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 _____	03/12/2025

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 recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/9/25 through 3/12/25. Five Counties Nursing Home was found not in compliance with the following requirements: F582, F583, F610, F655, F658, F699, F700, F725, F727, F732, F755, F758, F761, F812, F835, F837, F847, F848, F851, F865, and F909.	F 000	This plan of correction is submitted as required under Federal and State regulations and statuses applicable to long-term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and such liability is hereby specifically denied.	
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items	F 582	Unable to change the outcome of the deficient practice for failure to ensure the proper Medicare Notices were completed accurately. The Medicare Notices were updated to accurately reflect the date of discharge on 03/12/2025. The Administrator educated the MDS Coordinator and Business Office Manager on 3/12/25 on the importance of documenting the discharge dates on the Medicare Notices. The Business Office Manager or designee will conduct weekly audits for four weeks and monthly for two months. The Business Office Manager will present findings from monthly audits for three months at QAPI meeting for review and recommendations.	04/26/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jordan Fish
TITLE: Administrator
(X6) DATE: 04/23/2025

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 582	Continued From page 1 and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure the proper Medicare Notices were completed accurately for: *Two of two sampled residents (10 and 33) who had remained in the facility following their discharge from Medicare part A skilled services. *One of one sampled resident (41) who had discharged to home following their discharge from Medicare part A skilled services. Findings include: 1. Review of resident 10's electronic medical	F 582		

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F 582	Continued From page 2 record (EMR) revealed: *She had a 3/4/25 Brief Interview for Mental Status (BIMS) assessment score of 14, which indicated she was cognitively intact. *Her last covered day of Medicare Part A skilled services was 10/30/24. *The section of the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form "Beginning on" with a blank for the date that her Medicare coverage ended was missing and appeared to have been whited out. *The signature box contained a handwritten note, "Phone: [name of family member]/[signature of director of nursing (DON) P]." -There was no documentation of the time of that notification. -There was no indication that the person phoned was a representative for the resident. *The date box had a typewritten date of 10/28/24. 2. Review of resident 33's EMR revealed: *She had a 3/4/25 BIMS assessment score of 15, which indicated she was cognitively intact. *Her last covered day of Medicare Part A skilled services was 12/24/24. *The section of the SNF ABN form "Beginning on" with a blank for the date that stated when her Medicare coverage ended was missing and appeared to have been whited out. *No box was checked in the Options section to have indicated whether the resident did or did not want to receive care. *The signature box contained a handwritten note, "Telephone: [name of family member]/[signature of DON P]." -There was no documentation of the time of that notification. -There was no indication that the person phoned was a representative for the resident.	F 582		

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F 582	Continued From page 3 *The date box had a typewritten date of 12/22/24. 3. Review of resident 41's EMR revealed: *Her last covered day of Medicare Part A skilled services was 12/23/24. *The section of the SNF ABN form "Beginning on" with a blank for the date that stated when her Medicare coverage ended was missing and appeared to have been whited out. *The date box had a typewritten date of 12/20/24. 4. Interview on 3/11/25 at 10:35 a.m. with administrator A regarding the SNF ABN Forms revealed: *She agreed that the section of the form that included the date Medicare coverage ended was missing from residents 10, 33, and 41's forms and appeared to have been whited out. *She was unsure why the SNF ABN forms for residents 10 and 33, who were cognitively intact, had been "telephone signed" by a family member and not the resident. *She stated that the previous DON P had been responsible for the SNF ABN forms at the time they were provided to residents 10, 33, and 41.	F 582		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a	F 583	Resident #9 and 21 reassessed on 3/13/25 for notification of video monitoring posting in the resident's room. A notification was placed on the doors contained in a cleanacle surface. An inservice education program was conducted by the Director of Nursing with all licensed staff addressing circumstances around resident privacy with video/audio monitoring. In addition to the current video monitoring policy at Five Counties Nursing Home that speaks to monitoring by family, a policy has been implemented that addresses video/audio monitoring by staff has been implemented.	04/26/25

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F 583	Continued From page 4 private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled resident (9 and 21) privacy had been maintained related to audio or video monitoring devices. The provider had not followed their policy for video monitoring related to: *Ensuring a cognitively intact resident had consented and been aware of the monitoring device in his room. *Staff training and awareness with the devices including which residents had them, when to turn off or block the device to ensure the residents' privacy, the process for consents by the residents and staff, and ensuring a sign was posted to	F 583	The Director of Nursing or designee will conduct a random audit weekly for four weeks and monthly for two months to ensure video monitoring notifications will be posted. The Director of Nursing or designee will present findings at monthly QAPI meetings for review and recommendations.	

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F 583	Continued From page 5 notify others of the video monitoring device. Findings include: 1. Observation on 3/9/25 at 2:36 p.m. of resident 9's room revealed there was a white ball-shaped device on a stand on the dresser with a camera lens that faced resident 9's bed. Observation on 3/10/25 at 1:47 p.m. of resident 9's room revealed: *The above observed device was no longer present. *There was no signage present at or near the entrance of his room that indicated the use of a video or auditory monitoring device. Review of resident 9's electronic medical record (EMR) revealed: *He was admitted on 4/28/20. *He had a 1/7/25 Brief Interview for Mental Status (BIMS) assessment score of 14, which indicated he was cognitively intact. *His diagnoses include anxiety disorder, major depressive disorder, severe with psychotic symptoms, repeated falls, dementia with other behavioral disturbances, and neurocognitive disorder with Lewy Bodies (a brain disease that affects movement, thinking, mood, and memory). *A 1/29/25 video monitoring consent form that indicated resident 9's son had given verbal consent to director of nursing (DON) B. -There was no documentation of resident 9 being informed of or signing a consent for the use of the video monitoring device. *A 2/13/25 physician's order for video monitoring for resident 9's "safety". *The intervention of video monitoring was added to in his care plan on 1/31/25. -The care plan did not indicate when staff should	F 583		

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F 583	Continued From page 6	F 583		

have shut off or blocked the video monitoring device to ensure resident 9's privacy.

Observation and interview on 3/10/25 at 1:56 p.m. with assistant director of nursing (DON) G in resident 9's room related to the video monitoring device revealed:
*The device that was used for video monitoring was currently not in use because it had not been helpful.
*It was put in place because resident 9 would "throw" himself on the floor.
*The device was a baby monitoring screen that was to be watched at the nurse's station.
*There was no sign placed at or near the entrance of his room that indicated video monitoring capability or use.
*Assistant DON G then removed the video monitoring device observed above from the top drawer of the resident's dresser that was manufacturer labeled "GoodBaby".

Interview on 3/11/25 at 2:29 p.m. with resident 9 revealed:
*He was not aware that there had been a video monitoring device in his room.
*When shown the video monitoring device he indicated he did not know what that device was and asked if it was the camera.

Interview on 3/11/25 at 2:40 p.m. with certified nursing assistant (CNA)/certified medication aide (CMA) J regarding video monitoring in resident 9's room revealed:
*She was aware there was a video monitoring device in the room.
*She was not instructed to turn off or move the video monitor while providing the residents' care.

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F 583	Continued From page 7 2. During the entrance conference on 3/10/25 at 8:39 a.m. with administrator A and DON B, administrator A indicated there was an "Alexa" type device in resident 21's room. Observation on 3/9/25 at 3:48 p.m. of resident 21 in her room revealed the following: *She was seated in her recliner, her feet were elevated, she was covered with a blanket, and her eyes were closed. -An Alexa Show (an electronic device that has a "drop in" feature capable of audio and video recording) was on the bookshelf next to her recliner that was facing her. *There was no sign at the entrance to the room or within the room that indicated an audio/video monitoring device was used in that room. Observation on 3/10/25 at 8:06 a.m. of resident 21 in her room revealed: *She was lying on her bed, her eyes were closed, and an Alexa Show device was on the bookshelf at the same height as her bed. -The device was facing her bed. *There was no sign at the entrance to the room or within the room that indicated an audio/video monitoring device was used in that room. Observation on 3/11/25 at 7:32 a.m. of resident 21 revealed: *She was in her bed, the Alexa Show device was on the second shelf of the bookstand with a pink sticky note on the front that showed where the volume buttons were, and a piece of black tape had been placed over the camera shutter. -The device was turned and facing the wall. *There was no sign at the entrance to the room or within the room that indicated an audio/video monitoring device was used in that room.	F 583		

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F 583	Continued From page 8 Review of resident 21's EMR revealed: *Her admission date was 5/3/23. *Her 1/14/25 Brief Interview of Mental Status assessment score was a 6, indicating she was cognitively impaired. *Her diagnoses included: dementia, major depressive disorder, abnormal involuntary movements, psychotic disturbance, anxiety, and mood disorder. *An 8/9/23 physician's order to "Make sure Alexa Show privacy shutter is closed when family is not present. every shift Pull device out of room and put [it] in [the] med room if the shutter is open. Notify DON [director of nursing] if you need to pull it". *Her 3/10/25 care plan had a 5/9/23 focus area of "Due to the possibility of COVID-19, I have the potential for a psychosocial well-being problem and am at risk for social isolation due to limited visitation possibilities during times of high-transmission rates." -An 8/3/23 intervention for that focus area indicated resident 21 "will be allowed to have her "Alexa Show" to be in contact with her family via video call. Family will sign a consent and follow policy for use." Interview and observation on 3/11/25 at 7:36 a.m. with CNA O in resident 21's room revealed she: *Was not aware of any residents having an Alexa Show or any other recording device in their rooms. *Stated there were night lights in resident rooms that look like an Alexa device, and when you touch it the night light turns on. *Observed resident 21's Alexa Show and stated she was unsure if it was a device that had audio or video monitoring capabilities.	F 583		

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F 583	Continued From page 9 Interview on 3/11/25 at 7:42 a.m. with resident care coordinator/Minimum Data Set (MDS) Coordinator H regarding video and audio monitoring devices revealed: *She was aware of an Alexa Show device in resident 21's room. -Staff were to turn the camera away from resident 21 when they provided care for her to ensure her privacy was maintained. -Resident 21's family had wanted the device in her room. -She was unsure of how long it had been in her room. *She was unsure if resident 21's family used the device's video feature with other family members. *She had not removed the camera from resident 21's room. 3. Interview on 3/11/25 at 8:32 a.m. with DON B, administrator A, and assistant DON G regarding audio/video monitoring devices in resident's rooms revealed: *DON B stated the Alexa Show in resident 21's room was not used for video purposes. -She thought it was used for the family to look at pictures when they visited resident 21, and was aware resident 21's daughter used the device for audio calls to other family members when she visited. -Administrator A and DON B were not aware that the Alexa Show device had a "drop-in" feature (a feature that allows instant video or audio conversations by outside contacts.) *DON B indicated resident 9 and his son were aware of the video monitoring device in his room. -DON B stated the device's video feature was to be turned off by staff when they provided care for the resident for privacy, and the device was in his	F 583		

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F 583	Continued From page 10	F 583		

room to monitor his behaviors and to be able to visualize if he "throws" himself on the floor.
*DON B stated staff were educated verbally to turn the camera away when they provided personal care to resident 9.
-That education was not documented.
*Assistant DON G stated that "everyone" knows to turn the device away from the resident while they provided care for that resident to maintain his privacy.

4. Interview and policy review on 3/11/25 at 4:45 p.m. with Administrator A, DON B, and assistant DON G, regarding audio/video device consents and the audio/video monitoring policy revealed the following:
*The policy included a consent was to be signed by staff members.
-Administrator A indicated none of the staff had signed the consent form.
*Administrator A thought the audio/video recording devices would be hooked up to the provider's guest Wi-Fi that was available to all residents and families with codes that were posted at the entrance to the facility.
-Administrator A stated the provider had not needed to provide written approval to the resident or their representative for the use of video recording devices to be used on the provider's guest Wi-Fi.

5. Review of the provider's undated Video Monitoring policy revealed the following:
*"Nursing staff must also complete and sign the consent form before a video monitoring device may be installed in the resident's room. The nursing staff member may refuse or withdraw consent to video monitoring."
*"Video monitoring restrictions:

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F 583	Continued From page 11 -Audio recording is prohibited. -A resident may not use a facility's local area network to connect the video monitoring device to the internet without the facility's written consent. -The facility may impose conditions on the installation of any wire, cable, or other technologies that may be necessary to connect the device to the internet." *"1. Resident Consent" -"The description of the video monitoring device I wish to install: --Brand Name: --Model Number: --Installation and operating requirements:" *"3. Restrictions (Please Indicate) -No restrictions -The video monitoring device must be pointed away from _____ [blank line] -No video recording -No broadcasting video recordings -Video monitoring device must be turned off or blocked during an examination or procedure by a health care provider. -Video monitoring device must be turned off or blocked while dressing, bathing, or personal care planner, intimate partner, ombudsman, spiritual advisor, or another visitor. -Other restrictions:" *"5. Staff Consent to Video Monitoring in [name] (resident) Room." -"Signature" -"Consent" -"Do Not Consent" *The last page of the policy indicated a sign was to be posted that included "THIS ROOM CONTAINS A VIDEO MONITORING DEVICE".	F 583		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610	The facility has determined that all have the potential to be affected.	04/26/25

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F 610	Continued From page 12 §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 on record review, interview, and policy review the provider failed to ensure a thorough investigation was completed regarding an allegation of abuse for one of one sampled resident (5). Findings include: 1.Review of a 12/25/24 grievance form completed by registered nurse (RN) Q regarding resident 5 revealed: *The nature of the grievance was "Resident reports CNA [certified nursing assistant] R used unnecessary force and maleficence [harmful] while giving cares in changing her brief and providing peri-care during repositioning/turning." *The incident was documented attached to the grievance as happening between 7:30 a.m. and 8:00 a.m. on 12/25/24.	F 610	Resident #5 is assessed every 2-3 weeks by Three Rivers Mental Health and can share her experiences in a safe environment. The Administrator and Interdisciplinary team will go back and review/follow up on all violations regardingthe nature of abuse since last survey 12/05/23. The Administrator, Director of Nursing, and Interdisciplinary team will review and revise as necessary the policy and procedures for investigating allegations of abuse and neglect. The Administrator, Director of Nursing or designee will conduct a thorough investigation and verify any injuries post allegation or findings of injury of unknown origin. The Administrator and Director of Nursing conducted an in-service education with all direct staff addressing circumstances that require reporting for timely investigations, and their responsibilities related to investigations. The Director of Nursing or designee will conduct a random audit of two residents weekly for four weeks and three 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. 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 610	Continued From page 13 *RN Q's documentation attached to the grievance stated, "Upon entering [the] resident's room she was visibly upset, looking to me and stating, 'I don't know what else to do. I know I can trust you to make this right.' She then reported the following:" - CNA R was in resident 5's room completing morning cares and resident 5 was lying on her right side holding onto the bed rail facing the wall. -Resident 5 then reported to RN Q, that CNA R "was short and mean with her, using a 'mean voice', and telling her to roll over. 'The way she was doing it, I couldn't brace myself enough on the bed handle (side rail). She was pushing me too hard and I told her to stop because I felt like I was going to fall between the wall and the bed. I was scared. She wouldn't listen to me when I told her to stop.' Resident [resident 5] is crying at this time, recalling her fear at falling from the bed and the aide not listening to her to her pleas to stop pushing." -Resident 5 "continues to cry, 'Please have someone else help me to the dining room. I could have been on the floor. I'm so scared. She scares me. I don't want her to come near me.' Resident [resident 5] later reports to me [RN Q], 'I don't feel safe with her [CNA R]. I choose not to have her [CNA R] care for me. Ever.'" *On 12/26/24 RN Q spoke with CNA R in a private location. CNA R denied wrongdoing and "curtly [abruptly] tells this nurse [RN Q], 'I did nothing wrong. I was only pushing her [resident 5] to her side and she wasn't helping. I was told she gets emotional.' CNA R has an attitude in responding to my questions, not allowing for constructive critique or approach in working with [resident 5]." *RN Q documented her evaluation of CNA R which included RN Q felt CNA R had "fluctuations	F 610	the next businss day. Insulin sliding scale TID	

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in presentation from being kind and helpful to angry and short-tempered."
*DON B documented on the grievance form that on 12/27/24 the grievance had been resolved and "CNA [CNA 5] agency asked to coach CNA- noted improvement by staff."

2. Review of an email dated 12/27/24 from DON P to DON B and administrator A revealed:
*DON P was in the facility on 12/25/24 and stated she had addressed the "issues" that had occurred on that day, and she had placed the grievance form in administrator A's box in the office.
*Her documentation in the email included:
-"I know these two have not gotten along but there is feedback coming from permanent and travel staff that her [CNA R] attitude is not good, she does not take suggestions and criticism well, and she is rough with the residents. None of the accounts that occurred on Christmas Day were witnessed by other staff members as she likes to work independently as well."
-"On Christmas day she [CNA R] was switched to a different group because [resident 5] said she was scared of her, [another resident] also complained, and I believe [an additional resident] mentioned something as well. All [complaints] determined not to be abuse but concerns [were] present. Yesterday she was also changed off that group to a different group just to have some time to follow up with the grievance and see if changing [the group] seems to help overall. With the admission and readmission yesterday, it was a bit busy prior to me leaving so I did not have much of a chance to deal with this outside of [CNA/CMA K] working on getting ahold of [a travel nursing agency]."

3. Review of resident 5's electronic medical

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F 610	Continued From page 15 record (EMR) revealed: *She was admitted on 7/10/18. *Her 12/26/24 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated she was cognitively intact. *The first skin observation tool assessment completed after the 12/25/24 reported incident was documented on 1/10/25, with no skin issues documented. *A psychosocial progress note entered by social services on 12/30/24 at 9:15 a.m. indicated resident 5 "was seen for session today. Concerns were addressed with nursing staff". -There was no documentation to support what those concerns were. 4. Interview on 3/12/25 at 10:08 a.m. with administrator A revealed: *She was made aware of the 12/25/24 reported incident on 12/27/24 via email from DON P. *DON P told her that she did not suspect abuse. *She had spoken with resident 5 "in passing" and she had not expressed any concerns regarding the 12/25/24 incident with CNA R. *She and DON B had reviewed resident 5's skin assessment and there were no identified concerns. -There was a skin assessment completed on 12/20/24, prior to the incident, and the next skin assessment was completed on 1/10/25, 16 days after the incident. -The grievance was documented as resolved on 12/27/24. *She confirmed that the 12/25/24 grievance written by RN Q was concerning as an allegation of abuse. *She would have reported abuse to the South Dakota Department of Health (SD DOH) if it was "warranted" or if she could prove it was abuse.	F 610	the next business day. Insulin sliding scale TID <15 minutes before meals. 0 Units for blood glucose <200 If resident is symptomatic, conscious, and able to swallow or has a feeding tube: * Administer 6oz fruit juice, milk, regular pop, or other high carbohydrate beverage orally or via feeding tube. * Repeat BG after 15 minutes; if <70 repeat above intervention *If after 2 attempts to treat and BG still <70, notify provider. All residents	

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5. Interview with 3/12/25 at 1:13 p.m. with DON B revealed:
*Any staff member had the ability to complete a SD DOH facility reported incident (FRI) report related to a suspicion of abuse.
*It was her expectation that she be notified of an incident and the charge nurse should complete the SD DOH FRI report.
*She did not feel that a report should have been made to the SD DOH regarding the 12/25/24 reported incident with resident 5 because there were no injuries identified.
*She verified the documents available regarding the 12/25/24 reported incident included the grievance form, the documentation completed by RN Q, the 12/27/24 email sent by DON P to administrator A and DON B, and documentation that CNA R 's travel employment agency had been notified of the grievance and her contract was terminated early on 1/6/25.
-She confirmed she was unable to locate further documentation to support the resident's grievance had been thoroughly investigated to ensure abuse had not occurred.

Review of the provider's undated Reporting Abuse to Facility Management policy revealed:
*"Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish."
*"Reports of any suspected abuse or incidents of abuse must immediately be reported to the Social Services Director, Administrator, and the Director of Nursing. In the absence of those listed above, such reports may be made to the Nurse Supervisor on duty."
*"The Administrator, Social Services Director and

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F 610	Continued From page 17 Director of Nursing must be immediately notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator, Social Service Director and/or Director of Nursing must be called and informed of such incident." *"When an incident of resident abuse is suspected or confirmed, the incident must be immediately reported to facility management regardless of the time lapse since the incident occurred. Reporting procedures should be followed as outlined in this policy." *"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 investigation will be provided to the Administrator within 5 working days of the occurrence of such incident." *"Upon receiving information concerning a report of abuse, the Director of Nursing will request that Social Services monitor and document the resident's reactions to statements regarding the incident and their involvement in the investigation." *"Unless the resident requests otherwise, the Social Service Director will give the Administrator and the Director of Nursing a written report of their findings." Review of the provider's undated Abuse Investigation policy revealed the following: *"All reports of resident abuse, neglect, injury of unknown source and misappropriation of resident property shall be promptly and thoroughly investigated by facility management." *"The individual conducting the investigation will, as [at] a minimum:	F 610	the next businss day. Insulin s	

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F 610	Continued From page 18 -a. Review the completed documentation form -b. Review the resident's medical record to determine events leading up to the incident -c. Interview the person(s) reporting the incident -d. Interview any witnesses to the incident -e. Interview the resident (as medically appropriate) -f. Interview the attending physician as needed to determine the resident's current level of cognitive function and medical condition -g. Interview staff members who have contact with the resident during the period of the alleged incident -h. Interview the resident's roommate, family members, and visitors as needed -i. Interview other residents to whom the accused employee(s) provides care or services for -j. Review all events leading up to 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, the Local Policy Department, the Ombudsman and others as may be required by state or local laws, within (5) working days of the reported incident." Review of the provider's undated Mandatory Reporting policy revealed the following: *"Abuse is the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish."	F 610		

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F 610	Continued From page 19 *"Willful" means the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish." *"Do an investigation, review the findings, and revise the care plan as necessary." *"Do an investigation and report per the appropriate timeline."	F 610		
F 655 SS=E	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 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	F 655	The facility has determined that all have the potential to be affected. Residents #25 and 142 were given a summary of their baseline care plan. A compy of the summary, signed by the resident, residen'ts representative if applicable, and a facility representative was placed in the medical record. All residents will be given their baseline care plans that have been admitted since 12/05/23. All interdisciplinary care plan team members responsible for writing baseline care plans will be re-educated on the facility's policy and procedure for developing Baseline Care plans, which includes procedures for providing the resident a written summary of their baseline care plan. The Director of Nursing or designee will complete weekly audits of baseline care plans for four weeks 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.	04/26/25

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F 655	Continued From page 20 (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 observation, record review, interview, and policy review, the provider failed to review with the resident or their representative, and provide a written summary of the baseline care plan for two of two sampled residents (25 and 142) within 48 hours of their admission. Findings include: 1. Observation of resident 25 on 3/9/25 at 5:24 p.m. in the main dining room revealed: *He had glasses on and was seated in his wheelchair at a table. *He turned from the table and self-propelled his wheelchair to turn to another table and around the dining room. -Licensed practical nurse (LPN) I assisted the resident returning to his table. Interview with LPN I at that time revealed the resident was blind in one eye, had low vision in his other eye, and he was hard of hearing.	F 655		

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F 655	Continued From page 21 Review of resident 25's electronic medical record (EMR) revealed: *He was admitted on 8/29/24. *His admission diagnoses included: muscle weakness, history of falling, abnormalities of gait and mobility, low vision in both eyes, anemia (low iron), and chronic congestive heart failure. *His 8/30/24 4:00 p.m. initiated interim care plan assessment was finalized/locked on 9/3/24 and indicated his 8/30/24 baseline care plan had included focus areas of: -Activities of daily living (ADL) assistance with transferring, ambulating, locomotion, dressing, personal hygiene, eating, toilet use, and bathing. -Visual impairment related to his severely impaired visual function. -Communication problems related to his hearing impairment. -Mobility assistance related to his history of falls, visual impairment, and gait/balance problems. *His 9/3/24 Brief Interview of Mental Status (BIMS) assessment score was 8, which indicated his cognition was moderately impaired. *There was no documentation that indicated the interim/baseline care plan had been reviewed or given to the resident or his representative. 2. Observation and interview on 3/10/25 at 8:51 a.m. of resident 142 revealed she: *Was seated in a wheelchair by the bathing room. *Stated she was recently admitted for occupational therapy and physical therapy. *Planned to return to her home within the next 30 days. Review of resident 142's EMR revealed: *She was admitted on 3/3/25. *Her 3/4/25 BIMS assessment score was a 14, which indicated her cognition was intact. *Her diagnoses included: muscle weakness,	F 655		

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F 655	Continued From page 22 Erythema Intertrigo (redness, inflammation, and irritation in the skin folds), lumbar radiculopathy (compressed or irritated nerves in the back that may cause pain and other symptoms), and retention of urine. *Her 3/4/25 baseline care plan included focus areas of: -She did not have a POA (financial and care). -She had the potential of a psychosocial well-being problem related to her major life adjustment of having admitted to the facility and losing her independence. -"To ensure on or before admission, and throughout stay, I am reviewed for appropriateness of placement." 3. Interview on 3/11/25 at 2:32 p.m. with social service director E regarding resident's baseline care plans revealed she was not aware if anyone: *Did or should have reviewed the baseline care plans with residents and/or their representative within 48 hours of the residents' admission. *Provided the baseline care plan to the resident and/or their representative within 48 hours of the residents' admission. Interview on 3/11/25 at 3:20 p.m. with director of nursing (DON) B regarding baseline care plans revealed: *She thought the Interim Care Plan (ICP) assessment demonstrated compliance with the baseline care plan requirements. *The Minimum Data Set (MDS) nurse had been responsible for completing the baseline care plans and had exceeded the required 48-hour time frame. -The ICP assessment was changed to one of the charge nurse's duties while completing the admission process for new residents.	F 655		

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F 655	Continued From page 23 Interview on 3/11/25 3:38 p.m. with DON B regarding baseline care plans revealed: *There was no documentation the resident and/or their representative reviewed and was given the baseline care plans. -She was not aware that a baseline care plan should have been reviewed and given to the resident and/or their representative within 48 hours of the resident's admission. Interview on 03/11/25 at 4:50 p.m. with administrator A revealed she was not aware baseline care plans should have been reviewed with and given to the resident and/or their representative within 48 hours of the residents' admission. 4. Review of the provider's December 2024 Care Plan Policy and Procedure revealed: *"Upon admission, resident will be assessed by the Charge Nurse and a baseline care plan will be developed with information gathered from the resident and the resident's family." *"The facility will inform the resident, in a language he or she can understand, of his or her rights regarding planning and implementing care, including the right to be informed of his or her total health status." *The policy had not addressed the requirements for the baseline care plan: -To be developed within 48 hours of a resident's admission. -To be provided to the resident and their representative.	F 655		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658	The facility has determined that all have the potential to be affected.	04/26/25

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F 658	Continued From page 24 §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 observation, record review, interview, and policy review, the provider failed to follow professional standards of practice related to: *Physician notification of and implementation of appropriate interventions for one of one sampled resident's (36) significant weight loss as directed in their policy. *Identification and implementation of interventions for one of one sampled resident (5) with low blood sugars. *Holding the administration of insulin for one of one sampled resident (5) with low blood sugars without a physician's order. Findings include: 1.Observation on 3/9/25 at 3:39 p.m. of resident 36 in the hallway revealed she had significant swelling to her ankles. Review of resident 36's electronic medical record (EMR) revealed: *She was admitted on 1/28/25. *Her 3/5/25 Brief Interview of Mental Status (BIMS) assessment score was 1, which indicated she had severe cognitive impairment. *Her diagnoses included disorder of electrolyte and fluid balance, heart failure, dehydration, and dementia. *A 2/10/25 physician's order for Ace wraps (elastic bandages) daily PRN (as needed) for edema (fluid retention and swelling). -There were no directions that addressed the	F 658	1. A Physician notification with request for implementation of appropriate interventions for resident #26 with significant weight loss was attributed to improved edema as explained by nursing staff. An audit with significant weight loss greater than 5% will be conducted for the past quarter to ensure identification and implementation of interventions are documented. All residents are monitored weekly for weight loss or gain. The Dietary Manager will communicate with the Dietician along with the resident's provider regarding weight loss greater than 5%. The Director of Nursing provided inservice training for all licensed staff regarding weight loss for residents and the expectation of physician notification for weight loss. The Director of Nursing or designee will monitor the provision of weight loss notifications for affected residents per week for four weeks then every two weeks for eight weeks. Discrepancies will be promptly reported to the Administrator. The Director of Nursing or designee will present findings from monthly audits for three months at QAPI meeting for review and recommendations. 2. Holding the administration of insulin for one of one sample resident #5 with low blood sugars without a physician's order occured in the past and no immediate action was required. A request for additional statements to hypoglycemia standing orders for blood sugars below 70 to the Medical Director will address holding the administration of insulin for one of one sampled resident #5 with low blood sugars without a physician order. All residents with orders for insulin will be reviewed for additional statements by physician to hold administration of insulin if appropriate. All residents are reviewed every 60days as required. Per current Diabetic Management Standing Orders: The provider is to be notified if two BG results are <70 or >400 in a 24-hour period and/or change in condition; if no condition change, notify provider on	

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	435090	A. BUILDING _____ B. WING _____	03/12/2025

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F 658	Continued From page 25 location of ace wrap application or how long the ace wraps should be left on. *A 2/11/25 physician's order for torsemide (a medication for fluid retention and swelling) 20 mg (milligrams) daily. *She did not have a physician's order for nutritional supplements. *It was documented from 2/17/25 through 3/4/25 resident 36 was offered a snack five times and accepted snacks three times. Review of resident 36's documented weights revealed: *On 2/3/25 she weighed 119 pounds. *On 2/4/25, 2/7/25, and 2/11/25 she weighed 120 pounds. *On 2/18/25 she weighed 122 pounds. *On 2/21/25, 2/25/25, 2/28/25, 3/4/25, and 3/7/25, she weighed 110 pounds. -On the 2/25/25 manager meeting notes, it was indicated resident 36 needed a reweigh related to weight loss. --The reweigh confirmed resident 36's weight loss. Observation on 3/10/25 at 1:51 p.m. of resident 36 in the hallway revealed ace wraps were not on her lower legs. There was no swelling to her lower legs or ankles noted at that time. Review of resident 36's treatment administration record (TAR) for February and March 2025 indicated no documented use of ace wraps for swelling. Review of resident 36's progress notes revealed: *On 2/3/25 at 1:04 p.m. a dietary note indicated, "[Resident 36] scored a 4 on her MNA [mini nutritional assessment]. (Malnourished) She was	F 658	the next business day. Insulin sliding scale TID <15 minutes before meals. 0 Units for blood glucose <200 If resident is symptomatic, conscious, and able to swallow or has a feeding tube: * Administer 6oz fruit juice, milk, regular pop, or other high carbohydrate beverage orally or via feeding tube. * Repeat BG after 15 minutes; if <70 repeat above intervention *If after 2 attempts to treat and BG still <70, notify provider. The Director of Nursing provided inservice training for all licensed staff regarding hypoglycemic standing orders and documentation of actions taken for hypoglycemic events. The Director of Nursing or designee will monitor the provision of hypoglycemic episodes for affected residents once per week for four weeks then every two weeks for eight weeks. Discrepancies will be promtply reported to the Administrator. The Director of Nursing or designee will present findings from monthly audits for three months at QAPI meting for review and recommendations.	

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recently hospitalized for septic shock and was placed on a feeding tube. The tube has been removed, and she is eating well, over 76% and she has had a swallowing eval [evaluation]. Her current diet is Mechanical Soft with moist foods. She is tolerating [it] well. She did lose 23# [pounds] while in the hospital. [Resident 36] is sitting with the restorative aide. They will encourage and help [resident 36] eat."
*There were no notes addressing resident 36's weight loss of 12 pounds from 2/18/25 to 2/21/25 that was indicated in her weight records.
*On 3/3/25 at 10:53 a.m. a skilled note indicated, "She has 3+ [deep pitting when an area is pressed on] edema [swelling] in her left lower leg" and "2+ [moderate pitting] edema in the right."
*On 3/6/25 at 2:23 p.m. a skilled note indicated, "She has 2+ edema to her left lower leg and 1+ [mild pitting] in the R [right] lower leg."
*On 3/11/25 at 12:43 p.m. a nutrition/dietary note indicated, "[Resident 36] has had a significant weight loss which could be from fluid [changes]. She is eating meals over 76% and is not having trouble chewing or swallowing at this time. She is being monitored, and RD [registered dietician] is aware of these issues."
*On 3/11/25 at 6:11 p.m. a late entry nutrition/dietary note was entered by consultant dietician M that indicated, "from discussion on [resident 36] during [a] site visit in February. She is a 81 y.o. [year old] Female with a BMI [body mass index] of 19.5- normal range. Wt. [weight] loss of -10lbs [pounds] over 30 days at 8.5%-moderate weight loss. Weight loss could be due to electrolyte imbalance, fluid imbalances and retention. Edema +3 previously, has reduced since then. New medications reported for fluid and anxiety. Zoloft may interact with diabetes medications causing hypoglycemia reported.

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F 658	Continued From page 27 Meal consumption has been over 75% and eating well has been reported. Continue goal of at least 75% completion at meals and monitoring weight. Calorie needs: 1,250-1,500 kcal [kilocalories]/day Protein needs: 50-60 grams/day Fluid needs: at least 1,500+ ml [milliliters]/day." Review of resident 36's 3/10/25 care plan revealed: *There was a focus area for "at risk for possible nutritional problem and risk for dehydration. Weight loss noted while in acute care prior to admit." -Interventions for this focus area included "Encourage intake of food and fluids. Provide and serve diet as ordered. SLP [Speech Language Pathologist] or Dietician Consult [consultation] as needed." *There were no further interventions related to weight loss on her care plan. Interview on 3/12/25 at 1:13 p.m. with director of nursing (DON) B revealed: *If nursing staff put on a resident's Ace wraps it should have been documented on that resident's TAR. *She confirmed resident 36's Ace wraps had not been documented that they were put on the resident since the physician's order was received on 2/10/25. *Dietary manager C was to monitor resident weights. *Dietary manager C was to notify DON B if a resident had a change in weight. *Consultant dietician M would work with DON B and dietary manager C to address residents with weight loss or significant weight fluctuations. *DON B would expect the resident's physician to be notified of a resident's "confirmed" weight gain	F 658		

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or loss.
*DON B explained she may monitor a resident's weight, reweigh the resident, and assess for other symptoms.
-She indicated she may not have notified the provider if there were no other symptoms identified with the resident's weight gain or loss.
*DON B verified resident 36's provider had not been notified of the significant weight loss.

Review of the provider's 1/28/25 Maintaining Nutrition Status policy revealed:
*"Significant weight changes are 5% in 30 days, 7.5% in 90 days or 10% in 180 days."
*"Significant weight losses will be reviewed by [the] Care Team and reported to [the] Residents [resident's] Physician/RD."
*"Care team will evaluate possible additional interventions to promote good nutritional status to residents when normal interventions (Supplements, Restorative dining program, Diet change) have proven unsuccessful in stop [stopping] unplanned weight loss when [the] loss is not unavoidable."

Review of the provider's undated Notification of Changes policy revealed:
*"The purpose of this policy is to ensure that [the provider] promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification."
*"Circumstances requiring notification include:
-"Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status."
-"Circumstances that require a need to alter

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F 658	Continued From page 29 treatment." 2. Interview on 3/9/25 at 3:42 p.m. with resident 5 in her room revealed she "sometimes" had low blood sugars. Review of resident 5's EMR revealed: *She was admitted on 7/10/18. *Her 12/16/24 BIMS assessment score was 15, which indicated she was cognitively intact. *She had a diagnosis of diabetes. *She had a 7/10/18 physician's order to check her blood sugars three times daily. *She had an order for, "NovoLOG Solution 100 units/ML [milliliter] (Insulin Aspart) [fast-acting insulin] Inject 10 units subcutaneously [the fatty tissue layer under the skin] three times a day related to TYPE 2 DIABETES MELLITUS." *She was to receive "Soliqua Subcutaneous Solution Pen-Injector 100-33 UNT[unit]-MCG[microgram]/ML[milliliter] (Insulin Glargine-Lixisenatide) [long-acting insulin] Inject 40 units subcutaneously one time a day related to TYPE 2 DIABETES MELLITUS WITH DIABETIC NEPHROPATHY." *There were no parameters provided on the physician's order to indicate if and when the insulins should have been held. Review of resident 5's blood sugars and progress notes from December 2024 through February 2025 revealed: *A progress note on 12/7/24 indicated resident 5's lunch novolog was held due to a blood sugar of 74 (below 70 is considered low for most individuals). *On 12/10/24 at 11:43 a.m. resident 5's blood sugar was 50. -The next blood sugar check was 85 at 4:24 p.m.	F 658		

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F 658	Continued From page 30 on 12/10/24. *On 1/27/25 at 5:35 p.m. resident 5's blood sugar was documented as 67. -The next blood sugar documented was 128 at 7:10 a.m. on 1/28/25. *Resident 5's blood sugar was documented as 213 at 11:40 a.m. on 1/29/25. -A progress note on 1/29/25 at 12:30 p.m. indicated, "Resident BS [blood sugar] was 213 prior to lunch. While sitting at the dining room table she was drooling, lethargic and not easy to arouse. I took Her BS and it [had] dropped to 51. DON [director of nursing] gave glucose gel to her. Will recheck BS. -A progress note on 1/29/25 at 12:50 indicated, "Resident is now awake and feeding herself. She is answering questions and responding." -The next blood sugar documented was 103 at 1:24 p.m. on 1/29/25. *A progress note on 1/31/25 at 4:35 p.m. indicated resident 5's NovoLog was held due to a blood sugar of 89. *A progress note on 2/1/25 at 12:05 p.m. indicated resident 5's NovoLog was held due to a blood sugar of 95. *A progress note on 2/10/25 at 11:53 a.m. indicated resident 5's NovoLog was held due to a blood sugar of 85. *A progress note on 2/13/25 at 8:22 a.m. indicated resident 5's NovoLog and Soliqua were held due to a blood sugar of 89. *A progress note on 2/22/25 at 9:06 a.m. indicated resident 5's NovoLog and Soliqua insulins were held due to a blood sugar of 89. *A progress note on 2/23/25 at 4:56 p.m. indicated resident 5's NovoLog was held due to a blood sugar of 96. *On 2/24/25 at 10:39 a.m. resident 5 had a blood sugar result of 63.	F 658		

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F 658	Continued From page 31 -There was no progress note that indicated she was symptomatic or if there were actions taken to address the low blood sugar. -The next documented blood sugar check on 2/24/25 at 1:11 p.m. was 150. *A progress notes on 2/26/25 at 4:58 p.m. indicated resident 5's NovoLog insulin was held for a blood sugar of 76. Review of the provider's documentation of physician notification related to resident 5's blood sugars and insulins for 12/1/24 through 3/11/25 revealed: *There were physician progress notes on 12/31/24 and 2/18/25 that indicated the physician had been notified of high blood sugars. *There was no documentation of physician notification related to the resident's insulins being held or the resident's low blood sugars related to the occurrences identified in the resident's progress notes. Interview on 3/11/25 at 2:32 p.m. with resident care coordinator/Minimum Data Set (MDS) coordinator H regarding blood sugar parameters revealed: *Per their providers' standing order a low blood sugar was one less than 70 and a high blood sugar was over 400. *If she identified a resident with a low blood sugar she would hold the insulin, give the resident a glass of juice and recheck the blood sugar in 15 minutes. *She would document the blood sugar recheck in the EMR under the vital signs tab. Interview on 3/12/25 at 1:13 p.m. with director of nursing (DON) B regarding low blood sugars revealed:	F 658	the next businss day. Insuli	

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F 658	Continued From page 32 *Her expectation was for staff to follow the provider's policy. *She indicated the treatment for a resident with a low blood sugar would be to give "glucagon or something" according to the physician's standing orders. *She would expect a blood sugar recheck after treatment for a low blood sugar. *She expected interventions and follow up regarding low blood sugars to be documented in the resident's EMR. Review of the provider's undated Physician Standing Orders policy revealed the following: *"Diabetic Management:" -"Notify provider if two BG [blood glucose] results are < [less than] 70 or > [greater than] 400 in a 24-hour period and/or change in condition; if no condition change, notify provider on the next business day." *"Hypoglycemia (BG <70) *If resident is symptomatic, conscious, and able to swallow or has a feeding tube: -Administer 6 ox [ounces] fruit juice, milk, regular pop, or other high carbohydrate beverage (eg. Ensure, Boost) orally or via feeding tube. -Repeat BG after 15 minutes; if <70 repeat above intervention. -If after 2 attempts to treat and BG still <70, notify provider." *"Once resident is stable, recheck BG after 60 minutes. *Communicate occurrence of any hypoglycemic event to provider the next business day." Review of the provider's undated Medication Management policy revealed, "Medications are administered in accordance with written orders of the attending physician or physician extender."	F 658		

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F 699 SS=E	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to assess two of two (24 and 36) sampled residents for their need for trauma-informed care. 1. Observation and interview on 3/9/25 at 3:10 p.m. with resident 24 revealed: *Her room had piles of clothing, books, and papers. *She believed someone had taken some of her belongings. *She believed her daughters had been molested by her husband. Review of resident 24's electronic medical record (EMR) revealed: *She was admitted on 11/1/23. *Her 1/27/25 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated she was cognitively intact. *Her diagnoses included anxiety and major depressive disorder. -A copy of resident 24's trauma-informed care assessment was requested from the provider on 3/11/25 at 4:10 p.m. but was not provided for review by the end of the survey.	F 699	The facility has determined that all residents have the potential to be affected. The Administrator, Director of Nursing, and the interdisciplinary team will review and revise as necessary the policy and procedure for Trauma Informed Care. Resident #24 has recieved a Trauma Informed Care Assessment. She has been offered counseling services but continuously refuses. A Trauma Informed Care Assessment was conducted on Resident #26, however, resident was unable to complete due to a BIMS of 1. Resident #26's care plan has been updated to reflect interventions for her behaviors and vocalizations. Resident has been recieving Rural Psychiatry services. All residents have a Trauma Informed Care Assessment completed. The Trauma Informed Care Assessment has been added to the admissions checklist to ensure all admission have a Trauma Informed Care Assessment completed. Inservice training will be conducted on 04/23/25 to review the Trauma Informed Care policy and procedure. The Director of Nursing or designee will ensure compliance by conducting monthly audits on admissions and readmissions for three months to ensure compliance. The Director of Nursing or designee will present findings from monthly audits for three months at the QAPI meeting for review and recommendations.	04/26/25

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F 699	Continued From page 34 Review of resident 24's 3/10/25 care plan revealed: *She had a focus area of, "behavior problem r/t [related to] Depression and Anxiety Disorders. History and current events of the following: refusal of care, verbal/physical behaviors that are inappropriate and directed towards staff, hoarding, self-isolation, and allegations of abuse and neglect. Along with manipulative behaviors such as misinformation and alterations in the truth." -One of the interventions was "Provide education to staff yearly and as needed regarding behaviors and trauma-informed care." *She had a focus area of "has a psychosocial well-being problem r/t Anxiety, several Disease Processes, and ineffective coping secondary to a past history of trauma and medical history of bipolar disorder." -Interventions for this were "Identify items that may trigger s/sx [signs and symptoms] of trauma-related responses or lessen the effects of trauma and provide comfort". -There was no documentation to support resident 24 had been assessed to determine if she had trauma or what her triggers would have been. 2. Observation on 3/9/25 at 3:39 p.m. of resident 36 revealed: *She hollered for "help" repeatedly. *She had repetitive and random indistinguishable vocalizations. *She wheeled her wheelchair in and out of her room repeatedly. Review of resident 36's EMR revealed: *She was admitted on 1/28/25. *Her 3/5/25 BIMS assessment score was 1, which indicated severe cognitive impairment.	F 699		

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F 699	Continued From page 35 *Her diagnoses included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. *There was no trauma-informed care assessment in resident 36's EMR. Review of resident 36's 3/9/24 care plan revealed it did not contain a focus area or interventions for her behaviors and vocalizations. Interview on 3/12/25 at 11:08 a.m. with administrator A regarding trauma-informed care revealed: *The provider did not complete an assessment for any residents on admit or re-admission. *The provider did not assess or reassess any residents for trauma-informed care. Review of the provider's 4/20/19 Trauma Informed Care Plan and Procedure revealed: *"Trauma-Informed Care understands and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize." *"Trauma Informed care will be addressed in the care plan of noted residents."	F 699	the next businss day. Insulin sliding scale TID <15	
F 700 SS=E	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.	F 700	The facility has determined that all have the potential to be affected. Resident #23 and 25 have signed consent forms for the use of bed rails. Education on risks of use versus benefits was provided to resident #9. Residents #6,9,13,21,23 and 36 will have updated bed rail assessments completed by 04/26/25. All residents with bed rails will be audited by 04/26/25 to ensure consent forms, education, and	04/26/25

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	435090	A. BUILDING _____ B. WING _____	03/12/2025

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

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F 700	Continued From page 36 §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. §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 record review, observation, interview, and policy review, the provider failed to ensure residents who used bed rails/assist bars had: *A signed consent for their use for two of twelve sampled residents (23 and 25). *The medical symptoms for use documented on the Side Rail Assessments for five of twelve sampled residents (6, 9,13, 21, and 36). *Received education on the risks of use versus benefits of use of side rails/assist bars for one of twelve sampled residents (9). *Other attempted interventions documented on the Side Rail Assessment for one of twelve sampled residents (23). Findings include: 1. Review of resident 23's 2/23/25 Side Rail Assessment revealed the area that was to indicate if a consent form had been signed was left blank. 2. Review of resident 25's 1/25/25 Side Rail Assessment revealed the area that was to	F 700	assessments were completed. Occupational Therapy has added additional assessments regarding side rails upon assessing new admissions. Inservice training will be held on 04/23/25 to provide education on citation F700 and the requirements. The Director of Nursing or designee will ensure compliance by conducting monthly audits on admissions for three months. The Director of Nursing or designee will present findings frmo monthly audits for three months at the QAPI meeting for review and recommendations.	

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F 700	Continued From page 37 indicate if a consent form had been signed was left blank. 3. Review of resident 6's 1/12/25 Side Rail Assessment revealed the area that was to have her medical condition/symptoms that made side rails necessary was left blank. 4. Observation on 3/9/25 at 2:36 p.m. of resident 9 revealed he had two quarter-length side rails in the up position at the head of his bed. Review of resident 9's 4/28/20 Side Rail Assessment revealed the area that was to have his medical condition/symptoms that made side rails necessary was left blank. 5. Review of resident 13's 3/4/25 Side Rail Assessment revealed the area that was to have her medical condition/symptoms that made side rails necessary was left blank. 6. Observation on 3/10/25 at 8:06 a.m. of resident 21 revealed: *She was lying in her bed with her eyes closed. *Her bed had side rails on both sides of her bed in the up position. Review of resident 21's electronic medical record revealed: *She was admitted on 5/3/23. *Her 1/14/25 Brief Interview of Mental Status assessment score was a 6, which indicated she had severe cognitive impairment. *Her 3/10/25 care plan indicated: -She was cognitively impaired. *She was to demonstrate the appropriate use of assist bars to maintain her ability to participate in bed mobility.	F 700		

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F 700	Continued From page 38 Review of resident 21's 1/14/25 Side Rail Assessment revealed the area that was to have her medical condition/symptoms that made side rails necessary had documented "POA requested Assist rails on bed." 7. Observation on 3/9/25 at 2:31 p.m. of resident 36 revealed she had two quarter-length side rails in the up position at the head of her bed. Review of resident 36's 1/29/25 Side Rail Assessment revealed the area that was to indicate medical condition/symptoms that made side rails necessary had "POAs request side rails" documented on it. 8. Further review of resident 9's 4/28/20 Side Rail Assessment revealed the are labeled "Potential risks reviewed with resident and/or significant others" was left blank. 9. Further review of resident 23's 2/23/25 Side Rail Assessment revealed: *The area to record other interventions included "POA signed consent for assist bars and requests that She has them". 10. Interview on 3/11/25 at 7:54 a.m. with resident care coordinator/minimum data set coordinator H regarding resident side rail/assist bar use revealed when a resident was admitted they were to be assessed by the admitting nurse for appropriate use of side rails by completing the Side Rail Assessment. 11. Interview on 3/11/25 at 4:42 p.m. with director of nursing (DON) B, assistant DON G and administrator A regarding side rail/assist bar use	F 700		

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F 700	Continued From page 39 revealed: *DON B indicated consent forms should be signed by the resident or their representative. *The Side Rail Assessment should be completed in full for each resident. *Administrator A stated she was not able to "speak to this" [topic]. 12. Interview and record review on 3/11/25 at 5:31 p.m. with Administrator A and DON B regarding the use of side rails revealed DON B stated the "process fell apart." 13. Review of the provider's undated Bed Assist Bar Policy & Procedure revealed: *"Policy: -Use bed assist bars to enhance resident mobility and independence. -Make sure resident and/or representative aware of risks of bed assist bars. -Ensure ongoing assessment and maintenance of resident bed assist bar use." *"Procedure: -1. Prior to installation of bed assist bar, charge nurse or designee must complete Assistive Device Assessment to determine appropriateness of using bed assist bars. -2. Decision to install bed assist bar shall be made based on the following information assessed in the Assistive Device Assessment: --a. Determine the reason for the bed assist bar and if it is likely to [for] the resident [to] meet his or her needs. --b. Evaluation of 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. --c. Assess the resident for risks to safety with	F 700		

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F 700	Continued From page 40 use of bed assist bar including cognition, mobility, communication, etc." -"Bed rail/assist bar evaluation form will be completed quarterly to assess appropriateness and need for continued use."	F 700		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview, Payroll Based Journal (PBJ)	F 725	Unable to change the outcome of the deficient practice for submitting accurate Payroll Based Journaling (PBJ). The Administrator and Director of Nursing or designee will continue to review the nursing schedule to ensure sufficient staffing needs are met. The facility has ensured licensed nursing coverage 24 hours, 7 days a week. The Administrator and Director of Nursing have streamlined the processes of providing accurate nursing hours to the Business Office Manager for Payroll Based Journaling. Director of Nursing or designee will email The Business Office Manager a monthly nursing schedule to ensure accurate hours are obtained for submission of PBJ. The Administrator educated the Director of Nursing and Business Office Manager on the process moving forward. The Administrator or designee will audit the nursing schedule once per week for four weeks and once per month for two months to ensure sufficient staffing needs are met. The Administrator will audit PBJ submission once per calendar quarter for one year to ensure proper data submission. The Administrator will present audit findings at monthly QAPI meetings for review and recommendations.	04/26/25

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F 725	Continued From page 41	F 725		

record review, employee timecard review, and policy review, the provider failed to ensure licensed nursing coverage for 24 hours a day for three federal fiscal quarters (Quarter 2, 1/1/24 through 3/31/24; Quarter 3, 4/1/24 through 6/30/24; and Quarter 4, 7/1/24 through 9/30/24). Findings include:

1. Interview on 3/9/25 at 2:08 p.m. with business office manager C during the entrance conference revealed the provider did not have any licensed nurse staffing waivers.

2. Interview on 3/9/25 at 3:42 p.m. with resident 5 revealed she had been told by staff members on multiple occasions they were short of nurses.

3. Review of the PBJ records submitted to the Center for Medicare and Medicaid Services (CMS) revealed the provider submitted the following for licensed nursing coverage not being covered 24 hours per day for:
*Quarter 2, 2024 for 34 days.
*Quarter 3, 2024 for 11 days.
*Quarter 4, 2024 for 30 days.

4. Review of the provider's employee timecards revealed:
*For Quarter 2, 2024; 24-hour licensed nursing coverage was unable to be verified on 1/1, 1/10, 1/11, 1/12, 1/31, 2/1, 2/2, 2/3, 2/9, 2/20, 2/24, 2/27,3/6, 3/7, 3/12, 3/13, 3/19, 3/20, 3/25, and 3/28.
*For Quarter 3, 2024; 24-hour licensed nursing coverage was unable to be verified on 4/6, 4/13, 4/17, 5/27, and 6/21.
*For Quarter 4, 2024; 24-hour licensed nursing coverage was unable to be verified on 7/13, 8/14, 8/22, 8/23, 8/24, 8/28, 8/29, 9/18, 9/19, 9/20,

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F 725	Continued From page 42 9/21, 9/22, 9/25, and 9/27. 5. Interview on 3/10/25 at 6:03 p.m. with business office manager C regarding PBJ data submission revealed: *She was aware the PBJ reports indicated there were days of not having 24-hours of licensed nursing coverage. *She did not know how there was missing data because she always got an indicator that 100% of the information was submitted and every report had been accepted. *She stated she entered the travel staff manually into PBJ and the other staffs' times were pulled in from their timecards. Review of the provider's undated Nursing Staffing and Posting policy revealed "The facility is required to provide licensed nursing staff 24 hours a day (except when waived), along with other nursing personnel, including but not limited to nurse aides."	F 725		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an	F 727	Unable to change the outcome of the deficient practice for failure to provide 8 hours of RN coverage for three days between January 1 through March 31, 2024. All residents have the potential to be affected by not utilizing the service of an RN 8 hours a day, 7 days a week. The Administrator and Director of Nursing reviewed the nursing schedule to ensure the required 8 hour RN coverage was met in April 2024. The facility has remained in compliance since. The Administrator and Director of Nursing have educated the scheduler and all nurses on RN rules and regulations in April of 2024. The Administrator and Director of Nursing or designee will continue to review the schedule	04/26/25

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F 727	Continued From page 43 average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on Payroll Based Journal (PBJ) reports, interview, staff timecard review, and policy review, the provider failed to ensure: *A registered nurse (RN) had been scheduled for eight consecutive hours of coverage for four days in quarter two (January 1 through March 31) of fiscal year 2024. *There was a full-time director of nursing (DON) for 16 randomly selected weeks between July and December 2024. 1. Interview on 3/9/35 at 2:08 p.m. with business office manager (BOM) C during the entrance conference revealed: *The provider did not have any nurse staffing waivers. *She stated the DON worked 36 hours per week. *The DON was paid hourly. 2. Review of the RN staff timecards for fiscal year 2024 revealed: *The DON timecard for 2/3/24 was not produced by the provider to verify hours worked. *RN coverage for eight consecutive hours could not be verified for 1/13/24, 1/14/24, and 2/17/24. 3. Interview on 3/11/25 at 6:00 p.m. with administrator A revealed: *The Minimum Data Set (MDS) nurse was scheduled from 8:00 a.m. to 5:00 p.m. Monday through Friday during quarter two of fiscal year 2024. *She was salaried. *The MDS nurse was a RN and would be considered to cover the requirement for an RN eight consecutive hours per day on the days she	F 727	to ensure that 8 hour RN coverage is ensured once per week for four weeks and once per month for two months. The Administrator and Director of Nursing or designee will present audit findings at monthly QAPI meeting for review and recommendations.	

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F 727	Continued From page 44 worked. *There was no RN scheduled for eight consecutive hours on 1/13/24, 1/14/24, and 2/17/24. *DON B had worked on 2/3/24. 4. Interview on 3/12/25 at 7:47 a.m. with administrator A revealed she thought DON B worked between 36 and 40 hours per week. Review of DON B's timecards revealed during 16 weeks of randomly selected timecards between July and December 2024, DON B averaged 23.125 hours per week. Review of the provider's undated Nursing Staffing and Posting policy revealed, "The facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week."	F 727		
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732	The facility has determined that all have the potential to be affected. The Director of Nursing reviewed the current form used to post nurse staffing information to ensure that all hours for licensed nurses to include administrative nurses are included in the posting. The location of the information posted will be moved 20 feet from the north wall next to the nurses' station to the south wall by the front entrance. An inservice training was conducted by the Director of Nursing with all licensed staff regarding the developement of the form to include all hours for licensed nurses in the building and how to complete the form to accurately reflect the hours worked daily. The Director of Nursing or designee will review the nurse staffing information posted for accuracy weekly for four weeks and monthly for	04/26/25

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F 732	Continued From page 45 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to post the required daily nurse staffing information in a prominent location that was readily accessible to residents and visitors and to include the actual hours worked of nursing staff. Findings include: 1. Observation 3/12/25 at 8:00 a.m. of the posted nurse staffing information revealed: *It was posted on a board near the nurse's station. *It would not be readable to a resident or visitor in a wheelchair at the height it was posted. *There were three categories of staff listed on the sheet: RN (registered nurse), LPN (licensed practical nurse), and CNA (certified nursing	F 732	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 732	Continued From page 46 assistant). *Under the LPN and CNA category the number of those staff scheduled for the day was listed by shift. *There were no numbers listed under the RN category. *There were no documented actual hours worked on the form for the nursing staff. 2. Interview on 3/12/25 at 8:54 a.m. with director of nursing (DON) B about posting the daily staffing revealed: *CNA/certified medication aide (CMA) K was responsible for developing the schedule. *CNA/CMA K would then transfer information from the schedule onto a daily assignment sheet. *The night nurse would use the daily assignment sheet to fill out the daily staffing sheet for the following day and would post it in the morning on the board at the nurse's station. *DON B was unaware that actual hours worked by each nursing discipline should have been listed on the posted staffing sheet according to the requirements. *She stated that was an old form and it needed to be updated to include a column for recording actual hours worked of nursing staff. 3. Review of the provider's undated Nursing Staffing and Posting Policy revealed: *"Posting of Staffing" -"It is the policy of [provider] to make nurse staffing information readily available in a readable format to residents, staff, and visitors at any given time." -"The nurse staffing will be posted daily and will contain the following information: --Facility Name --The current date	F 732		

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F 732	Continued From page 47 --Facility's current resident census --The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: ---Registered Nurses ---Licensed Practical Nurses/Licensed Vocational Nurses ---Certified Nurse Aides" -"The information posted will be: --Presented in a clear and readable format. --In a prominent place readily accessible to residents, staff, and visitors."	F 732		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755	~~The facility that all residents utilizing narcotic medications have the potential to be affected by this practice.~~ ~~The Director of Nursing discussed the protocol for receiving narcotics to ensure that the pharmacy was able to collaborate with Five Counties Nursing Home to comply with the requirement that drug records are in order and all controlled drugs are reconciled.~~ ~~The facility procedure for reviewing narcotic medications was reviewed on 3/12/25 by the Director of Nursing.~~ ~~The Director of Nursing reviewed guidelines with staff nurses and nurse managers on 3/12/25.~~ The Director of Nursing or designee will audit recording of receiving and documentation of narcotic medications weekly for three months to ensure compliance. The Director of Nursing or designee will present findings from audits for three months at QAPI meeting for review and recommendations.	04/26/25

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	435090	A. BUILDING _____ B. WING _____	03/12/2025

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FIVE COUNTIES NURSING HOME	405 6TH AVENUE WEST LEMMON, SD 57638

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F 755	Continued From page 48 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and policy review, the provider failed to follow their policies for controlled medications (medications with risk for abuse, addiction, and potential theft) to ensure accurate and complete documentation for those medications related to their receipt, counts, administration details including the dates given and the resident names, and destruction process. Findings include: 1. Observation on 3/10/25 at 2:07 p.m. of the North wing medication cart revealed: *There was a three-ring binder labeled "North Narcotic Binder" on top of the medication cart that contained: -A March 2025 "CONTROLLED DRUG COUNT RECORD". --That form had two columns for nurse initials labeled "NURSE ON" and "NURSE OFF" and rows numbered 1 through 31 which indicated days of the month. --There were no nurse initials for two nurses on 3/1/25 and 3/2/25 and only one nurse on 3/4/25. -Multiple forms labeled "CONTROLLED DRUG RECORD Individual Patient's Narcotic Record". --Those forms included areas for the resident's name, medication name and strength, directions	F 755	The facility has deemed all residents utilizing narcotic medications have the potential to be affected by this practice. The Director of Nursing discussed the protocol for receiving narcotics on 03/12/25 with the pharmacy to ensure that the pharmacy was able to collaborate with Five Counties Nursing Home to comply with the requirement that drug records are in order and all controlled drugs are reconciled. The facility procedure for reviewing narcotic medications was reviewed on 3/12/25 by the Director of Nursing and Consulting Pharmacist. The Director of Nursing reviewed quidelines with staff nurses, nurse managers and CMAs.	

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F 755	Continued From page 49 for administration of the medication, doctor, pharmacy, who the medication was received by, date received, and time received. *Those forms did not have a pharmacist signature and had only one signature of the individual who received the medication. 2. Observation on 3/10/25 at 2:11 p.m. of the three-ring binder labeled "West Narcotic Binder" on the west wing medication cart revealed: *The binder was set up the same as the "North Narcotic Binder". *The West March 2025 Controlled Drug Count Record had no nurse initials for two nurses on 3/1/25 and 3/2/25 and one nurse on 3/11/25. *One Individual Patient Record belonged to resident 35, who had discharged from the facility on 3/9/25 and indicated: -30 tablets of Tramadol (a controlled pain medication) 50 milligrams (mg) received on 7/16/24. -The Tramadol had been signed out for administration to resident 17 three times, according to staff signatures and the medication count. -There were no dates documented for the three times the medication was removed for administration. 3. Observation and interview on 3/10/25 at 2:20 p.m. with Certified Medication Aide (CMA) Z revealed: *She entered the facility with a pharmacy bag that contained residents' prescription medications. -One of those medications was Morphine (a controlled pain medication) solution (liquid form). *She obtained a blank Individual Patient's Narcotic Record from the nurse's station and wrote the prescription information on the form.	F 755		

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F 755	Continued From page 50 *She signed that she received the medication, dated it 3/10/25 and identified she received "30". -She did not identify if the "30" indicated tablets, milliliters, ounces, etc. *She then placed that Individual Patient's Narcotic Record in the North Narcotic Binder and put the Morphine in a locked compartment in the North medication cart. *She stated that she had gone to the pharmacy and picked up the medications for the newly admitted resident. *CMAs or nurses were to complete the Individual Patient's Narcotic Record when the medication was received from the pharmacy and put the form in the appropriate medication cart's binder. *She did not confirm the quantity of the morphine with another nurse or CMA. *The controlled drug count record was a different form used by staff to document who counted the controlled medications when they came on and went off their shifts to confirm counts of all controlled medications. *She indicated that the nurses worked from 6:00 a.m. to 6:00 p.m. and the nurse going off duty would count the controlled medications with the nurse coming on and document the counts on the controlled drug count record form. *The CMAs worked 7:00 a.m. to 5:00 p.m. so they would count with the nurse on duty when the CMAs arrived and when they left. *She verified there were not enough columns on the form to document all the controlled medication counts based on the changes in staff as she described. *She stated that sometimes the nurse and CMA would double sign in a column, but that did not always happen. *She verified she had already initialed for the 3/10/25 5:00 p.m. controlled medication count	F 755		

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F 755	Continued From page 51 record which was prior to the count occurring. *She verified that there were three staff's initials documented for the 3/11/25 controlled medication count but the current date was 3/10/25. 4. Observation and interview on 3/10/25 at 2:32 p.m. with CMA Z in the medication storage room revealed: *The controlled medications stored in the medication storage room were to be counted by the nurses when they came on and went off their shifts. *The controlled medications stored in the medication storage room included: -Stock controlled medications. -Residents' controlled medication cards, when the pharmacy dispensed more than one card. The cards not in use would be stored in the medication room until it was needed. *The Controlled Drug Count Record for the medication storage room was set up the same as the medication carts. *The March 2025 Med Rm [medication room] Controlled Drug Count Record had no nurse initials for two nurses on 3/1/25, 3/2/25, 3/4/25, 3/7/25, one nurse on 3/10/25. 5. Review of the stock-controlled medication cards and the Individual Patient's Narcotic Record with CMA Z in the medication storage room on 3/10/25 at 2:40 p.m. revealed: *The Individual Patient's Narcotic Records identified the name of the medication and the dose. In the location designated for a resident's name was "stock" or "Five Counties Stock". *There was card of Tramadol 50 mg (milligrams). -The card was received on 1/3/24 with 10 tablets. -There were six doses removed and signed out to be administered.	F 755		

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F 755	Continued From page 52 --One of those doses did not indicate which resident it was removed for. --Four doses did not include the year the medication was removed for administration. *There were two cards of oxycodone (a controlled pain medication)10 mg. . -Oxycodone card one was received on 3/6/23 with 16 tablets. --Nine doses documented as removed for administration did not indicate which resident it was for. --Four doses removed for administration did not include the year the medication was removed. --Two half-tablet documented destructions did not contain a second signature to indicate a licensed staff member witnessed the destruction. --Two times a CMA was identified as being the witness of the controlled medication destruction. -Oxycodone card two was received on 7/26/24 with 16 tablets. --One half-tablet was removed for administration with no documentation of what was done with the remaining half tablet. --There was one removal for administration that documented the other half was put in "lock box for next admin [administration]". --Six administrations did not identify the resident the medication was removed for. -One time a CMA was identified as being the witness of controlled medication destruction. *There were three cards of lorazepam (a controlled anti-anxiety medication) 0.5 mg. -Lorazepam card one was received on 12/30/22 with 16 tablets. --One dose removed did not identify which resident it was administered to. --Four times a half tab was administered without documentation of where or how the remaining portion of the tablet was stored for the next	F 755		

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F 755	Continued From page 53 administration. --Fifteen of fifteen of the documented removals for administration did not contain a year the medication was removed. -Lorazepam card two was received on 12/30/24 with 16 tablets. --Two of two removals for administrations had not identified the resident the medication was removed for. -Lorazepam card three did not have an Individual Patient's Narcotic Record. There was a plain white sheet of paper that had handwritten notes of "Controlled Drug Record for Lorazepam 0.5 mg tablets Total 16 verified by" with a signature following. --There was no date to indicate when the lorazepam was received. *There was an opened bottle of liquid lorazepam 2 mg/ml (milligrams per milliliter). -30 ml was documented as received on 2/20/24. -14 doses had been removed from the bottle. -There were three different residents identified that the lorazepam had been removed for. -Two doses did not indicate the resident the medication was removed for. 6. Review of the provider's February 2025 Controlled Drug Count Records revealed: *The West wing Controlled Drug Count Records had a squiggly line drawn through the documentation areas: -For three nurses' initials on 2/3/25. -For one nurses' initials on 2/13/25, 2/14/25, and 2/15/25. -For two nurses' initials on 2/30/25. *The medication room Controlled Drug Count Record had a squiggly line drawn through the areas for documentation for three nurses on 2/4/25 and two nurses on 2/9/25.	F 755		

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F 755	Continued From page 54 7. Observation and interview on 3/10/25 at 2:47 p.m. with assistant director of nursing (ADON) G in the medication storage room revealed: *She verified there were missing staff signatures on the March 2025 medication room's Controlled Drug Count Record. *The Individual Patient's Narcotic Records for the stock medications should have indicated which resident the medications were removed for. *She verified there were missing resident identifiers on the Individual Patient's Narcotic Records. *She expected the date the controlled medication was removed from the medication room for administration to be documented in the Individual Patient's Narcotic Records. *She stated that any nurse or CMA could check-in medications when they were received, including controlled substances. *The opened bottle of stock liquid lorazepam in the medication room did not have a date to indicate when it was opened. 8. Interview on 3/11/25 at 4:37 p.m. with consultant pharmacist N revealed: *His role in the facility included managing medication profiles, controlled medication disposal, and to answer staffs' medication related questions. *The provider received residents' medications from a local pharmacy. *It was his expectation that each resident's individual controlled drug record be initiated by the pharmacy dispensing the medication and it was to be sent with the medication to the facility. *He expected controlled medications be delivered by a pharmacist or picked up by a licensed nurse to ensure control and accountability of those	F 755		

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F 755	Continued From page 55 high-risk medications. *It was his expectation that the controlled medications be counted at each shift change by the person coming on a shift with the person leaving a shift. *The signatures on the Controlled Drug Count Record would indicate the controlled medication counts had been completed and the counts were accurate. *He indicated the use of a stock supply of controlled medications should not be the process. -Each card of controlled medications should have been assigned to a specific resident because a hard copy physician prescription would be needed to dispense and administer the medication to the resident. *He expected that if a half-tablet of a controlled medication was unused it would have been wasted and documented as wasted by a licensed nurse or pharmacist. 9. Interview on 3/12/25 at 1:13 p.m. with director of nursing (DON) B revealed: *When a resident's-controlled medication was discontinued and was to be destroyed, she and consultant pharmacist N would reconcile the count of the controlled medication and document the medication to be destroyed. *Consultant pharmacist N destroyed the medications. *She did not watch the actual destruction of the controlled medications by consultant pharmacist N. *She thought the Individual Patient's Narcotic Record was initiated at the pharmacy. *It was her expectation that two staff verify the receipt of controlled medications and both sign the form in verification of that for an accurate count.	F 755		

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F 755	Continued From page 56 *It was her expectation that the controlled medications be counted between each shift by the incoming and off going staff members. *The signatures on the Controlled Drug Count Record would indicate the counts were completed and accurate. *She would expect to be notified if there was an issue in the controlled drug counts. *She agreed there was no column on the Controlled Drug Count Record to account for the controlled medication count with the CMAs. *It was her expectation that two people witness the destruction of the controlled medications. *She would expect a date to be documented when controlled medications were removed for administration. 10. Review of the provider's undated Medication Management Policy revealed the following: *"If breaking tablets is necessary to administer the proper dose ..., the following guidelines are followed:" -"c. If using only one-half of the tablet from a unit dose package, the remainder is disposed of if not used within 24 hours according to facility procedure. If in a vial the half-tablet is returned to the vial." -"Medications supplied for one resident are never administered to another resident." Review of the provider's undated Pharmacy Services policy revealed the following: *"The facility will provide pharmaceutical services to include procedures that assure [ensure] the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of	F 755		

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F 755	Continued From page 57 practice." *"The facility in coordination with the licensed pharmacist, will provide for: -a. A system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications; -b. Prompt identification of loss of or potential diversion of controlled medications; and -c. Determination of the extent of loss or potential diversion of controlled medications." *"The facility will maintain a limited supply of medications for emergency or after-hours situations in accordance with facility policy and applicable state laws." *"The pharmacist, in collaboration with the facility and medical director, may include other aspects of pharmaceutical services such as: -a. Development of procedures and guidance in relations to medication issues and/or adverse effects; -b. Development of processes for receiving, transcribing or recapitulation of medication orders; -c. Interaction with the quality assessment and assurance committee to develop procedures and evaluate pharmaceutical services." Review of the provider's undated Proper Storage, Usage and Documentation of Narcotics (controlled medications)-policy revealed the following: *"When a narcotic is being accepted, please verify the correct drug and amount. The nurse who accepts the medication should add the count sheet to the narcotic book, notating the date and the time, along with any other needed documentation. *Access to narcotics is to be by a licensed staff and Director of Nursing ONLY! Scheduled II	F 755		

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F 755	Continued From page 58 Narcotics are to be kept locked in a separate are from non-scheduled drugs such as the lock box. Refrigerated scheduled II Narcotics should be stored and locked separately. *Narcotics are to be counted every shift by nursing staff (AM, PM, NOC). They should not be assumed all accounted for, therefore the nurse going off her shift and the nurse coming on shift should count together and then sign that all narcotics are accounted for. *When administering narcotics the following should be done: -After pouring the narcotic, the count should be signed and verified for accurate county [count]. Signing the count sheet does not mean you gave the medication. It is only showing that the count is correct. -Any refused narcotics that have been poured should not be taped back into the card but should be wasted and disposed of properly. -There should always be a count sheet for ALL NARCOTICS. If one was not sent from the pharmacy, it can be requested. All count sheets should be used properly, and counts should be accurate. When they are complete the count sheet should be sent to medical records and kept for 3 years."	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758	The facility has determined all residents receiving psychotropic drugs to include anti-psychotic, anti-depressant, anti-anxiety, and hypnotic medications have the potential to be affected. All residents on a psychotropic will be reviewed and ensure that GDRs are implemented during Consulting Pharmacists May on-site visit. Rural Psychiatry Associate patients are reveiwed monthly during their rounds. Discussion held with consulting Pharmacist. GDRs will be provided by consulting Pharmacist as indicated. The Director of Nursing will conduct inservice	04/26/25

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F 758	Continued From page 59 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758	training to all licensed staff regarding the policy for use of psychotropic medications. The Director of Nursing or designee will complete weekly audits for ten random residents per week for four weeks and every two weeks 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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(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 758	Continued From page 60 This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure documentation related to a gradual dose reduction (GDR) had occurred to support the rationale for not completing a GDR for one of one sampled resident (5) who received psychotropic medications (any medication that affects brain activities associated with mental processes and behaviors). Findings include: 1. Observation and interview on 3/9/25 at 3:42 p.m. of resident 5 in her room while she was in bed revealed she had slow slurred speech. 2. Review of resident 5's electronic medical record (EMR) revealed: *She was admitted on 7/10/18. *Her 12/26/24 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated she was cognitively intact. *Her diagnoses included schizoaffective disorder (a mental health condition that includes symptoms of both schizophrenia and mood disorder), depression, and anxiety. *She had a physician order to receive mental health services. *She had multiple psychotropic medications ordered for her schizoaffective disorder including: -Aripiprazole 5 mg (milligrams) daily. -Bupropion 150 mg twice daily. -Clozapine 100 mg at bedtime. -Divalproex delayed release 500 mg twice daily. *She had been on the same dose of Divalproex since 3/19/24. *The Consultant Pharmacist Review 2024 and 2025 annual forms did not include divalproex as a psychotropic medication.	F 758		

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	435090	A. BUILDING _____ B. WING _____	03/12/2025

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F 758	Continued From page 61 *Her Abnormal Involuntary Movement Scale (AIMS) evaluations (a rating scale to measure involuntary movements that can sometimes develop as a side effect of long-term use of antipsychotic medications) was a zero until 12/28/23, when it increased to two and then on 3/19/24 it increased to a four, which indicated an increase in involuntary movements. *Review of the mental health providers progress notes revealed: -There was no documentation of notification related to the change in the AIMS score. -Each visit contained the statement, "Previous attempts to GDR resident's psychotropic medications have failed with exacerbation of symptoms including hospitalization, the current medications are appropriate for diagnosis and provided in appropriate amounts. NO GDR is considered or appropriate for this resident." --There were no changes documented to the divalporex. --Other psychotropic medications had been dose adjusted or changed to or from a different medication. *Review of minimum data set (MDS) assessments (a standardized comprehensive assessment of functional, medical, psychosocial, and cognitive status) completed revealed: *A GDR had not been attempted since 8/18/2020. *She had not been hospitalized in the past year. 3. Interview on 3/11/25 at 3:26 p.m. with director of nursing (DON) B revealed: *During a phone conversation on 3/11/25 with consultant pharmacist N, DON B was told that consultant pharmacist N did not complete GDR recommendations for residents that were prescribed psychotropic medications and were being seen by mental health because the mental	F 758		

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F 758	Continued From page 62	F 758		

health provider managed their medications.
*She had not been previously aware that he was not completing GDR recommendations for residents that were on a psychotropic medication and being seen by a mental health provider.

4. Interview on 3/11/25 at 4:37 p.m. with consultant pharmacist N revealed:
*He verified that if a medication that was not classified as a psychotropic and it was being used to affect a person's mental state it would qualify for a GDR review.
*He did not complete GDR reviews or provider recommendations for residents who were prescribed psychotropic medications and receiving mental health services.
*He considered every visit with a mental health practitioner a GDR visit.
*If a resident was on more than one psychotropic medication and one of the medications was changed, he had not been addressing the other medications for GDRs.
*He did not address each psychotropic medication individually when a resident was on more than one.
*He indicated he would have asked for a diagnosis clarification if a medication was being used as a psychotropic medication that was not in a class of medications identified as a psychotropic medication.
*Divalproex (a medication used to treat seizures that is also used as a mood stabilizer) was on resident 5's medication list with a diagnosis of schizoaffective disorder and was not being addressed as a medication that required a GDR, according to the list on his Consultant Pharmacist Review 2024 and 2025 annual forms.
*He stated there may have been a gap in services when a GDR was not presented to the

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F 758	Continued From page 63 resident's primary care physician or mental health provider. 5. Interview on 3/12/25 at 11:27 a.m. with assistant director of nursing (ADON) G revealed neither the physician nor the mental health provider was notified of the changes in resident 5's AIMS evaluations. 6. Review of the provider's undated Antipsychotic Medication Policy revealed the following: *"Nursing will monitor antipsychotic drug use daily noting any adverse effects such as increased somnolence (excessive sleepiness), functional decline, cardia [cardiac] arrhythmias (abnormal heart rhythm), parkinsonism (characterized by the same motor symptoms as Parkinson's disease), akathisia (movement disorder characterized by a feeling of restlessness and an inability to sit still), tardive dyskinesia (repetitive, involuntary movement disorder), dystonia (involuntary, sustained muscle contractions), anticholinergic effects (side effects caused by medications that block the action of the neurotransmitter acetylcholine), orthostatic hypotension (low blood pressure after standing up from a sitting or lying position) and cerebrovascular evens [events] (conditions that affect the blood vessels in the brain) which can include stroke, TIA [transient ischemic attack] (a "mini-stroke"), and heart failure. If any of these adverse effects are noted, the charge nurse will chart detailing in progress noted [notes] in [EMR] and notify primary care physician of findings." *"AIMS assessment will be performed every 3-6 months and quarterly psychotropic drug assessment will be performed on a quarterly basis with the MDS assessment schedule and any changes will be reported to the physician."	F 758		

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F 758	Continued From page 64 *"Efforts to reduce dosage or to discontinue use of antipsychotics will be ongoing, as appropriate, for the clinical situation. Use will be reviewed at care conferences and recommendations for gradual dose reduction (GDR) will be given to physician, unless clinically contraindicated, to assess effectiveness and/or need for continues [continued] use of antipsychotic. Pharmacy consultant will review [antipsychotic] use and offer recommendations as indicated." *"Definition of Clinically Contraindicated for Antipsychotics: -"The physician has documented the clinical rationale for why an additional attempted dose reduction would likely impair the resident's function or increase distressed behavior." -"For [a] resident with a psychiatric disorder other than dementia: --a. If the continues [continued] use in [is] in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any additional attempted dose reduction would likely impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder. --b. If the resident's symptoms returned or worsened after the most recent GDR attempt and the physician has documented the clinical rationale for why any additional attempted dose reduction would likely impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder."	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761	The facility has determined that all residents receiving insulin have the potential to be affected. The opened insulin pens were discarded and new ones opened and labeled properly with date opened as to follow manufacturer's instructions for the use by date. Pens are	04/26/25

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F 761	Continued From page 65 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to: *Ensure medications were labeled properly for four of four random residents (3, 5, 20, and 32) related to having the pharmacy label remain with the medication and to follow the manufacturers' instructions for use-by dates. *Ensure proper labeling and storage of medication for one of one resident (29) with a medicated ointment stored unsecured in her room. Findings include: 1. Observation on 3/10/25 at 2:32 p.m. of the medication storage room with certified medication	F 761	labeled on the cap and pen itself to identify the correct resident. An in service education program was conducted by the Director of Nursing with staff nurses on 4/4/25 addressing the facility policy regarding the proper storage of medications. The Director of Nursing or designee will inspect all insulin pens for two weeks then weekly for three months to ensure correct labeling. The Director of Nursing will present findings at monthly QAPI meetings for review and recommendations.	

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F 761	Continued From page 66 aide (CMA) Z revealed: *There were three insulin pens on the top of the treatment cart. -The pens were labeled for residents 3, 5, and 20. *All three insulin pens had the pharmacy label attached to the removable cap. *All three insulin pens were insulin aspart (a fast-acting insulin) and were not labeled with a date to have indicated when the pen was removed from the refrigerator for its first use or when they should have been used by. 2. Interview on 3/10/25 at 2:47 p.m. with assistant director of nursing (ADON) G revealed: *She confirmed the insulin pens were not dated when opened to ensure they were used by or discarded according to the manufacturer's instructions for use. *She confirmed there was a possibility the removable caps on the insulin pens could have been switched between resident's insulin pens. -With the pharmacy labels being on the removable caps of the pens it could not be verified to only be used for the specific resident that pen was dispensed to. *She was not aware of a resource list for medications with shortened expiration dates (a resource that indicated how long a medication could be used for once it was opened for use if it was different than the original expiration date). 3. Observation on 3/11/25 at 7:26 a.m. of the medication carts revealed: *A bottle of Latanoprost eye drops for resident 32 was not marked with a date to indicate when the bottle was opened. *A bottle of Latanoprost eye drops for resident 3 was not marked with a date to indicate when the bottle was opened.	F 761		

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F 761	Continued From page 67 4. Interview on 3/11/25 at 8:00 a.m. with certified nursing assistant/certified medication aide (CNA/CMA) K revealed: *All medications were supposed to be dated when opened. *She thought there was a guideline for staff to use for medications that had specific use-by dates, but she was unsure where it was located. 5. Interview on 3/11/25 at 10:36 a.m. with director of nursing (DON) B revealed: *She was not aware there were medications that had specific use-by dates after opening. *If insulin pens were not dated there was no way to confirm they were being used prior to the use-by date. 6. Observation and interview on 3/9/25 at 4:08 p.m. with resident 29 revealed: *There was a container of partially used Vicks Vapor rub ointment on her bedside table in her room. *The Vicks Vapor rub was not stored in a secure location to prevent other residents or unauthorized staff from accessing the medication. 7. Interview on 3/10/25 at 1:54 p.m. with ADON G revealed: *Resident 29 did not self-administer medications and should not have had medications stored in her room. *The Vicks Vapor rub may have been on the table in her room, but the night nurse puts it on her. 8. Observation on 3/11/25 at 2:26 p.m. of resident 29's room revealed: *The Vicks Vapor rub was in the top drawer of her bedside stand.	F 761		

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F 761	Continued From page 68 *There was no resident name or date on the container that indicated who it was for or when it was opened. 9. Interview on 3/11/25 at 2:39 p.m. with CNA/CMA K and resident care coordinator/Minimum Data Set coordinator H revealed: *They were not aware resident 29 had Vicks Vapor rub at her bedside. *Vicks Vapor rub would not normally be left at a resident's bedside. 10. Review of resident 29's electronic medical record (EMR) revealed: *She was admitted on 8/28/24. *Her 3/4/25 Brief Interview of Mental Status (BIMS) assessment score was 6, which indicated severe cognitive impairment. *She did not have a physician order for Vicks Vapor rub. 11. Interview on 3/12/25 at 1:13 p.m. with DON B revealed: *Resident 29 should not have had Vicks Vapor rub at bedside. *It was her expectation that medications were to be dated when opened, appropriately labeled with the resident's name, and stored securely. Review of the provider's undated Cart Organization and Proper Medication Storage policy revealed: *"When opening any Multi-Dose container/items-they should be dated with the open date immediately." Review of the provider's undated Medication Storage and Labeling policy revealed the	F 761		

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F 761	Continued From page 69 following: *"Labels for multi-use vials must include: -The date the vial was initially opened or accessed (needle-punctured); -All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial." -"Labels for medications designed for multiple administrations (such as inhalers, eye drops), the label will identify the specific resident for whom it was prescribed."	F 761		
F 812 SS=F	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, record review, interview, and policy review, the provider failed to follow	F 812	The Dietary Manager conducted an inservice meeting with the Dietary team on 3/26/25. Education regarding recording dishwasher, refridgerator, and freezer temps, the use of single-use containers and drying clean dishes on a cloth towel was provided. The Administrator and Dietary Manager conducted an audit and bought new containers and disposed of all single-use containers. The Dietary Manager or designee will ensure compliance by conducting weekly audits for four weeks on temperature logs, single-use containers, and drying dishes and then monthly for two months. The Dietary Manaer or designee will present the findings from these audits monthly for three months at the QAPI meeting for review and recommendations.	04/26/25

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F 812	Continued From page 70 standard food safety practices to ensure: *The mechanical dishwashers, refrigerator, and freezer temperatures were monitored and logged according to their policy. *Single-use food containers were not used to store leftover food. *Clean dishes were not stored on frayed cloth towels. Findings include: 1. Observation on 3/9/25 at 1:59 p.m. in the kitchen revealed the posted dishwasher temperature log for March 2025 was not completed for 3/4/25 through 3/7/25 and 3/9/25. *The dishwasher temperature logs for January, February, and March 2025 had no temperatures documented on 36 of 67 days. *The freezer temperature logs for February and March 2025 had no temperatures documented on 15 of 36 days for two of two freezers. *The walk-in cooler temperature logs for February and March 2025 had no documented temperatures on 8 of 36 days. *The satellite kitchen refrigerator/freezer temperature logs for February and March 2025 had no temperatures documented on 7 of 31 days. Interview on 3/11/25 at 4:40 p.m. with dietary manager (DM) D revealed: *She confirmed the logs were not complete. *She stated they were working on a new process for the temperature logs. *She agreed they were not monitoring and recording temperatures according to their policy. Review of the provider's 1/27/25 Dishwashing Machine Use policy revealed: *"Temperature Records"	F 812		

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F 812	Continued From page 71 -"The operator will check temperatures using the machine gauge with each dishwashing cycle, and will record the temperatures in a facility approved log." Review of the provider's 1/8/25 Refrigerator policy revealed: *"Temperatures will be taken twice a day according to staff assignment." *"Staff will record the temperature on a chart." Interview on 3/11/25 at 4:54 p.m. with administrator A regarding monitoring temperatures of dishwashers, freezers, walk-in coolers, and the satellite kitchen revealed: *She confirmed there were days the temperatures had not been logged. -She would have expected those to be completed and logged. *She confirmed their policies for monitoring the temperatures of dishwashers, freezers, walk-in coolers, and the satellite kitchen were not being followed. 2. Observation on 3/9/25 at 2:05 p.m. in the kitchen revealed: *The walk-in freezer contained several single-use containers with food items labeled with masking tape which included: -Two margarine containers labeled "pork roast." --There was no date written on the masking tape. -A cottage cheese container labeled "beef juice 2/17." -A margarine container labeled "beef juice 2/28." -A vanilla ice cream container labeled "chocolate chip cookies 3/3." *The walk-in refrigerator contained single-use containers with food items that were labeled with masking tape which included:	F 812		

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F 812	Continued From page 72 -A sour cream container covered with cellophane that contained grapes. -A cottage cheese container labeled "peaches 3/9." -A cottage cheese container labeled "applesauce 3/4." -An additional seven other single-use containers labeled with leftover food items that were dated. Observation on 3/9/25 at 5:28 p.m. in the dining room revealed that single-use containers were being used to serve leftover food to residents in the dining room. Interview on 3/11/25 at 11:36 a.m. with DM D about single-use containers revealed: *She confirmed the containers were single-use containers and should not have been used to store leftover food items. *She stated she would re-educate staff on not using single-use containers to store leftovers. Interview on 3/11/25 at 4:51 p.m. with administrator A revealed she was aware that single-use containers were being used for leftover food storage and serving. Those single-use containers should not have been used. Review of the Administrative Rules of South Dakota (ARSD) 44:02:07:43 revealed: "Materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food. Under normal use conditions materials must be safe; durable; corrosion-resistant; nonabsorbent; sufficient in weight and thickness to withstand repeated warewashing; finished to have a smooth, easily cleanable surface; and	F 812		

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F 812	Continued From page 73 resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition." Review of the provider's 1/28/25 Refrigerator Policy revealed: *"It is the intent of [provider] that our residents enjoy a home like atmosphere. We also take all measures to make sure the food they enjoy is safely stored." -The policy did not address food storage containers. 3. Observation on 3/9/25 at 2:57 p.m. of the kitchen revealed: *A stainless-steel table was located at the clean end of the area of the dishwasher. On that stainless-steel table was the following: -A cloth towel that had frayed edges with two coffee carafes and a glass sugar dispenser with no lid stored upside down it. -There were what appeared to be water calcium spots on that table around the cloth towel. Observation on 3/11/25 at 11:29 a.m. in the kitchen revealed two frayed wet bath towels on a stainless-steel table with three empty ice-cream buckets and an empty glass sugar dispenser and the lid for it lying on top of the towels. -There was a clear liquid on the stainless counter that appeared to be water. Interview on 3/11/25 at 11:36 a.m. with DM D regarding the above observations revealed: *Towels were placed on the stainless-steel table to keep the water from the wet dishes from dripping onto the floor. -She agreed the towels were wet and would not have allowed the dishes to air dry.	F 812		

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	435090	A. BUILDING _____ B. WING _____	03/12/2025

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F 812	Continued From page 74 Interview on 3/11/25 at 4:59 p.m. with administrator A regarding the use of cloth towels in the kitchen revealed she was not aware that cloth towels should not have been used to store wet dishes on. Review of the Food and Drug Administration Food Code 2022 revealed: *"Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS:" -"Shall be air-dried or used after adequate draining" -"May not be cloth dried except that UTENSILS that have been air-dried may be polished with cloths that are maintained clean and dry." Review of the ARSD for Lodging and Food Service revealed: *"Cleaned equipment and utensils must be stored as follows:" -"In a clean, dry location;" -"Where they are not exposed to splash, dust, or other contamination;" -"In a self-draining position that permits air drying; and" -"Either covered or inverted." *"After sanitizing, equipment and utensils must be air-dried or may be used after adequate draining."	F 812		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 835	Unable to change the outcome of the deficient practices. Refer to plan of corrections for tags F852,F583,F610,F655,F658,F699,F700,F725, F727,F732,F755,F761,F812,F847,F865, and F909.	04/26/25

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F 835	Continued From page 75 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure the facility was operated and administered by administrator A, director of nursing (DON) B, and assistant director of nursing (ADON) G, in a manner that ensured quality of life and overall well-being for all 39 residents in the facility. Findings include: 1. Observations, interviews, record reviews, and policy reviews throughout the survey on 3/9/25 from 1:00 p.m. through 6:00 p.m., 3/10/25 from 7:30 a.m. through 6:15 p.m., 3/11/25 from 7:00 a.m. through 6:00 p.m., and 3/12/25 from 7:30 a.m. through 5:30 p.m., revealed administrator A, DON B, and ADON G, had not ensured the management, safety, quality of life, and overall well-being of all the residents who lived in the facility. Those were evidenced by: *A widespread system breakdown to ensure services provided: -Met professional standards as it pertained to: --Medication administration and storage. --Addressing and notifying the physician of the significant weight loss for one resident (36). --Identifying and addressing low blood sugars for one diabetic resident (5). -Met the requirements for sufficient nursing staff including: --Full-time DON. --Registered nurse coverage for eight hours each day. --Twenty-four-hour licensed nurse coverage. --The daily posting of nurse staffing. -Addressed trauma informed care. -Monitored for appropriate temperatures of	F 835		

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F 835	Continued From page 76 mechanical dishwashers, refrigerators and freezers in the kitchen. -Addressed appropriate storage of leftover food. -Allowed for residents' and their representatives' right to make informed decisions and choices about important aspects of residents' health, safety, and welfare related to binding arbitration agreements to resolve disputes. -Included providing a written summary of the baseline care plan within 48 hours of a resident's admission. -Included a preventative maintenance program for the safe use of resident side rails. *Ensuring the proper Medicare notices were completed accurately for three residents (10, 33, and 41) prior to their discharge from Medicare Part A skilled services. *Responding to a resident's (5) concern with a staff member, certified nursing assistant R. *Ensuring privacy and signage had been maintained for two residents (9 and 21) with audio/video monitoring devices in their rooms. *Implementing an effective performance improvement plan and quality assurance program. 2. Review of the provider's undated job description for the administrator revealed: *"Summary: Administers, directs and coordinates all activities of the care center to carry out its objectives as to the care of the individuals who need nursing care ..." *Essential Duties included: -"Coordinates and integrates the total overall program of the facility." -"Make sure residents are meeting their highest level of professional care needed." -"Develops and monitors all departments within the facility to meet the standards put forth by the	F 835		

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F 835	Continued From page 77 governing board, management, and state and federal regulations." Review of the provider's 10/30/15 job description for the director of nursing revealed: *Summary: This individual directs the licensed and non-licensed staff who provide health care and nursing services to residents of the facility. The Director of Nursing's primary responsibility is to ensure the provision of quality nursing care on a 24-hour basis to the residents of the care center in accordance with Federal, State and Local standards and regulations." *Essential Duties included: -"Monitors the staffing levels of various nursing sections ..." -"Develops and directs nursing services objectives, policies and procedures." -"Assures that there is compliance with the regulations pertaining to care plans and resident assessments." -"Collaborates with outside providers such as ... pharmacy companies to enhance the quality of care for the residents." Refer to F582, F583, F610, F655, F658, F699, F700, F725, F727, F732, F755, F761, F812, F847, F865, and F909.	F 835		
F 837 SS=F	Governing Body CFR(s): 483.70(d)(1)-(3) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and	F 837	Unable to change the outcomes of the deficient practices. Refer to plan of corrections for tags F852,F583,F610,F655,F658,F699,F700,F725, F727,F732,F755,F758,F761,F812,F835,F847, F848,F851,F865, and F909.	04/26/25

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F 837	Continued From page 78 §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. §483.70(d)(3) The governing body is responsible and accountable for the QAPI program, in accordance with §483.75(f). This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and policy reviews, the governing body failed to ensure the facility was operated in a manner that ensured the safe management and overall well-being for all 39 residents in the facility. Findings include: 1. During the survey on 3/9/25 from 1:00 p.m. through 6:00 p.m., 3/10/25 from 7:30 a.m. through 6:15 p.m., 3/11/25 from 7:00 a.m. through 6:00 p.m., and 3/12/25 from 7:30 a.m. through 5:30 p.m., it was identified that the provider had not operated in a manner to ensure residents received quality care. Administrator A had not been assisted with her duties to ensure she was able to effectively provide guidance to staff to be able to provide quality care. Those were evidenced by: *A widespread system breakdown to ensure services provided: -Met professional standards as it pertained to: --Medication administration and storage. --Addressing and notifying the physician of the significant weight loss for one resident (36).	F 837		

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F 837	Continued From page 79 --Identifying and addressing low blood sugars for one diabetic resident (5). -Met the requirements for sufficient nursing staff including: --Full-time DON. --Registered nurse coverage for eight hours each day. --Twenty-four-hour licensed nurse coverage. --The daily posting of nurse staffing. -Addressed trauma informed care. -Monitored for appropriate temperatures of mechanical dishwashers, refrigerators and freezers in the kitchen. -Addressed appropriate storage of leftover food. -Allowed for residents' and their representatives' right to make informed decisions and choices about important aspects of residents' health, safety, and welfare related to binding arbitration agreements to resolve disputes. -Included providing a written summary of the baseline care plan within 48 hours of a resident's admission. -Included a preventative maintenance program for the safe use of resident side rails. *Ensuring the proper Medicare notices were completed accurately for three residents (10, 33, and 41) prior to their discharge from Medicare Part A skilled services. *Responding to a resident's (5) concern with a staff member, certified nursing assistant R. *Ensuring privacy and signage had been maintained for two residents (9 and 21) with audio/video monitoring devices in their rooms. *Implementing an effective performance improvement plan and quality assurance program. Refer to F582, F583, F610, F655, F658, F699, F700, F725, F727, F732, F755, F758, F761,	F 837		

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F 837	Continued From page 80 F812, F835, F847, F848, F851, F865, and F909.	F 837		
F 847 SS=F	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement	F 847	The facility has determined that all residents have the potential to be affected. The Administrator and Social Services Director created a policy and revised the Arbitration Agreement. Education regarding the Arbitration Agreement and process has been created and will be sent to residents and family members by 05/09/2025. The policy and additional documents have been included in the Admissions packet. The Administrator and Social Service Director will ensure that residents and family members have a clear understanding of the Arbitration Agreement. The Administrator or designee will audit all new admissions once per month for three months to ensure Arbitration Agreements have been addressed. The Administrator or designee will present audit findings at monthly QAPI meetings for review and recommendation.	04/26/25

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F 847	Continued From page 81 for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on record review, interview, and Arbitration Agreement review, the provider failed to ensure seven of thirteen sampled residents (13, 21, 23, 24, 25, 36, and 142) and three of three recently admitted residents (38, 39, and 142) who had entered into an Arbitration Agreement upon admission to the facility: *Were not required to sign a binding arbitration agreement as a condition of admission to receive care at the facility. *Were explained the arbitration agreement in a form and manner including a language that the resident or his/her representative understood. *Were explicitly granted the right to rescind the agreement within 30 calendar day of signing it. Findings include: 1. Record review on 3/10/25 at 1:00 p.m. of the Resident List Report printed at 12:10 p.m. that day by administrator A revealed: *The report listed forty residents which included thirty-nine residents in the facility and one resident who was hospitalized. *A handwritten note by administrator A that	F 847		

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F 847	Continued From page 82 indicated "All residents have a signed arbitration agreement. No active disputes." 2. Interview on 3/10/25 at 4:28 p.m. with resident 38 in his room regarding the Arbitration of Disputes admission agreement addendum he had signed on 2/13/25 revealed: *He did not recall signing any admission documents and asked if he had signed it or "one of his kids?" *After showing him a copy of the signed one-page Arbitration of Disputes and asking him if he remembered signing that document he stated "Not at all". -After reviewing his signature, he agreed he had signed that agreement. -He could not remember what the agreement was about. Review of resident 38's electronic medical record (EMR) revealed: *He was admitted on 2/13/25. *His 2/13/25 admission agreement was signed by resident 38, his son/durable power of attorney (DPOA)/DPOA healthcare (DPOA-HC), and administrator A. -The Admission Agreement Addendum included the one-page Arbitration of Disputes dated 2/13/25 that was signed by the resident. --The resident's son/DPOA/DPOA-HC had not signed this agreement. *His 2/18/25 brief interview for mental status (BIMS) assessment score was 12, which indicated his cognition was moderately impaired. 3. Review of resident 142's EMR revealed: *She was admitted on 3/3/25. *Her 3/3/25 admission agreement was signed by her daughter/DPOA/DPOA-HC, and social	F 847		

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F 847	Continued From page 83 services director (SSD) E. -The Admission Agreement Addendum included the one-page Arbitration of Disputes dated 3/3/25 that was signed by the resident's daughter/DPOA/DPOA-HC. *Her 3/4/25 BIMS assessment score was 14, which indicated she was cognitively intact. Phone interview on 3/10/25 at 4:50 p.m. with resident 142's daughter/DPOA/DPOA-HC regarding the Arbitration of Disputes admission agreement addendum she had signed on 3/3/25 revealed she: *Could not recall understanding the arbitration process and stated: -She would discuss "anything that wasn't right" with the provider. -"I didn't think we were totally giving up the right to litigate" in a court proceeding. *Had "No idea [what she was signing] as that was a very stressful day." *Could not remember if her right to terminate or withdraw from the agreement within 30 days of signing had been discussed. *Stated admitting her mother to the facility had been a long day and there was a lot of paperwork. 4. Review of resident 39's EMR revealed: *She was admitted on 2/26/25. *Her 2/26/25 admission agreement was signed by her daughter/DPOA/DPOA-HC, and SSD E. -The Admission Agreement Addendum included the one-page Arbitration of Disputes dated 2/26/25 that was signed by the resident's daughter/DPOA/DPOA-HC. *Her 3/4/25 BIMS assessment score was 13, which indicated she was cognitively intact.	F 847		

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F 847	Continued From page 84 Phone interview on 3/10/25 at 5:04 p.m. with resident 39's daughter/DPOA/DPOA-HC regarding the Arbitration of Disputes admission agreement addendum she had signed on 3/3/25 revealed she: *Was at work, but was able to answer a few questions. *Could not recall what the arbitration agreement was about. *"Felt it was a form that needed to be signed." 5. Review of resident 25's EMR revealed: *He was admitted on 8/29/24. *His 8/29/24 admission agreement was signed by his niece/responsible party and SSD E. -The Admission Agreement Addendum included the one-page Arbitration of Disputes dated 8/29/24 that was signed by the resident's niece/responsible party. *His 9/5/24 BIMS assessment score was 8 which indicated his cognition was moderately impaired. 6. Review of resident 13's EMR revealed: *She was admitted on 11/27/24. *Her 11/27/24 admission agreement was signed by her son/DPOA/DPOA-HC, and SSD E. -The Admission Agreement Addendum included the one-page Arbitration of Disputes dated 11/27/24 that was signed by the resident's son/DPOA/DPOA-HC. *Her 12/3/24 BIMS assessment score was 12 which indicated her cognition was moderately impaired. 7. Review of resident 36's EMR revealed: *She was admitted on 1/28/25. *Her 1/28/25 admission agreement was signed by her daughter/DPOA and SSD E. -The Admission Agreement Addendum included	F 847		

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F 847	Continued From page 85 the one-page Arbitration of Disputes dated 1/28/25 that was signed by the resident's daughter/DPOA. *Her 2/4/25 BIMS assessment score was 7 which indicated her cognition was severely impaired. 8. Interview on 3/10/25 at 5:10 p.m. with SSD E regarding the one-page Arbitration of Disputes form revealed: *The form was included in the admission agreement binder that included the paperwork the resident and/or representative signed upon admission. *She had not had anyone refuse to sign it. *She had no training on the form or how to discuss the agreement with the resident and/or representative on admission. *She had not ensured the person signing the form understood their right: -To refuse to enter into an arbitration agreement. -To rescind the agreement within 30 days of signing that form. *She stated she treated the form as informational acknowledgment and not as an agreement. *Her responsibilities included having the resident and/or representative sign the Admission Agreement paperwork. -For most admissions, while the resident was involved with the nurse's physical assessment, she would have the representative complete the admission paperwork. --That is what had happened with residents 39 and 142 noted above. -If she was unavailable, Administrator A would fill-in and complete the resident's admission agreement paperwork with the resident and/or representative. --She was not available on 2/13/25, when resident 38 had admitted to the facility.	F 847		

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F 847	Continued From page 86 --Administrator A had completed the admission paperwork for resident 38's admission. Interview on 3/10/25 at 5:43 p.m. with administrator A revealed: *SSD E completed the admission paperwork with most of the residents' admissions. -She assumed SSD E discussed the arbitration agreement appropriately with residents and/or representatives. *She agreed she had completed the admission paperwork for resident 38 on 2/13/25. -She stated resident 38, his daughter, his son/DPOA/DPOA-HC, and his son's wife were all present when the admission paperwork was completed. -She confirmed that this admission agreement was signed by resident 38, his son/DPOA/DPOA-HC, and administrator A. -She stated resident 38's son/DPOA/DPOA-HC read the paperwork prior to signing. --Resident 38's family read the arbitration agreement and stated resident 38 could sign that agreement. --Resident 38 was not really interested in reading the arbitration agreement and had commented "You just want my signature." Interview and record review of the undated one-page Arbitration of Disputes Admission Agreement Addendum on 3/11/25 at 8:24 a.m. with administrator A revealed: *The arbitration agreement was reviewed to ensure it clearly stated that the resident or his or her representative was not required to enter into the agreement as a condition of admission to the facility. -Administrator A agreed that was not clearly stated in the agreement.	F 847		

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	435090	A. BUILDING _____ B. WING _____	03/12/2025

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F 847	Continued From page 87 -Administrator A stated it was a poorly written agreement. Further interview that day with administrator A at 8:30 a.m. after reviewing the requested arbitration agreements for three residents (21, 23, and 24) and a handwritten note from SSD E revealed: *On 11/8/22, SSD E was provided notice to add the Arbitration of Disputes form to the Admission Agreement packet. *Administrator A confirmed that residents who were admitted to the facility prior to 11/8/22 had not entered into the arbitration agreement. Interview on 3/11/25 at 9:51 a.m. with SSD E regarding requested arbitration agreements revealed: *She confirmed that prior to 11/8/22 the residents admitted to the facility had not signed an arbitration agreement upon their admission. *Those residents had not been asked to sign the arbitration agreement after 11/8/22, when the arbitration agreement was added to the admission agreement packet. *A printed email, that she provided, indicated on 11/8/22 at 1:48 p.m. the administrator of the facility, at that time, had e-mailed the "Arbitration of Disputes" as an attachment with the message "Please include this in your admission packet." -She confirmed that was her notice and that she had received no training on that form or the arbitration process. Interview on 3/11/25 at 1:10 p.m. with administrator A regarding the requested policy on arbitration agreements revealed the provider did not have such a policy.	F 847		
F 848 SS=F	Binding Arbitration Agreements	F 848	The facility has determined that all residents have the potential to be affected.	04/26/25

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F 848	Continued From page 88 CFR(s): 483.70(m), 483.70(m)(2)(iii)(iv)(6) §483.70(m) Binding Arbitration Agreements. If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(2) The facility must ensure that: (iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and (iv) The agreement provides for the selection of a venue that is convenient to both parties. §483.70(n)((6) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for inspection upon request by CMS or its designee. This REQUIREMENT is not met as evidenced by: Based on interview and Arbitration Agreement review, the provider failed to ensure the provider's Arbitration Agreement: *Included the arbitration organization's name and how to contact that organization. *Provided for the selection of a neutral arbitrator agreed upon by both parties. *Provided for a location that was convenient for both parties for an arbitration dispute. Findings include: 1. Interview and record review of the provider's one-page arbitration agreement on 3/10/25 at 5:43 p.m. with administrator A revealed that the agreement had not included:	F 848	The Administrator and Social Services Director reviewed and revised the Arbitration Agreement. A policy was created, along with an updated agreement, and a checklist. The Arbitration Agreement has our organization's name, contact information, and guidance for selecting an arbitrator and location agreed upon by both parties. The revised Arbitration Agreements will be administered to residents and responsible parties for updated signatures of agreement or declination. The revised Arbitration Agreements along with supporting documents have been incorporated into the Admissions packet to ensure future compliance. The Administrator or designee will audit all new admissions once per month for three months to ensure Arbitration Agreements have been addressed. The Administrator or designee will present audit findings at monthly QAPI meetings for review and recommendation.	

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F 848	Continued From page 89 *The arbitration organization's name and how to contact that organization. *For the provision of the selection of a neutral arbitrator agreed upon by both parties. *For the provision of a location that was convenient for both parties for an arbitration dispute. *Administrator A agreed with those findings above. Interview on 3/11/25 at 1:10 p.m. with administrator A regarding the arbitration agreement revealed: *The provider had no policy regarding arbitration agreements. *She agreed the arbitration agreement was "poorly written."	F 848		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does	F 851	Unable to change the outcome of the deficient practice for submitting inaccurate payroll based journaling records. Hours per shift per day for nursing will be added manually to staffing data when reporting. IT and TMS (TImeclock Management System) were contacted to ensure settings and access were accurate. The Administrator or designee will monitor and review staffing data reports and will continuously monitor, and after each quarter's report is submitted. Policy has been revised and updated. The Administrator or designee will report findings quarterly at monthly QAPI meetings for four quarters until regulation is met.	04/26/25

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F 851	Continued From page 90	F 851		

not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(p)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(p)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(p)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

§483.70(p)(5) Submission schedule.
The facility must submit direct care staffing information on the schedule specified by CMS,

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F 851	Continued From page 91 but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on Payroll Based Journal (PBJ) record review, employee timecard review, and interview, the provider failed to submit PBJ data accurately for three of three federal fiscal quarters reviewed Quarter 2, 2024 (January 1 through March 31, 2024); Quarter 3, 2024 (April 1 through June 30, 2024)2024); and Quarter 4, 2024 (July 1 through September 30, 2024). Findings include: 1. Review of the PBJ records submitted to the Center for Medicare and Medicaid Services (CMS) revealed the provider submitted the following for licensed nursing coverage not being covered 24 hours per day for: *Quarter 2, 2024 for 34 days. *Quarter 3, 2024 for 11 days. *Quarter 4, 2024 for 30 days. 2. Review of the PBJ records submitted to CMS revealed the provider submitted the following for RN (registered nurse) coverage for 8 consecutive hours per day for: *Quarter 2, 2024 for 16 days. *Quarter 4, 2024 for 4 days. 3. Review of the provider's employee timecards revealed: *Quarter 2, 2024; 24-hour licensed nursing coverage was verified for 13 of the 34 days that were triggered for no 24-hour licensed nursing coverage and for 12 of the 16 days triggered for no RN coverage for 8 consecutive hours per day. *Quarter 3, 2024; 24-hour licensed nursing coverage was verified for 6 of the 11 days that were triggered for no 24-hour licensed nursing	F 851		

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F 851	Continued From page 92 coverage. *Quarter 4, 2024; 24-hour licensed nursing coverage was verified for 16 of the 30 days that were triggered for no 24-hour licensed nursing coverage and for all the days triggered for no RN coverage for 8 consecutive hours per day. *The timecard information supported the PBJ records were not accurate. 4. Interview on 3/10/25 at 6:03 p.m. with business office manager C regarding PBJ data submission revealed: *She was responsible for submission of the PBJ data. *She stated she entered the travel staff hours worked manually into the PBJ and the other staff hours worked were transferred electronically from their timecards into the PBJ online reporting system. *She was aware there were days on the PBJ reports that indicated there was no 24-hour licensed nursing coverage and no RN coverage for 8 consecutive hours per day. *She did not know how there was missing data because with each submission she received an indicator that 100% of the information was submitted and the report had been accepted. -She was not aware that the indicator only provided notification that the information submitted was accepted at 100% and not if that data was accurate to actual hours worked by staff.	F 851		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of	F 865	Unable to change the outcome of the deficient practice. Refer to plan of corrections for tags F655,F700,F725,F727,F732,F755,F761,F847, F848,F851, and F909.	04/26/25

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F 865	Continued From page 93 a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:	F 865		

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F 865	Continued From page 94 §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance	F 865		

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F 865	Continued From page 95 indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, and quality assurance and performance improvement (QAPI) plan policy review, the provider failed to ensure they had identified and corrected quality deficiencies when they occurred throughout the facility and that performance improvement projects (PIP) had been thoroughly identified, implemented, or monitored regarding nurse staffing, siderails, medication administration and storage, baseline care plans, and arbitration agreements. Findings include: 1. Interview on 3/12/25 at 11:29 a.m. with administrator A regarding the QAPI program and committee revealed: *She was the QAPI coordinator for the provider and stated each department manager conducted	F 865		

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F 865	Continued From page 96	F 865		

their own audit, discussed that audit with the QAPI committee, and implemented any plan needed for correction.
*The provider's QAPI committee was comprised of:
-All the department managers.
-Administrator A.
-Director of nursing (DON) B.
-The following committee members attended on a quarterly basis:
--The medical director.
--The executive director.
--The consultant dietitian (by phone).
*The QAPI committee was currently working on projects that included new carpet for the facility, new dining room chairs, and new activity room chairs.
*The QAPI committee's current performance improvement project (PIP) was aimed at improvements regarding residents at risk for or experiencing weight loss.
*Regarding areas of non-compliance identified by the survey team that included:
-Staffing concerns related to a full-time DON, registered nurse (RN) coverage for at least eight hours a day, licensed nurse coverage 24 hours a day, and the required posting of that nurse staffing information.
--She stated they were in a transition period from the previous full-time DON who was employed at the facility from 7/1/24 to 1/31/25.
--DON B was currently mentoring assistant DON (ADON) G to assist with the DON role.
--She stated the QAPI committee had not addressed the required full-time director of nursing position.
-The three days during January and February 2024 with no RN hours was during a transition period.

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F 865	Continued From page 97 -The numerous days without licensed nurse coverage 24 hours a day was due to a documentation error. --She stated the QAPI committee was not aware of those issues. -Bedrail concerns related to assessments; lack of consents; and lack of a preventative and safety maintenance program ensuring the safe use of those bedrails. --She stated the QAPI committee was not aware of those issues. -Medication administration and storage concerns related to receipt, administration, accountability, storage, labeling, and destruction of medications. --She stated the QAPI committee was not aware of those issues. -Baseline Care Plan concerns related to providing those to the resident/representative within 48 hours of admission. --She stated the QAPI committee was not aware of those issues. -Arbitration agreements concerns. --She stated the QAPI committee was not aware of those issues. -She confirmed their QAPI process had not been effective in identifying these quality issues that could have impacted the resident's care. 2. Review of the provider's 6/25/24 QAA (Quality Assessment and Assurance) Committee Policy revealed: *"Intent: These policies are intended to ensure that [Name of Provider] develops a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of	F 865		

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F 865	Continued From page 98 life and resident safety." *The policy indicated the QAA committee would: -"Develop and implement appropriate plans of action to correct identified quality deficiencies." -"The quality assessment and assurance committee reports to the facility's governing body, or designated person (Administrator)." Review of the provider's 7/31/24 QAPI Plan revealed: *"The QAPI program will aim for safety and high quality with all clinical interventions and service delivery... by ensuring our data collection tools and monitoring systems are in place and are consistent for proactive analysis, system failure analysis, and corrective action." *"The scope of the QAPI program encompasses all types and segments of care and services that impact clinical care, quality of life, resident choice, and care transitions..." *"The governing body, administrator, and/or management firm are responsible for the development and implementation of the QAPI program..." Refer to F655, F700, F725, F727, F732, F755, F761, F847, F848, F851, and F909.	F 865		
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.	F 909	Assessments have been conducted on residents #2,3,5,6,9,13,16,21,23,24,25,36 and 142. Assessments on all residents were completed and reported on in April's QAPI on 04/17/2025. The Director of Maintenance has added assessing of side rails to his routine safety and preventative maintenance checklist. The Director of Maintenance will conduct monthly audits on all residents beds to ensure compliance. The Director of Maintenance will present	04/26/25

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F 909	Continued From page 99 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to assess side rails on 13 of 13 sampled residents' beds (2, 3, 5, 6, 9, 13, 16, 21, 23, 24, 25, 36, and 142) routinely as a part of a safety and preventative maintenance program to ensure those side rails were in good working order and safe from possible resident entrapment or injury. Findings include: 1. Observation on 3/9/25 at 2:31 p.m. of resident 36 revealed she had two quarter-length side rails in the up position at the head of her bed. 2. Observation on 3/9/25 at 2:32 p.m. of resident 24 revealed she had two quarter-length side rails in the up position at the head of her bed. 3. Observation on 3/9/25 at 2:36 p.m. of resident 9 revealed he had two quarter-length side rails in the up position at the head of his bed. 4. Observation on 3/9/25 at 3:42 p.m. of resident 5 revealed she had two quarter-length side rails in the up position at the head of her bed. 5. Observations on 3/9/25 between 3:48 p.m. and 5:30 p.m. and on 3/10/24 between 8:12 a.m. and 11:00 a.m. of sampled resident rooms revealed 2, 3, 5, 6, 9, 13, 16, 21, 23, 24, 25, 36, and 142 had quarter-length side rails on one or both sides of their beds. 6. Interview on 3/11/25 at 3:09 p.m. with maintenance director F regarding safety and preventative maintenance of side rail on residents' beds revealed: *The physical therapists initiated the use of side	F 909	findings at monthly QAPI meetings for three months for review and recommendations.	

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 _____	03/12/2025

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 909	Continued From page 100 rails for residents. *He was aware of one bed with side rails attached, the bed in room number 11. -That resident was not an identified sampled resident. -That resident had purchased his own bed, and it had a box spring and metal frame, and on 5/2/24 maintenance director F had installed side rails on that bed. -He monitored only that residents' bed and the side rails attached to it monthly for safety. *He thought all other residents' beds with side rails in the up position were for the remote of the electronic bed. *He was not aware the other residents' beds with side rails attached were being assessed by the nursing staff for use as side rails. -He had not performed safety and preventative maintenance of side rails for any other residents' beds with side rails to ensure they were appropriately secured and in safe working order to prevent injuries. 7. Review of the provider's Transfer Bar/Bed Rail Maintenance Log revealed: *The form included areas to be documented in as: date, Room # [number] Monitored, Date Repairs Done, Comments, and Initials. -The first date on the form was on 5/2/24 with Room # Monitored as "#11-2", Date Repairs Done "5-2 installed", Comments included "will check quarterly" and the Initials of [maintenance director F]. Review of the provider's undated Bed Assist Bar Policy & Procedure revealed: *"Policy: -Ensure ongoing assessment and maintenance of resident bed assist bar use."	F 909		

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 _____	03/12/2025

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 909	Continued From page 101 *"Procedure: -"4. Initial actions to prevent deaths and injuries from entrapment and/or falls from bed assist bars: --a. Ensure bed dimensions are appropriate for resident. --b. Confirm that the bed rails to be installed are appropriate for the size and weight of the resident using the bed. --c. Check with the manufacturer(s) to make sure the bed assist bar, mattress, and bed frame are compatible." --"d. Install bed assist bars using the manufacturer's instructions and specifications to ensure a proper fit. -5. Inspect and regularly check the mattress and bed assist bar for areas of possible entrapment. --a. Regardless of mattress width, length, and/or depth, the bed frame, bed assist bar, and mattress should leave no gap wide enough to entrap a resident's head or body. --b. Check bed assist bars regularly to make sure they are still installed correctly as bars may shift or loosen of loosen over time. --c. Follow manufacturer equipment alerts and recalls. --d. Conduct routine preventative maintenance of beds and bed assist bars to ensure they meet current safety standards and are not in need of repair."	F 909		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/12/2025**

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
K 000	INITIAL COMMENTS A recertification survey for compliance was conducted on 3/12/25. Five Counties Nursing Home (building 01) was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 3/12/25. Please mark an F in the completion date column for K225 and K374 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K293 and K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 225 SS=C	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 REQUIREMENT 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 three stairwells (southwest stair enclosure). Findings include:	K 225		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jordan Fish — TITLE: Administrator — (X6) DATE: 04/11/25

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/12/2025**

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
K 225	Continued From page 1 1. Observation on 3/12/25 at 8:30 a.m. and review of the previous survey report dated 12/5/23 revealed the first-floor door swung into the southwest stair enclosure. That door in the open position restricted the egress to 17 inches measuring from the latch side of the door leaf to the stair newel post. The building meets FSES. Please mark an "F" in the completion date column.	K 225		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the emergency exit light for one randomly observed exit doors in the activities room (southeast fire exit). Findings include: Observation and interview on 3/12/24 at 11:15 a.m. in the activities room with the maintenance director revealed: *The southeast fire exit door had a red sign on the door stating, "Emergency Exit Only" and was equipped with an emergency exit light above the door. *The emergency exit light above the door was not	K 293	The Director of Maintenance fixed the exit light located at the Southeast fire door exit and has added it to his preventative maintenance routine. The Director of Maintenance or designee will audit all other exit lights to ensure all other exit lights are in working order. The Director of Maintenance will ensure compliance by conducting monthly audits on all emergency exit signs once per month for three months The Director of Maintenance will present findings from these audits monthly for three months at the QAPI meetings for review until the QAPI committee advises to discontinue monitoring.	04/26/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/12/2025**

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
K 293	Continued From page 2 lit. *He had been employed at the facility since September 2023 and was not aware of that door ever being used since he had started. *He had overlooked the southeast fire exit door and had not included it in his preventative maintenance routine. *He agreed the emergency light should have been fixed.	K 293		04/26/25
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K 321	The Director of Maintenance has fixed the ninety-minute fire rating door to the boiler room to ensure closure. All fire doors will be auditted to ensure proper closure. The door will remain closed, and audits will be conducted weekly for four weeks and monthly for two months. The Director of Maintenance will present findings from these audits monthly for three months at the QAPI meeting for review until the QAPI committee advises to discontinue monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/12/2025**

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
K 321	Continued From page 3 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the self-closing feature for one of one ninety-minute fire rated door to the boiler room (a hazardous area). Findings include: 1. Observation and interview on 3/12/24 at 10:20 a.m. in the basement where the boiler room was located with the maintenance director revealed: *The self-closing device had been removed from the ninety-minute fire rated door to the boiler room and the door was in the open position. *The self-closing device had been removed prior to him being employed in September 2023. *He was not aware the door to the boiler room was required to be self-closing.	K 321		
K 374 SS=C	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	K 374		F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/12/2025**

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

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K 374	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the provider failed to maintain clear door widths at least 32 inches for one randomly observed smoke barrier located on the first floor of the original building (between the original building and the 1962 addition). Findings include: 1. Observation on 3/12/25 at 10:40 a.m. revealed the cross-corridor doors between the original building and the 1962 addition were only 30 inches wide and did not provide a clear opening width of 32 inches. Review of the previous survey report dated 12/5/23 revealed those doors were the original doors. The building meets the FSES. Please mark an "F" in the completion date column.	K 374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING **02 - BUILDING 02** B. WING _____	**03/12/2025**

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
K 000	INITIAL COMMENTS A recertification survey for was conducted on 3/12/25. Five Counties Nursing Home (building 02) was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K222 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		04/26/25
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is	K 222	The latching hardware on the fire exit door located in the dining room has been removed. The Director of Maintenance and Administrator audited all exterior/fire exit doors to ensure no latching hardware was identified. The Director of Maintenance or designee will audit all exterior/fire doors to ensure all other doors are in compliance. The Director of Maintenance or designee will audit all exterior/fire doors monthly for three months and present findings from these audits monthly for three months at the QAPI meeting for review until the QAPI committee advises to discontinue monitoring.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jordan Fish — TITLE: Administrator — (X6) DATE: 4/11/25

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING **02 - BUILDING 02** B. WING _____	**03/12/2025**

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
K 222	Continued From page 1 protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain one randomly observed exit from the dining room. Findings include:	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING **02 - BUILDING 02** B. WING _____	**03/12/2025**

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
K 222	Continued From page 2 1. Observation and interview on 3/12/25 at 11:00 a.m. with the maintenance director of the exit from the dining room revealed: *The exit had an emergency exit sign and went out of the building. *It was equipped with a barrel lock that when engaged would lock the exit from use. *The door was equipped with latching hardware that could be locked with a key from the outside. *The latching hardware was not locked from the outside so residents could come and go. *He was not aware if anyone used the latching hardware key lock to secure that door from entry from the outside. *He had installed the barrel lock to add security from intruders coming in that door. *He had not thought about the exit being rendered unusable when the barrel lock was engaged. *He agreed if the barrel lock was engaged the exit was not usable until the lock was disengaged.	K 222		

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
	435090	A. BUILDING _____ B. WING _____	03/12/2025

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

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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 on 3/12/25. Five Counties Nursing Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jordan Fish
TITLE: Administrator
(X6) DATE: 4/11/25

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.

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 _____	03/12/2025

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 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/9/25 through 3/12/25. Five Counties Nursing Home was found not in compliance with the following requirement: S037.	S 000	This plan of correction is submitted as required under Federal and State regulations and statuses applicable to long-term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusisons are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.	
S 037	44:74:02:08 Notice of Change in Approved Training Program The entity offering an approved nurse aide training program shall submit to the department, within 30 days after the change, any substantive changes made to the program during the two-year approval period. The department shall notify the entity of its approval within 90 days after receipt of the information. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to notify the South Dakota Board of Nursing (SD BON) of changes in the nurse aide training program (NATP) coordinator within thirty days after the change. Findings include: 1. Review of the provider's SD BON NATP 7/9/24 Application for Faculty Changes to a Currently Approved Training Program form revealed: *The NATP had been approved until 3/31/25. *The NATP coordinator was changed to previous director of nursing (DON) P. *The NATP primary instructor was changed to licensed practical nurse (LPN) I. -The form stated "remains the same", but there was no record that LPN I held that position previously.	S 037	The South Dakota Board of Nursing has been notified of the changes in the Nurse Aide Training Program (NATP) Coordinator on March 25, 2025. The Administrator or designee will audit once per month for three months to ensure the NATP coordinator is registered with SDBON. The Administrator or designee will report findings at monthly QAPI for further review and consideration.	04/26/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jordan Fish | TITLE: Administrator | (X6) DATE: 04/21/25

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S 037	Continued From page 1 2. Interview on 3/12/25 at 9:45 a.m. with LPN I revealed she was the primary instructor for the provider's NATP. 3. Interview on 3/12/25 at 1:13 p.m. with DON B revealed she: *Had worked with the South Dakota Health Care Association to achieve certification for proctoring and skills demonstration with nurse aides. *Had taken over as the NATP coordinator since DON P left that position on 1/31/25. *Was not aware the SD BON should have been notified of that change within 30 days. *Stated, "I'll do whatever is needed." *Agreed that no change had been submitted to the SD BON for the change of the NATP coordinator. 4. Interview on 3/12/25 at 4:30 p.m. with administrator A revealed: *Former DON P had worked at the facility from 7/1/24 to 1/31/25. *DON B had worked at the facility as a nurse executive while DON P was employed. *DON B took over as the DON on 2/1/25. *She confirmed no change had been submitted to the SD BON for the change of the NATP coordinator.	S 037		
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 3/9/25 through 3/12/25. Five Counties Nursing Home was found not in compliance with the following requirements: S169, S206, S278, and S301.	S 000		

South Dakota Department of Health

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S 169	44:73:02:18(5-7) Occupant Protection The facility shall: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically-activated audible alarm on all unattended exit doors. Any other exterior doors must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence when the door is closed; (7) Prohibit the use of a portable space heater, portable halogen lamp, household-type electric blanket, or household-type heating pad in the facility; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to install an electrically activated audible alarm on one of two exterior doors located in the activities room (southeast fire exit). Findings include: 1. Observation and interview on 3/12/24 at 11:15 a.m. in the activities room with the maintenance director revealed: *There were two exterior doors located in the activities area the patio door and the southeast fire exit door. *The patio door had an alarm that sounded when the door was opened. *When the southeast fire exit door was opened no alarm sounded. *He had been employed at the facility since September 2023 and that was the first time he had seen that door opened. *He was not aware the door was not equipped	S 169	All residents have the ability to be affected by this deficiency. The Director of Maintenance has electrically activated the Southeast fire exit door with an audible alarm. The Administrator, Director of Maintenance, and interdisciplinary team have audited all exterior doors to ensure audible alarms are placed and working. The Director of Maintenance or designee will ensure compliance by conducting weekly audits for four weeks and monthly for two months on fire doors for three months to assure audible alarm activates. The Director of Maintenance or designee will report audit findings at monthly QAPI meetings for further review and consideration.	04/26/25

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S 169	Continued From page 3 with an electrically activated audible alarm. *When he tested door alarms, he tested the patio door because that is the one that everyone used. *He had overlooked the southeast fire exit door. *He agreed it should have been equipped with an alarm and he should have been checking it when he tested door alarms.	S 169		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section.	S 206	CNA S is a travler. A process is being created with our contracted travel MSP agency to ensure state inservice training courses are completed prior to the state date. All travel staff will be required to meet the required 44:73 training requirements. All Travel staff will be required to meet the required 44:73 training requirements by 05/01/2025. Employee T has been educated and required to complete the required trainings. She is in compliance. The Business Office Manager is responsible for the completion of employee files per job description. The Business Office Manager will audit all other employee files by 04/26/25 to ensure that all other employees completed the training required. The Business Office Manager will audit all travelers by 05/01/25 to ensure they are in compliance. The Business Office Manager will ensure compliance by conducting monthly audits for three months to ensure compliance with all training requirements. The Business Office Manager will report audit findings at monthly QAPI meetings for further review and consideration.	04/26/25

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S 206	Continued From page 4 The facility shall provide additional personnel education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee training records review and interview, the provider failed to ensure mandatory training was provided on all the required training subjects for two of five sampled employees (S and T). Findings include: 1. Review of certified nursing assistant (CNA) S's training records revealed: *She was hired on 2/12/24. *She had not received training during orientation regarding the following required topics: -Infection control and prevention. -Resident rights. -Mandatory reporting. -Dining assistance, nutritional risks, hydration. 2. Review of environmental services aide T's training records revealed: *She was hired on 4/29/24. *She had not received training during orientation regarding the following required topics: -Fire prevention/response. -Emergency procedures/preparedness. -Infection control and prevention. -Accident prevention and safety procedures. -Proper restraint use. -Resident rights. -Confidentiality of resident information. -Mandatory reporting. -Dining assistance, nutritional risks, and hydration. -Abuse, neglect, misappropriation, and mistreatment. -Advanced directives.	S 206		

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S 206	Continued From page 5 3. Interview on 3/11/25 at 4:52 p.m. with administrator A revealed: *She expected staff to complete the required training. *Staff could complete the training by: -Attending the monthly all-staff meeting where one required subject was covered each month. -Utilizing an online app that covered the required subjects at their own pace. *She confirmed that CNA S and environmental services aide T had not completed the required orientation training.	S 206		
S 278	44:73:06:03 Director of Nursing A facility shall have a full-time registered nurse designated as the director of nursing who is responsible for the organization of the entire nursing service and who serves during the day shift. The director may not serve in a dual role as the administrator of the facility and the director of nursing. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to: *Have a full-time registered nurse designated as the director of nursing (DON). *Have the DON not serve in a dual role as the administrator of the facility and the DON. Findings include: 1. Interview on 3/9/25 at 1:45 p.m. with business office manager C and social services director E during the entrance conference revealed: *The provider did not have any nurse staffing waivers.	S 278	Five Counties had a Full-Time Director of Nursing. With recent changes our contracted Nurse Executive has assumed the Director of Nursing title and all functions. The contract reflects 40 hours per week to ensure compliance with state requirements. The Administrator will audit once per month for three months to ensure the facility has registerd nurse full-time as the Director of Nursing. The Administrator will report audit findings at monthly QAPI meeting for further review and consideration.	04/26/25

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S 278	Continued From page 6 *DON B worked between 32 to 40 hours per week. *DON B was paid hourly. 2. Interview on 3/12/25 at 7:47 a.m. with administrator A revealed DON B worked between 36 and 40 hours per week. 3. Review of DON B's timecards revealed during 16 weeks of randomly selected timecards between July and December 2024, she averaged 23 hours of work per week. 4. Interview on 3/12/25 at 4:30 p.m. with administrator A revealed: *She had started working at the facility on 11/20/23: -At that time BOM C held the nursing facility administrator's (NFA's) emergency permit for the provider. *On 12/5/23 Administrator A held the NFA's emergency permit until 6/5/24. --That emergency permit was re-extended until 12/9/24. *DON B was hired on 10/5/23 and worked as the DON until 6/30/24. *On 7/1/24: -DON B was promoted to the nurse executive position. -DON P was hired as the DON and reported to the DON B as when she held the position of a nurse executive. *On 12/9/24 DON B held the NFA's emergency permit for the provider. *On 1/31/25 DON P's employment as the DON ended. *On 2/1/25 DON B began the role of DON for the provider. *DON B continued up to the time of this interview those roles of being both the DON and the NFA's	S 278		

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S 278	Continued From page 7 emergency permit holder. -Administrator A stated she filled the administrator position and role, but DON B held the NFA's emergency permit. -Administrator A stated she was aware that the DON was not permitted to serve in a dual role as the administrator of the facility and the director of nursing. Review of the South Dakota Board of Nursing Facility Administrators website's List of Emergency Permit Holders revealed DON B held the active emergency permit for the provider which had a start date of 12/9/24 and an end date of 6/9/25.	S 278		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on dietary employee training records	S 301	The Dietary Manager and Administrator will streamline the annual dietary training process to ensure compliance. Dietary aid U, V, W, X, and Y will receive education on the required annual trainings and will be in compliance. In service training will be conducted on 04/23/25 and all dietary topics will be covered to ensure compliance. The Dietary Manager is responsible for the completion of in service trainings. The Dietary Manager will complete monthly audits for three months to ensure compliance with all educational requirements. The Dietary Manager will report audit findings at monthly QAPI meetings for further review and consideration.	04/26/25

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S 301	Continued From page 8 review, and interview, the provider failed to ensure: *The required annual dietary training for food safety, handwashing, food handling/preparation, food-borne illnesses, serving and distribution procedures, leftovers, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation had been completed for three of five sampled dietary staff members (U, V, and X). *The required orientation dietary training for food safety, leftovers, time and temperature controls for food preparation and service, and sanitation had been provided for two of five sampled dietary staff members (W and Y). Findings include: 1. Review of dietary aide (DA) U's training records revealed: *She was hired on 12/9/23. *There was no record that she had completed training on the required annual dietary topics for 2024. 2. Review of cook V's training records revealed: *She was hired on 8/9/12. *There was no record that she had completed the required annual dietary training for food safety for 2024. 3. Review of DA/housekeeping W's training record revealed: *She was hired on 2/2/24. *There was no record that she had completed the required orientation dietary training for: -Food safety. -Leftovers. -Time and temperature controls. 4. Review of DA/cook X's training record	S 301		

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S 301	Continued From page 9 revealed: *He was hired on 10/15/19. *There was no record that he had completed the required annual dietary training for 2024 for: -Food safety. -Leftovers. -Time and temperature controls. 5. Review of DA/cook Y's training record revealed: *She was hired on 5/15/24. *There was no record that she had completed the required orientation dietary training for: -Food safety. -Sanitation. 6. Interview on 3/11/25 at 11:36 a.m. with dietary manager (DM) D revealed she: *Confirmed the required annual dietary training had not been completed for the three sampled dietary staff members (U, V, and X). *Confirmed the required orientation dietary training had not been completed for the two sampled dietary staff members (W and Y). *Stated she had taken a leave of absence and was aware the training had not been completed while she was gone.	S 301		