| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435092 | A. Building<br>B. Wing | 01/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Highmore Health | 410 8th Street SE<br>Highmore, SD 57345 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, observation, interview, and policy review, the provider failed to ensure the safety of one of one resident (1) identified at risk for elopement (leaving the facility without staff knowledge) who left the building from the east door on 1/17/26 and was found by a citizen. The east door was not alarmed or monitored at the time of the resident's elopement. This citation is considered past noncompliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include:1. Review of the SD DOH FRI received on 1/17/26 revealed that on the evening of 1/17/26 at around 9:00 p.m., registered nurse (RN) G could not locate resident 1. After a preliminary search of the building, RN G contacted director of nursing (DON) B and administrator A. Administrator A came to the facility to help look for resident 1. They searched the facility including all rooms, closets, bathrooms, beds, and ancillary rooms. Staff noted that the east door alarm was turned off. The facility grounds were searched and resident 1 was located at around 9:25 p.m. sitting on the ground across the street. The report did not specify who found resident 1.Resident 1 was assisted back inside the facility and staff helped to warm him up by wrapping him in blankets, sitting him next to the heater, and applying warm socks to his hands. He was assessed from head to toe, and his vital signs were checked. His vital signs were normal; except he was cold with a temperature of 96.4 degrees Fahrenheit. There were no signs or symptoms of frostbite. Resident 1's wife and his primary care provider were notified.Staff reviewed and revised his care plan. Staff were educated to make sure door alarms remain turned on at all times. Hourly checks were initiated to monitor that the door alarms were turned on, and to monitor resident 1's location. A new door was ordered to replace the east door and to change the alarm to a keypad code entry system as the east door experienced higher traffic due to entry/exit through that door by outpatient therapy, deliveries, and visitors.2. Review of publicly available weather data obtained from https://www.wunderground.com/dashboard/pws/KSDHIGHM17/graph/2026-01-17/2026-01-17/daily revealed that there was a personal weather station (weather station ID KSDHIGHM17) located approximately 5.16 miles northeast of the nursing home. The temperature at around 9:00 p.m. on 1/17/26 was 7 degrees Fahrenheit, with wind speeds at 7 miles per hour and wind gusts at 9 miles per hour. There was no precipitation at that time, meaning it was not snowing, raining, or sleeting.According to the Wind Chill Chart, obtained from https://www.weather.gov/safety/cold-wind-chill-chart, the air temperature would feel like negative 5 degrees Fahrenheit when the air temperature is at 7 degrees Fahrenheit, and the wind speed is at 7 miles per hour. Additionally, a person could develop frostbite on exposed skin in about 30 minutes when outside in that temperature.3. Observations throughout the survey from 1/20/26 to 1/21/26 revealed that the exit doors were all alarmed and testing revealed the alarms were functioning.4. Interview on 1/20/26 at 2:17 p.m. with administrator A revealed that a performance improvement project (PIP, a concentrated effort<br><br>(continued on next page) |

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.

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

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | to improve care or services in a facility area that needs improvement) was initiated regarding resident elopements. The Minimum Data Set (MDS) coordinator was in charge of that PIP.5. Interviews with several individuals throughout the survey from 1/20/26 to 1/21/26 (certified nursing assistants (CNA) D, E, F, H, I, K, and M, licensed practical nurses (LPN) J and L, registered nurse (RN) G, visitor 1, resident 1's wife, and citizen 1) revealed that they were aware of resident 1's elopement on 1/17/26.LPN L indicated she had turned off the east door alarm at around 7:10 p.m. to allow a different resident and his family to enter the building without triggering the alarms, and she forgot to turn the door alarm back on. RN G and CNAs D, E, F, and M confirmed the door alarm had not sounded on 1/17/26 when resident 1 eloped.RN G and CNAs D, E, F, and M were unable to determine what time resident 1 left the facility. At around 9:00 p.m., RN G could not find resident 1. She and other staff searched each room in the facility, around the outside of the facility, and around the city block where the facility was located. Visitors 1 and 2 assisted in the search.At around 9:20 p.m., citizen 1 and his dog found resident 1 on the ground in a neighbor's yard. Citizen 1 flagged down the search party and assisted in getting resident 1 into a van.Once back at the facility, the staff assisted resident 1 into clean clothes and assessed his skin. There were no concerning skin issues. Staff warmed him up by wrapping him in blankets, rubbing his feet, and placing him next to a heater. He was agitated when he was brought back in from outside as he was described as resistive to cares, grabbing at staff, and attempting to hit others. CNA E mentioned that was not his normal behavior, but she guessed he was overwhelmed with the amount of people trying to help him at one time. He relaxed as he warmed up. Staff and resident 1's wife reported that his behavior returned to his baseline and there were no lasting negative effects.Staff confirmed there was education regarding the provider's elopement policy, hourly audits were implemented on the exit door alarm status and the locations of all five residents who were identified at risk of eloping and resided at the facility, a new door was ordered to replace the door the resident eloped from, a new style of door alarm was ordered for the other doors, and a performance improvement project was initiated regarding elopements.6. Record review confirmed that staff were educated about the elopement policy, and staff were performing the hourly audits on the five residents at risk for elopement and the door alarms.7. Observation and interview on 1/20/26 at 4:55 p.m. with resident 1 revealed that he was sitting on the edge of his recliner chair in his room. The chair was in the reclined position. He said he needed help standing up. A staff member responded immediately when the call light was triggered and assisted resident 1 with standing. Resident 1 was pleasant and was talking in a clear voice. He thanked the staff member and sat back down in his recliner and readjusted his sitting position. He mentioned that he had a hard time getting his legs to work so he could stand up by himself. He said he did not have any pain at that time.Resident 1 was oriented to himself, but not to time, place, or situation. He spoke fondly of the farm he lived on with his wife and family. He talked about his time spent serving in a war and mentioned that he was drafted when he was [AGE] years old.While the survey team was speaking with resident 1, LPN J came into his room with a clipboard and peeked his head around the privacy curtain. LPN J greeted resident 1, nodded, and wrote something down on the clipboard before exiting the room.8. Review of resident 1's electronic medical record (EMR) revealed he admitted to the facility on [DATE]. He had a primary diagnosis of unspecified dementia, with other behavioral disturbances. This meant that he had a brain disorder that caused memory and communication issues, and changes in his normal behaviors.His 11/18/25 quarterly Brief Interview for Mental Status score was 4, which indicated that his cognition was severely impaired.He was assessed for his risk for elopement on 7/23/25 (admission), 10/23/25 (quarterly), and 1/17/26 (after his elopement event).On 7/23/25, his elopement risk score<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was 4, indicating a potential for elopement. The elopement analysis and prevention plan included, Ensure all door alarms are on at all times to alert staff should they open. Redirect [resident 1] as needed.On 10/23/25, his elopement score was 5, indicating a potential for elopement. The elopement analysis and prevention plan included, Ensure all door alarms are on at all times to alert staff should they open. Redirect [resident 1] as needed.On 1/17/26, his elopement score was 8, indicating a potential for elopement. The elopement analysis and prevention plan included, Ensure all door alarms are on at all times to alert staff should they open. Redirect [resident 1] as needed. Additional comments were added that read, Actual elopement on 1/17/26 with no injuries noted. Care plan updated.Review of his care plan at the time of his elopement on 1/17/26 revealed that there was a focus area that read, At risk for elopement r/t [related to] dementia. That was initiated on 7/23/25. The goal was, Staff will be aware of [resident 1's] whereabouts and redirect as needed. That was initiated on 7/23/25. Interventions included, All doors will remain alarmed to alert staff to possible elopement, Elopement assessment quarterly and PRN [as needed], and Staff will redirect [resident 1] if/when he is noted to be headed towards an exit. Those interventions were initiated on 7/23/25.Review of his updated care plan after the elopement event on 1/17/26 revealed the focus area was updated to read, At risk for elopement r/t [related to] dementia, impaired safety awareness, exit seeking behavior, and history of elopement. Resident eloped from facility on 1/17/26 via east door. Resident was returned with no apparent injuries. Incident reviewed and elopement risk reassessed [on] 1/17/26. An additional goal was added that read, [Resident 1] will remain within the facility unless signed out by family with no further elopement incidents. Interventions were added that included, Conduct frequent visual checks [every] hour, especially during high-risk times (shift change, evenings, visiting hours). This log will be kept hourly for 72 hours from incident, Monitor for exit-seeking behaviors, restlessness, anxiety, or verbalization of wanting to ‘go home,' and Offer structured activities and purposeful engagement to reduce wandering or elopement attempts. Those interventions were initiated on 1/17/26.Further review of his care plan revealed there was another focus area that read, Wandering behavior r/t [related to] dementia. That was initiated on 11/17/25. The goal included, Will wander safely within environment aeb [as evidenced by] no serious injuries from fall and no elopement events through review date. That was initiated on 11/17/25. Interventions included, Assess for pain, hunger, thirst, or discomfort during wandering episodes, Attempt to determine cause of wandering and relieve, if possible ([i.e.,] boredom, looking for someone or something), Ensure that hallways are free from spills, clutter and other hazards, Keep familiar routines intact if possible, [NAME] room door with name or familiar photo, to aid in remembering room location, and Provide a program of activities to minimize potential for wandering while meeting need for social/cognitive stimulation. Those interventions were initiated on 11/17/25.A nursing progress note that was added on 1/18/26 at 2:29 a.m. read, Attempted to locate resident for his medications at 2100 [9:00 p.m.]. Unable to locate. Staff checked all the rooms, closets and beds. [DON B] was notified. [Administrator A] came to the facility and assisted in searching for resident. Resident was found across the street on the ground at 2150 [9:50 p.m.]. Very cold to touch. Was wrapped in blankets and checked vitals. Very combative at the time. Incident was reported online to the State [SD DOH]. An hourly log on location of resident will be kept for 72 hours. Temp at this time is 97.7 [degrees Fahrenheit] temporal. Resting well in recliner by the Nurse's station. Wife was notified. Dr. will be faxed. Will monitor location and make sure the door alarms are set at all times.A late entry nursing progress note was added that read, Edited to correct documentation that resident was actually found at 2125 [9:25 p.m.] (or possibly before), not 2150 [9:50 p.m.]. This RN received a call at home from the nursing home at 2130 [9:30<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | p.m.] stating that resident had been found several minutes ago and that he was inside already being warmed up with blankets, heating pads, and sitting next to the heater. He was found within 30 minutes of when it was noted that he was missing which was at 2058 [8:58 p.m.], so 911 was not called per policy.Review of his behavior documentation revealed that after the elopement incident on 1/17/26, he was grabbing, hitting, and scratching others. There was no documentation of those behaviors during the previous 30 days. His documented behaviors returned to his baseline after 1/17/26.9. Observation with LPN J on 1/21/26 at 9:55 a.m. of resident 1's skin revealed no signs or symptoms of frostbite.10. Review of the provider's 5/25 Resident Incident Policy and Procedure revealed the purpose read, A resident incident report/unusual occurrence report will be completed following any unusual occurrence involving a resident including.elopement.General Incident Procedures included notification to the primary care provider, resident's representative, and the director of nursing. First aid was to be administered as indicated. The incident report was to be completed in the Risk Management section of the EMR. The policy listed instructions for reporting to the SD DOH as appropriate. The resident's care plan was to be reviewed and revised if needed. Follow through included monitoring vital signs, assessing for pain or discomfort for at least 24 hours, and implementing any new interventions while documenting the effectiveness. The policy included to make any internal changes needed to minimize reoccurrence.Under the elopement section, the policy indicated that residents are assessed for risk of elopement on admission, quarterly, and with significant change of condition including an elopement or attempted elopement. Residents with identified elopement risks were to have elopement-prevention interventions in their care plan. The policy indicated that, a door alarm system is in place on exit doors and must be in the ‘on' position at all times. Staff is required to investigate every time the alarm sounds to ensure that residents are accounted for.The elopement section included step-by-step instructions of what the staff were to do in the event of an elopement, including performing a head count on all residents, searching all parts of the building, expanding the search outside block-by-block, calling in off-duty staff to aid in the search, calling emergency services if the resident cannot be located within 30 minutes, notifying the resident's family and physician of the elopement, and assessing the resident after the resident was found.11. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 1/21/26 after record review revealed the facility had followed their quality assurance (QAPI) process regarding elopement and resident safety, education was provided to all staff regarding the resident elopement policy, interviews revealed staff understood the education provided regarding those topics, and audits were implemented regarding the location of the five residents at higher risk of elopement and the status of the door alarms. The audits were to continue until the new security keypads and east door could be installed. Based on the above information, noncompliance at F689 occurred on 1/17/26, and based on the provider's implemented corrective action for the deficient practice confirmed on 1/21/26, the noncompliance is considered past noncompliance. |