STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING _____ B. WING _____	C 04/09/2025

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 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/7/25 through 4/9/25. The area surveyed was resident safety related to a potential accidental ingestion of another resident's medication by a resident who required emergency room evaluation. Five Counties Nursing Home was found not in compliance with the following requirements: F610, F658, F686, F760, and F761.	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. 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.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of the provider's South Dakota Department of Health Facility Reported Incident (SD DOH FRI), observation, record review, interview, and policy review, the provider failed to	F 610	Unable to change the outcome of the deficient practice. Administrator and DON conducted an inservice education on 04/23/25 with all staff addressing circumstances that require reporting for timely investigations, and their responsibilities related to investigations. The Administrator and DON conducted an inservice education with direct staff on 04/23/25 addressing reporting of injuries of unkown origin. The DON or designee will conduct a random audit of one resident weekly for four weeks and two residents monthly for two months. These residents will be assessed and interviewed to ensure that any injurieis are identified, properly investigated and reported to the appropriate people. The DON or designee will present findings from monthly audits for three months at QAPI meeting for review and recommendations.	05/02/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jordan Fish	Administrator	05/09/25

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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ensure a thorough investigation was completed and reported to the SD DOH regarding a facial bruise of unknown origin for one of one sampled resident (1).
Findings include:

1. Review of the provider's 3/25/25 SD DOH FRI regarding resident 1 revealed:
*On 3/25/25 at 10:30 a.m. in the activity room resident 1 was found unresponsive, "shaking", with a "weak pulse" and a blood pressure of 81/47.
-She was transported to the emergency room by ambulance.
*The emergency department performed a drug screen.
-The drug screen indicated resident 1 had a benzodiazepine medication in her system.
-Resident 1 was not on a prescribed benzodiazepine medication.
*The SD DOH FRI did not indicate resident 1 had any injuries or bruises.

Observation on 4/9/25 at 8:45 a.m. of resident 1 at the breakfast table revealed:
*She was seated in a wheelchair.
*A purple/yellow/green skin discoloration was noted just to the left of the center of her forehead that measured approximately 3 centimeters (cm) by 3 cm.

Review of resident 1's electronic medical record revealed:
*She was admitted on 7/18/22.
*Her 1/21/25 Brief Interview of Mental Status assessment score was 10, which indicated she had moderate cognitive impairment.
*Her diagnoses included: chronic obstructive pulmonary disease (disease that restricts

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breathing), insomnia, emphysema (lung condition that causes shortness of breath), dementia without behavioral disturbance, psychotic disturbance (altered reality/thoughts), mood disturbance, anxiety, and respiratory failure.
*Her care plan included:
-A 10/28/24 focus area that indicated she was dependent on staff for meeting her physical needs related to cognitive deficits.
-A 7/29/22 focus area that indicated she needed staff assistance with her activities of daily living.
--Interventions for that focus area included she needed the assistance of a staff member for her bathing/showering, repositioning, dressing, personal hygiene/oral care, use of a toilet, and assistance with setup for eating.
-A 10/28/24 focus area indicated that she had impaired cognition related to dementia.

Review of resident 1's nurse progress notes revealed:
*On 3/25/25 a note indicated "Resident continues to have increased confusion. Resident was in bed calling out stating she was falling. Resident constantly taking of [off] oxygen tubing and using it as thread for sewing. Resident noted to have a bruise to the forehead. Resident assisted to bathroom with can [certified nursing assistant] report [of the resident having said] 'let me put on my new ankles.'"
-There was no additional information that indicated an assessment, or investigation was completed regarding the bruise on her forehead.
*On 3/29/25 she was found on the floor in her room.
-She had a "bruise and bump" on her left elbow.
*On 3/29/25 her daughter was notified of the 3/29/25 fall and "POA questioned about bruising on her forehead. This nurse researched through

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the notes. Notes read to POA."
*On 3/29/25 a note indicated "Review of resident 1's 3/25/25 ambulance transport report revealed it was noted that she had a "1 x 1 [one by one] square bruising above [her] left eye."

Review of resident 1's 3/25/25 emergency room visit report revealed "Noted small bruise to the forehead and a couple to her shins."

Review of resident 1's skin assessments completed on 3/26/25 and on 4/2/25 had not indicated a bruise on her forehead.

Interview on 4/7/25 at 4:33 p.m. with certified nurse aide/certified medication aide (CNA/CMA) N revealed:
*She noticed the bruise on resident 1's forehead a "few days ago".
*She believed the bruise was from resident 1's fall on 3/29/25.

Interview on 4/8/25 at 3:05 p.m. with director of nursing B regarding resident 1's forehead bruise that was identified as a bruise on 3/25/25 revealed:
*She was not notified or aware of resident 1's forehead bruise.
*She did not think administrator A had been notified of the bruise.
*There was no investigation completed to identify a potential cause of the bruise.
*She stated she had previously provided education, on various occasions, with staff regarding reporting resident injuries.

Interview on 4/9/25 at 7:35 a.m. with CNA/CMA N revealed:
*She would report any signs of abuse, bruises,

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skin issues, and resident concerns to the charge nurse.
*If the charge nurse did not respond to her concerns, she would report her concern to the director of nursing or the administrator.

Interview on 4/9/25 at 8:35 a.m. with CNA/CMA L revealed:
*She would report any concerns such as bruises, skin issues, and resident concerns to the charge nurse.
*She noticed the bruise on resident 1's face in March but did not recall what day.
*She indicated she did not report the bruise to the charge nurse because she was told in shift report that the previous CNA had notified the charge nurse.

Interview on 4/9/25 at 8:48 a.m. with CNA Q revealed:
*He noticed the bruise on resident 1's forehead the day after she fell on 3/29/25.
*He would report anything out of the ordinary for a resident to the charge nurse.
-He verified that included skin issues, changes in condition, and resident concerns.

Interview on 4/9/25 at 9:50 a.m. with director of nursing B revealed there was no documentation to verify when or what resident information was passed on by staff during the nurse shift report.

Administrator A was not available for an interview during the survey.

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

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F 610	Continued From page 5 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 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."	F 610		

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F 610	Continued From page 6 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: -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	F 610		

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F 610	Continued From page 7 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 infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." *"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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on review of the provider's South Dakota Department of Health Facility Reported Incident (SD DOH FRI), record review, observation, and interview, the provider failed to follow professional standards to ensure a resident's physician ordered: *Fluid restriction was implemented effectively and accurately documented for one of one sampled resident (1). *Basic metabolic panel (BMP) laboratory (lab) test (a common blood test that measures levels	F 658	1. All residents on fluid restrictions have the potential to be affected by stated deficiency; no similar findings and/or negative effects have been identified by this alleged deficient practice. Resident (1) fluid intake will be accurately recorded on an intake and output form located in resident (1) room. Resident (1) care plan was reviewed and updated as deemed necessary. All residents on fluid restrictions have intake and output forms located in their rooms to ensure accurate recordings. All residents with fluid restricitions care plans have been reviewed and updated as deemed necessary. The DON provided inservice education on 04/23/25 to all staff regarding how to implement and manage fluid restrictions to include recording and documenting of intake into the EMR.	05/02/25

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F 658	Continued From page 8 of key electrolytes including sodium, glucose, and kidney function indicators) was not completed for one of one sampled resident (1) who had been diagnosed with a low sodium level (hyponatremia). Findings include: 1. Review of resident 1's electronic medical record revealed: *She was admitted on 7/18/22. *Her 1/21/25 Brief Interview of Mental Status assessment score was 10, which indicated she had moderate cognitive impairment. *Her diagnoses included: hypertension (high blood pressure), hypo-osmolality (a condition where bodily fluids have a lower-than-normal concentration of solutes, such as sodium and other electrolytes), and hyponatremia (low sodium), constipation, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. *She had physician orders: -On 5/3/24 to be given Arginaid supplement every day and evening shift. -On 10/29/24 to be weighed twice weekly on Wednesdays and Saturdays. -On 3/26/25 to be placed on a fluid restriction of 40 ounces (oz) or 1200 cubic centimeters (cc) per day for her low sodium level. -On 3/25/25 a BMP lab (a basic metabolic panel, a common blood test that measures levels of key electrolytes including sodium, glucose, and kidney function indicators that was to be completed on 3/31/25. *Her care plan indicated she had dementia related cognitive impairments, was dependent on staff to assist her with her activities of daily living including bathing, repositioning, dressing, personal hygiene, oral care, bathroom use, and	F 658	The nursing staff is required to record and document fluids into the EMR. The Interdisciplinary Team participate in a daily manager huddle to ensure awareness of residents placed on fluid restrictions. The DON or designee will conduct weekly audits for four four weeks and monthly for two months on all residents with an ordered fluid restriction to ensure proper documentation. The DON or designee will present findings and trends at monthly QAPI meetings for further review and considerations. Any adverse findings will be immediately addressed and corrected with nursing staff. 2. All residents have the potential to be affected by stated deficiency as all residents have diagnostic tests ordered as eeded by providers. Labs on resident (1) were completed on 04/10/25. All nursing staff are required to order, report, and reconcile diagnostic tests according to facility policy. The DON provided inservice reeducation regarding diagnostic test ordering protocol to include placement of order, report to provider, and reconciliation of completed diagnostics. The Interdisciplinary team participate in a daily manager huddle to ensure awareness of residents who have diagnostic tests ordered. Interdisciplinary team reviewed policy and updated as deemed necessary. The DON or designee will conduct weekly audits for four weeks and montly for two months on all residents with ordered diagnostic tests to ensure labs are completed per order. The DON or designee will present findings and trends at monthly QAPI meetings for further review and considerations.	

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F 658	Continued From page 9 eating setup and received a dietary supplement. *Her fluid intake documentation included the following fluid intake amounts: -On 3/26/25 a total of 240 cc. -On 3/27/25 a total of 540 cc. -On 3/28/25 a total of 260 cc. -On 3/29/25 a total of 450 cc. -On 3/30/25 a total of 380 cc. -On 3/31/25 a total of 400 cc. -On 4/1/25 a total of 240 cc. -On 4/2/25 a total of 800 cc. -On 4/3/25 a total of 730 cc. -On 4/4/25 a total of 190 cc. -On 4/5/25 a total of 330 cc. -On 4/6/25 a total of 300 cc. *Those were all below her daily allowed fluid amount of 1200 cc. Observation on 4/9/25 at 8:45 a.m. of resident 1 at the breakfast table revealed: *She had an almost empty coffee cup and a half-empty glass of juice on the table in front of her. *She required staff to cue her to eat and drink. Observation on 4/8/25 at 3:40 p.m. of resident 1's over-the-bed table in her room revealed: *A half empty glass of orange juice. *A half empty pitcher of water without ice. Observation on 4/9/25 at 7:35 a.m. of resident 1's room revealed two unopened individual-sized containers of Jello on her bedside table. Interview on 4/8/25 at 1:44 p.m. with resident 1's daughter revealed resident 1 took a "drink made up with something so her bed sores heal". Interview and record review on 4/8/25 at 2:51	F 658	Any adverse findings will be immediately addressed and corrected with nursing staff.	

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F 658	Continued From page 10 p.m. with certified nursing assistant (CNA)/certified medication aide (CMA) N revealed: *She was aware of three residents who had fluid restrictions, resident 1 was one of the three. *Residents who required fluid restrictions had a physician order for the specific restriction. -Activity staff members would "know [which residents had fluid restrictions]." -Dietary staff members would "know [which residents had fluid restrictions], as [those residents were] only allowed so much [fluids] at breakfast, lunch, and supper." -Nursing did not document any fluids consumed by residents on fluid restrictions as they "only give enough [fluid] to swallow [the] medication." *Staff were "alerted" to which residents were on fluid restrictions at staff huddles (meetings). *She thought resident 1 was on a 1500 cc fluid restriction. -She reviewed resident 1's EMR and then stated, "She is on 40 ounces, 8 ounces with each meal and two 8 ounces outside of meals". Interview on 4/8/25 at 3:12 p.m. with dietary manager G regarding residents' fluid restrictions revealed: *The cooks were to document the resident's fluid intake during mealtimes. *CNA's were to document the residents' fluid intakes "when they collect water pitchers, they measure [the amount consumed] and document." *Activities staff were to document consumed fluid amounts for residents on fluid restrictions also. Interview on 4/9/25 at 8:35 a.m. with CNA/CMA L revealed: *The water pitchers were passed to the resident rooms at 4:00 a.m. and 2:00 p.m.	F 658		

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*The CNAs were responsible for documenting residents' fluid intakes not consumed at meals in the residents' EMR.
*She was aware resident 1 was on a fluid restrictions since she returned from her most recent hospitalization.
*Water pitchers were not to be provided to residents on a fluid restriction.
*The nurses should have informed the CNAs how much fluid a resident may receive when on a fluid restriction.
*Resident 1 received a supplement at 10:00 a.m. and it was to be documented as fluid intake in the EMR by the nurse.
*She was not aware that Jello should be counted as a fluid, she indicated she documented Jello as a snack.

Interview on 4/9/25 at 8:48 a.m. with CNA Q revealed:
*If a resident was on a fluid restriction he would limit the resident's fluid intake.
*He indicated resident 1 was on a fluid restriction.
*When a resident was on a fluid restriction a water pitcher should not be provided in the resident's room.
*He documented a resident's fluids intake consumed outside of meals in the resident's EMR.

Interview on 4/9/25 at 9:39 a.m. with CNA/CMA N revealed:
*Resident 1's Arginaid supplement was documented on the treatment administration record (TAR).
*The nurse on duty was responsible for completing the TAR documentation.

Interview on 4/9/25 at 9:50 a.m. with director of

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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 658	Continued From page 12	F 658		

nursing (DON) B revealed:
*Resident 1's fluid restriction information was passed on to staff during the nursing shift report.
*There was no documentation to verify when or what resident information was passed on during those nurse shift reports.
-Resident 1's 3/25/25 physician ordered BMP lab that was to be completed on 3/31/25 was not completed as ordered.

Interview on 4/9/25 at 10:35 a.m. with licensed practical nurse (LPN) F revealed:
*The nurses were responsible for completing the TAR documentation.
*The kitchen would bring resident 1's Arginaid supplement to the nurse's station and the CNAs would distribute the supplement to the resident.
-The nurses would document that the Arginaid was administered to the resident in their EMR, but the nurses would not administer it or document how much the resident drank.
-The CNAs were responsible for documenting the resident's fluid intake that resulted from the administration of the supplement in the EMR.
*She verified the nurses would document on the fluid restriction order in the resident's TAR.
-She indicated that documentation of the resident's fluid restriction in the TAR was the nurse's acknowledgement that the resident was on the fluid restriction not that the nurse had monitored the resident's fluid intake.
*It was her expectation that a resident on a fluid restriction only received a partial pitcher of water in the resident's room.

Interview on 4/9/25 at 10:40 a.m. with CNA/CMA N revealed:
*Resident 1 did not have a designated task in the EMR to document the amount she consumed of

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F 658	Continued From page 13 her Arginaid supplement. *She verified not all fluid intake was documented in the resident's EMR. *She verified CNA documentation of resident's fluid intake was inconsistent and on some days there was no CNA charting of resident fluid intakes. *She indicated a resident on a fluid restriction should not have a pitcher of water in the resident's room. *She stated there was no way for a CNA to know how much fluid intake a resident had consumed in order to determine if the resident had exceeded the maximum ordered fluid intake allowed for the day. A fluid restriction policy was requested from DON B but was not provided by the end of the survey.	F 658		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 686	All residents have potential to be affected by stated deficiency; no similar findings have been identified by this alleged deficient practice. Resident (1) has been evaluated by OT for appropriate use of interventions to relieve current and prevent future pressure ulcers. Resident (1) recieved a wound evaluation on 04/10/25 and received appropriate orders from physician. Resident (1) care plan was reviewed and updated as deemed necessary with proper documentation reflecting the care and the effect of the interventions. The DON conducted an inservice education on 04/23/25 with nursing staff on pressure ulcer prevention and management. Per policy staff are required to use the risk management tools (Braden Scale) and conduct weekly skin assessments. The facility provides modifying	05/02/25

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F 686	Continued From page 14 and policy review, the provider failed to implement pressure ulcer prevention interventions for one of one sampled resident (1) identified at risk for pressure ulcers who developed a pressure ulcer to her spinal area. Findings include: 1. Observation on 4/7/25 at 2:48 p.m. of resident 1 in her room revealed: *She was lying on her back in her bed. *She was very thin in appearance. *There were Prevalon boots (cushioned boots used to decrease heel pressure) on the floor next to her closet. *There was a cushion in the seat of her wheelchair. 2. Review of resident 1's electronic medical record revealed: *She was admitted on 7/18/22. *Her 1/21/25 Brief Interview of Mental Status assessment score was 10, which indicated she had moderate cognitive impairment. *Her 1/18/25 Braden Scale for Predicting Pressure Sore Risk assessment indicated she was "At Risk" for the development of a pressure ulcer. *Her physician orders indicated: -On 5/22/24 to use pressure relieving mattress on her bed. -On 11/22/24 to use a pressure relieving cushion in her wheelchair. -On 11/19/24 a reminder to change the resident's position frequently. -On 11/7/24 a skin assessment was to be completed weekly. -On 3/5/25 to off load the resident's heels when she was in bed as needed to prevent skin	F 686	environmental control measures, such as pressure-reducing mattresses and consultations with a wound care specialist or consultant as needed. Interdisciplinary team reviewed policy and updated as deemed necessary. The Interdisciplinary Team participate in daily manager huddles to ensure awareness of residents who have active skin issues. The DON or designee will audit skin assessments weekly for four weeks and monthly for two months to ensure compliance with proper documentation. The DON or designee will present findings and trends at monthly QAPI meetings for further review and considerations. Any adverse findings will be immediately addressed and corrected with nursing staff.	

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F 686	Continued From page 15	F 686		

breakdown.
-On 4/8/25 "On open areas of [the] spine area, use wound cleanser, pat dry. APPLY XEROFORM ONLY TO THE OPEN AREAS. Cover [the] area with ABD [abdominal gauze] pad and use soft silicone Tape to apply to the skin. Change daily and PRN. Document wound condition."
-On 4/8/25 "STRICT OFFSETTING Q [every] 2 HRS TO KEEP RESIDENT OFF HER BACK. Every 2 hours for Wound injury to spine area."

*Her care plan included:
-Her care plan indicated she had dementia related cognitive impairments, was dependent on staff to assist her with her activities of daily living including bathing, repositioning, dressing, personal hygiene, oral care, bathroom use, and eating set up and received dietary supplement.
-A 1/8/25 revised focus area that she had the potential for pressure ulcer development related to her limited mobility.
--Interventions for that focus area included: encouragement and assistance with the use of assist bars on her bed to assist with turning and repositioning. "Education given about importance of offloading pressure, refuses to offload pressure and lay down throughout day", follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor nutritional status, monitor intake and record, pressure relieving cushion to wheelchair and mattress to bed, protect heels from pressure, use padding to help prevent pressure areas, 11/22/24 intervention of "Sacral dish cushion placed on [the] backrest [her] of WC [wheelchair] at an elevated position to assist in pressure relief per OT [occupational therapy]."

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*Her kardex included "Sacral dish cushion on backrest of WC at an elevated position to assist in pressure relief per OT."

*A 3/23/25 progress note completed by the dietician revealed resident 1 "is a 83 y.o. [year old] female with a BMI of 17 (underweight) that presents with COPD [chronic obstructive pulmonary disease] on a regular diet. Inadequate intake related to decreased appetite as evidence by 50% avg [average] meal completion with wt [weight] change of -5.0% change over 30 days (Comparison Weight 2/19/2025, 104 Lbs [pounds], -12.5%, -13 Lbs). Encourage meal completion of >= [greater than or equal to] 65% and a nutritional supplement BID [twice daily]."
-The dietician's progress note did not address past or current skin conditions or the risk for the redevelopment of pressure ulcers.

*Review of Resident 1's skin assessments revealed:
-Her 11/20/24 skin assessment indicated "mid spine between the shoulder blades on the boney [bony] prominence she now has an open area that is 2.0 cm [centimeters] x [by] 1.0 cm" and she had an alternating pressure relieving mattress on her bed.
-Her 3/5/25 skin assessment indicated she had a "slight pink area on the mid upper spine."
-Her 4/8/25 skin assessment indicated, "Wound location: Spine, skin trauma/skin tear. Full thickness ...total length is 8.0 cm width 2.2 cm and depth 0.1 cm ...She has two open areas that are adjoining together. Suspected deep tissue injury on [the] surrounding area."

*Review of the resident's pain assessments in the EMR revealed she was last documented as being

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F 686	Continued From page 17 assessed for pain on 4/4/25 at 3:12 p.m. when she indicated her pain was "0" on a scale from zero to ten (0-10). 3. Phone interview on 4/8/25 at 1:45 p.m. with resident 1's daughter revealed: *She felt her mother had "taken a turn for the worse." *Resident 1 did not want to eat by herself and wanted to lie in bed all the time. 4. Interview on 4/8/25 at 3:30 p.m. with licensed practical nurse (LPN) F regarding resident 1 and pressure ulcer prevention revealed: *LPN F was wound certified and was able to document and initiate treatment for wounds under the guidance of a wound specialist and the resident's physician. *Resident 1 had a newly identified pressure ulcer on her back along her spine. *She indicated there were two open skin wounds over the resident's spine with the edges of the skin rolled back and the skin edges were black in color. *The area surrounding the open wound was dark red to purple which she identified as a suspected deep tissue injury (underlying tissue injury due to prolonged pressure). *LPN F stated resident 1 preferred to lie on her back and had been noncompliant with the use of wedges for positioning to relieve pressure. *She had a cushion in the seat of her wheelchair. *There was no cushion for the back of resident 1's wheelchair that LPN F was aware of. *Resident 1 did not have a specialized mattress on her bed, but LPN F had requested an alternating pressure relieving mattress be applied to resident 1's bed due to her newly developed pressure ulcer on 4/8/25.	F 686		

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F 686	Continued From page 18 *She had implemented a "strict" repositioning schedule for resident 1 after that pressure was identified. *She indicated that when a pressure ulcer was identified she notified the resident's physician, the resident's family and the director of nursing (DON). *The dietary manager would only be notified if the physician had ordered a dietary supplement. 5. Observation on 4/8/25 at 3:40 p.m. of resident 1 in her room revealed: *She was lying on her side with the wedge cushion behind her back. *The bones of her spine could be visualized through her shirt. *She did not have a specialized mattress on her bed. *She had Prevalon boots on both feet. *Her wheelchair had a cushion on the seat of the chair. *There was no cushion or added protection on the back of her wheelchair. 6. Interview on 4/9/25 at 7:35 a.m. with certified nurse aide (CNA)/certified medication aide (CMA) N regarding resident 1 revealed: *She was not aware that resident 1 had a pressure ulcer previously. *She was not aware that resident 1 was to have a sacral dish cushion in her wheelchair to decrease pressure to her back. *She indicated the only cushion resident 1 used in her wheelchair was the cushion on the seat. *Staff would reposition her in bed but resident 1 was noncompliant and would often remove the wedge cushion and lie on her back. 7. Interview on 4/9/25 at 8:35 a.m. with CNA/CMA	F 686		

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F 686	Continued From page 19	F 686		

L regarding resident 1 revealed:
*Staff would lay resident 1 down after meals, apply Prevalon boots to her heels and turn her from side to side while she was in bed.
*She indicated the Prevalon boots were a new intervention started about three days ago.
*She indicated resident 1 did not like to be repositioned.
*She was not aware of previous open skin areas to resident 1's back, but stated she had an open area to her buttocks previously.
*She indicated resident 1 previously had a cushion for her back in her wheelchair but it was no longer available.

8. Interview on 4/9/25 at 8:48 a.m. with CNA Q revealed:
*Resident 1 used to have a cushion for her back in her wheelchair.
*Therapy had removed the cushion because she was sliding down in her wheelchair.
*There were no alternate pressure relieving interventions put in place when that cushion was removed.

9. The occupational therapist was not available during the survey for interview related to the sacral dish cushion for the resident's wheelchair.

10. Interview and review of the provider's undated Nursing Skin Care Protocol on 4/9/25 at 12:05 p.m. with DON B revealed she:
*Was aware of resident 1's previous skin issues on her back but was unsure if they were pressure ulcers.
*Indicated she would have to review resident 1's care plan to determine what pressure prevention interventions were in place prior to resident 1's development of her current pressure ulcer on

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F 686	Continued From page 20 4/8/25. *Recalled resident 1 had wedge cushions to be used for repositioning in bed but resident 1 had been noncompliant with the use of them. *Expected if the sacral dish cushion was in her care plan to decrease pressure to her back, the staff should have followed the resident's care plan. *Was not aware that staff were no longer using the sacral dish cushion when the resident was in her wheelchair. *Expected the charge nurse to request an occupational therapy evaluation if it was determined the current interventions were needed to be changed related to the sacral dish cushion. *Indicated the Nursing Skin Care Protocol was the policy the facility used related to skin issues and pressure ulcers. *Stated, after reviewing the Nursing Skin Care Protocol, the protocol was not up to date and did not reflect the provider's current process. -She believed the process on the Nursing Skin Care Protocol was prior to the implementation of the EMR. 11. Review of the provider's undated Nursing Skin Care Protocol revealed: *"All skin care issues require the assessment of the resident's overall clinical status using the following guide. -1. Complete the skin assessment tool (Braden) and communicate the results in a Progress note (under skin/wound note) with notification to the CNA with guidance for turn reposition if indicated. -2. Assess the skin care issue and document findings in the progress notes (under skin/wound note). -3. Review causative factors and implement preventative/pressure relief devices if indicated.	F 686		

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F 686	Continued From page 21 (document in skin/wound note) -4. PCP [primary care provider] notification of skin care issues and obtain treatment order. DO NOT classify an ulcer as pressure without PCP consultation. (document notification in skin/wound note) -5. Notify DON, Dietary Manager, and MDS [Minimum Data Set] Coordinator of skin care issues via email. (document notification in skin/wound note) -6. Recommended appropriate diet changes: Registered Dietician will perform a nutritional needs needs assessment/ (document notification skin/wound note) -7. Review resident's pain level (pain tool) and implement/revise/continue and individualized pan [pain] management program. (document pain level in skin/wound note) -8. Notify family/responsible person with condition changes. (Document notification in skin/wound note) -9. Daily and weekly narrative documentation is required (see criteria and examples for each.) Skin sheets will be completed if: a. The resident has a significant bruise b. The resident has an open wound or skin tear c. The resident has a suspected deep tissue injury d. The resident has any skin issues requiring follow-up or treatment -10. Document education given to family/resident and response to the education. -11. Notify PCP and family/resident at 14 days s/p [status post] "no response" to treatment. Change in treatment plan may be indicated if not improvement is observed. (Document notifications in the progress note under skin/wound note.)"	F 686		

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F 760	Continued From page 22	F 760		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to ensure one of one sampled resident (1) was free from a significant medication error that involved a controlled medication (medications with risk for abuse and addiction) that she did not have orders to receive. She required an emergency room (ER) evaluation and treatment related to a change in her condition. Findings include: 1. Review of the provider's 3/25/25 SD DOH FRI regarding resident 1 revealed: *Staff found resident 1 unresponsive, "shaking", with a "weak pulse" and a blood pressure of 81/47. -She was transported to the ER by ambulance. *A drug screen was performed at the ER. -The drug screen indicated resident 1 had a benzodiazepine (sedative) medication in her system. -Resident 1 was not on a prescribed benzodiazepine medication. *Resident 1 was returned to the facility via ambulance on 3/25/25 at 4:00 p.m. *The provider did not identify when or how resident 1 received a benzodiazepine that was not prescribed to her. Administrator A, licensed practical nurse (LPN) H,	F 760	All residents have the potential to be affected by stated deficiency; no similar findings have been identified by this alleged deficient practice. Resident (1) is alleged to have been affected by significant medication error. Resident (1) was seen at the hospital for a seizure like episode and treatment was not deemed necessary for an alleged medication error. A thorough investigation of a medication error was completed to ensure resident was safe and not at harm for a medication error. Investigation revealed all benzodiazepines were accounted for and no aversions from best practice discovered. During investigation Administration Record was audited and all medications were accounted for. Resident (1) medication was reviewed by physician and unnecessary medications were discontinued. Resident (1) care plan was reviewed and updated as deemed necessary. The DON conducted an inservice education on 04/23/25 with nursing staff on the proper medication administration regulations and policy. The DON conducts routine mediciation reviews with the pharmacist. Medication Administration policies have been reviewed by the Administrator, DON, and MD. The Interdisciplinary Team participate in a daily huddl to ensure awareness of Psychotropic and pertinent medication changes. The DON or designee will conduct medication administration audits weekly for four weeks and monthly for two months.	05/02/25

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F 760	Continued From page 23 and registered nurse (RN) I had completed the investigation for the SD DOH FRI, but were not available for interview. 2. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on 7/18/22. *Her 1/21/25 Brief Interview of Mental Status assessment score was 10, which indicated she had moderate cognitive impairment. *Her diagnoses included: Chronic Obstructive pulmonary disease, hypertension, hypo-osmolality and Hyponatremia, constipation, insomnia, emphysema, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, respiratory failure, osteoporosis, atelectasis. *Her physician orders indicated the medications she was prescribed were: -"Calcium-Vitamin D Tablet 600-400 MG-UNIT [milligrams-unit] (Calcium Carb-Cholecalciferol) Give 1 tablet by mouth two times a day". -"Fluticasone-Umeclidin-Vilant Aerosol Powder Breath Activated [inhaler used to treat breathing issues] 100-62.5-25 MCG/INH [micrograms/inhalation] 1 puff inhale orally one time a day" -"Psyllium Husk Powder Give 1 Tbsp [tablespoon] by mouth one time daily for constipation". -"Citalopram Hydrobromide [anti-depressant medication] Oral Tablet 10 MG Give 10 mg by mouth one time a day related to ANXIETY DISORDER". *Resident 1's EMR indicated she was to receive her medications whole. *According to resident 1's medication administration record (MAR) on 3/25/25 at 8:08 a.m. resident 1 received her Calcium-Vitamin D tablet, citalopram, psyllium husk powder, and her	F 760	The DON or designee will present all findings and trends at monthly QAPI meeting for further review and considerations. Any adverse findings will be immediately addressed and corrected with nursing staff.	

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inhaler from certified nurse assistant/ certified medication aide (CNA/CMA) N.

Review of resident 1's progress notes revealed:
*On 3/25/25 at 10:35 a.m. licensed practical nurse (LPN) F was called to the activity room where she witnessed resident 1 "shaking, having almost seizure like activity. Non responsive. Vitals taken, O2 sats [oxygen saturation] dropping. BP [blood pressure] 81/47. Arms limp. Pupils fixed non reactive. Shallow breathing. Sudden onset."
*On 3/25/25 at 10:37 a.m. LPN F documented in a progress note, "Ambulance called and hospital called."
*Resident 1 left in the ambulance at 11:02 a.m. with emergency medical services (EMS) staff.
*On 3/25/25 at 3:38 p.m. "Received report from ER, She [resident 1] was found to have benzodiazepines in her system. She continues to be very lethargic and unable to sit up in [a] wheelchair, she was sent back to the facility via ambulance. She is on oxygen via NC [nasal cannula] and [an] order has been placed to monitor resident status and vitals hourly until she returns to baseline, it is possible that she will return to baseline by morning per the ER staff. They gave her a 500ml [milliliter] bolus and has been on a normal saline drip [intravenous fluids]. She continues on Bactrim [antibiotic] for 2 more administrations. Her sodium is low at 121- they are not going to do anything to treat it, daughter [name] was in the ER with her and was in agreement with that. She is back in the facility since 1500 [3:00 p.m.]. She arrived back via ambulance in [a] hospital gown, they cut her clothes off of her upon arrival to the ER. Her vitals are stable, O2 [oxygen] 91% on 4L [liters] via NC, BP 153/66, HR [heart rate] 91, T [temperature] 97.6 [degrees Fahrenheit]. She is in bed sleeping

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F 760	Continued From page 25 at this time. Review of the 3/25/25 ambulance report regarding resident 1 revealed: *Resident 1 was "foaming [at the] mouth on sight". *Her oxygen was increased from 2L to 4L. *Her pupils were nonreactive to light. *Her skin was cold to the touch. *At 11:19 a.m. resident 1 opened her eyes. *At 11:23 a.m. resident 1 "moans/groans". *They arrived at the hospital with resident 1 at 11:25 a.m. Review of the 3/25/25 Emergency Room Note regarding resident 1 revealed: *EMS had reported oxygen saturations (O2 level in blood) between 50% and 70%. *During the assessment in the emergency room resident 1 withdrew from painful stimuli and as the examination progressed, she became more alert. *She began to smile and attempt to answer questions. *Physical examination noted "Patient appears obtunded [slowed responses and not alert]." *Resident 1's urine drug screen was positive for benzodiazepines. *Her problem list indicated "Drug ingestion, accidental". *The emergency department plan indicated "It does appear she has ingested a benzodiazepine. Not on her medical record. Administration at [the] nursing facility was advised and are investigating/reporting [the] medication error resulting in [the] hospital visit." Review of resident 1's 3/26/25 repeat urine drug screen revealed she had tested positive for	F 760		

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F 760	Continued From page 26 benzodiazepines. 3. Review of records regarding residents who resided at the facility with a physician's order for a benzodiazepine medication revealed: *There were six residents prescribed benzodiazepines. -Two of those residents were prescribed clonazepam (a controlled medication used to treat anxiety). -Four of those residents were prescribed lorazepam (a controlled medication used to treat anxiety). *Two residents were documented as having received their ordered benzodiazepine medication in the morning of 3/25/25 as follows: -Resident 2 received lorazepam at 7:36 a.m. on 3/25/25. -Resident 3 received clonazepam at 8:03 a.m. on 3/25/25. 4. Interview on 4/7/25 at 4:33 p.m. with certified nursing assistant (CNA)/certified medication side (CMA) N revealed: *On 3/25/25 at 8:08 a.m. she had crushed resident 1's medications, put them in pudding, and administered them to her in the dining room. *She indicated resident 1 was "fine" at that time. *At approximately 10:00 a.m. activities director O came out of the activity room to alert staff of a change in resident 1's condition. *CNA/CMA N responded with LPN F to the activity room where resident 1 was noted to be unresponsive, her face was gray, and her lips were blue. *CNA/CMA N was unable to feel a pulse in resident 1's wrist. LPN F was able to feel a pulse in resident 1's neck. *Resident 1's oxygen was on.	F 760		

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*LPN F performed a sternal rub (firmly rubbing the breastbone with knuckles to assess response) with no response from resident 1.
*CNA/CMA N stated she "knew" she had not given resident 1 a benzodiazepine because resident 1 was not near anyone who received a benzodiazepine at the time her morning medications were administered to her.
*She indicated she did not know how resident 1 could have taken a benzodiazepine unless the night nurse had given her someone else's medication.

5. Interview on 4/7/25 at 4:47 p.m. with activities director O revealed:
*On 3/25/25 resident 1 was in the activity room while other residents played Yahtzee (a dice game) after breakfast.
*Activities director O stated that resident 1 usually played Yahtzee but had not that day or a couple of days prior.
*There was no food or drink in the activity room during that time.
*Activities director O stated she was alerted by another resident that resident 1 had "tightened up".
*Once she saw resident 1, she went out to the nurse's station to get help from the nurse.

6. Interview on 4/8/25 at 8:17 a.m. with LPN F revealed:
*She was the charge nurse on 3/25/25 when resident 1 was sent to the ER.
*She stated when she saw resident 1 in the activity room the resident was shaking, her lips were blue, her blood pressure was low, her pulse varied, her oxygen saturations were low, her fingers were blue, and her pupils were pinpoint in size and did not react to light.

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F 760	Continued From page 28 *Staff assisted resident 1 to her room to lie her down and the ambulance was called and transported her to the ER. *The hospital later called with a report and informed the facility staff that resident 1 had tested positive for benzodiazepines in her urine. *During the investigation of that incident RN I asked LPN F about medications having been brought in by a visitor and given to resident 1. *LPN F indicated the only visitor resident 1 had was her daughter and she had not been in the facility since the Thursday prior [3/20/25]. *LPN F stated resident 1's room was searched for medications, and none were found. *LPN F indicated RN I and LPN H had not reviewed the controlled medications in the medication carts after the facility staff were notified that resident 1 had tested positive for benzodiazepines. *LPN F indicated she was not sure how resident 1 had received a benzodiazepine but it could have possibly been a medication error. *When asked about resident 1's mealtime tablemates she stated resident 1 sat with one other resident, resident 4, and resident 4 was not prescribed a benzodiazepine medication. 7. Interview on 4/8/25 at 9:50 a.m. with environmental services staff K revealed: *She had, at times, found medications in residents' rooms when she cleans the rooms. *When she found a medication, she took it to the charge nurse. 8. Interview on 4/8/25 at 9:55 a.m. with doctor C revealed he: *Was resident 1's primary physician. *Was aware of resident 1's unresponsive episode on 3/25/25 that resulted in an ER visit where she	F 760		

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tested positive for benzodiazepines.
*Verified Citalopram or any of the resident's other prescribed medications would not have caused a false positive benzodiazepine level in the urine.
*Verified resident 1 did not have an impaired liver or kidneys that may alter the absorption or elimination of a benzodiazepine.
*Reviewed the ambulance report and indicated none of the staff on the ambulance during resident 1's transfer to the ER were able to administer medications.
*Indicated that the ambulance does not have a benzodiazepine available in its medication box.
*Indicated resident 1's sodium level alone would not have caused the symptoms that she had that day.
*Felt resident 1 had a reaction to a medication she was not supposed to have received.

9. Interview on 4/8/25 at 1:45 p.m. with resident 1's daughter revealed:
*The nurse practitioner (NP) at the hospital ER had told her, "Someone gave her a sedative".
*She stated the NP told her she was going to report the incident because mistakes could happen, but this mistake should not have happened.
*She did not know how her mother could have gotten a medication she was not prescribed.
*She did not feel her mother would ever willingly take another resident's medications because she did not like taking medications.
*She felt her mother had declined since she was sent to the ER on 3/25/25.

10. Interview on 4/8/25 at 1:59 p.m. with consultant pharmacist E revealed:
*He confirmed resident 1 was not prescribed a benzodiazepine.

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F 760	Continued From page 30 *Resident 1 was not prescribed a medication that would have resulted in a positive for a benzodiazepine in her urine *He indicated lorazepam would start taking effect in about 15 to 40 minutes after administration and the effects would last about six hours. *Clonazepam would start taking effect in about 30 to 40 minutes after administration and the effects would last up to a day later. *He did not think the medication had been administered the night before because of the time of the onset of resident 1's symptoms. Continued interview on 4/8/25 at 4:07 p.m. with consultant pharmacist E revealed: *He felt lorazepam was more likely to have been the benzodiazepine ingested by resident 1 rather than clonazepam due to the length of time the symptoms lasted. *He stated he had reached out to a laboratory, and they had indicated clonazepam, and lorazepam could remain detectable in the resident's urine for one to five days after ingestion. *After he reviewed resident 1's urine drug tests, he felt there had been one or very few administrations of the benzodiazepine because of the amount of time resident 1 remained positive. 11. Interview on 4/9/25 at 11:13 a.m. with director of nursing (DON) B revealed: *She was not in the facility on 3/25/25 but did provide phone consultation to administrator A and RN I related to resident 1's event. *When she was notified of the incident, she advised RN I to be sure resident 1 had not received another resident's medication. *DON B sent administrator A a list of medications that may cause a false positive for	F 760		

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benzodiazepines in a urine drug screen.
*She advised administrator A and RN I to consult a pharmacist regarding resident 1's event.
*She indicated, although resident 4 did not have a prescribed benzodiazepine, resident 1 was moved from her table in the dining room because resident 4 liked to share her food and they wanted to be sure there was no chance that resident 1 could have received something from her.
*Resident 4 was the only resident at the breakfast table with resident 1's on 3/25/25 and there were no other residents at nearby tables that were prescribed a benzodiazepine medication.
*DON B reported resident 1's room was searched while resident 1 was in the ER and there were no medications found.
*She indicated they were not able to identify how resident 1 could have taken or been given a benzodiazepine.
-The possibilities that were identified included a family member, the hospital staff, the ambulance staff, or a medication error by the facility staff, but those were all "speculation".
*She agreed that a resident receiving a benzodiazepine that was not prescribed for that resident is a medication error.
*She indicated administration had not investigated the time between resident 1 receiving her morning medications and the onset of her symptoms to determine the potential time the resident would have received the medication.
*She stated that they had concluded the onset of symptoms was variable after their discussion with the pharmacist during their investigation.

12. Review of the provider's undated Medication Administration- Required and Critical Performance Criteria policy revealed:

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F 760	Continued From page 32 *"The CMA will administer oral ... ...medications utilizing the following criteria. -1. Check the Medication Administration Record (MAR) against the physician orders as recommended by the facility. -4. Perform 3 checks on each medication. -8. Safely administer medications to resident utilizing the 7 rights of administration --a. Right drug --b. Right dose --c. Right patient/resident --d. Right route --e. Right time --f. Right technique --g, Right documentation -9. Ensure that all oral medication as offered is swallowed by the resident." Review of the provider's undated Medication Error Reporting policy revealed: *"Includes: -Wrong Medication -Wrong Person -Wrong Dose -Wrong Route -Missed Medication" Review of the provider's undated Medication Management Policy revealed: *"Medications will be administered to residents as prescribed". *"Medications are administered in accordance with written orders of the attending physician or physician extender." *"Residents are identified before medication is administered. Methods of identification include: -a. Checking photograph attached to medical record. -b. Asking a resident to say and/or spell his/her	F 760		

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F 760	Continued From page 33 name. -c. If necessary, verify resident identification with other facility personnel." *"Medications supplied for one resident are never administered to another resident." *"The resident is always observed after administration to ensure that the dose was completely ingested."	F 760		
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 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:	F 761	Unathorized individuals are not permitted to enter the medication storage room without being attended by an authorized individual. The Director of Nursing and Administrator educated the Director of Maintenance he is not to enter the medication storage room without being accompanied by an authorized individual. The DON or designee will conduct random weekly audits to ensure entry into the medication room are by authorized individuals for four weeks and monthly for two months. The DON or designee will present findings and trends at monthly QAPI meetings for further review and consideration.	05/02/25

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F 761	Continued From page 34 Based on record review, interview, and policy review, the provider failed to ensure medications were securely stored and inaccessible to unauthorized individuals including: *Two of two unauthorized individuals (administrator A and maintenance director M) who had access to one of one medication room where controlled medications (medications at risk for abuse and addiction) were stored in an unsecured manner. *One of one certified nursing assistant (CNA)/certified medication aide (CMA) N who had not securely stored the keys to one of two medication cart and a drawer where controlled medications were stored for two of two observations. Findings include: 1. Observation on 4/7/25 at 2:40 p.m. of the medication carts near the nurse's station revealed: *The keys to open one of the two medication carts were stored on an open shelf on the side of the medication cart beside the water cups. -Those were accessible to visitors and unauthorized individuals. *There was no staff member present within sight of the medication carts. Interview on 4/7/25 at 2:43 p.m. with CNA/CMA N revealed: *She had left the keys on a shelf on the medication cart. *She verified those keys opened the north wing medication cart and that key ring also contained the keys to open the drawer where the controlled medications were stored. *She indicated it was not her normal practice to leave those keys unattended on the medication	F 761		

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cart.
*She indicated she usually kept the keys in her pocket.
*She verified the keys were accessible to anyone when they were stored on an open shelf on the side of the medication cart.

Observation on 4/8/25 at 8:36 a.m. of a medication cart in the west hallway revealed it was unlocked and there were no staff members in sight of the medication cart.

2. Observation on 4/7/25 at 2:57 p.m. of the medication room with licensed practical nurse (LPN) J revealed:
*The medication room was secured with a coded keypad on the door.
*The refrigerator in the medication room was not locked.
*In the unlocked refrigerator there was a lock box that contained a bottle of liquid lorazepam (a controlled anti-anxiety medication).
*That lock box in the refrigerator was not locked.

3. Interview on 4/7/25 at 4:33 p.m. with CNA/CMA N revealed the nurses, CMAs, administrator, and maintenance staff knew the code to enter the medication room where medications were stored.

4. Interview and observation on 4/8/25 at 8:17 a.m. with LPN F in the medication room revealed:
*She indicated the nurses, CMAs, administrator, and maintenance staff knew the keypad code to enter the medication room where medications were stored.
*She stated the code to the medication room had been changed one time, by maintenance, because the keypad needed to be changed. Prior to that the code was the same for years.

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F 761	Continued From page 36 *During the interview with LPN F, maintenance director M entered the medication room with the use of the keypad door code. *LPN F indicated maintenance director M previously had been in the medication room without the nursing staff being aware he was in there. *LPN F removed the lock box from the unlocked refrigerator in the medication room. *She verified the lock box was not locked, and that it contained lorazepam. 5. Interview on 4/9/25 at 7:30 a.m. with maintenance director M revealed: *He had changed the keypad codes to other doors within the facility but had never changed the code to the medication room's keypad. *He knew the keypad code to enter the medication room. *He went into the medication room to deliver pop for a resident, run water in the sink drain, and complete any maintenance required in the room. *He "at times" was in the medication room without another staff member present. 6. Interview on 4/9/25 at 11:39 a.m. with director of nursing (DON) B revealed: *She verified the nurses, CMAs, administrator A, and maintenance director M had access to the medication room where medications were stored. *Maintenance director M had keys to all the doors in the building, including the medication room, in case there was a fire, an emergency, or he needed to work on something such as plumbing or electricity. *She indicated administrator A also had access to every room in the facility. *DON B agreed administrator A and maintenance director M would have access to medications that	F 761		

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were stored in the medication room.
*She stated that the medications stored in the medication room were to be locked or in a medication cart except for the stock medications.
*She indicated administrator A and maintenance M should not have access to controlled medications.
*She was aware that the refrigerator in the medication room was not locked.
*She was not aware that the lock box for controlled medications in the refrigerator was not locked.
*She expected that lock box to be locked in order to secure the controlled medications from unauthorized access.
*It was her expectation that the keys for the medication carts would be in the CMAs' or nurses' pocket or locked in the medication cart to prevent access from unauthorized individuals.
*She would not expect the keys to be left unattended on an open shelf on the medication cart.

7. Review of the provider's undated Proper Storage, Usage and Documentation of Narcotics [controlled medications] policy revealed "Access to narcotic is to be by a licensed staff and Director of Nursing ONLY!"

Review of the provider's undated Medication Storage and Labeling policy revealed "Medications and biologicals will be stored in locations accessible only to designated staff."

Review of the provider's undated Medication Management policy revealed:
*"During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING _____ B. WING _____	C 04/09/2025

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 761	Continued From page 38 *"The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by."	F 761		