until 1:45 a.m. 2/12/16.</p> <p>*On 2/12/16 at 1:45 a.m., "Complains of nausea refuses antacids. Says they don't work. No emesis. Resident refuses to eat. MS given at 12:00 a.m. Says pain is a 10." That note had been signed by LPN H.</p> <p>*No further nurse's notes until 2/13/16 at 3:30 a.m.</p> <p>*On 2/13/16 at 3:30 a.m., "Resident complained of nausea. He assured me he was comfortable and might take his Morphine ER (extended release) later if his stomach felt better. He did appear to be sick. He felt he just had "the flu" At 4:20 a.m. still complains of nausea. Zofran 4 milligram order received from physician assistant and if he wasn't better by 8:00 a.m. to call ER and send resident over for nausea concerns regarding dehydration, ongoing abdominal pain and nausea since Wednesday." The notation had been signed by RN I.</p> <p>**On 2/13/16, Physician contacted at 11:00 a.m. Resident reported pain in right upper quadrant of his abdomen at 9. He stated he felt like someone "hit me." "He has been in bed for two consecutive days. Very nauseated. Low grade fever of 99.3 range for consecutive days." "Left in the ambulance at 11:35 a.m." Family had been notified. That note had been signed by LPN J.</p> <p>*On 2/14/16 at 0005, "Report from ER was he</p>	F 281		

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F 281	<p>Continued From page 15 was full of stool." That note had been signed by RN I.</p> <p>There had been no documentation in any of the above nurses' notes or in the medical record for resident 2 regarding assessment or examination of his abdomen. There had been no mention of urinary or bowel elimination assessments or monitoring. There had been no documentation of assessment for bowel sounds. There had been no documentation of palpation to his lower abdomen for nursing assessment reasons.</p> <p>Review of resident 2's Pain/PRN Monitoring Tool revealed on 2/11/16 at: *9:30 a.m., his pain level remained at 9.5. That was one hour and fifteen minutes after the prn medication had been received by resident 2. *10:45 a.m., Mylanta was given with no relief. *3:30 p.m., MS IR was given to the resident with no relief at 4:20 p.m.</p> <p>Review of resident 2's February 2016 medication administration record revealed he received Morphine for pain management.</p> <p>Resident 2's bowel elimination record was requested from the director of nurses (DON) on 6/15/16 at 11:00 a.m. She stated "We don't keep those. There are more than one resident's names listed on it, so we shred them at the end of each month." She stated she thought "He had been having bowel movements." She stated there had been no record available of the resident's bowel or bladder elimination.</p> <p>Interview on 6/15/16 at 1:20 p.m. with the DON revealed: *The February 2016 resident bowel elimination</p>	F 281		

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F 281	<p>Continued From page 16 records had been shredded.</p> <p>*She agreed she could not verify if resident 2 had been urinating or having bowel movements.</p> <p>*She agreed there had been no assessment of the resident's lower abdomen documented from 2/11/16 at 2:40 p.m. through 2/13/16 at 11:00 a.m.</p> <p>*She thought "He had been having bowel movements and urinating."</p> <p>*She knew Morphine was a narcotic and could cause drug induced constipation.</p> <p>*The night nurse was responsible for checking to see who needed to have laxatives. She was to review the bowel elimination records each night. She then made a list for the day nurse of those residents needing laxatives.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Televiser, St. Louis, Mo., 2013, pages 1046 and 1091 revealed: *"With urinary retention a patient [resident] may void small amounts of urine 2 or 3 times an hour." "Assess the abdomen for evidence of bladder distention and tenderness. Medication side effects may result in urinary retention [1046]." *"Constipation can be caused by medications. Opiates for pain often require a stool softener or laxative to prevent constipation [1091]."</p> <p>2. Observation on 6/14/16 at 11:30 a.m. of LPN F while she administered insulin with an insulin pen to resident 16 revealed she did not prime the pen prior to the injection</p> <p>Interview on 6/15/16 at 11:00 a.m. with the consultant pharmacist revealed his expectation was for insulin pens to be primed with two units of insulin prior to injecting.</p>	F 281		

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F 281	<p>Continued From page 17</p> <p>Interview on 6/15/16 at 11:30 a.m. with LPN F confirmed she had not primed the insulin pen prior to using it. She stated she knew she should have, but forgot.</p> <p>Interview on 6/15/16 at 1:30 p.m. with the DON revealed her expectation for using insulin pens was for them to have been primed with two units of insulin before injecting the insulin. She agreed LPN F had not followed the correct process for use of the insulin pen.</p> <p>Review of the provider's July 2012 Skills Checklist: Administration of Insulin Via Medication Pen revealed the insulin pens were to have been primed before each injection.</p> <p>3. Observation on 6/15/16 at 8:30 a.m. of the medication cart while in the dining room revealed two medication pill cards laying part way inside a three ring binder. That binder laid on top of the medication cart. One of the medication cards had been empty. The other medication card contained fourteen tablets of furosemide 80 mg.</p> <p>Interview with LPN F at that same time revealed she laid the cards there, so she would remember to take them to the medication room. She agreed they were not secured, and there had been residents, staff, and visitors present in the dining room area.</p> <p>Review of the provider's January 2005 Medication Administration General Guidelines policy revealed no medications were to have been kept on top of the cart.</p>	F 281	<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>F283</p> <ol style="list-style-type: none"> <li>1.) Recapitulation by a nurse will be done on every resident discharged from the facility beginning on our next discharged resident.</li> <li>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.</li> <li>3.) Director of Nursing or designee will audit <del>call</del> <sup>MP/SDO/HJEL</sup> recapitulation of discharged residents monthly for 3 months.</li> <li>4.) Findings will be reported to monthly QAPI committee meetings with further follow-up as recommended by committee. <sup>MP/SDO/HJEL</sup></li> </ol> <p><i>*The DON or Designee will report the results.</i></p> <p style="text-align: right;"><b>8/4/16</b></p>
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS	F 283	

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F 283	Continued From page 18  When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.  This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on record review and interview the provider failed to ensure a thorough summary of stay was completed upon discharge for one of one sampled closed resident (10) record reviewed. Findings include:  1. Interview on 6/15/16 at 3:15 p.m. with the director of nursing revealed she had never heard a summary was needed for discharged residents.  2. Review of resident 10's medical record revealed a summary of stay was not recorded on the chart.	F 283	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:  <i>*The emergency permit holder will monitor the maintenance Supervisor monthly for completion of the monthly maintenance checklist. This will be done monthly for 3 months. MP/SD/DH/EL</i>	
F 323 SS=D	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 adequate supervision and assistance devices to prevent accidents.	F 323	1.) All areas of peeling paint and uncleanable wood surfaces have been painted over. Whirlpool tub will be repaired. The concrete slab will be replaced. 2.) The facility will be inspected by the Maintenance Supervisor or designee for exposed wood that could give splinters, cracked concrete that could cause someone to trip, peeling paint, the whirlpool arm rests for missing foam pieces and the whirlpool tub for exposed raw metal that poses a safety hazard. 3.) Maintenance Supervisor or designee will add to his monthly preventative maintenance checklist to check the facility for peeling paint, exposed wood, the outside concrete and the whirlpool tub. 4.) Maintenance Supervisor or designee will bring the results to the monthly QAPI meetings for review.	8/4/16

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F 323	Continued From page 19  This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, interview, testing, and checklist review, the provider failed to ensure potential accident hazards were repaired or replaced for: *Two of two wooden trim pieces in two of two hallways with large scraped areas exposing wood and splinters. *One of two hallways (west wing) with missing and peeling paint. *Two of two foam arm rests with pieces missing on one of one whirlpool tub chair created a safety hazard for residents' skin. *One of one whirlpool tub with chips in the epoxy base exposing raw metal created a safety hazard for residents. *One of one concrete loading pad with large cracks and crevices creating a trip hazard for residents. Findings include:  1. Observation and interview with the maintenance and housekeeping supervisors during the survey times revealed the above areas were in need of repair or replacement. All areas created unsafe conditions and potential accident hazards for residents.	F 323	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:  F371  1.) Policies on glove use, handwashing and food temperatures were reviewed and revised as necessary. Protocol for cleaning and sanitizing the dietary cards was reviewed. 2.) Dietary Director or designee will review policies on glove use, food temperatures and handwashing with dietary staff including cook C and Cook D. A policy will be created for the cleaning and sanitizing of the dietary cards and reviewed with the dietary staff. 3.) Dietary Director or designee will do audits on glove use, food temperatures, handwashing and cleaning and sanitizing the dietary cards weekly for four weeks then monthly for two more months. 4.) Dietary Director or designee will report results from audits at the monthly QAPI meetings for review.		
F 371 SS=F	1. Refer to F253, findings 1, 3, 4, 5, and 6. 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	F 371		8/4/16	

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NAME OF PROVIDER OR SUPPLIER  <b>HIGHMORE HEALTH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 8TH STREET SE HIGHMORE, SD 57345</b>	
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F 371	<p>Continued From page 20 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, record review, and policy review, the provider failed to for two of two meals observed: *Test the temperature of foods served to the residents on a consistent basis for two of two cooks (C and D).V *Use proper glove and handwashing technique when serving food for one of one cook (C). *Clean resident diet cards used in the kitchen tray line. Findings include: 1. Observation on 6/14/16 at 11:40 a.m. revealed Cook C did not use proper glove use when serving residents their meal. *She had left tray line and walked over to counter. *She had gotten a slice of bread out of sack. *She then had gotten a knife out of the drawer and buttered bread. *She then cut the piece of bread in half and put on the tray. *She then returned to the tray line and served food to residents without changing gloves are washing her hands.</p> <p>Observation on 6/15/16 from 5:45 to 6:15 p.m. with Cook C revealed she: *Had gloves on from serving the tray line. *Had went to the storage room for can of soup.</p>	F 371		

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F 371	<p>Continued From page 21</p> <ul style="list-style-type: none"> <li>*Then opened the soup, put it in a bowl and heated it in the microwave.</li> <li>*Then handed the soup to a server through the window.</li> <li>*Then took off gloves without washing her hands.</li> <li>*Put ground meat and tomatoes in the refrigerator.</li> <li>*Rinsed dishes in the dishwashing area.</li> <li>*Then washed hands for three seconds and turned off the faucet with her bare hand.</li> <li>*Then threw away garbage and put on new gloves without washing her hands and returned to the tray line and served residents food.</li> </ul> <p>2. Observation on 6/13/16 during supper time and 6/14/16 during breakfast serving time revealed:</p> <ul style="list-style-type: none"> <li>*Individual resident dietary cards were handled by: <ul style="list-style-type: none"> <li>-Cooks.</li> <li>-Servers.</li> <li>-Residents.</li> <li>-Dishwashers.</li> </ul> </li> <li>*Those cards went out on diet trays and returned back to the kitchen on dirty trays.</li> <li>*The cards were then piled on the counter for the next meal without being wiped down.</li> </ul> <p>Review of the documented tray line temperatures (temps) for June 1-14th revealed:</p> <ul style="list-style-type: none"> <li>*Cereal was the only food temped for breakfast for ten of eleven breakfasts recorded.</li> <li>*Six of thirteen evening meals temperatures were not taken for any foods.</li> </ul> <p>3. Interview on 6/15/16 at 4:00 p.m. with the dietary manager revealed:</p> <ul style="list-style-type: none"> <li>*Staff were expected to wash hands every time they left the tray line.</li> <li>*Temperatures should have been taken for all hot</li> </ul>	F 371		

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F 371	Continued From page 22 and cold foods at every meal. *Dietary cards were cleaned weekly.  4. Interview on 6/15/16 at 6:00 p.m. with cook D revealed: *She had been trained to only take the temperature of the cereal in the mornings. *Some dietary staff did not take any temperatures of any food.  3. Review of the provider's September 2014 Handwashing policy revealed: *"Moisten hands and apply a good lather with soap using friction for at least twenty seconds." *"Turn off the faucet with towels." *The policy said to wash hands: -Before beginning work. -Before and after handling or serving food. -Before and after the handling of meat. -Before and after handling soiled dishes.  Review of the 2005 Becky Dornier and Associates Policy and Procedure manual revealed: *All hot food items must be served at a temperature of at least 140 degrees Fahrenheit (F). *All cold food items must be served at a temperature of 40 degrees F or below. *Cooking temperatures must be reached and maintained according to regulation.	F 371	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:  F441  1.) Director of Nursing or designee will review and revise as necessary policies and procedures about the blood glucose meter, splitting medications, placement of syringes and other objects taken into residents' rooms, and cleaning of oxygen concentrator filters. Housekeeping Supervisor or designee will review and revise as necessary policies and procedures about contact time for cleaning products.  2.) Appropriate glucometer use, medication splitting method, placement of objects taken in to residents' rooms, and cleaning oxygen concentrator filters mandatory in-service was held and included LPN (F), UAP (G), and other staff involved in these procedures. Housekeeping Supervisor or designee will hold mandatory in-service with housekeeping staff including housekeeper A on contact time for cleaning products.  3.) Director of Nursing or designee will audit blood glucose meter use, medication splitting, clean object placement in residents' rooms, and cleaning of oxygen concentrator filters weekly for 4 weeks and monthly for 2 more months. Housekeeping Supervisor or designee will audit contact time of cleaning products weekly for 4 weeks and monthly for 2 more months.  4.) Findings will be reported to monthly QAPI committee meetings with further follow-up as recommended by committee.	
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.	F 441		

*MR 8/14/16  
\*the  
results  
will be  
reported  
by the DON  
or designee*

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F 441	Continued From page 23  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (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: 29162 Based on observation, record review, interview, and policy review, the provider failed to ensure: *One of one observed unlicensed assistive personnel (UAP) (G) completed handwashing	F 441			

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F 441	<p>Continued From page 24</p> <p>correctly during two of two observed handwashes.</p> <p>*The blood glucose monitor (BGM) case had been cleaned before it had been put back into the medication cart by one of one observed UAP (G).</p> <p>*One of one observed UAP (G) broke a medication tablet in half correctly.</p> <p>*An insulin pen and prefilled insulin syringe had been placed in a clean place before they were administered by one of one observed licensed practical nurse (LPN) (F).</p> <p>*One of one randomly observed resident's (12) oxygen concentrator filter was maintained in a clean manner.</p> <p>*One of two housekeepers (A) knew the correct contact time for use of the disinfectant for cleaning bathroom fixtures.</p> <p>Findings include:</p> <p>1. Observation on 6/14/16 at 11:00 a.m. of UAP G while she completed a blood glucose test for resident 17 revealed she:</p> <p>*Washed her hands two times.</p> <p>-Both of those times she washed her hands for five seconds.</p> <p>-She turned off the water with her wet, bare hands both times.</p> <p>*Placed the BGM case on her lap, the resident's bedside table, and on the resident's bed.</p> <p>*Did not clean or sanitize the BGM case before she put it back into the medication cart.</p> <p>Review of the provider's undated Hand Washing Policy and Procedure revealed:</p> <p>*Hands were to have been washed for "at least 15-20 seconds."</p> <p>***"Avoid touching sink or faucet."</p> <p>***"When finished, turn off the faucet with a clean paper towel."</p>	F 441		

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F 441	<p>Continued From page 25</p> <p>Review of the provider's undated Blood Glucose Meter Cleaning and disinfecting Policy and Procedure revealed no mention of cleaning the BGM case.</p> <p>2. Observation on 6/14/16 at 8:45 a.m. of UAP G while she administered medications to resident 18 revealed the resident asked her to break one of the medication tablets in half. UAP G laid the tablet on the table and pressed idown on it with her bare fingers. She then handed it to the resident.</p> <p>Interview on 6/14/16 at 12:07 p.m. with UAP G revealed she had not broken medication tablets before. She stated she just thought to break it like that so she did. She agreed she should not have had bare hand contact with the resident's medication.</p> <p>Review of the provider's last revised 1/1/13 General Dose Preparation and Medication Administration policy revealed; *"Staff should not touch the medication when opening a bottle or unit dose package." *"If a licensed nurse must split a tablet, the nurse should wear gloves and break only scored tablets."</p> <p>3. Observation on 6/14/16 at 11:30 a.m. and at 5:00 p.m. of LPN F while she was preparing to administer insulin to residents 16 and 18 respectively revealed she: *Entered their rooms and went into their the bathrooms. *Placed the insulin pen or insulin syringe on the counter directly beside the sink. -Did not lay down a clean barrier for the insulin</p>	F 441		

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F 441	<p>Continued From page 26</p> <p>pen or syringe.</p> <p>-There had been wet areas on the counters.</p> <p>-There had been miscellaneous toiletry items on the counters.</p> <p>*Washed her hands.</p> <p>*Picked up the insulin pen or syringe from the counter by the sink.</p> <p>*Administered the insulin from the pen or syringe to the resident.</p> <p>4. Observation on 6/13/16 at 3:45 p.m. of resident 12 revealed she was sitting in the chair in her room. She had oxygen on per nasal canula. Inspection of the filter on the oxygen concentrator at that time revealed it was covered with dust. When it was removed from the concentrator many dust particles dropped from it. No part of the front of the filter was visible to the eye, because it was covered with dust.</p> <p>5. Interview on 6/15/16 at 1:20 p.m. with the director of nurses confirmed:</p> <p>*UAP G had not correctly washed her hands before giving insulin.</p> <p>*The BGM case should not have been returned to the medication cart without cleaning or sanitizing it.</p> <p>*Resident 18's medication tablet had been broken in half in an incorrect manner.</p> <p>*The insulin pen and insulin syringe should not have been laid beside the sink when LPN F had washed her hands.</p> <p>*Resident 12's oxygen concentrator filter had been dust covered.</p> <p>Surveyor: 23059</p> <p>6. Observation and interview on 6/14/16 at 8:55 a.m. with housekeeper A revealed she used</p>	F 441		

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F 441	Continued From page 27 Betco Stix to clean the bathrooms. She stated she sprayed it on the fixtures and immediately wiped it off. She was not aware the manufacturer's instructions on the label stated the contact surfaces should remain wet for ten minutes to ensure disinfection.  Interview on 6/14/16 at 9:10 a.m. with the housekeeping supervisor revealed he knew the above Betco disinfectant should stay on surfaces for five to ten minutes. He stated he usually left it on surfaces while he cleaned other areas but had not timed how long it remained wet.  Review of the provider's undated Housekeeping Department policy revealed all directives pertaining to cleaning procedures and schedules would be in writing. Each member of the housekeeping staff would be trained to follow them. There were no directions in that policy regarding manufacturer's instructions for disinfecting surfaces.	F 441	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:	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	F514  1.) Director of Nursing or designee will review and revise as necessary policy and procedure for resident changes of condition being assessed and documented appropriately. *This includes resident 2. 2.) Appropriate assessment and documentation mandatory in-service was held and included staff involved in resident assessment and documentation. 3.) Director of Nursing or designee will audit acute charting on residents weekly for 4 weeks and monthly for 2 more months. *This includes residents on skilled services recommended by committee. 4.) Findings will be reported to monthly QAPI committee meetings with further follow-up as recommended by committee. Antibiotic therapy post fall and with a change in condition. *The DON or designee will report to QAPI. MP/SDDOH/EL	8/4/16

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F 514	<p>Continued From page 28</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review, interview, and policy review, the provider failed to ensure one of one resident (2) who had been hospitalized for fecal retention and urinary retention had his condition assessed and documented. Findings include:</p> <p>1. Review of resident 2's medical record revealed he had been hospitalized for fecal retention and urinary retention. there had been no nursing documentation completed related to assessment of bowel sounds or lower abdomen. Refer to F281, finding 1.</p>	F 514		

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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/14/16. Highmore Health was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiencies identified at K038 and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 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>	

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

*Kim Knox*

TITLE

*Emergency Permit Holder*

(X6) DATE

*7/8/16*

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 ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>435092</b>	MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - MAIN BUILDING 01</b> B. WING _____	DATE SURVEY COMPLETE: <b>6/14/2016</b>
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NAME OF PROVIDER OR SUPPLIER <b>HIGHMORE HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 8TH STREET SE HIGHMORE, SD</b>
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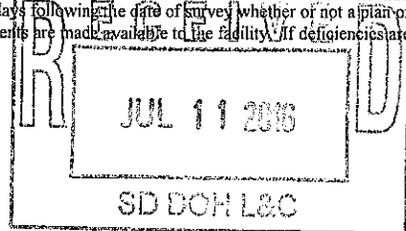
**ORIGINAL**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<p><b>K 038</b></p>	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.19.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain proper hardware on exit pathway doors. The main entrance vestibule door was equipped with a kickdown. Findings include:</p> <p>1. Observation at 8:00 a.m. on 6/14/16 revealed the main entrance vestibule exterior door was equipped with a kickdown. The kickdown could become wedged between the door and the ground surface immobilizing the door and restricting egress in an emergency situation. Interview with the interim administrator at 3:00 p.m. revealed the door had been equipped with a kickdown for years.</p> <p>The deficiency had the potential to affect 100% of the building occupants.</p>
<p><b>K 062</b></p>	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, record review, and interview, the provider failed to maintain the sprinkler system as required by the National Fire Protection Association (NFPA) Life Safety Code (LSC) 101. Sprinklers at the main entrance had mud and debris on them and there was no special wrench in the spare sprinkler box. Findings include:</p> <p>1. Observation at 10:00 a.m. on 6/14/16 revealed the main entrance patio had sidewall sprinklers installed. There was mud and debris situated on the sprinkler glass for three of three sprinklers. Interview with the maintenance supervisor at the time of the observation revealed bird nests had been on the top side of the sprinklers and had been removed by staff. He did not realize the muddy debris left on the sprinklers could affect the functioning of the sprinklers.</p> <p>2. Observation at 11:00 a.m. on 6/14/16 revealed the spare sprinkler storage box located at the sprinkler riser in the maintenance room was not provided with a special tool (wrench) for use with the sprinkler installations. Interview with the maintenance supervisor at the time of the deficiency revealed he had requested a special tool from the contractor working on the building's system since the previous life safety code survey dated 7/21/15. Record review of the previous life safety survey notes revealed the absence of the special tool had been noted and needed to be replaced.</p> <p>The deficiencies had the potential to affect 100% of the occupants in the building.</p>

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

The above isolated deficiencies pose no actual harm to the residents



STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>435092</b>	MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - MAIN BUILDING 01</b> B. WING _____	DATE SURVEY COMPLETE: <b>6/14/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>HIGHMORE HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 8TH STREET SE HIGHMORE, SD</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>K 062</b>	Continued From Page 1		

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10628</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>06/15/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HIGHMORE HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 8TH ST SE HIGHMORE, SD 57345</b>
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S 000	Compliance/Noncompliance Statement <i>*Addendums noted with an asterisk</i> Surveyor: 18087 <i>per 7/25/16 per telephone with facility's emergency permit holder.</i> A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing facilities, requirements for nursing facilities, was conducted from 6/13/16 through 6/15/16. Highmore Health was found not in compliance with the following requirements: S045, S075, S323, S346, and S347. <i>MP/SDDOH/EL</i>	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 323	44:73:08:06 Documentation of Drug Disposal  Legend drugs not controlled under SDCL chapter 34-20B shall be destroyed or disposed of by a nurse and another witness. Destruction or disposal of medications controlled under SDCL chapter 34-20B shall be witnessed by two persons, both of whom are a nurse or pharmacist, as designated by facility policy. Methods of destruction or disposal may include: (1) Disposal by using a professional waste hauler to take the medications to a permitted medical waste facility or by facility disposal at a permitted municipal solid waste landfill. Prior to disposal all medications shall be removed from original containers and made unpalatable by the addition of adulterants and alteration of solid dosage forms by dissolving or combination into a solid mass; (2) Return to the dispensing pharmacy for destruction or dispose according to federal and state regulations; (3) Return to an authorized reverse distributor company licensed by the South Dakota Board of Pharmacy; or (4) Release to resident upon discharge after authorization by the resident's prescribing practitioner.	S 323	S323  1.) Director of Nursing or designee will review and revise as necessary policy and procedure about documentation of drug disposal upon resident discharge. 2.) Drug disposal mandatory in-service was held and included staff involved in drug disposal upon resident discharge. 3.) Director of Nursing or designee will audit charts of discharged residents to make sure adequate physicians orders have been received to allow release of medications to resident upon discharge monthly for 3 months. <i>*all MP/SDDOH/EL</i> 4.) Findings will be reported to monthly QAPI committee meetings with further follow-up as recommended by committee.  <i>*Findings will be reported by the DON or Designee! MP/SDDOH/EL</i>	8/4/16

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

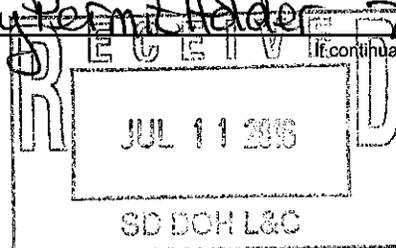
*Kim Knox*

TITLE

*Emergency Permit Holder*

(X6) DATE

*7/18/16*



SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10628</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/15/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>HIGHMORE HEALTH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 8TH ST SE HIGHMORE, SD 57345</b>		
(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 323	Continued From page 1  This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 36413 Based on record review, interview, and policy review, the provider failed to have a physician's order for one of one discharged resident (10) to take medications home. Findings include:  1. Closed record review revealed resident 10 had taken home an open insulin bottle and eye drops. There had been no physician order for her to have taken the medications when discharged.  Interview on 6/15/16 at 3:30 p.m. with the director of nursing revealed she could not find an order for resident 10 to take her medications home.  Review of the November 2002 Discharge of Resident policy revealed physician's order was to have been obtained for release of medications.	S 323	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 346	44:73:09:06 Retention of Medical Records  A facility shall retain medical records for a minimum of ten years from the actual visit date of service or resident care. The retention of the record for ten years is not affected by additional and future visit dates. Records of minors shall be retained until the minor reaches the age of majority plus an additional two years, but no less than ten years from the actual visit date of service or resident care. Initial, annual, and significant-change resident assessment records, as required in §§44:73:06:10 and 44:73:06:11, shall be retained for ten years from the actual visit date of resident care. The retention of the record for ten years is not affected by additional and future visit dates.	S 346	S346  1.) Director of Nursing or designee will review and revise as necessary policy and procedure about maintaining bowel elimination records. 2.) Retention of bowel elimination records mandatory in-service was held and included staff involved in keeping bowel elimination records. 3.) Director of Nursing or designee will audit monthly maintenance of bowel elimination records for 3 months. 4.) Findings will be reported to monthly QAPI committee meetings with further follow-up as recommended by committee.  <i>*The findings will be reported by the DON or designee. MP/SDDO/H/L</i>	8/4/16

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10628</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/15/2016</b>
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NAME OF PROVIDER OR SUPPLIER  
**HIGHMORE HEALTH**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**410 8TH ST SE  
HIGHMORE, SD 57345**

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S 346	<p>Continued From page 2</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 29162 Based on interview, the provider failed to maintain bowel elimination records for all thirty-five residents residing in the facility. Findings include:</p> <p>1. Interview on 6/15/16 with the director of nurses revealed: *She had been unable to provide a bowel elimination record for resident 2. *The resident's bowel elimination records prior to March 2016 had been shredded. *They shredded all bowel elimination records of all residents on a monthly basis or when they had been done using them. *The bowel elimination record included many residents' names, so she did not think they had to keep it.</p> <p>A policy for maintaining of resident bowel elimination records had been requested. There had been no policy specific to managing the bowel elimination records.</p>	S 346	<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>S347</p> <ol style="list-style-type: none"> <li>1.) The medical records room in the shed is locked and the key is in a secure area. A locking file cabinet was purchased and put in the MDS Coordinator's office for medical records to be secured at all times.</li> <li>2.) The MDS Coordinator or designee will file medical records in the new locked file cabinet located in her office. All personnel that take closed medical records out to the locked room in the shed were updated to the location of the key.</li> <li>3.) The Emergency Permit Holder or designee will audit medical record storage in the shed and the MDS Coordinator's office once a week for four weeks then monthly for two more months.</li> <li>4.) The Emergency Permit Holder or designee will report findings at the monthly QAPI meetings for review.</li> </ol>	
S 347	<p>44:73:09:07 Storage of Medical Records</p> <p>A facility shall provide for filing, safe storage, and easy accessibility of medical records. The medical records shall be preserved as original records or in other readily retrievable and reproducible form. Medical records shall be protected against access by unauthorized individuals. All medical or records shall be retained by the health care facility upon change of ownership.</p> <p>This Administrative Rule of South Dakota is not</p>	S 347	<ol style="list-style-type: none"> <li>1.) The medical records room in the shed is locked and the key is in a secure area. A locking file cabinet was purchased and put in the MDS Coordinator's office for medical records to be secured at all times.</li> <li>2.) The MDS Coordinator or designee will file medical records in the new locked file cabinet located in her office. All personnel that take closed medical records out to the locked room in the shed were updated to the location of the key.</li> <li>3.) The Emergency Permit Holder or designee will audit medical record storage in the shed and the MDS Coordinator's office once a week for four weeks then monthly for two more months.</li> <li>4.) The Emergency Permit Holder or designee will report findings at the monthly QAPI meetings for review.</li> </ol>	8/4/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10628</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/15/2016</b>
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S 347	<p>Continued From page 3</p> <p>met as evidenced by: Surveyor: 36413 Based on observation, interview, and policy review, revealed the provider failed to ensure all residents' medical records were stored in a secured area.</p> <p>1. Observation on 6/15/16 at 11:00 a.m. in the medical records storage shed revealed the: *Outer lock to the shed was not routinely locked. *Small inside area was left unlocked. *Key hung beside the medical records door in plain site.</p> <p>2. Interview on 6/15/16 at 11 a.m. with Minimal Data Set (MDS) coordinator revealed: *Boxes of medical records were kept in her office. *She shared her office with the beautician. *Her office was not locked during the work day.</p> <p>Observation on 6/15/16 at 1:15 p.m. revealed an unidentified resident was alone in the office/beauty shop while getting her hair done.</p> <p>Interview on 6/15/16 at 2:10 p.m. with the director of nursing confirmed medical records were kept in the MDS coordinator's and beautician's office.</p> <p>3. Interview on 6/15/16 at 2:20 p.m. with the emergency permit holder revealed she was unaware the medical records were to have been kept in a secured area.</p> <p>Review of the November 2002 Health Information Management Services policy revealed confidentiality of all medical records must be maintained.</p>	S 347		

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S 000	Continued From page 4	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:	8/4/16
S 000	Compliance/Noncompliance Statement  Surveyor: 29162 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 6/13/16 through 6/15/16. Highmore Health was found not in compliance with the following requirements: S045 and S075.	S 000		
S 045	44:74:02:10 Qualification of Program Coordinator  The program coordinator of a nurse aide training program shall be a registered nurse. The program coordinator is responsible for the general supervision of the program. General supervision means providing guidance for the program and maintaining ultimate responsibility for the course. The program coordinator shall have a minimum of two years of nursing experience, at least one year of which is in the provision of long-term care services. The director of nursing of a facility may serve simultaneously as the program coordinator but may not perform training while serving as the director of nursing.  This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 29162 Based on record review and interview, the provider failed to ensure: *The new nurse aide training program coordinator had been updated with the South Dakota Board of Nursing. *Records had been kept for all students to verify course completion in all areas. Findings include:	S 045		
			<p>S045</p> <ol style="list-style-type: none"> <li>1.) The application for faculty changes to a currently approved Nurse Aide training program was completed and faxed to the South Dakota Board of Nursing. A list of Nurse Aide skills was developed and included pass/fail for skills training.</li> <li>2.) The Nurse Aide application for faculty changes will be updated as necessary. A Nurse Aide skills checklist has been implemented for all future Nurse Aide training.</li> <li>3.) The Emergency Permit Holder or designee will audit the application for faculty changes to a Nurse Aide training program and the skills checklist for Nurse Aide training monthly for three months.</li> <li>4.) The Emergency Permit Holder or designee will report on the results of the audits at the monthly QAPI meetings for review.</li> </ol>	

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S 045	<p>Continued From page 5</p> <p>1. Interview on 6/15/16 at 2:00 p.m. with the administrator and Minimum Data Set (MDS) assessment coordinator revealed the director of nurses (DON) was the program coordinator. The emergency permit holder stated that changed when the DON took over. There had been no request for a change in primary instructor sent to the Board of Nursing for approval. The MDS coordinator stated she no longer was in charge of the nurse aide training.</p> <p>2. Interview on 6/15/16 at 11:45 a.m. with licensed practical nurse (LPN) K revealed she was the primary program instructor. The students used We Care online training and she completed the skills with them. She stated she used the skills listed at the back of the book from the South Dakota Health Care Association. That list of skills listed the steps that were required for completion of the proctored skills examination test. They did not teach how to do the skills when caring for a resident. She stated she does not keep skills competency records for the students to verify if they had passed or failed the skills training. She had a statement on a piece of paper that said, "Clinical class for _____ (student name) was 3/28/16 and 5/17/16." There was no other information on that form to indicate pass or fail for nurse aide training.</p> <p>A policy for nurse aide training was request. The emergency permit holder stated they went by the South Dakota Board of Nursing guidelines.</p>	S 045	<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>S075</p> <p>1.) Resident actor forms were completed and faxed to the Headmaster. <i>*for two current actors. 8/4/16</i></p> <p>2.) The test observer and resident actors were made aware of correct forms.</p> <p>3.) If there is a new resident actor, forms will be completed per protocol. The DON or designee will be responsible for the updating of forms.</p> <p>4.) The DON or designee will bring the resident actor forms to be reviewed and discussed at the next QAPI meeting.</p>	
S 075	<p>44:74:02:19 Facility Proctoring of Examination</p> <p>The written, oral, or skills demonstration examination may be conducted in a facility and proctored by facility personnel if the facility</p>	S 075		

SD Department of Health Vital Records

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S 075	<p>Continued From page 6</p> <p>obtains department approval before giving the examinations. The facility shall ensure that the examination is secure from tampering. Department approval may be withdrawn if there is evidence of tampering. Scoring of the examination shall be done by the professional testing company under contract with the department to administer the examination.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 29162 Based on interview and record review, the provider failed to ensure nurse aide testing was completed using an approved actor for the skills demonstration testing. Findings include:</p> <p>1. Interview on 6/15/16 at 2:15 p.m. with the facility testing proctor and emergency permit holder revealed they had not used a specific actor when they had proctored the skills demonstration testing for nurse aides. They both stated the emergency permit holder most often was the actor. The dietary manager and other staff members had also been used when necessary. They had been unaware the actor should have been trained and approved by the approved testing company.</p> <p>Review of the last update 10/20/10 South Dakota Test Observer Information Manual for Nurse Aide Testing provided by the South Dakota approved testing company of Headmaster revealed: *When test candidates arrive the testers should introduce themselves as "the Actor and Proctor." **"All actors need to review the Actor Training handbook with the Test Observer before each testing day begins." *Actors must complete and sign two forms: "(151SD-Actor Agreement Form) and</p>	S 075		

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S 075	Continued From page 7  (1511SD-Confidentiality/Non-Disclosure Form)." *Both of the forms were to have been faxed or mailed to Headmaster for approval of the actor participation. They would then be included with the provider's information for testing participation.	S 075		