STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE COUNTIES NURSING HOME	405 6TH AVENUE WEST 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) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/21/25 through 1/22/25. Areas surveyed included admissions, transfers, discharges, nursing services, resident rights, resident abuse and quality of care related to oxygen tubing not being changed, resident falls, length of time a resident laid on the floor after a fall and length of time the physician was notified after the resident fell. Five Counties Nursing Home was found not in compliance with the following requirements: F684.	F 000		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), complaint report, record review, interview, and policy review, the provider failed to ensure: *They had followed their policy after one of one sampled resident (1) who had fallen and was not referred to therapy after those falls. *Assessments accurately reflected a resident's status for five of five sampled residents (2, 3, 4, 5, 6). Specifically, the provider failed to assess	F 684	1. Unable to correct non-compliance. This deficient practice has the potential to harm all residents. Fall policy and checklist have been reviewed and revised by Administrator, DON, and Interdisciplinary team. Administrator and DON revised the fall checklist to include scanning all PT/OT referrals into the residents charts. DON has provided education to all-staff responsible for completing the post-fall checklist and re-educated the nurses on the requirements to complete and scan referrals to PT/OT. All falls in the past quarter have been audited by Administrator. DON or designee will ensure compliance of post-fall communication with PT/OT and conduct audits once a week for four weeks and once per month for two more months. DON or designee will present findings from these audits monthly for three months at the QAPI meetings for review until the QAPI committee advises to discontinue monitoring.	02/07/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jordan Fish	Administrator	02/05/2025

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 684	Continued From page 1 vital signs and ensure that vital signs were documented accurately on skilled nursing assessments. Findings included: 1. Review of the provider's SD DOH FRI submitted on 1/7/25 at 12:38 p.m. regarding resident 1 revealed: *Staff assisted the resident to the bathroom, gave her the call light, remindered her to ring the call light when she was done and left to help another resident. *Staff had heard resident 1 calling for help and found her on the bathroom floor with her pants and incontinence pull-up down, sitting on her bottom with her right arm in the wheel of the wheelchair (wc) and her left arm behind her to support herself. *Staff had moved the wc and did a quick assessment, then moved the resident to the wc where the registered nurse completed a full assessment. -"Redness noted to buttock where she was sitting on the floor, some redness noted to leftunderarm [left under arm] (resident states this is from bars on the side of toilet)". -"Resident is c/o [complaining of] pain in left ankle. Mild redness noted there and some puffiness, much like the right ankle and CNA [certified nursing assistant] reports it may have been like that prior to fall." *"At 5:00 am, resident continues to complain of left ankle pain an ER [emergency room] physician notified." *"Resident was transported to the clinic for a physician ordered x-ray which determined a non-displaced fracture." Review of resident 1's electronic medical record	F 684	2. Unable to correct non-compliance. This deficient practice has the potential to harm all residents. Administrator, DON, and Interdisciplinary team have reviewed the Medicare Documentation Guidelines and revised Medicare A skilled charting policy. DON has educated all personnel responsible for Skilled Charting on the guidelines. DON or designee will ensure compliance with Med A Skilled Charting by conducting weekly audits for four weeks and once per month for two more months. DON or designee will present findings from these audits monthly for three months at the QAPI meetings for review until the QAPI committee advises to discontinue monitoring.	02/07/25

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(EMR) revealed:
*She was admitted to the facility on 5/21/24.
*Her diagnoses included: chronic systolic heart failure, diabetes, macular degeneration, hypertension, and muscle weakness.
*She had started physical therapy (PT) on 5/22/24. Her PT Assessment indicated:
-Her therapy diagnosed included: a history of falls, risk of falls, weakness, and imbalance.
-She required the use of a a sit-to-stand (mechanical lift used to assist from a seated to standing position) supervision or minimal assistance. For chair-to-bed or chair-to-chair transfers, she required moderate staff assistance. For toilet transfers, she required moderate staff assistance.
*She was discharged from PT servoces on 6/19/24.
*Her PT discharge assessment indicated:
-For the chair-to-bed or chair-to-chair transfers, she required staff supervision or minimal assistance. For toilet transfers, she required staff supervision or minimal assistance.
-She was to have restorative therapy for ambulation, transfers, and active range of motion (AROM) for upper and lower extremities, three to five times a week.
*Minimum Data Set (MDS) review note from PT on 8/22/24 stated: "[resident 1] uses a w/c for mobility around the facility. She is refusing to ambulate. She is requires mod [moderate] assistance in transfers. She is on a walk-to dine and AROM. Restorative programs atthis [at this] time. No therapy indicated at this time."
*She had fallen on 8/27/24, 10/20/24 and 1/4/25.
*The falls event checklist related to her falls on 8/27/24 and 10/20/24 did not have the therapy department box checked as notified.
*After her 8/27/24 and 10/20/24 falls, there was

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no documention that indicated physical therapy was notified or a therapy referral was sent.
-Death in the facility on 1/19/25.

Interview on 1/22/25 at 10:45 a.m. with physical therapist C revealed:
*He was one of two physical therapist who were employed with the facility.
*He was unaware of any referrals sent to the physical therapy department for resident 1 after she had fallen on 8/27/24 or 10/20/24.
*He stated if the therapy department had gotten a referral there would have been documentation in the resident's chart.
-There was no documentation in resident 1's chart for a therapy referral or therapy services after she had fallen.

Interview on 1/22/25 at 2:05 p.m. with director of nursing (DON) B revealed:
*She was unaware a referral had not been sent to the therapy department after resident 1 had fallen on 8/27/24 and 10/20/24.
*She was not sure why the therapy department was not notified.
*She confirmed the therapy department notifiation box on the falls event checklist for resident 1's falls on 8/27/24 and 10/20/24 were not check marked.

Review of the provider's reviewed December 2024 Fall policy revealed:
*Purpose: To provide a safe living environment for residents and to protect them from injury.
*Post-Fall Management:
-PT will be notified of each fall as it occurs. Referrals for evaluation made as indicated.

2. Review of SD DOH complaint report submitted

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on 1/15/25 at 4:53 p.m. revealed:
*The complainant wished to remain anonymous.
*The complainant reported concerns with the accuracy of resident assessments and timeliness of the documentation of resident assessments at the facility.

3. A review of resident 2's electronic medical record (EMR) revealed:
*Her diagnoses included secondary hypertension (high blood pressure from an underlying medical condition), hyperlipidemia (high cholesterol), chronic obstructive pulmonary disease (COPD), anemia, peripheral vascular disease (progressive circulation disorder caused by narrowing, blockage, or spasms in a blood vessel), and essential hypertension (the most common type of high blood pressure).
*Previous vital signs were documented instead of having checked and documented her current vital signs each day. From 10/4/24 to 11/12/24, her:
- Blood pressure was checked on 33 out of 41 days.
- Pulse was checked on 24 out of 41 days.
- Temperature was checked on 25 out of 41 days.
- Respirations were checked on 24 out of 41 days.
-Oxygen saturation was checked on 26 out of 41 days.

4. A review of resident 3's EMR revealed:
*Her diagnoses included COPD, atrial fibrillation (a condition that causes an irregular heartbeat), secondary hypertension, weakness, and essential hypertension.
*Previous vital signs were documented instead of having checked and documented her current vital signs each day. From 10/1/24 to 10/29/24, her:
- Blood pressure was checked on 11 out of 29

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days.
- Pulse was checked on 11 out of 29 days.
- Temperature was checked on 10 out of 29 days.
- Respirations were checked on 11 out of 29 days.
- Oxygen saturation was checked on 12 out of 29 days.

5. A review of resident 4's EMR revealed:
*Her diagnoses included severe chronic kidney disease, heart failure, essential hypertension, Type 2 Diabetes, peripheral vascular disease, and chronic myeloproliferative disease (rare blood cancers).
*Previous vital signs were documented instead of having checked and documented her current vital signs each day. From 11/26/24 to 12/24/24, her:
- Blood pressure was checked on 20 out of 29 days.
- Pulse was checked on 20 out of 29 days.
- Temperature was checked on 19 out of 29 days.
- Respirations were checked on 20 out of 29 days.
- Oxygen saturation was checked on 20 out of 29 days.

6. A review of resident 5's EMR revealed:
*Her diagnoses included dementia, adult failure to thrive, acute kidney failure, heart failure, muscle weakness, and other specified disorders involving the immune mechanism.
*Previous vital signs were documented instead of having checked and documented her current vital signs each day. From 9/18/24 to 10/17/24, her blood pressure, pulse, temperature, respirations, and oxygen saturation were checked on 13 out of 29 days.

7. A review of resident 6's EMR revealed:

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*His diagnoses included essential hypertension, diabetes mellitus due to underlying condition, and 2-part displaced fracture of surgical neck of left humerus (upper part of the left humerus bone near the shoulder has fractured into two pieces that are significantly displaced).
*Previous vital signs were documented instead of having checked and documented his current vital signs each day. From 12/13/24 to 1/20/25, his blood pressure, pulse, temperature, respirations, and oxygen saturation were checked on 26 out of 38 days.

8. Interview with Nurse Executive/Director of Nursing (DON) B revealed she agreed that a current set of a resident's vital signs needed to be a part of a skilled nursing assessment. She stated, "I assume it is just pulling from the last documented vital signs if they aren't entering current vitals."

9. Review of the provider's undated "How to Chart on Medicare A Residents" policy revealed:
*" What do you need?"
- "Full set of vitals on the resident (BP, Pulse, Temp, O2 Sat, RR [respiratory rate])."
*" How Often Do I need to do this charting?"
- "For Medicare to reimburse us for services, we need to do this charting every 24 hours."