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 _____	R-C 05/15/2025

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 An onsite revisit survey was conducted from 5/14/25 through 5/15/25 for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities for all previous deficiencies cited on 4/9/25. Five Counties Nursing Home was found not in compliance with the following requirements: F610 and F658.	{F 000}		
{F 610} SS=D	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 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based plan of correction (POC) with a completion date of 5/2/25 for the 4/9/25 complaint survey review, policy review, record review, and interview, the provider failed to follow their POC to ensure: *A thorough investigation was completed for one of one sampled resident (3) who had eloped (left	{F 610}	Unable to change the outcome of the deficient practice. The facility has determined all residents have the potential to be affected. Final report was submitted to DOH on 05/20/25 for resident #2 and was accepted. Final report was submitted to DOH on 4/12/25 for resident #3 and accepted. The Administrator, DON, ADON, MDS Coordinator, SSD, CDM, BOM, Director of Maintenance and Activities Director met on 05/22/25 to review the policy, no revisions were made. All-staff training was provided on 05/27/25 educating on Abuse and Neglect and Reporting Requirements. Table top exercise on elopement was completed and signatures were acquired. Nursing In-Service Training was conducted on 05/27/25 on how to conduct investigation and proper forms to use. Those unable to attend are able to complete training through online education platform (EdApp) or review education provided at Nurses Station.	05/27/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tamara Derschan	Administrator	06/03/25

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 610}	Continued From page 1 the facility without staff knowledge). *A thorough investigation and final report was submitted to the South Dakota Department of Health (SD DOH) for one of one sampled resident (2) who had a fallen and sustained a fracture. Findings include: 1. Review of the provider's POC with a compliance date of 5/2/25 revealed: *"The DON or designee will conduct a random audit of one resident weekly for four weeks and two residents monthly for two months. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated and reported to the appropriate people." 2. Review of the provider's 5/1/24 Reporting Abuse to Facility Management Policy revealed, "A completed copy of documentation forms and witness statements, if any, must be provided to the Administrator within 24 hours of the occurrence of an incident of suspected abuse. An immediate investigation will be made and a copy of the findings of such an investigation will be provided to the Administrator within 5 working days of the occurrence of such an incident." 3. Review of the provider's undated Abuse Investigation policy revealed: *"All reports of resident abuse, neglect, injury of unknown source and misappropriation of resident property shall be promptly and thoroughly investigated by facility management. *"Policy interpretation and Implementation" -"Should an incident or suspected incident of resident abuse, mistreatment, neglect, injury of unknown source or misappropriation of resident	{F 610}	All investigations will be conducted and completed with facility approved investigation forms. The investigations will include signed statements from witnesses, date of completion, and who completed the investigation. The Social Services Director or designee with the Administrator are to follow up on all investigations and submit a final report to the SDDOH within 5 days upon initial reporting. The DON, ADON, and MDS Coordinator are educated in submitting reports to the DOH in case the Administrator or Social Services Director are unable. The Administrators Email is to be included in all reports submitted to the DOH for tracking purposes. The Administrator or desginee will conduct weekly audits on all investigations for four weeks and monthly for two months to ensure a proper investigation is completed and submitted to DOH. The Administrator or designee will present findings from monthly audits for three months at QAPI meeting for review and recommendations.	

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{F 610}	Continued From page 2 property be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident." -"Witness reports will be obtained in writing. Witnesses will be required to sign and date such reports." -"The results of the investigation will be recorded on approved documentation forms." -"The Administrator or his/her appointed member of management will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency [SD DOH], the local police department, ombudsman and others as may be required by state or local laws, within five (5) working days of the reported incident." 4. Policy review, record review, and interview, on 5/15/25 at 2:43 p.m. with administrator A revealed: *She had reviewed all resident incidents since the 3/12/25 recertification survey, that were reported to the SD DOH, for completeness of investigation and reporting. *She had determined that all of the incidents reviewed had complete investigations, and the final reports had been appropriately reported to the SD DOH. Review of the provider's submitted SD DOH Facility Reported Incidents (FRIs) for resident 3's elopement (left the facility without staff knowledge) on 4/12/25, and for resident 2's fall and sustained fracture on 4/25/25, revealed that no 5-day final report of the investigation had been submitted to the SD DOH for those two reported incidents. *Administrator A indicated she had investigated the incidents herself.	{F 610}		

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{F 610}	Continued From page 3 *The provider's investigation documents were typed sheets of paper that did not include a signature or date of who completed the investigation. -The investigation documents did not include signed statements from witnesses. -She confirmed she had not obtained signed statements from witnesses. *She stated there were no approved documentation forms for investigations. *She was aware that a 5-day final report for reported incidents was to be submitted to the SD DOH. *Administrator A confirmed that there was no 5-day final report submitted to SD DOH for the above two incidents. *Administrator A confirmed that the 4/9/25 complaint survey POC with a completion date of 5/2/25 had not been followed.	{F 610}		
{F 658} SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on plan of correction (POC) with a completion date of 5/2/25 for the 4/9/25 complaint survey review, interview, record review, and policy review, the provider failed to ensure the POC was followed for the accurate recording of fluid intakes for four of four sampled residents (1, 4, 5 and 6) who had physician-ordered fluid restrictions. 1. Review of the provider's POC revealed:	{F 658}	Unable to change the outcome of the deficient practice. The facility has deemed all residents placed on fluid restrictions have the potential to be affected. Education was provided on 05/20/25 to all residents placed on fluid restrictions regarding risks vs. benefits of following fluid restrictions. Care plans on all residents with ordered fluid restrictions were reviewed and revised as necessary. Order obtained by physician on 05/22/25 to discontinue fluid restrictions on resident #4. Order obtained by physician on 06/03/22 to discontinue fluid restrictions on resident #3.	05/27/25

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{F 658}	Continued From page 4 *"Resident (1) fluid intake will be accurately recorded on an intake and output form located in resident (1) room." *"All residents on a fluid restriction have intake and output forms located in their rooms to ensure accurate recordings." *"Nursing and line staff [all other staff members] have been educated on fluid restrictions. A list of residents with fluid restrictions is posted on the EMR [electronic medical record]." *"The nursing staff is required to record and document fluids into the [resident's] EMR." Record review and interview on 5/14/25 at 5:35 p.m. with director of nursing B and administrator A regarding residents with physician-ordered fluid restrictions revealed: *Resident 1 had a 1200 milliliter (ml) fluid restriction. *Resident 4 had a 2000 ml fluid restriction. *Resident 5 had a 1200 ml fluid restriction. *Resident 6 had a 2000 ml fluid restriction. *DON B indicated: -Nursing staff had been educated on fluid restrictions and their responsibility in documentation related to fluid restrictions. A list of residents with fluid restrictions was posted on the EMR home page for all staff members' awareness. -The nursing staff was required to record and document fluids into the EMR for all residents on a physician-ordered fluid restriction. -She had placed "intake and output record forms" in each resident's room for staff members to record the amount of fluid intake each resident consumed. --She had not considered those forms as a part of the resident's medical record. --Staff had not documented on the forms as they	{F 658}	The Fluid Restriction Policy was revised on 05/20/25 to include nursings responsibility for documenting all fluids on residents with restrictions. In-service training on fluid restrictions conducted on 05/27/25 for nursing, dietary, and activities. The Nursing Department is responsible for charting on all fluids for residents with ordered fluid restrictions in PCC. Dietary Department and Activities Department were notified on 05/27/25 that residents with fluid restrictions are to be charted by nursing staff only. Those unable to attend are able to complete training through online education platform (EdApp) or review education provided at Nurses Station. The Director of Nursing or designee will audit all charting of fluids on residents with fluid restrictions daily for one week weekly for three and monthly for two months. The Director of Nursing or designee will present findings from monthly audits for three months at QAPI meeting for review and recommendations.	

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{F 658}	Continued From page 5	{F 658}		

should have.
*She stated additional fluid intake documentation was found in each resident's medical record and was not the same as what was documented on the intake and output record forms.
*She confirmed the POC was not followed as the resident's intake and output amounts were not recorded on those forms accurately.
*She stated most residents do not intake enough fluids to go over their physician-ordered fluid restriction amount.
*Administrator A stated that resident 4 drank more fluids than his physician-ordered fluid restriction amount.
-She stated he "gets thirsty, it is his right to drink what he wants".
-She acknowledged resident 4 was not educated on the risks of consuming more fluids than was ordered by his physician.
-She stated at "the end of the day, it is the nursing responsibility to ensure documented [fluid intakes]."
*Administrator A stated there was a report that could be printed from the residents' EMRs that would show what the dietary department had provided residents for fluids, but that "is not done unless we ask [for it]."
*Administrator A confirmed the POC with the completion date of 5/2/25 for the 4/9/25 complaint survey had not been followed.

Interview on 5/15/25 at 12:40 p.m. with DON B and administrator A revealed:
*Residents on fluid restrictions had not been provided education on the risks or benefits of following their physician-ordered fluid restrictions.
*DON B stated the physician should have talked to residents about this.
-There was no documentation to support that the

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{F 658}	Continued From page 6 physician had explained the risks versus the benefits of residents not following their physician-ordered fluid restrictions. Review of the provider's revised 5/15/25 Fluid restriction policy revealed: *"It is the policy of [provider's name] to ensure that fluid restrictions will be followed in accordance to physician's orders." *"The nurse will obtain and verify the physician's order for the fluid restriction and an order written to include the breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department and will be recorded in [EMR]." *"The fluid restriction distribution will take into consideration the amount of fluid to be given at mealtimes, snacks, and medication passes." *"The resident has the right to refuse the fluid restriction, and if refused, documentation should support the reason for the refusal, the education of risks and benefits, and any supporting documentation of the resident's continued refusal, assessment for any changes in condition related to the refusal, and the notification of the physician about the resident's refusal."	{F 658}		