STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING B. WING	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Counties Nursing Home	405 6TH AVENUE WEST , LEMMON, South Dakota, 57638

(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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/5/26 through 5/7/26. Five Counties Nursing Home was found not in compliance with the following requirements: F550, F554, F689, and F812.	F0000		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to follow standard food safety practices regarding: *Hand hygiene (handwashing or the use of an	F0812	Unable to change the outcome of the deficient practice for failure to ensure food procurement, storage, preparation, and serving sanitary practices. All residents have the potential to be affected. Staff involved were immediately re-educated on proper hand hygiene, glove use, prevention of cross-contamination, and proper handling of food. The garbage container was immediately removed from the portable food serving station. Hand Hygiene and Food Procurement policies were reviewed and revised by IDT Team. All dietary, nursing, and restorative staff were educated regarding proper hand hygiene, glove use, prevention of cross contamination, proper handling of food and proper garbage disposal. The MDS Coordinator/Infection Preventionist will conduct weekly audits on Hand Hygiene for four weeks and monthly for two months. The MDS Coordinator/Infection Preventionist will present findings from monthly audits for three months at monthly QAPI meeting for review and recommendations.	06/05/2026

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jordan Fish	Administrator	06/02/2026

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F0812 SS = E	Continued from page 1 alcohol-based hand sanitizer) and glove use by two of two cooks (J and K) who did not wash their hands as required and wore soiled gloves to handle ready-to-eat foods, one of one restorative therapy (RT) (D) who did not wash her hands between feeding a resident and eating her own meal, and one of one certified nursing assistant (CNA)/certified medication aide (CMA) (E) who did not remove her soiled gloves before handling food items during two of two meal services. *The disposal of garbage away from a portable food serving station during one of two observed meal services. Findings include: 1. Observation and interview on 5/5/26 with cook J from 12:15 p.m. through 12:45 p.m. during the mid-day meal service in the dining room revealed cook J washed his hands, used his clean, wet hands to turn the unclean faucet handles off, and dried his hands with a clean paper towel. He then put his unclean hands into a pair of clean gloves. During the meal service, cook J used those same gloved hands to open the cabinet door handles, touch individual resident menus, and then handle ready-to-eat food items (baked potatoes and bread slices) he was serving. Cook J acknowledged that his improper hand hygiene and handling of the ready-to-eat food with his unclean gloves had increased the risk for cross-contamination to occur. 2. Observation on 5/6/26 from 8:05 a.m. through 8:15 a.m. of cook K during the breakfast meal service revealed she wore the same pair of gloves while touching and handling ready-to-eat food items (grapes, bananas, waffles, bread, and boiled eggs). After her left glove became greasy from handling buttered toast and waffle slices, cook K used her gloved right hand to remove the left glove. Cook K discarded the left glove into a small garbage container that hung over the side of the portable food serving station she was using. The unlidded garbage container was three to five inches from opened peanut butter and brown sugar containers, and a bag of opened grapes. Cook K wiped her ungloved left hand on her unclean apron and, with	F0812		

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Five Counties Nursing Home	**405 6TH AVENUE WEST , LEMMON, South Dakota, 57638**

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F0812 SS = E	Continued from page 2 her gloved right hand, put a new glove on her unclean left hand. That contaminated both gloves. Cook K resumed food service and distribution with those gloved hands. 3. Interview on 5/6/26 at 8:25 a.m. with dietary manager (DM) I and cook K revealed the above ready-to-eat food items should have been handled using tongs, spoons, or some other clean serving utensil. Cook K did not follow infection prevention and control practices for proper glove use, hand hygiene, and garbage disposal, which increased the risk of a food-borne illness occurring. 4. Interview on 5/6/26 at 2:00 p.m. with administrator A regarding the above food service observations revealed DM I had discussed the above observations with her, and DM I began immediately re-educating her staff members regarding safe food-handling practices. 5. Observation on 5/5/26 from 12:02 p.m. through 12:55 p.m. in the dining room revealed RT D helping residents 15 and 23 eat their lunches. She did not perform hand hygiene between assisting the two residents to eat their meals. At 12:40 p.m., RT D got up from the table and went to the serving counter. She picked up a plate with a baked potato and butter. She took that plate back to the table and sat between residents 15 and 23. She put the butter on the potato and took a bite of the potato. Without performing hand hygiene, she assisted resident 15 to take a bite of Jello with a spoon. She set that spoon down, picked up her own fork, and took another bite of her potato without performing hand hygiene. This practice continued for the rest of the lunch meal service. 6. Observation on 5/6/26 at 9:34 a.m. in the dining room revealed CNA/CMA E picking up the plates of the residents who were done eating breakfast. She took one dirty plate from the table with gloved hands and brought it to the dirty dish container. She then walked over to another table and asked the resident if he wanted his unopened juice cup. The resident did not want the juice, so with that same gloved hand, CNA/CMA E picked up the juice cup and brought it over to the refrigerator. She opened the handle to that refrigerator with her gloved hand and placed the unused juice cup inside.	F0812		

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F0812 SS = E	Continued from page 3 7. Interview on 5/6/26 at 1:52 p.m. with director of nursing (DON) B revealed that she expected the staff to follow hand hygiene practices in the dining room environment. She agreed that RT D did not follow the expected practices when she ate from her own plate and then assisted a resident to eat from their plate without performing hand hygiene between those two actions. DON B expected CNA/CMA E to dispose of her gloves after touching a plate that a resident had eaten from. She acknowledged that touching the clean cup with those dirty gloved hands would have made that cup dirty and it should not have been put back in the refrigerator with clean food items. 8. Interview on 5/7/26 at 10:18 a.m. with administrator A revealed that the staff was allowed to eat with the residents, but hand hygiene practices were expected to be followed if they were assisting the resident with eating. She expected RT D to perform hand hygiene between eating her own food and assisting residents 15 and 23 to eat their food. She also expected the staff to throw away their soiled gloves and perform hand hygiene after touching a plate that a resident had eaten from. She agreed that touching a clean cup with dirty gloves and placing it back in the refrigerator while wearing those gloves would have contaminated that cup and the door handle of the refrigerator. 9. Review of the provider's reviewed March 2026 Hand Hygiene policy revealed that after washing and rinsing the hands, the staff was expected to thoroughly dry their hands with a single-use paper towel and use a clean towel to turn off the faucet. "The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves." 10. Review of the provider's revised January 2026 Use of Disposable Gloves policy revealed disposable gloves were expected to be changed "after touching any object or surface that could possibly be contaminated."	F0812		

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F0812 SS = E	Continued from page 4 11. Review of the provider's 3/26 Hand Hygiene policy revealed that using gloves still requires hand hygiene before and after wearing those gloves. Hand hygiene procedures were intended to "prevent the spread of infection to other personnel, residents, and visitors". 12. Review of the provider's undated Food Safety Requirements policy revealed, strategies to prevent foodborne illness included "a. Preventing cross-contamination of foods."	F0812		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F0550	Unable to change the outcome of the deficient practice for failure to ensure a homelike environment. All residents have the potential to be affected. Staff involved were immediately educated regarding dignity, maintaining a homelike environment, meaningful engagement during meals, and minimizing nonessential documentation during meal service. The Resident Rights and Responsibilities policy was reviewed and revised by IDT Team. All nursing and ancillary staff have been educated on resident dignity, maintaining a homelike environment, and meaningful resident engagement during meal service. The Social Services Director or designee will conduct weekly audits on inappropriate charting during mealtimes weekly for four weeks and monthly for two months. The Social Services Director or designee will present findings from monthly audits for three months at monthly QAPI meeting for review and recommendations.	06/05/2026

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F0550 SS = D	Continued from page 5 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure a homelike environment and staff assistance was provided in one of one dining room during two of two observed mealtimes. Findings include: 1. Observation on 5/5/26 from 12:02 p.m. through 12:55 p.m. of restorative therapy (RT) D in the dining room revealed that she sat between residents 15 and 23 for the meal service, and they both required assistance to eat their meals. Resident 23's eyes were closed for most of the meal service, but she would open them when spoken to by RT D. Resident 23 was given one sip of juice from RT D, and they did not converse with one another at the table. 2. Observation on 5/6/26 from 9:15 a.m. through 9:43 a.m. of certified nursing assistant (CNA) G in the dining room revealed that she sat between residents 23 and 30 at a dining room table. Two other unidentified residents sat at that same table. The four residents did not converse with one another, but resident 30 responded to the staff who passed by the table and spoke to her. Resident 23's eyes were closed. Breakfast was not served yet. CNA G's head was lowered, and she remained silent while she used the iPad on the table in front of her. At 9:25 a.m., she got up from her chair and walked out of the dining room. At that same time, CNA/certified medication assistant (CMA) H sat down between resident 23 and one of the unidentified residents. In response to CNA/CMA H speaking to her, resident 23 opened her eyes and drank juice that was offered to her by CNA/CMA H. At 9:28 a.m., CNA G returned to the dining room table and resumed working on her iPad without speaking to the residents at the table. At 9:32 a.m., she got up from the table and left the dining room, returned to the table at 9:34 a.m., and she resumed using the iPad. CNA G did not establish eye contact or verbally engage with any of the residents at that table during this observation. At 9:36 a.m., resident 30 was served breakfast. Her eyes were closed. CNA	F0550		

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F0550 SS = D	Continued from page 6 G said resident 30's name and asked the resident, "Are you thirsty?", but the resident did not respond. CNA G returned her attention to the iPad from 9:36 a.m. until 9:43 a.m., then attempted to feed resident 30 her breakfast. 3. Interview on 5/7/26 at 8:45 a.m. with CNA G regarding resident meal services revealed that she encouraged residents to make choices and allowed them to do as much for themselves during a meal as possible. She stated, "good conversation and laughter [with the residents]" was expected. CNA G acknowledged that during the above mealtime observation, she used the iPad for work-related documentation. It's "something I try to do when I'm waiting [for the meal to be served]." During the above meal service, CNA G stated that she had rubbed resident 30's back and encouraged the resident a "few times", but she stated "I could have done more," such as making eye contact with all the residents seated at the table and engaging in conversation with them. 4. Interview on 5/7/26 at 9:00 a.m. with administrator A and director of nursing (DON) B revealed that the staff were expected to respect and maintain residents' dignity before, during, and after meal services. That did not occur when CNA G prioritized the use of an iPad over interacting and assisting the residents during the above breakfast meal service. 5. Review of the provider's revised August 2025 Resident Rights and Responsibilities policy revealed, "Residents shall be treated with dignity, respect, and consideration at all times, including during the provision of care and services."	F0550		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure a self-administration of medication assessment was completed for one of one sampled resident (10) who	F0554	Unable to change the outcome of the deficient practice for failure to complete Self-Administration of Medication Assessment. All residents have the potential to be affected. Resident 10 had a Medication Self-Administration safety screen completed immediately on 5/19/2026. Resident 10 records were updated to reflect that Tramadol is to be administered and observed by nursing staff prior to the resident self-administering remaining HS medications.	06/05/2026

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F0554 SS = D	Continued from page 7 was allowed to keep her bedtime medications in a cup on her nightstand without supervision. Findings include: 1. Review of resident 10's electronic medical record (EMR) revealed that she was admitted to the facility on 5/5/22 and had a Brief Interview for Mental Status (BIMS) score of 15, which indicated her cognition was intact. Resident 10 had a 11/14/25 "medication self-administration safety screen" to self-administer saline nasal mist (non-medicated mix of salt and water designed to moisturize and flush out irritants in the nasal passages) and Refresh eyedrops (artificial tears used to treat dry, burning, or irritated eyes). The staff's instructions on the safety screen were to "complete this assessment prior to the resident initiating self-administration of medication and with any medication order changes, change in function/condition that might affect the residents ability to safely self-administer medications." Her 5/3/24 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) had a focus section that indicated she was able to self-administer saline nasal mist and Refresh eyedrops. The interventions under this focus section included to "assess resident's ability to safely self-administer medications" and that she "often wants to wait until she's ready for bed before taking her pills. If the night nurse comes before that time, it has been ok'd by [her] physician to leave the pill cup bedside for her to take prior to going to bed." Resident 10 had a 2/4/26 physician's order that stated, "ok to self-administer meds [medications] when nurse leaves [them] on her nightstand." She took four scheduled medications at bedtime, and they included a thyroid (an endocrine gland at the front of the neck that produces hormones) medication, a blood thinner medication, a blood pressure medication, and an opioid (a class of drugs used to treat moderate-to-severe pain) medication. She did not have a "medication self-administration safety screen" documented for these four medications. 2. Interview and EMR review on 5/6/26 at 1:40 p.m. with registered nurse (RN) C revealed that residents	F0554	Will review all other residents who self-administer medications for completed assessments and proper medication supervision. Staff involved in Medication Administration were educated regarding the self-administration of Medication assessment process and resident supervision expectations. The Director of Nursing will conduct weekly audits for four weeks then monthly for two months of all residents identified as self-administering medications to ensure medication administration processes are completed appropriately. The Director of Nursing will present findings from audits at the monthly QAPI meeting for review and recommendations for three months.	

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F0554 SS = D	Continued from page 8 were not allowed to self-administer opioid medications at the facility. If a resident wanted to self-administer medications, then the staff were to obtain a physician's order and perform a self-administration screening assessment. The nursing staff were expected to educate and monitor the resident on appropriate administration techniques for that medication to ensure that the resident was able to perform that administration safely. RN C reviewed resident 10's EMR and agreed that a self-administration assessment was not performed on the resident's oral medications at bedtime, and that those bedtime medications included Tramadol, an opioid medication. 3. Interview on 5/6/26 at 1:52 p.m. with director of nursing (DON) B revealed that residents were not allowed to self-administer opioid medication at the facility. She looked at resident NORA's EMR and agreed that a self-administration assessment was not performed on the resident's bedtime oral medications. She acknowledged that having a self-administration assessment on her bedtime medications should not have included an opioid medication. 4. Interview on 5/7/26 at 10:18 a.m. with administrator A revealed that the residents were not allowed to self-administer opioids at the facility. She acknowledged that even though resident 10's cognition was intact, the practice of leaving an opioid at the bedside of a resident put the resident, the resident's roommate, the facility, and staff members at risk for negative outcomes such as diversion of medications. She expected a self-administration assessment to be performed for every one of resident 10's bedtime medications to determine if she was safely able to perform that self-administration. 5. Review of the provider's January 2026 Self-Administration of Medications policy revealed that "an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility". After this assessment was performed by the interdisciplinary team, "the results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record".	F0554		

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F0554 SS = D	Continued from page 9 6. Review of the provider's undated Medication Management policy revealed that residents were allowed to self-administer medications with a physician's order and "in accordance with procedures for self-administration of medication".	F0554		
F0689 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 the safety of one of one sampled resident (31) who was left outside of his room unsupervised by one of one certified nurse aide (CNA) (M) after his room was cleaned and the floor was wet, which placed the resident at risk for falling and sustaining an injury. Findings include: 1. Observation on 5/5/26 at 12:55 p.m. revealed CNA M walked beside resident 31 and used physical and verbal cues to guide the resident towards his room. The resident wore a pair of Crocs (lightweight, slip-on foam clogs) on his feet. There was a "Caution Wet Floor" sign placed on the floor at the entrance of the resident's room. The room floor was visibly wet. CNA M instructed resident 31 to "wait" before he entered his room because the floor was still wet from having been mopped. CNA M then walked away from the resident. 2. Interview on 5/5/26 at 1:00 p.m. with environmental services L revealed she had recently cleaned resident 31's room, which included mopping the room floor. She placed the caution sign in front of his door after she cleaned his room because the floor was still wet. She stated the room floor had to be "absolutely dry" before the resident re-entered	F0689	Unable to change the outcome of the deficient practice for failure to provide an environment free of accident hazards. All residents have the potential to be affected. Staff involved were educated regarding resident supervision, wet floor safety precautions, and the importance of maintaining a safe environment for Resident 31. Interventions were implemented to help ensure Resident 31 remains safe while waiting for floors to dry following environmental services cleaning procedures. Resident 31 is relocating to a non-hazardous area away from the affected environment until the hazard has been removed and the area is safe for resident access. All other residents and their BIMS score will be reviewed to ensure they are able to follow safety interventions. All affected residents will be relocated to a non-hazardous area away from the affected environment until the hazard has been removed and the area is safe for resident access. The Environmental Services Director or designee will complete weekly environmental and supervision audits for four weeks then monthly for two months to monitor compliance with wet floor safety and resident supervision practices. The Environmental Services Director, or designee will present findings from monthly audits for three months at monthly QAPI meeting for review and recommendations.	06/05/2026

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Five Counties Nursing Home	405 6TH AVENUE WEST , LEMMON, South Dakota, 57638

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F0689 SS = D	Continued from page 10 his room. "We don't want them [the residents] to fall and hurt themselves." A mopped floor usually took about ten minutes to dry. When the floor was dry, it was her responsibility to remove the caution sign. That notified the residents and the staff that it was safe to re-enter the room. 3. Interview on 5/5/26 at 1:05 p.m. with CNA M revealed she knew the floor was still wet in resident 31's room when she asked the resident to wait outside of his room before going in. The resident usually complied with the staff's instructions. She did not know resident 31 had entered his room after she had told him to wait outside the room for the floor to dry. CNA M stated she should have stayed with resident 31 until she knew the floor was dry to mitigate his risk of falling on a wet floor and possibly injuring himself. 4. Interview on 5/5/26 at 1:07 p.m. with administrator A revealed she removed the caution sign by resident 31's door because she assumed his room was cleaned and the floor was dry, even though she knew it was environmental services staff's responsibility to have removed that sign. 5. Review of resident 31's electronic medical record (EMR) revealed his 4/20/26 Brief Interview for Mental Status assessment score was 12. That indicated he had moderate cognitive impairment. His diagnoses included autism (a chronic neurological and developmental condition that affects how people interact with others, communicate, learn, and behave) and visual impairment. 6. Interview on 5/6/26 at 10:30 a.m. with resident 31 in his room revealed his verbal interaction was limited to short word responses to questions. He stated that his vision was limited to some light and shadows, and he liked his personal belongings to be consistently kept in the same place so that he knew where to find them. 7. Review of the provider's revised May 2025 Potential Hazard Prevention policy revealed the provider was responsible to "ensure that the resident's environment remains as free as possible of accident hazards and that each resident receives adequate supervision and assistive devices to prevent accidents."	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING **01 - MAIN BUILD...** B. WING	**05/05/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Counties Nursing Home	**405 6TH AVENUE WEST , LEMMON, South Dakota, 57638**

(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
K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 5/5/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Five Counties Nursing Home (building 1) was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies via the Fire Safety Evaluation System (FSES) dated 5/7/26. Please mark an "F" in the completion date column for K225 and K374 deficiencies identified as meeting the FSES.	K0000		
K0225 SS = C Bldg. 01	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is NOT MET as evidenced by: Based on observation and record review, the provider failed to maintain a minimum clear space of 22 inches between the swing of the door and the newel post in one of the three stairwells (southwest stair enclosure). Findings include: Observation on 5/5/26 at 2:30 p.m. revealed the first-floor door swung into the southwest stair enclosure. That door in the open position restricted the egress to 17" measuring from the latch side of the door leaf to the stair newel post. Later review of the previous survey report dated 3/12/25 and communication with the facility administrator on 5/7/26 at 1:02 p.m. confirmed the continued finding.	K0225		F

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other afeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 0 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 4 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 ogram participation.

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jordan Fish	Administrator	05/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435090	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/05/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Counties Nursing Home	**405 6TH AVENUE WEST , LEMMON, South Dakota, 57638**

(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
K0225 SS = C Bldg. 01	Continued from page 1 The building meets the FSES. Please mark an "F" in the completion date column.	K0225		
K0374 SS = C Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation, discussion, and record review, the provider failed to maintain clear door widths at least 32 inches for one smoke barrier located on the first floor of the original building (between the original building and the 1962 addition). Findings include: Observation on 5/5/26 at 1:50 p.m. revealed the cross-corridor doors between building 1 and building 2 had a clear opening width of 30 inches which is less than the required minimum of 32 inches. Later review of the previous survey report dated 3/12/25 and communication with the facility administrator on 5/7/26 at 1:02 p.m. confirmed the continued finding. The building meets the FSES. Please mark an "F" in the completion date column.	K0374		F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Counties Nursing Home	**405 6TH AVENUE WEST , LEMMON, South Dakota, 57638**

(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
K0000 Bldg. 02	INITIAL COMMENTS A recertification survey was conducted on 5/5/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Five Counties Nursing Home (building 2) was found in compliance.	K0000		

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other afeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 0 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 4 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 rogram participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING B. WING	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Counties Nursing Home	**405 6TH AVENUE WEST , LEMMON, South Dakota, 57638**

(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
E0000	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 on 5/5/26. Five Counties Nursing Home was found in compliance.	E0000		

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 reverse for further 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
Jordan Fish	Administrator	05/20/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10641	A. BUILDING: _____ B. WING _____	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE COUNTIES NURSING HOME	405 6TH AVENUE W LEMMON, SD 57638

(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 5/5/26 through 5/7/26. Five Counties Nursing Home was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jordan Fish

TITLE: Administrator

(X6) DATE: 05/20/2026