STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435092	A. BUILDING _____ B. WING _____	03/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/27/23 through 3/2/23. Highmore Health was found not in compliance with the following requirements: F600, F609, F610, F655, F657, F686, F689, and F700. On 3/1/23 at 8:58 a.m., immediate jeopardy was identified related to reporting of abuse at F610. At 12:08 p.m., administrator A provided a plan for the removal of the immediate jeopardy. At 12:22 p.m., the removal plan was accepted by the survey team. On 3/1/23 at 1:30 p.m., the survey team reviewed the provider's documentation for the removal of the immediate jeopardy. Immediacy was removed at 12:45 p.m. The resident census was 39.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600	1. Abuse, Neglect, Misappropriation Policy reviewed and revised. Care Plans were updated on resident 89 and resident 90. 2. All residents are vulnerable adults and are potentially affected. 3. All staff will be re-educated on the Abuse, Neglect, Misappropriation Policy on 3/23/23. Investigations, root cause analysis, grievance and concern reporting, and reporting to State DOH will be reviewed with all staff at the meeting on 3/23/23. Administrator or designee will continue to provide education and give a copy of the policy to all new hires and all new admits. New hire education is placed in their file. New admits education is placed in their chart. Social Services designee or designee will continue yearly education for staff which is documented in the all staff meetings binder. 4. The Administrator or designee will audit all investigations (including falls) in Risk Management and all issues reported as grievances or concerns to discern if proper procedure was followed in investigation and documentation weekly for 4 weeks and then monthly for the next 2 months. The audits will ensure that no residents have been missed for this issue. The Administrator or designee will report results of audits at monthly QAPI meetings for review.	3/23/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Knox	Administrator	3/23/2023

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 600	Continued From page 1	F 600		

physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and policy review, the provider failed to ensure one of one sampled resident (90) was protected from verbal and physical abuse by his roommate (resident 89). Findings include:

1. Observation and interview on 2/27/23 at 3:54 p.m. with resident 89 in his room revealed he:
*Was sitting in his recliner.
*Had been admitted earlier in the month because he had fallen at home and fractured his pelvis.
*Had communicated during the interview that his roommate (resident 90) was in the room touching his belongings. He had asked him to stop and the roommate had continued to touched his personal items.
*Then pushed the roommate.
*Was able to slide up to the front of the recliner seat and displayed how he pushed his rommate back behind the privacy curtain by using a motion with his arm.
*Stated the roommate had stumbled back, had fallen, and staff came into the room and picked him up off the floor.
*Stated that if his roommate touched his belongings again he would 'lay him out'.
*Then expressed he understood resident 90 was not well and had not always understood what was going on.

Review of resident 89's medical record revealed:
*He was admitted on 2/9/23.
*His 2/15/23 Brief Interview for Mental Status (BIMS) score was 15, indicating his cognition was intact.

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F 600	Continued From page 2 *His diagnoses included: fracture of superior rim of right pubis, contusion right shoulder, fracture of unspecified parts of the lumbosacral spine and pelvis, chronic kidney disease, pain, repeat falls, pressure-induced deep tissue damage of the left heel, and obesity. Review of resident 89's 2/24/23 care plan revealed his mood and behavior had not been addressed so there had been no goals or interventions put in place. 2. Observation on 2/27/23 at 3:54 p.m. of resident 90 revealed: *He was confused wandering in the hallway outside of his room. *His speech was garbled. *He could not answer questions when asked. *He had not appeared to have any injuries or bruising. Review of resident 90's medical record revealed: *He was admitted on 2/10/23. *He was unable to complete the BIMS due to his cognition. *His 2/16/23 Medical Data Set assessment indicated he had short and long-term memory problems. *His diagnoses included: Alzheimer's disease, cellulitis of left upper limb, heart failure, anxiety disorder, and amnesia. *He had fallen on 2/11/23, 2/19/23, and 2/20/23. Review of resident 90's interdisciplinary progress notes from 2/11/23 through 3/1/23 revealed he was having multiple behaviors that included: -Wandering throughout the facility and into other resident's rooms. -Looking through other residents' belongings.	F 600		

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F 600	Continued From page 3 -Exit seeking. -Becoming verbally and physically abusive with staff. -Removing his clothing in public areas. Review of resident 90's Fall Reports revealed on: *2/11/23: -He had an unwitnessed fall in the dining room. -No investigation had been completed. -No interventions had been put into place to prevent another fall. *2/19/23: -He had been found lying on the floor in his room. -No investigation had been completed. -No interventions had been put into place to prevent another fall. *2/20/23: -He had been found on the floor in his room and had been incontinent of bowel. -No investigation had been completed. -No interventions had been put into place to prevent another fall. Review of resident 90's 3/1/23 care plan revealed: *He had a "Potential for falls r/t [related to] impaired cognition." *Interventions were: *"Appropriate non-slip footwear." *"Be sure call light is within reach and encourage to use it for assistance as needed." *"Coordinate with appropriate staff to ensure a safe environment with: Floors even and free from spills or clutter, Adequate, glare-free light, Call light, Personal items within reach." *"PT evaluate and treat as ordered or PRN [as needed]." *No new fall interventions had been added to the care plan since 2/13/22.	F 600		

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F 600	Continued From page 4 *He had behaviors related to dementia and from being in a new environment. *His behaviors were wandering, exit-seeking, and going through other's personal belongings. *The interventions included the following: -"Anticipate and meet needs of resident including toileting on a schedule every 2 hours at the least." -"Attempt non-pharmacological interventions such as giving resident a magazine, the tinkering box with locks and latches, a snack." -"Ensure that hallways are free from spills, clutter and other hazards." -"Redirect resident to a new activity if he is wandering into other's rooms or getting into other's stuff." 3. Review of resident 89's 2/22/23 nursing progress note revealed: *"Resident became angry at roommate and started shouting at him. *The nurse intervened just as the resident was about to kick and hit his roommate [resident 90]. *The resident was talking to his son on the phone during that time. *The nurse immediately removed the roommate from the situation. *It appeared the roommate [resident 90] was previously just standing in the room. *[Resident 89's] son called nurse and spoke to nurse expressing concern for the situation and worried that his dad has "a temper". *DON [director of nursing] notified of situation." 4. Interview on 2/28/23 at 3:15 p.m. with DON B and social services designee (SSD) G regarding the situation between residents 89 and 90 revealed: *They both were unaware that resident 89 had pushed resident 90.	F 600		

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F 600	Continued From page 5 *DON B was aware of the incident that occurred between the residents on 2/22/23. *DON B had not really identified that the incident on 2/22/23 was resident-to-resident abuse. *The nurse involved in the incident had educated resident 89 that it was not appropriate to yell or threaten his roommate. *There was no documentation of resident 89's education by the nurse. *Since there had been no other incidents since 2/22/23 the residents had not been moved or separated. *Residents were not monitored twenty-four hours a day. *Staff may not have been aware of another incident that had occurred between the residents because the residents had not been monitored twenty-four hours a day. *They had not completed an investigation of the incident that occurred on 2/22/23 between the residents. Interview on 3/1/23 at 8:18 a.m. with DON B regarding the situation between residents 89 and 90 revealed: *They had planned on moving resident 90 into another room but had been waiting on a family consent to move another resident first. *No other resident safety interventions had been put into place to protect resident 90 until the room move was completed. *No investigation for the resident-to-resident incidents had been started. Interview on 3/1/23 at 8:58 a.m. with administrator A and DON B regarding the situation between residents 89 and 90 revealed: *SSD G had spoken with resident 90 yesterday about his behaviors.	F 600		

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F 600	Continued From page 6 *Had been waiting for resident 22's family to call and consent to a room change so the residents could be moved away from each other. *Staff had been observing the residents when they were awake but not when they were asleep. *Agreed either resident could have awoken and staff would not have known if they were up and moving. *They did not have one-to-one staff monitoring in place for resident 89 or 90 to ensure their safety. *Agreed they had not investigated the verbal abuse that had occurred on 2/22/23. 5. Interview on 3/2/23 at 10:52 a.m. with DON B regarding falls revealed: *Nurses did not document interventions put into place after a resident had fallen. *Falls had only been reviewed by the interdisciplinary team (IDT) on Monday mornings. *The IDT did not complete an investigation or implement new interventions when a resident had a fall. Refer to F610 finding 1 for policies.	F 600		
F 609 SS=G	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609	1. Abuse, Neglect, Misappropriation Policy reviewed and revised. Care Plans were updated on resident 89 and resident 90. Incident reported to Dept. of Health on 3/1/23. 2. All residents are vulnerable adults and are potentially affected. 3. All staff will be re-educated on the Abuse, Neglect, Misappropriation Policy on 3/23/23. Investigations, root cause analysis, grievance and concern reporting, and reporting to State DOH will be reviewed with all staff at the meeting on 3/23/23. DON or designee will complete final investigation and report to SDDOH if applicable. Administrator or designee will continue to provide education and give a copy of the policy to all new hires and all new admits. New hire documentation will be placed in their file and new admits documentation is placed in their chart. DON or designee will continue yearly education for staff which is documented in the all staff meetings binder. 4. The Administrator or designee will audit all investigations (including falls) done by the nurses in Risk Management, reports sent to SDDOH, and all issues reported as grievances or concerns to discern if proper procedure was followed in investigation and documentation weekly for 4 weeks and then monthly for the next 2 months. The audits will ensure that no residents have been missed for this issue. The Administrator or designee will report results of audits at monthly QAPI meetings for review.	3/23/2023

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F 609	Continued From page 7	F 609		

serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and policy review, the provider failed to investigate and report alleged abuse to the South Dakota Department of Health (SD DOH) for two of two sampled residents (89 and 90) who had inappropriate verbal and physical behavior between each other and one of the residents (90) was cognitively impaired. Findings include:

1. Observation and interview on 2/27/23 at 3:54 p.m. with resident 89 in his room revealed he had pushed his roommate (resident 90) causing his roommate to fall.
Refer to F600 finding 1 and F610 finding 1.

Review of resident 89's 2/22/23 nursing progress note revealed:
*Resident 89 had been found to be shouting at resident 90 and threatening to hit and kick him when a nurse intervened.

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F 609	Continued From page 8 *There was no investigation related to that incident. -This incident had not been reported to the South Dakota Department of Health (SD DOH). Refer to F610 finding 1. Interview on 2/28/23 at 3:15 p.m. with director of nursing (DON) B and social services designee (SSD) G revealed: *They were not aware resident 89 had pushed resident 90 causing him to fall. *DON B was aware of the incident that had occurred between residents 89 and 90 on 2/22/23 but there had been no investigation completed. *Neither incident had been reported to the SD DOH. Refer to F610 finding 1.	F 609		
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 610	1. Abuse, Neglect, Misappropriation Policy reviewed and revised. Care Plans were updated on resident 89 and resident 90. 2. All residents are vulnerable adults and are potentially affected. 3. All staff will be re-educated on the Abuse, Neglect, Misappropriation Policy on 3/23/23. Investigations, Risk Management documentation, root cause analysis, grievance and concern reporting, and reporting to State DOH including timelines for reporting will be reviewed with all staff at the meeting on 3/23/23. DON or designee will complete final investigation and report to SDDOH if applicable. Administrator or designee will continue to provide education and give a copy of the policy to all new hires and all new admits. New hire documentation is in their file and new admit documentation is in their chart. DON or designee will continue yearly education for staff which is documented in the all staff meetings binder. 4. The Administrator or designee will audit all investigations (including falls) done by the nurses in Risk Management, reports sent to SDDOH, and all issues reported as grievances or concerns to discern if proper procedure was followed in investigation and documentation weekly for 4 weeks and then monthly for the next 6 months. The audits will ensure that no residents have been missed for this issue. The Administrator or designee will report results of audits at monthly QAPI meetings for review.	3/23/2023

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F 610	Continued From page 9	F 610		

appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and policy review, the provider failed to investigate two incidents of resident-to-resident altercation involving two of two sampled residents (89 and 90). Findings include:

1. Observation and interview on 2/27/23 at 3:54 p.m. with resident 89 in his room revealed he:
*Was sitting in his recliner.
*Had been admitted earlier in the month because he had fallen at home and fractured his pelvis.
*Had communicated during the interview that his roommate (resident 90) was in the room touching his belongings. He had asked him to stop and the roommate had continued to touched his personal items.
*Then pushed the roommate.
*Was able to slide up to the front of the recliner seat and displayed how he pushed his roommate back behind the privacy curtain by using a motion with his arm.
*Stated the roommate had stumbled back, had fallen, and staff came into the room and picked him up off the floor.
*Stated that if his roommate touched his belongings again he would 'lay him out'.
*Then expressed he understood resident 90 was not well and had not always understood what was going on.

Review of resident 89's medical record revealed:
*He was admitted on 2/9/23.
*His 2/15/23 Brief Interview for Mental Status (BIMS) score was 15, indicating his cognition was intact.
*His diagnoses included: fracture of superior rim

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F 610	Continued From page 10 of right pubis, contusion right shoulder, fracture of unspecified parts of lumbosacral spine and pelvis, chronic kidney disease, pain, repeat falls, pressure-induced deep tissue damage of left heel, and obesity. Observation on 2/27/23 at 3:54 p.m. of resident 90 revealed: *He was confused wandering in the hallway outside of his room. *His speech was garbled. *He could not answer questions when asked. *He did not appear to have any injuries or bruising. Review of resident 90's medical record revealed: *He was admitted on 2/10/23. *He was unable to complete the BIMS. *His 2/16/23 Medical Data Set assessment indicated he had short and long-term memory problems. *His diagnoses included: Alzheimer's disease, cellulitis of left upper limb, heart failure, anxiety disorder, and amnesia. Review of resident 89's 2/22/23 nursing progress note revealed: *"Resident became angry at roommate and started shouting at him. *nurse intervened just as this resident was about to kick and hit his roommate. *Resident was talking to his son on the phone during this time. *Nurse immediately removed roommate from the situation. *It appeared roommate was previously just standing in the room. *[Resident 89's] son called nurse and spoke to nurse expressing concern for the situation and	F 610		

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F 610	Continued From page 11	F 610		

worried that his dad has "a temper".
*DON [director of nursing] notified of situation."

Interview on 2/28/23 at 3:15 p.m. with DON B and social services designee (SSD) G regarding the situation between residents 89 and 90 revealed:
*They both were unaware that resident 89 had pushed resident 90.
*DON B was aware of the incident that occurred between the residents on 2/22/23.
*DON B had not really identified that the incident on 2/22/23 was resident-to-resident abuse.
*The nurse involved in the incident had educated resident 89 that it was not appropriate to yell or threaten his roommate.
*There was no documentation of resident 89's education by the nurse.
*Since there had been no other incidents since 2/22/23 the residents had not been moved or separated.
*Residents were not monitored twenty-four hours a day.
*Staff may not have been aware of another incident had occurred between the residents because the residents had not been monitored twenty-four hours a day.
*They had not completed an investigation of the incident that occurred on 2/22/23 between the residents.

Interview on 2/28/23 at 4:29 p.m. with occupational therapist (OT) L regarding resident 89 revealed he:
*Was admitted and receiving OT services.
*Had not informed her he had pushed or hit his roommate.
*Had not spoken to her about expressing verbal or physical behaviors towards his roommate or other residents.

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HIGHMORE HEALTH	410 8TH STREET SE HIGHMORE, SD 57345

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F 610	Continued From page 12 Interview on 3/1/23 at 8:18 a.m. with DON B regarding the situation between residents 89 and 90 revealed: *They had planned on moving resident 90 into another room but had been waiting on a family consent to move another resident first. *No other resident safety interventions had been put into place to protect resident 90 until the room move was completed. *No investigation for the resident-to-resident incidents been started. Interview on 3/1/23 at 8:58 a.m. with administrator A and DON B regarding the situation between residents 89 and 90 revealed: *SSD G had spoken with resident 90 yesterday about his behaviors. *Had been waiting for resident 22's family to call and consent to a room change so the residents could be moved away from each other. *Staff had been observing the residents when they were awake but not when they were asleep. *Agreed either resident could have awoken and staff would not have known if they were up and moving. *They did not have one-to-one staff monitoring in place for resident 89 or 90 to ensure their safety. *Agreed they had not investigated the verbal abuse that had occurred on 2/22/23. IMMEDIATE JEOPARDY HARM Interview with resident 89 revealed he had pushed resident 90 resulting in resident 90 falling. Resident 89 indicated if resident 90 had touched his belongings again he would "lay him out". There had been documentation in resident 89's medical record showing staff had been aware of his verbal and physical aggression towards	F 610		

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F 610	Continued From page 13 resident 90. IMMEDIATE JEOPARDY NOTICE On 3/1/23 at 8:58 a.m. an immediate jeopardy had been determined when the provider failed to ensure resident 90 had been safe from abuse by his roommate. Administrator A and DON B were asked for an immediate removal plan. IMMEDIATE JEOPARDY REMOVAL PLAN: On 3/1/23 at 12:08 p.m. administrator A provided the survey team with a final written approval plan. The approval plan had been approved by the long-term care advisor for the department of health on 3/1/23 at 12:22 p.m. The facility provided the following acceptable removal plan on 3/1/23 at 12:08 p.m.: "Corrective Action: 1. Resident 90 was moved to 111-2. Care plan updated to reflect monitoring of resident to detour from wandering unwanted into other resident rooms. A Velcro stop sign has been placed on resident 89's door. Reviewed and revised resident 89's care plan to reflect the Velcro STOP sign on door as deterrent for entry of wandering or unwanted resident entry. Reviewed and revised as needed resident incident policy. Identification of Others: 2. All other residents will be reviewed by the interdisciplinary team today regarding aggression toward residents who wander in their room. All staff will be educated on resident Incidents immediately on 3/1/2023. System Changes: 3. Any resident that is identified as having	F 610		

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aggression toward residents who wander will have a Velcro stop sign placed in their doorway.
Monitoring:
4. Director of Nursing or designee will do audits every 15 minutes for 24 hours then hourly audits for the next 24 hours If there are no further issues then the audits will be 3 times a shift for 3 days to ensure stop signs are preventing wandering resident from entering resident 89's room and getting into his belongings.
5. Anticipated completion date: 3/1/2023"

The immediate jeopardy had been removed on 3/1/23 at 12:45 p.m. after verification that the provider had implemented their removal plan. After removal of the Immediate Jeopardy, the scope/severity of the citation level is "G."

Review of resident 89's 2/24/23 care plan revealed his mood and behavior had not been addressed so there had been no goals or interventions in place.

Review of resident 90's 3/1/23 care plan revealed:
*He had behaviors related to dementia and being in a new environment.
*His behaviors were wandering, exit-seeking, and going through others belongings.
*The interventions included the following:
-"Anticipate and meet needs of resident including toileting on a schedule every 2 hours at the least."
-"Attempt non-pharmacological interventions such as giving resident a magazine, the tinkering box with locks and latches, a snack."
-"Ensure that hallways are free from spills, clutter and other hazards."
-"Redirect resident to a new activity if he is wandering into other's rooms or getting

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F 610	Continued From page 15 into other's stuff." Review of the provider's September 2012 Long Term Care Facilities Resident's Bill of Rights booklet provided in the resident's admission packet revealed: *"A facility must provide care and an environment that contributes to your quality of life including: -1. A safe, clean, comfortable and home-like environment." -"4. Freedom from theft of personal property; verbal, sexual, physical or mental abuse; and involuntary seclusion, neglect or exploitation imposed by anyone." Review of the provider's November 2018 Abuse, Neglect, and Misappropriation of Property Prevention Policy revealed: *"Employees will identify, intervene, and correct situations in which abuse, neglect and/or misappropriation of patient/resident's property may occur. This includes assessment of the patient's/resident's environments, adequate staffing to meet patient needs, and supervision of staff to identify inappropriate behaviors." *"Patients/residents will be continually assess, care planned, and monitored in order to identify needs and behaviors which might lead to conflict or neglect." *"When an incident occurred, a report would be completed and followed up on by the administrator or DON." *"All incidents will be investigated thoroughly by administration. Any complaints will be reported within 24 hours to the South Dakota Department of Health, Pierre, SD, followed by a written report within 5 working days." Review of the provider's November 2022	F 610		

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F 610	Continued From page 16 Resident Incident Policy and Procedure revealed: *"A resident incident report/unusual occurrence report will be completed following any unusual occurrence involving a resident including but not limited to: falls, abuse, neglect, resident-to-resident altercations, injury of unknown source, elopement, and medications errors." *"2) Resident-to-Resident Altercations: -a) Take immediate and necessary actions to intervene while providing appropriate supervision and monitory to protect the resident and other resident(s). -b) Determine if the altercation was willful. "Willful" means the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish. Even though a resident may have cognitive impairment, he/she could still commit a willful act." -"ii) If the act was willful and resulted in the infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish, then do an investigation and report to DOH [Department of Health] per the appropriate timeline." *"Document occurrence, effect, and resolution in notes."	F 610		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident	F 655	1. The Baseline Care Plan regulation was reviewed. The Care Plan policy was reviewed and revised. No corrective action was taken for residents 9, 28, 32, 89, and 90 Baseline Care Plans because they were past the 48 hour window for completion. 2. All new residents must have a Baseline Care Plan done within 48 hours of admission. 3. All staff will be re-educated on the Baseline Care Plan on 3/23/23. MDS Coordinator or designee will be responsible for completing the Baseline Care Plan, reviewing it with resident/representative, having them sign it, and placing it in the resident's chart so that it is accesible to staff. MDS Coordinator or designee will continue yearly education for staff which is documented in the all staff meetings binder. 4. Director of Nursing or designee will audit all new residents' Baseline Care Plans weekly for 4 weeks and then monthly for the next 2 months. The audits will ensure that no residents have been missed for this issue. Director of Nursing or designee will report results of audits at monthly QAPI meetings for review.	3/23/2023

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F 655	Continued From page 17 that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure five of five	F 655		

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F 655	Continued From page 18 newly admitted residents (9, 28, 32, 89, and 90) had a baseline care plan established and reviewed with the resident, their representative, or their responsible family member. Findings include: 1. Interview on 2/27/23 at 11:25 a.m. with resident 28 regarding her admission and baseline care plan revealed she had "been here a couple of months," but she did not recall staff discussing with her the initial plan of care and services or receiving a summary of her baseline care plan. Review of resident 28's medical record revealed: *She had been admitted on 1/6/23. *Her 1/12/23 brief interview for mental status (BIMS) score was a 15, meaning she was cognitively intact. *She required staff support to ensure all her care needs had been met. -Those care needs included transfers, dressing/undressing, personal hygiene, walking/moving, toileting, and repositioning in her bed. *Her baseline care plan had been started on 1/6/23. -That care plan had been developed by registered nurse (RN) D and MDS assessment coordinator I. *There were four focus areas on the resident's baseline care plan addressing her: -Pressure ulcer. -ADLs. -Potential for falls. -Discharge plan. *There was no focus area documentation to support the following: -Her dietary needs. -Her therapy service needs.	F 655		

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F 655	Continued From page 19 -Her social service needs. *There was no documentation to support she or her representative had received a summary of her baseline care plan. 2. Review of resident 32's medical record revealed: *She had been admitted on 11/2/22. *Her admission assessment indicated she was alert, oriented, and able to communicate effectively. *She required staff support to ensure all her care needs had been met. -Those care needs included transfers, dressing/undressing, personal hygiene, mobility, toileting, and repositioning in her bed. *Her baseline care plan had been started on 11/4/22. -That care plan had been developed by the Minimum Data Set (MDS) coordinator I. *There were two focus areas on the baseline care plan addressing her: -Activities of daily living (ADLs). -Potential for pressure ulcer development. *There was no focus area documentation to support: -Her dietary needs. -Her therapy service needs. -Her social service needs. *There was no documentation to support she or her representative had received a summary of her baseline care plan. 3. Review of resident 9's medical record revealed: *She had been admitted on 5/12/22. *There was no documentation to support a baseline care plan had been established and reviewed with the resident or her representative.	F 655		

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F 655	Continued From page 20 4. Review of resident 89's medical record revealed: *He had been admitted on 2/9/23. *There was no documentation to support a baseline care plan had been established and reviewed with the resident or his representative. 5. Review of resident 90's medical record revealed: *He had been admitted on 2/10/23. *There was no documentation to support a baseline care plan had been established and reviewed with his representative. 6. Interview on 2/28/23 at 9:16 a.m. with MDS coordinator I revealed: *She used the resident's electronic health record to initiate the baseline care plan, typically on the day following the resident's admission. *She did not print or save the initial baseline care plan in the resident's medical record. *She had not met with the resident and/or representative to review and provide a summary of the baseline care plan. *The baseline care plan was further revised for the resident's implemented comprehensive care plan. *She confirmed the above residents and their representatives had not received a summary of their baseline care plans within the required time frame. Interview on 2/28/23 at 3:37 p.m. with administrator A revealed her expectation would have been for the baseline care plan's to have been completed within 48 hours and provided to the resident and their representative.	F 655		

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F 655	Continued From page 21 7. Review of the provider's 11/8/18 Care Plan Policy and Procedure revealed: *Basic Responsibility: MDS Coordinator or designee. *General Instructions: -"Upon admission, resident will be assessed by the MDS Coordinator and a baseline care plan will be developed with information gathered from the resident and resident's family within 48 hours." Review of the provider's MDS Coordinator Job Description revealed: *Job Summary: -"...Assist with the development, implementation, and evaluation of the care plans for each resident in accordance with other health care providers and physicians. *Essential Functions and Responsibilities: -"Complete health assessments on all residents at time of admission to establish baseline and initial care plan..." -"Meet all submission timelines of reports/records/documentation as required by state and federal rules, regulations, and laws for healthcare facilities."	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657	1. Care Plan Policy reviewed and revised. Care plans were updated and revised on residents 18, 21, 89, and 90. 2 All residents require care plans and are potentially affected. 3. Care plan timing and revision will be reviewed with all staff at the meeting on 3/23/23. MDS Coordinator or designee will set up care conferences upon admission during baseline care planning process to ensure that all new admissions have a timely first care conference. MDS Coordinator or designee will keep copies of care conference invitations that were given to residents/representatives. MDS Coordinator or designee will ensure that care plans are updated with changes upon admission, quarterly, anually, and with significant changes. Significant changes and/or new care concerns possible interventions will be discussed daily by the Interdisciplinary Team. MDS Coordinator or designee will ensure that changes discussed will be implemented. 4. MDS Coordinator or designee will audit at least 3 residents weekly until all residents have had care plans reviewed. Will also audit timeliness and invitation of residents/representatives of initial care conferences on all new admissions for 3 months. The audits will ensure that no residents have been missed for this issue. MDS Coordinator or designee will report results of audits at monthly QAPI meetings for review.	3/23/2023

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F 657	Continued From page 22 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure: *One of one sampled resident (28) and her family had the opportunity to participate in the plan of care process. *Care plans were reviewed and revised to ensure care needs were accurately reflected for 4 of 14 sampled residents (18, 21, 89, and 90). Findings include: 1. Interview on 2/27/23 at 11:25 a.m. with resident 28 revealed she could not remember attending a care conference to discuss her plan of care. Review of resident 28's medical record revealed: *She had been admitted on 1/6/23. *She had good memory recall and could make her needs known. *There was no documentation that the resident or	F 657		

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her representative had attended a care planning meeting since her admission to the facility.
*There was no documentation that the resident or her representative had been invited or had refused to attend a care planning meeting since her admission to the facility.
*Her paper chart had no care plan signature form indicating who had been present at the care planning meeting.

Interview on 2/28/23 at 2:01 p.m. with social service designee G regarding resident 28's care conference meeting revealed:
*She could not recall a care conference meeting for the resident.
*She stated the resident's care conference was not listed on the January 2023 schedule.
*She clarified care conferences for new admissions might have been scheduled after the month's calendar had been developed and distributed to the care plan interdisciplinary team.

Interview on 2/28/23 at 2:15 p.m. with MDS Coordinator I regarding resident 28's care conference meeting revealed she:
*Stated, "To be honest, I don't know if we've done one."
*Then confirmed, "I know we didn't have a care conference for her. We had to reschedule due to the weather. I missed that one."

Interview on 3/2/23 at 12:22 p.m. with MDS Coordinator I revealed her practice was to schedule resident care conferences the week after the resident's MDS is completed.

2. Observation on 2/27/23 at 12:22 p.m. of resident 21's room revealed:
*She was not in her room.

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F 657	Continued From page 24 *A sign attached to the wall above the side of her bed that read, "Blue heel protectors to be worn in bed". *The bed had bilateral side rails in the up position. Observation on 2/28/23 at 2:23 p.m. and at 3:01 p.m. of resident 21 in her room revealed: *She was lying in her bed with her eyes closed. -She was not wearing the blue heel protector boots. *The blue heel protector boots were on floor at the end of her bed. *The bilateral side rails on her bed were in the up position. Observation on 3/2/23 at 7:50 a.m. of resident 21 revealed: *She was lying in her bed with her eyes closed. *The blue heel protector boots were on the floor next to the bed. *The bilateral side rails on her bed were in the up position. Interview on 3/1/23 at 1:58 p.m. with certified nursing assistant (CNA) J regarding resident 21 revealed: *She was to wear the blue protector boots when in bed and when she was up in her chair. -Sometimes she would kick off those blue heel protector boots. *She used the side rail for repositioning when in her bed. Interview on 3/02/23 at 9:58 a.m. with CNA K regarding resident 21 revealed the resident would sometimes kick off her blue heel protector boots. Review of resident 21's medical record revealed: *She was admitted on 1/24/23 and her diagnoses	F 657		

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included pressure-induced deep tissue damage to both of her heels, pain, dementia, mood disturbance, and anxiety.
*Her 1/25/23 Brief Interview for Mental Status score was a 3, meaning she had severe cognitive impairment.
*Her Care plan included that she:
-Wore heel protectors when in bed.
--There was no documentation that she would kick them off at times.
-Required extensive assistance of two staff members for bed mobility.
--There was no documentation that she used side rails to reposition herself.
-Had the potential for pressure ulcers related to her impaired mobility.
--There was no documentation that she had pressure-induced deep tissue damage to both of her heels.

Interview on 3/2/23 at 10:13 a.m. with MDS coordinator I regarding resident 21's care plan revealed:
*The care plan should include the current care that the resident was receiving.
*When a resident had an actual pressure ulcer it should have stated that on the resident's care plan.
-She thought she had updated the care plan to reflect her pressure ulcers.

Interview 3/2/23 at 11:39 a.m. with DON B regarding resident 21's care plan revealed her expectation was for resident's current care needs to have been addressed on their individualized care plan, including the residents pressure ulcers.

3. Review of resident 18's medical record revealed she:

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F 657	Continued From page 26 *Had been receiving hospice services. *Was taking an antipsychotic medication [a medication used to treat psychotic disorders] for her behaviors. *Had behaviors that included the following: -Looking for her children. -Using a trash bin for a toilet. -Rummaging through items on the nurse's station or medication carts. -Wandering through out the facility. Review of resident 18's 2/22/23 care plan revealed it had not been updated to include: *She was receiving hospice services and what type of care was included in the hospice service. *She was taking an antipsychotic and what side effects she could have had from taking that medication. *Her current behaviors or any interventions to assist staff in managing her behaviors. 4. Observation and interview on 2/27/23 at 3:54 p.m. with resident 89 revealed: *He had bilateral side rails on his bed. *The side rails had been on the bed when he was admitted to the facility. *He had used the side rails to position himself in the bed and to transfer in and out of the bed. Review of resident 89's 2/22/23 nursing progress note revealed he had been observed yelling at his roommate and threatening to hit and kick him. Review of resident 89's initiated 2/13/22 care plan revealed the side rails and his verbal and physical behaviors were not addressed in his care plan. 5. Observation on 2/27/23 at 3:54 p.m. of resident 90's bed revealed bilateral side rails in the up	F 657		

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F 657	Continued From page 27 position. Review of resident 90's medical record revealed: *He was admitted on 2/10/23. *He had 3 falls in less than a month since his admission. *He was taking antianxiety and antipsychotic medications. Review of resident 90's initiated 2/13/22 care plan revealed: *The side rails had not been included in his care plan. *There had been no new interventions implemented for his falls since 2/13/23. *There was no documentation for his antianxiety or antipsychotic medication use or what side effects he could have from taking those medications. 6. Interview on 2/28/23 at 2:43 p.m. with social service designee G regarding resident care plans revealed she: *Had updated resident 18's care plan the week prior. *Was responsible for updating the resident care plans when there was a change in behaviors, mood, or psychotropic medications. Interview on 3/1/23 at 2:44 p.m. with Minimum Data Set (MDS) coordinator I revealed when a resident was receiving hospice services that should have been added to the residents care plan. Interview on 3/2/23 at 12:01 p.m. with administrator A revealed: *She was not aware resident care plans were not being updated to reflect the currents needs of the	F 657		

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F 657	Continued From page 28 residents. *It was the entire interdisciplinary team's responsibility to update resident care plans. 7. Review of the provider's 11/8/18 Care Plan Policy and Procedure revealed: *"Purpose: Care plans will be developed by an interdisciplinary team with participation of the resident, family, and/or representative (when available). Care plans include active and historical diagnoses, goals and/or expected outcomes, specific nursing interventions so that any nursing staff member is able to quickly identify a resident's individual needs and to decrease the risk of incomplete, incorrect, or inaccurate care, and to enhance continuity of care." -"General Instructions:" --"4. MDS Coordinator or designee will be in charge of notifying the following departments for completion of the care plan by day 14 of admission. Each discipline will update the care plan as changes occur between assessments and scheduled care conferences. ---Social Services ---Dietary ---MDS Coordinator ---Activities" --"5. Care Plans will be reviewed quarterly, annually, and with any significant change, and at the request of residents, families, or staff." --"7. Care plans are written by exception... They include measurable outcomes and identify interventions that are specific to the individual resident with defined time frames and parameters."	F 657		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		

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F 686	Continued From page 29 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to assess and document timely, implement, monitor, and review and update care for three of four sampled residents (21, 28, and 89) who had multiple medical conditions and were at risk for pressure ulcer development. Findings include: 1. Review of resident 89's medical record revealed: *He was admitted on 2/9/23. *His 2/15/23 Brief Interview for Mental Status (BIMS) score was 15, indicating his cognition was intact. *His diagnoses included the following: fracture of superior rim of right pubis, contusion right shoulder, fracture of unspecified parts of lumbosacral spine and pelvis, chronic kidney disease, pain, repeat falls, pressure-induced deep tissue damage of left heel, and obesity. *His Braden Scale score (used to predict risk of developing a pressure ulcer) on 2/15/23 was 20,	F 686	1. Skin and Wound Management Policy reviewed. Reviewed and updated the current pressure injury intervention(s) residents 21, 28, 89 care plans. 2. All residents are at risk of developing a pressure injury. 3. All staff will be educated on the prevention of pressure injuries, identification of pressure injuries, assessments and monitoring, appropriate interventions, documentation, and notification on 3/23/23. One charge nurse has been designated as the wound care nurse. This nurse has been educated on wounds and has been given access to Restorix as a resource. DON or designee is completing audits on intervention implementation. This will ensure that staff is following through on the implementation of the interventions. On 3/23/23 at all staff meeting, staff will be trained to edit care plans immediately with changes in skin interventions to facilitate communication on interventions. Administrator or designee will continue to provide education to all new hires which will be placed in their file. DON or designee will continue yearly education for staff which is documented in the all staff meetings binder. 4. Director of Nursing or designee will audit all active wound assessments weekly for 4 weeks and then monthly for the next 6 months. DON or designee will audit initial skin assessments on all new admissions for 6 months. The audits will ensure that no residents have been missed for this issue and that all interventions have been implemented. Director of Nursing or designee will report results of audits at monthly QAPI meetings for review.	3/23/2023

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F 686	Continued From page 30 indicating he was not at risk. Review of resident 89's nursing progress notes from 2/14/23 through 2/28/23 revealed: *On 2/14/23 he had a discoloration to his left heel measuring 0.5 centimeters (cm) x 0.9 cm. -He was places on a list for physician to see him on 2/16/22. *On 2/16/23 he was seen by a physician. The nurses note addressed a sore behind his ear and a corn on his left lateral foot, but had not addressed the area to his heel. *On 2/23/23 "Brought to nurse's attention that resident continues with left heel discoloration. Upon assessment, wound is oblong in shape, 1.2 cm x 1 cm, black/blue in color. Resident states area is very tender, but when he is walking on it the pain goes away. It was brought to [physician's name] attention on 2/16/23 with no new orders. Resident does off load pressure on boney surfaces himself. He does reposition himself. Is mobile with assist of one r/t [related to] safety. Wears shoes while walking. Pressure relieved mattress and cushion to chair." *On 2/24/23 the dietary manager was informed of the suspected deep tissue injury to his right heel and consulted with a registered dietician (RD) to increase his protein intake. Review of resident 89's 2/16/23 physician's long-term care progress note revealed there was no documentation about the suspected deep tissue injury to his left heel. Review of resident 89's 2/24/23 weekly wound documentation revealed: *The wound to his left heel was a suspected deep tissue injury (SDTI) and measured 1.2 cm x 1 cm. *Date of onset was 2/14/23.	F 686		

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F 686	Continued From page 31 *The wound was not open or draining. *AMT (American Medical Technologies) guidelines would have been followed for treatment of the wound, and no treatment was required at the time of the nurse's assessment. Continued review of resident 89's medical record revealed: * On 2/24/23 the nurse faxed the physician a copy of the 2/24/23 weekly wound documentation. *On 2/24/23 the physician returned a fax back to the facility that read "Noted, deep tissue injury precautions noted for left heel area. Monitor closely." Review of resident 89's February 2023 medication and treatment administration records revealed: *A physician order for a skin assessment to have been completed weekly on Tuesdays and as needed. *A physician order with a start date of 2/24/23 for the following: -"Pressure Injury Treatment/Prevention on each shift two times a day. --1. Check that air mattress is on bed and operating correctly. --2. Float heels when in bed. --3. Pressure redistribution cushion in w/c [wheelchair]. --4. Reposition q2-3h [every two to three hours]. --5. Pericare as indicated. --6. Heel protectors while in bed." *They had not addressed the resident had a SDTI or where it was located. *There had been no treatment or daily monitoring orders of the SDTI to his left heel. Review of resident 89's 2/23/23 care plan	F 686		

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revealed it had been updated on 2/23/23 to include:
*The SDTI to his left heel.
*"1. Float heels while in bed
*2. Wear heel protectors as tolerate while in bed
*3. Weekly wound assessments
*4. Encourage resident to keep shoes off except while transferring."

Interview on 3/1/23 at 2:31 p.m. with registered nurse (RN) D regarding resident 89 revealed:
*She had found the spot on his heel on 2/14/23.
-She did not put any interventions in place at that time.
-She added him to the list to have been seen by his physician on 2/16/23.
*His physician had seen him on 2/16/23 and all he seen was a corn on his foot so nothing further was ordered for SDTI to his left heel.
*When she observed it again during his next skin assessment on 2/24/23 it was larger.
*The area would only have been assessed weekly during his skin assessment.
*There were no treatments ordered because the wound was not open.

Interview and observation on 3/02/23 at 10:20 a.m. with RN D of resident 89's SDTI to his left heel revealed:
*He had a discolored brownish area to his left heel about the size of a quarter.
*He denied pain to the area.
*There was no dressing on the area of his left heel and it was left open to air.

Interview on 3/2/23 at 10:52 a.m. with director of nursing (DON) B regarding pressure ulcers revealed:
*The week after the physician had assessed at

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the wound on resident 89's left heel it had worsened.
*After the area had worsened then it was decided it was a SDTI.
*Staff was encouraging resident 89 to take his shoes off when not up walking and to elevate his heels off the mattress when he was in bed.
*Nurses only assessed SDTI's to heels weekly when scheduled skin assessments were completed.
*Certified nursing assistants (CNAs) looked at residents skin during personal care and would let the nurse know if there had been a change.
*It was not in the CNA's scope of practice to assess resident wounds.
*AMT guidelines were used when deciding on a treatment for wounds.
*Having the nurse assess SDTIs weekly had not followed the AMT guidelines.

2. Observation and interview on 2/27/28 at 11:25 a.m. with resident 28 revealed:
*She had "been here a couple of months."
*There were bilateral assist bars on her bed, an air mattress on her bed, and a cushion in her chair.
*She was able to easily engage in conversation.

Review of resident 28's medical record revealed:
*She had been admitted on 1/6/23.
*Her 1/12/23 brief interview for mental status (BIMS) score was a 15, meaning she was cognitively intact.
*Her diagnoses included multiple medical conditions and a Stage II pressure ulcer of the sacral region.
*She had required staff support to ensure all her needs had been met.

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F 686	Continued From page 34 -Stage II pressure ulcer identified as oval-shaped and present on her coccyx. --1.5 centimeters (cm) x 0.6 cm. --No drainage was noted. --Had 100% granulation. --The pressure ulcer caused the resident pain. -Treatment and interventions for pressure ulcer included cleanse with normal saline (NS), apply hydrogel gauze cut to fit, and cover with foam dressing. --Reposition approximately Q [every] 2-3 hours. --Pressure relieving mattress and pressure reducing cushion in chair. --Air mattress to bed. *"Family or resident notified of wound and educated on 01/06/2023." Review of resident 28's care plan revealed: *The plan was initiated on 1/6/23, with a focus area pressure ulcer related to diagnoses of severe malnutrition and impaired mobility. *Goal to have pressure ulcer show signs of healing and remain free from infection through review date of 1/24/23. *Identified interventions included the treatment interventions as well as assist rails to aid in turn and repositioning. *Weekly skin inspections by licensed staff with daily skin inspections with cares. Review of resident 28's Weekly Wound Documentation revealed: *From admission on 1/6/23 through 1/13/23, the pressure ulcer had increased and worsened in size from an oval-shaped 1.5 centimeters (cm) by 0.6 cm Stage II pressure ulcer on her coccyx with no drainage and 100% granulation (an indicator of healing) to 2.0 cm by 1.5 cm with "serous" drainage (thin, watery fluid), and deteriorated to	F 686		

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F 686	Continued From page 35 75% granulation and 25% slough (dead tissue). *On 1/23/23, ten days later, the wound assessment identified two separate pressure ulcers. -The first identified on admission 1/6/23, remained the same as noted on 1/13/23. -The new, facility-acquired circular shaped pressure ulcer was on her right buttock and measured 0.3 cm by 0.3 cm with serous drainage, 75% granulation and 25% slough. On 1/31/23, the wound assessment identified the first pressure ulcer and noted an increase in size to 2.5 cm by 1.5 cm, serous drainage and 100% granulation. -The facility-acquired pressure ulcer was not addressed. On 2/7/23, the wound assessment addressed both pressure injuries. -The first pressure ulcer remained the same as noted on 1/31/23. -The facility-acquired pressure ulcered was indicated as an onset of 2/7/23 and was noted as 0.2 cm by 0.2 cm with "serosanguineous" (thin, watery pink tinged fluid) drainage with 90% granulation and 10% slough. --"Same treatment for coccyx wound and right middle buttock wound." *From 2/8/23 through 2/21/23, there were no documented wound assessments. *On 2/22/23, the wound assessment addressed both pressure ulcers. -The first pressure ulcer on her coccyx measured 1.5 cm by 0.5 cm with serous drainage and 100% granulation. -The facility-acquired pressure ulcer on her right buttock had increased in size to 0.6 cm by 0.4 cm by 0.1 cm and had serosanguineous drainage with 90% granulation and 10% slough.	F 686		

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F 686	Continued From page 36 Review of resident 28's treatment administration record (TAR) revealed: *Her January 2023 TAR included the treatment plan for the pressure ulcer to her coccyx. -It did not reflect any plan for care for the facility-acquired right buttock pressure ulcer identified on 1/23/23. *Her February 2023 TAR reflected change on 2/7/23, to include care for both coccyx and buttock pressure ulcer. Interview and review about resident 28's wound assessment, wound care, and documentation on 3/2/23 at 1:11 p.m. with DON B revealed and confirmed: *Resident 28 had been admitted on 1/6/23, with the pressure ulcer to her coccyx. *The pressure injury was deteriorating on 1/13/23. *On 1/23/23, a facility-acquired pressure injury was identified by registered nurse D. -She had not documented notification of family or physician. -No new treatment plan had been initiated from 1/23/23 through 2/6/23. -There was no assessment of the new pressure ulcer on 1/31/23 -On 2/7/23, the physician was notified of the facility-acquired pressure ulcer with treatment orders. - --Family was not notified. *No wound assessments of either pressure ulcer were conducted from 2/8/23 through 2/21/23. *The only intervention change reflected the initiation of wound care for the right buttock pressure ulcer on 2/7/23. 3. Observation on 2/27/23 at 12:22 p.m. of resident 21's room revealed:	F 686		

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F 686	Continued From page 37 *She was not in her room. *A sign attached to the wall above her bed that read, "Blue heel protectors to be worn in bed". Observation on 2/28/23 at 2:23 p.m. and at 3:01 p.m. of resident 21 in her room revealed: *She was in her bed with her eyes closed. *She did not have on blue protector boots. *There were blue protector boots on floor at the end of her bed. Observation on 3/02/23 at 7:50 a.m. of resident 21 revealed: *She was in her bed with her eyes closed. *Her legs were covered with a blanket. *There was one blue protector boot on the floor next to the bed. Interview on 3/1/23 at 1:58 p.m. with CNA J regarding resident 21 revealed: *She was to wear the blue protector boots when in bed and up in her chair. *Sometimes she would kick off her blue protector boots. Review of resident 21's medical record revealed: *She was admitted on 1/24/23 and her diagnoses included: a 1/24/23 diagnosis of pressure-induced deep tissue damage of her left and right heels, pain, dementia, mood disturbance, and anxiety. *Her 1/25/23 BIMS score was a 3, meaning she had severe cognitive impairment. *Review of her hospital notes from 1/18/23 to 1/24/23 revealed she had bilateral heel pain during her hospital stay. *Her 1/30/23 Braden scale score was 18, meaning she was at low risk for development of pressure ulcers.	F 686		

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F 686	Continued From page 38 Review of resident 21's 1/25/23 nursing admission assessment revealed: *She had no open areas, ulcers, or other skin issues identified. *Both of her heels were boggy, reddened, but blanchable and she had reported pain to both heels. Review of resident 21's physician orders revealed: *On 1/24/23 to complete skin assessments weekly. *On 2/2/23 to treat her left heel SDTI per AMT guidelines. *On 2/8/23 to have pressure Injury treatment/prevention on each shift two times a day related to pressure-induced deep tissue damage of her right and left heels. --To check that air mattress was on the bed and operating correctly. --To ensure bilateral heel protectors were worn at all times except during transfers. --To ensure dressings were in place as ordered. --To have a pressure redistribution cushion in her wheelchair. --Reposition her every two to three hours. Review of resident 21's 2/8/23 care plan included: *She required extensive assist of two staff members for care including repositioning in bed. *A 1/25/23 focus of a potential for pressure ulcer related to her impaired mobility and incontinence. -Her goal for the focus was to have intact skin, free of redness, blisters, or discoloration. -Interventions on 1/25/23 for the focus and goal included weekly skin inspections by licensed staff and daily skin inspections with care, turn and reposition every two to three hours and as needed (prn), and to float heels.	F 686		

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	435092	A. BUILDING _____ B. WING _____	03/02/2023

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F 686	Continued From page 39 --Interventions added on 2/8/23 included heel protectors in bed and shoes for transfers only. -Her care plan had not included that she had SDTI of her left and right heels or that she kicked off her heel protectors at times. Review of resident 21's progress notes revealed: *On 2/4/23 her heels were slightly reddened, and she was wearing blue protector boots when in bed for her boggy/painful heels. -Staff floated her heels using pillows under her legs. -She had a pressure redistribution mattress on her bed and a pressure redistribution cushion in her wheelchair. -She was repositioned every two to three hours and prn. *On 2/8/23, "Brought to nurse's attention this morning that resident's heels have dark spots. Nurse assessed and sees dark purple/maroon area of discolored in tact [intact] skin to bilat [bilateral] heels. Upon admission, resident had reddened, boggy heels. Area is oval in shape. Peri-wound is slightly reddened and boggy. Resident does c/o pain to heels. Does wear heel protectors/booties at all times except for transfers. Air mattress to be placed on bed." Review of resident 21's weekly wound documentation assessments revealed: *They had been completed on 2/8/23, 2/16/23, and 2/23/23 and included: -Wound onset date of 2/8/23 with the wounds being classified as SDTI. --Measurements of her left heel included: ---On 2/8/23 2.7 cm (centimeters) x 1.7 cm. ---On 2/16/23 2.7 cm x 1.7 cm. ---On 2/23/23 2.5 cm x 2 cm. --Measurements of her right heel included:	F 686		

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F 686	Continued From page 40 ---On 2/8/23 2 cm x 1.5 cm. ---On 2/16/23 2 cm x 1.5 cm. ---On 2/23/23 1.9 cm x 2.5 cm. Observation and interview on 3/2/23 at 10:31 a.m. of resident 21 with physical therapist (PT) H in the therapy room revealed: *She had dark brown areas to bilateral heels. -The left was about the size of a nickel. -The right was about the size of a dime. *Resident stated she had pain to those areas on her heels. *PT H stated they had tried not having any heel protectors on when resident 21 was first admitted but she was digging her heels into her footrest, so the heel protectors were put on her feet. *PT H confirmed that resident 21 often rubbed her heels on the bed. Interview, record review, and AMT guidelines review on 3/2/23 at 11:07 a.m. with registered nurse D revealed: *Resident 21's wound assessments were completed weekly by a nurse unless the CNA's notified the nurse of a skin concern. -She confirmed they had not been following the 2/2/23 physician's order or AMT guidelines for SDTI. --She stated the AMT guidelines indicated to assess the wounds daily. --There was no designated wound care nurse on staff, the charge nurse for the day would have been responsible for assessing the wounds. Interview, record review and AMT guidelines review on 3/2/23 at 11:39 a.m. with DON B regarding resident 21's SDTI revealed: *The charge nurses completed weekly wound assessments on all wounds.	F 686		

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F 686	Continued From page 41 *CNAs would observe the wounds daily when providing routine personal care. -There was no documentation to reflect daily CNA observing and reporting wound observation to the nurse(s). *She confirmed they had not been following the 2/2/23 physician's order or AMT guidelines for the SDTI for resident 21's bilateral heels. 4. Review of 2013 AMT guidelines for SDTI revealed: *"Avoid topical agents until wound had fully evolved; eschar is present and begins to separate; and/or drainage is present with the exception of moisture barrier products for incontinence prone areas. *Eliminate pressure as much as possible. *Off-load heels. *Monitor diligently and document tissue characteristics daily, as DIT [deep tissue injury] can change rapidly."	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure interventions were in place and updated for one of one sampled resident (90) who had multiple	F 689	1. Resident Incident Policy and Procedure reviewed. Care plan was updated on resident 90. 2. All residents are at risk for falls and are potentially affected. 3. All staff will be educated on resident incidents and proper procedure including investigation and interventions. Post-Fall huddle will be implemented by the charge nurse on duty using Post-Fall huddle form for consistency following each fall for staff on duty to review immediately following a fall and submit the form for review to the interdisciplinary team. Falls will be among topics discussed at each daily stand-up meeting with the interdisciplinary team. Administrator or designee will continue education on falls with new hires which will be placed in their file. DON or designee will continue education yearly for all staff which will be documented in the all staff meetings binder. 4. Director of Nursing or designee will audit all falls including investigation and intervention portions weekly for 4 weeks and then monthly for the next 2 months and report results of audits at monthly QAPI meetings for review.	3/23/2023

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F 689	Continued From page 42 falls from 2/11/23 through 2/20/23. Findings include: 1. Observation on 2/27/23 at 3:54 p.m. of resident 90 revealed: *He was confused and wandering in the hallway outside of his room. *His speech was garbled. *He could not answer questions when asked. *He did not appear to have any injuries or bruising. Review of resident 90's medical record revealed: *He was admitted on 2/10/23. *He was unable to complete the BIMS due to his cognition. *His 2/16/23 Minimum Data Set assessment indicated he had short and long-term memory problems. *His diagnoses included: Alzheimer's disease, cellulitis of left upper limb, heart failure, anxiety disorder, and amnesia. *His 2/16/23 Fall Risk Assessment revealed he had a score of 14, indicating he was at high risk for falls. *He had a fall without injury on 2/11/23, 2/19/23, and 2/20/23. Review of resident 90's Fall Incident Reports revealed on: *2/11/23: -He had an unwitnessed fall in the dining room. -No investigation had been completed. -No interventions had been put into place to prevent another fall. *2/19/23: -He had been found lying on the floor in his room. -No investigation had been completed. -No interventions had been put into place to	F 689		

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F 689	Continued From page 43	F 689		

prevent another fall.
*2/20/23:
-He had been found on the floor in his room and had been incontinent of bowel.
-No investigation had been completed.
-No interventions had been put into place to prevent another fall.

Review of resident 90's 3/1/23 care plan revealed:
*He had a "Potential for falls r/t [related to] impaired cognition."
*Interventions were:
*"Appropriate non-slip footwear."
*"Be sure call light is within reach and encourage to use it for assistance as needed."
*"Coordinate with appropriate staff to ensure a safe environment with: Floors even and free from spills or clutter, Adequate, glare-free light, Call light, Personal items within reach."
*"PT evaluate and treat as ordered or PRN [as needed]."
*No new fall interventions had been added to his care plan since 2/13/22.

Interview on 3/2/23 at 10:52 a.m. with DON B regarding falls revealed:
*Nurses did not document interventions put into place after a resident had fallen.
*Falls had only been reviewed by the interdisciplinary team (IDT) weekly on Monday mornings.
*The IDT did not complete an investigation or implement new interventions when a resident had a fall.

Review of the provider's November 2022 Resident Incident Policy and Procedure revealed:
*"A resident incident report/unusual occurrence

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F 689	Continued From page 44 report will be completed following any unusual occurrence involving a resident including but not limited to: falls, abuse, neglect, resident-to-resident altercations, injury of unknown source, elopement, and medications errors. *"5) Incident report completed in Risk Management section in PointClickCare [electronic health record keeping system]." *"7) Document occurrence, effect, and resolution in notes. *8) Care Plan is revised and updated if necessary." *"10) All incident reports are reviewed by DON or designee." *"11) Make any internal changes needed to minimize reoccurrence."	F 689	1. Reviewed and revised Bed Assist Bar Policy and Procedure to include a list of alternatives to bed assist bars in the policy. The interdisciplinary team discussed bed assist bar alternatives that may be appropriate for residents 21, 28, and 90. Resident 89's bed assist bar alternatives were not discussed because he was already discharged. No corrective action taken for residents 21, 28, 89, or 90 consents or assessments due to informed consents having already been received and assessments having already been done just not prior to implementation. 2. Residents requiring bed assist bars are potentially affected. 3. All staff will be educated on alternatives of bed assist bars and proper procedure for implementation on 3/23/23. MDS Coordinator or designee will ensure that all residents determined to need a bed assist bar will have alternatives attempted and documented prior to implementation. MDS Coordinator or designee will ensure that all residents requiring a bed assist bar will have a completed assessment and consent on file including educating them on the risks versus benefits. Interdisciplinary Team, which meets every morning, or the requesting party will notify MDS Coordinator regarding residents needing assist bars. Environmental Services Officer will ensure that bed assist bars are removed when residents using them are discharged. 4. MDS Coordinator or designee will audit all residents requiring an assist bar for alternatives considered and consents including the education on the risks versus benefits monthly for 3 months. MDS Coordinator or designee will report results of audits at the monthly QAPI meetings for review.	3/23/2023
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 700		

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F 700	Continued From page 45 §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to follow their policy for completing and accurately documenting assessment for need that included informed consent for four of five sampled residents (21, 28, 89, and 90) prior to implementation or installation of side rails and bed assist bars. Findings include: 1. Review of resident 21's medical record revealed: *She was admitted on 1/24/23 and her diagnoses included dementia, psychotic disturbance, mood disturbance, anxiety, pain, osteoporosis, deep tissue damage of right and left heels, and incontinence. *Her 1/25/23 Brief Interview of Mental Status (BIMS) score was a 3, meaning she had severe cognition impairment. *Her 1/24/23 bed assist bar assessment revealed there was no documentation that alternatives to side rails had been attempted prior to installation and use of side rails. *Interview on 3/1/23 at 1:58 p.m. with certified nursing assistant (CNA) J revealed resident 21 used the side rails for repositioning when in bed. 2. Observation and interview on 2/28/23 at 9:31 a.m. with resident 89 revealed: *There were bilateral side rails attached to his bed. *They had been there when he was admitted. *He did not remember signing a consent form.	F 700		

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F 700	Continued From page 46 Review of resident 89's medical record revealed: *He had been admitted on 2/9/23 and his diagnoses included multiple medical conditions and fractures. *His BIMS score was a 15 meaning he was cognitively intact. *His 2/9/23 bed assist bar assessment revealed there was no documentation that alternatives to side rails had been attempted prior to installation and use of side rails. 3. Observation on 2/28/23 at 9:56 a.m. of resident 90's room revealed there were bilateral side rails attached to his bed. Review of resident 90's medical record revealed: *He was admitted on 2/10/23, with multiple medical conditions that included Alzheimer's disease. *His 2/10/23 BIMS score was a 0 meaning he had severe cognitive impairment. *Review of his 3/1/23 bed assist bar assessment revealed there was no documentation that alternatives to side rails had been attempted prior to installation and use of side rails. 4. Interview on 3/2/23 at 11:15 a.m. with registered nurse D regarding side rail use for residents 21, 89, and 90 revealed she could not not remember if they had tried alternatives before the installation of side rails on their beds. Interview on 3/2/23 at 11:35 a.m. with director of nursing B regarding side rail use revealed: *There had not been any other interventions attempted prior to the installation of side rails on those resident's beds. *She was not aware of what other interventions should have been tried.	F 700		

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F 700	Continued From page 47 Interview on 3/2/23 at 12:44 p.m. with administrator A revealed she was unsure if other alternatives to side rails were tried prior to implementing side rails on the resident's beds. 5. Observation and interview on 2/27/23 at 11:38 a.m. with resident 28 revealed: *Assist bars on both sides of her bed and she used them to turn and reposition herself. *Resident 28 stated she did not recall having a discussion regarding the assist bars including the risks and benefits of having the assist bars on her bed. Review of resident 28's medical record revealed: *She had been admitted on 1/6/23. *She had good memory recall and could make her needs known. *She had required one staff person's support to ensure all her needs had been met. -Those needs had included transfers, dressing/undressing, personal hygiene, walking/moving, toileting, and repositioning in her bed. *A 1/6/23 "Bed Assist Bar Assessment" paper form completed by social service designee (SSD) G containing the resident's son/power of attorney (POA) signature. *Her care plan included an intervention for "Assist rails to aid in turning and repositioning." initiated on 1/8/23. *A 1/23/23 "Bed Assist Bar Assessment" computerized form completed by MDS coordinator I. Interview on 3/2/23 at 8:55 a.m. with DON B revealed she had asked SSD G to complete the bed assist bar assessment on resident 28's day of admission.	F 700		

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F 700	Continued From page 48 Interview on 3/2/23 at 8:57 a.m. with SSD G further clarified she was a registered nurse and had completed the bed assist bar assessment for resident 28 on her day of admission as MDS Coordinator I was gone that day and DON B had asked SSD G to complete it. Interview on 3/2/23 at 12:32 p.m. with MDS Coordinator I, reviewing the "Bed Assist Bar Assessment" revealed: *She was the staff person who completed this assessment for residents. *When asked about the form's first section on "Screening & General Information" which assessed alternatives with directions to "List any bed assist bar alternatives attempted that failed to meet the resident's needs prior to use and installation and alternatives considered but not attempted because they were considered to be inappropriate." -MDS Coordinator I stated she usually listed no alternatives as she felt the bed assist rails were the most appropriate. -She further stated that the "little bar on their bed was completely beneficial" and gave the resident something "solid to hang on to." *When asked about the form's section on "Resident Considerations" with directions to identify: -"Medical diagnoses that may affect bed assist bar use." --MDS Coordinator I stated I do look at the resident's diagnoses, but do not list them on the form. -"Number of medications that may affect safe bed assist bar use (i.e. diuretics, laxatives, anxiolytics or other meds that may be sedating or affect cognition)" with an area to individually list	F 700		

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F 700	Continued From page 49 "Medications that may affect safe bed assist bar use:" --MDS Coordinator I stated she was not able to list a resident's diagnoses or medications on the computerized form. "I tried, but it's grayed out and won't let me." *When asked about the form's section on "Entrapment Risk Assessment" with directions to assess risks for entrapment. -MDS Coordinator I stated, "you'd have to be a contortionist" to get their hand or arm stuck in that "little bar on their bed." -MDS Coordinator added that severely impaired residents don't have the assist bars on their bed. *When asked about the form's section on "Informed Consent" with directions "If resident and/or representative are available, please print assessment and have them sign below." -MDS Coordinator I stated most of these consents were "handled over the phone" and I don't usually print and have them sign. Interview on 3/2/23 at 12:48 p.m. with administrator A regarding the assist bars on the resident beds revealed she: *Was surprised to hear the bed assist bars were on some of the resident beds prior to admission. *Would expect alternatives to be tried before implementing the bed assist bars for residents. Interview on 3/2/23 at 1:03 p.m. with DON B regarding the bed assist bars revealed: *MDS Coordinator I did not know how to properly use the computerized form by using the computer mouse to click on the magnifying glass within the assessment to auto-populate resident diagnoses, medications, etc. on the form. *She would expect alternatives to be attempted prior to implementing the bed assist bars.	F 700		

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

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 2/27/23 through 3/2/23. Highmore Health was found in not in compliance with the following requirement: E001.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements.	E 001	1. The facility Emergency Preparedness Plan was reviewed and revised to include a procedure for on-duty staff during an emergency; the 1135 Waivers during a declared emergency; a plan and arrangements with other long term facilities in case of evacuation; all Doctors' Physicians Assistants', and Nurse Practioners' names listed individually; a plan to provide information about our occupancy, needs and/or our ability to assist during an emergency; a system to share our Emergency Preparedness Plan with residents and families/representatives. 2. All residents and staff are potentially affected in the case of an emergency. 3. Administrator or designee will updat the Emergency Preparedness Plan yearly and as needed. All staff will be educated on 3/23/23 about the procedure for on-duty staff during an emergency; the plan and arrangements with other long term care facilities in case of evacuation; a plan to provide information about our occupancy, needs and/or our ability to assist during an emergency; and the system to share our Emergency Preparedness Plan with residents and families/representatives. All current residents will be given education on the Emergency Preparedness Plan. All new admissions will be given education on the Emergency Preparedness Plan going forward. Continue education for all new hires and yearly re-education for all staff on the Emergency Preparedness Plan. 4. The Administrator or designee will audit that all new admissions and all new hires have received education on the Emergency Preparedness Plan monthly for 3 months. The Administrator or designee will report results of audits at the monthly QAPI meetings for review for 3 months.	3/23/2023

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

Kim Knox | Administrator | 03/23/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435092	A. BUILDING _____ B. WING _____	03/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001	Continued From page 1 The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on interview and emergency preparedness plan review, the provider failed to ensure a complete emergency response plan had been developed and implemented. Findings include: 1. Interview and emergency preparedness plan review on 3/2/23 at 12:15 p.m. with administrator A revealed: *She agreed not all emergency preparedness items had been identified, developed, and implemented. *The plan had not addressed the following: -A procedure for on-duty staff during an emergency. -The role of the provider that was under a waiver in accordance with section 1135 of the Act. -A plan, contractual agreements or arrangements with other long-term care facilities to receive individuals in the event of any emergency limitations or facility shutdown. -A listing with names and contact information for	E 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435092	A. BUILDING _____ B. WING _____	03/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001	Continued From page 2 resident physician and other long-term care facilities. -A plan to provide information about their occupancy, needs, and/or their ability to assist, and to the authority with jurisdiction to act in an emergency. -A system to share their emergency plan information with residents and their families or representatives.	E 001		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435092	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	02/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/27/23. Highmore Health was found in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities.	K 000		

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

Kim Knox | Administrator | 3/23/2023

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10628	A. BUILDING: _____ B. WING _____	03/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/27/23 through 3/2/23. Highmore Health was found not in compliance with the following requirement: S270.	S 000		
S 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to complete employee health screening forms within 14 days after the hire date for three of five employee health records (E, F, and G). Findings include: 1. Record review of the provider's Employee	S 210	1. Reviewed the state regulation for the Employee Health Program and the facility Employee Health Policy was reviewed and revised. Medical History Questionnaires for employees E, F, and G were reviewed and signed by a licensed healthcare professional. 2. All residents are potentially affected if employees' medical history is not properly reviewed. 3. The Business Office Manager or designee will double-check any and all new hire paperwork within 14 days of hire to ascertain that the Employee Medical History Questionnaire is there and signed by a licensed healthcare professional. 4. The Business Office Manager or designee will audit all new hire paperwork for every new hire for the Employee Medical History Questionnaire form and report findings. The Business Office Manager or designee will report results of audits at monthly QAPI meetings for review for 3 months.	3/23/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim Knox — TITLE: Administrator — (X6) DATE: 3/23/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10628	A. BUILDING: _____ B. WING _____	03/02/2023

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S 210	Continued From page 1 Medical History Questionnaires revealed: *Employee E was hired on 12/29/22. *Employee F was hired on 12/20/22. *Employee G was hired on 8/1/22. -The Employee Medical History Questionnaire for the above employees not been signed within 14 days of their hire date. Interview on 3/1/23 at 4:10 p.m. with director of nursing (DON) B regarding employee health screens revealed: *She was aware employee health screens were to have been completed for new employees within 14 days of hire, reviewed, and signed by a licensed health professional. *The provider's process was for the employee health screens were to have been reviewed by DON B before the forms were filed in the individual employee files. *The facility's business office manager C was responsible for filing the forms and should have given DON B the forms to review and sign. *That had been an ongoing issue with business office manager C and she has had discussions with her. Interview on 3/2/23 at 11:48 a.m. with administrator A regarding employee health screens revealed: *She was aware employee health screens were required to have been completed for all new employees within 14 days of hire, reviewed, and signed by a licensed health professional. *She confirmed employee health screens for employees E, F and G had not been signed by a licensed health professional. *Business office manager C was responsible for all the new employee's paperwork, review them for accuracy, and she had not ensured a licensed health professional reviewed and signed those	S 210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10628	A. BUILDING: _____ B. WING _____	03/02/2023

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S 210	Continued From page 2 forms. *That had been an ongoing issue with business office manager C. Interview on 3/2/23 at 1:05 p.m. with business office manager C regarding employee health evaluations revealed: *She was responsible for filing the completed forms. *She had not reviewed employees E, F, and G Employee Medical History Questionnaires before filing to ensure they had been reviewed by a licensed health professional. *She was unsure as to why she had not reviewed them and given the forms to DON B for review and signature. Review of the provider's undated Employee Health Policy and Procedure revealed: *"Policy: Prohibit employees with communicable disease or with infected skin lesions from direct contact with residents or their food." -The policy had not addressed the 14-day completion time for employee health forms after the employee's hire date.	S 210		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 2/27/23 through 3/2/23. Highmore Health was found in compliance.	S 000		