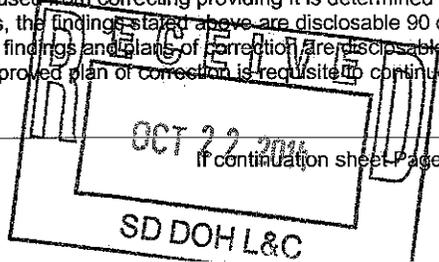


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/25/2014
NAME OF PROVIDER OR SUPPLIER HIGHMORE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 410 8TH STREET SE HIGHMORE, SD 57345	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 23059 A complaint 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. Areas surveyed included quality of care and treatment. Highmore Health was found not in compliance with the following requirement: F281.	F 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:	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. 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, 2, 3, 4, and 5). Findings include: 1. Review of resident 1'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. Review of the provider's investigation report from 7/10/14 through 7/12/14 regarding resident 1	F 281	F 281 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. *# in see page in SDSD000H/MF *3 All staff responsible for the tasks of follow-up on resident falls were reeducated October 21 st 2014 regarding the Fall policy and appropriate follow-up protocol. *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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ude Beckue 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.



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

PRINTED: 10/07/2014
FORM APPROVED
OMB NO. 0938-0391

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 C 09/25/2014
NAME OF PROVIDER OR SUPPLIER HIGHMORE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 410 8TH STREET SE HIGHMORE, SD 57345	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 1 revealed: *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 breath 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 1's vital sign (blood pressure	F 281	*5 JD/SBDDH/MF The Director of Nursing or designee will be responsible for this area of compliance. *#2. All residents including residents 2, 3, 4 and 5 will have the appropriate fall follow-up documentation per facility protocol and policy. JD/SBDDH/MF	11/14/14

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

PRINTED: 10/07/2014
FORM APPROVED
OMB NO. 0938-0391

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 C 09/25/2014
NAME OF PROVIDER OR SUPPLIER HIGHMORE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 410 8TH STREET SE HIGHMORE, SD 57345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 2</p> <p>[b/p], pulse, and respirations) record report from 2/12/14 through 7/10/14 revealed his b/p ranged from 110/50 to 140/70.</p> <p>Review of resident 1's 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 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</p>	F 281			

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

PRINTED: 10/07/2014
FORM APPROVED
OMB NO. 0938-0391

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 C 09/25/2014
NAME OF PROVIDER OR SUPPLIER HIGHMORE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 410 8TH STREET SE HIGHMORE, SD 57345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 3 documented.</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,</p>	F 281			

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

PRINTED: 10/07/2014
FORM APPROVED
OMB NO. 0938-0391

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 C 09/25/2014
NAME OF PROVIDER OR SUPPLIER HIGHMORE HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 410 8TH STREET SE HIGHMORE, SD 57345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 4 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.</p> <p>Interview on 9/25/14 at 12:20 p.m. with the director of nurses (DON) regarding resident 1 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 2's medical record revealed: *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> <p>Review of the provider's November 2002 fall 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):</p>	F 281		

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

PRINTED: 10/07/2014
FORM APPROVED
OMB NO. 0938-0391

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 C 09/25/2014
NAME OF PROVIDER OR SUPPLIER HIGHMORE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 410 8TH STREET SE HIGHMORE, SD 57345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 5</p> <p>-"Monitoring vital signs as indicated by 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 2 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 5'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 5'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>	F 281			

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

PRINTED: 10/07/2014
FORM APPROVED
OMB NO. 0938-0391

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 C 09/25/2014
NAME OF PROVIDER OR SUPPLIER HIGHMORE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 410 8TH STREET SE HIGHMORE, SD 57345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 6</p> <p>Interview on 9/25/14 at 12:25 p.m. with the DON revealed she would have expected neurological checks and vital signs to have been documented on resident 5 according to their policy.</p> <p>Surveyor: 32333</p> <p>4. Review of resident 3'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 3'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 4'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 4'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</p>	F 281			

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

PRINTED: 10/07/2014
FORM APPROVED
OMB NO. 0938-0391

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 C 09/25/2014
NAME OF PROVIDER OR SUPPLIER HIGHMORE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 410 8TH STREET SE HIGHMORE, SD 57345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	Continued From page 7 been no further follow-up documented regarding 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 to 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			