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 _____	11/03/2022

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 10/31/22 to 11/3/22. Five Counties Nursing Home was found not in compliance.with the following requirements: F700.	F 000	F 700 Residents # 4, 5, 21, 24, 25, 27, 28, 29, 33, and 27 have been evaluated for appropriateness of bed rails (assist bars). Risks and benefits have been reviewed with resident/resident representative and informed consent is obtained. The facility immediately implemented a consent form for the use of bed rails (assist bars) for current residents and for new admissions at time of admission to the facility. Consents will be obtained for all residents by November 30,2022. Staff education will take place November 30,2022 All residents have the potential to be affected by this deficiency. DON and Administrator reviewed and revised policy to include a consent form for use of bed rails along with risk/benefit and it was implemented on 11/3/2022. New admissions will be evaluated at time of admission by Social Services and consent will be offered if resident/resident representative choose to have assist bars. The DON or designee will be responsible for oversight of compliance and will monitor until substantial compliance is met. DON will conduct an audit monthly on new admissions and review chart for evaluation on assist bars. Audits will be done monthly x3 then as deemed necessary by QAPI committee. Findings of audit will be discussed at monthly QAPI meeting.	12/23/2022
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. §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 observation, interview, record review, and policy review the provider failed to ensure risk versus benefits education for resident and family or representative, informed consent from	F 700		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X5) DATE

ADMINISTRATOR 11-23-2022

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 _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE COUNTIES NURSING HOME	406 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 700	Continued From page 1 resident and family or representative, and physician acknowledgement for side rails had been completed and documented for 10 of 10 sampled residents (4, 5, 21, 24, 25, 27, 28, 29, 33, and 37) prior to the implementation of side rails. Findings include: 1. Observation and interview on 10/31/22 at 2:37 p.m. with resident 4 revealed: *There had been bilateral side rails attached to the upper portion of the bed in the up position. *Her 8/29/22 brief interview of mental status (BIMS) score was a 13, meaning she was cognitively intact. *She seldom used the side rails. *They had been attached to the bed when she was admitted on 5/5/22. Review of resident 4's medical record revealed her care plan included she used an assist bar [side rail] for turning and repositioning in bed. 2. Observation and interview on 11/1/22 at 9:27 a.m. with resident 37 and her daughter revealed: *Her daughter stated resident 37 had a brain tumor removed and did not remember things. *There had been bilateral side rails attached to the upper portion of the bed in the up position. *She used the side rails to help position herself when in bed and to get in and out of bed. *Her daughter did not remember receiving or signing a risk education versus benefit education and informed consent. Review of resident 37's medical record revealed: *Her 8/29/22 BIMS was 8, meaning she had moderate cognitive impairment. *She had been admitted on 6/1/22. *Her care plan included she used an assist bar	F 700	Resident # 4, 5, 21, 24, 25, 27, 28, 29, 33, and 27 continue to reside in facility with no ill effect. The listed above residents have been evaluated for appropriateness of bed rails (assist bars). Risks and benefits have been reviewed with resident/resident representative and informed consent is obtained. The facility will immediately implement a consent form for the use of bed rails (assist bars) for current residents, and for new admissions an assistive device assessment will be completed and if indicated, a consent form explaining risk/benefits will be obtained for use of bed rails. Bed rail use will be re-evaluated quarterly for appropriateness. Staff education will take place 11/29/22. The facility recognizes that all residents have the potential to be affected by this practice. The current policy is being reviewed and revised; an assistive device assessment (implemented 11/29/22) and consent form for use of bed rails along with risk/benefit was implemented on 11/3/2022. New admissions will be screened using the assistive device assessment to determine if there is a need/recommendation for use of assist bars by MDS nurse or designee and consent will be obtained if assist bars are appropriate. The DON or designee will be responsible for oversight of compliance and will monitor until substantial compliance is met. DON will conduct an audit monthly on new admissions and review chart for evaluation on assist bars. Audits will be done monthly x3 then as deemed necessary by QAPI committee. Findings of audit will be discussed at monthly QAPI meeting. Date of Correction: 11/29/22	12-2-22

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 _____	11/03/2022

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 700	Continued From page 2 for turning and repositioning in bed. 3. Observation 11/3/22 from 8:27 a.m. through 8:44 a.m. revealed residents' 5, 21, 24, 25, 27, 28, 29, and 33's rooms there had been bilateral side rails attached, to each of their beds, on the upper portion of the bed in the up position. 4. Interview on 11/2/22 at 11:45 a.m. with director of nursing B and social service designee P revealed there had not been risk education versus benefit education and informed consent completed with any residents who had side rails installed on their beds. 5. Interview on 11/2/22 at 4:45 p.m. with administrator A regarding the side rails revealed: *He had been aware that risk education versus benefit education and informed consent needed to be completed with all residents who had side rails installed on their beds. *He was not aware they had not been done. 6. Review of the provider's November 2018 assist bar [side rail] policy revealed: *"Policy statement: [Provider] will not routinely use half rails or transfer bars unless indicated by physician or therapist. Some beds are equipped with assist bars that residents can use for bed mobility." *The policy had not included that risk education versus benefit education and informed consent were required.	F 700		

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 _____	11/03/2022

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
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 from 10/31/22 through 11/3/22. Five Counties Nursing Home was found not in compliance with the following requirement: E0001.	E 000		
E 001 SS=D	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements.	E 001	E 001 Administrator, Maintenance Director and Qapi committee will review and revise the Emergency Preparedness plan to include the following: an all-hazards approach. Resident population, including person at-risk and type of services we have the ability to provide in an emergency, process for cooperation and collaboration with State and Federal emergency preparedness officials, plan or contractual agreement or	12/23/2022

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

[signature] ADMINISTRATOR 11-23-2022

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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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 _____	11/03/2022

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
E 001	Continued From page 1 The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on interview and emergency preparedness plan review, the provider failed to ensure a complete response plan had been developed and implemented. Findings include: Interview and emergency preparedness plan review on 11/2/22 at 4:00 p.m. with administrator A revealed: *There was not an all-hazards approach. *Resident population, including person at-risk and type of services the provider had ability to provide in an emergency was not identified. *There was not a process for cooperation and collaboration with State and Federal emergency preparedness officials developed. *There was no evidence of a plan or contractual agreement or arrangements with other long term care facilities to receive individuals in the event of any emergency limitations or ceasing of operation. -He believed that plan had been completed but was not aware of with whom or the facilities	E 001	arrangements with other long term care facilities to receive individuals in the event of any emergency limitations or ceasing of operation . The plan will include listing of names and contact information for residents, physicians, other long term care facilities and volunteers and contact information for the State Licensing and Certification Agency and the Office of the State Long Term Care Ombudsman, Means to provide information about their occupancy, needs, and its ability to help, to the authority with jurisdiction in an emergency. A method to share emergency plan information with residents and their families or representatives will be updated and added. A policies and procedures about Sewage and waste disposal will be included and documentation that protected confidentiality of resident information, security, and maintenance as well as availability of records. The plan will also include the use of volunteers or other emergency staffing strategies in an emergency. The Emergency Preparedness plan will be updated by December 23,2022. All residents have the ability to be affected by this deficiency. Maintenance Director and Administrator will bring the updated plan to the December Qapi meeting for review and recommendation.	

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 _____	11/03/2022

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
E 001	Continued From page 2 involved. *There was no listing of names and contact information for residents, physicians, other long term care facilities and volunteers. *Contact information for the State Licensing and Certification Agency and the Office of the State Long Term Care Ombudsman was not included. *There was not a means identified to provide information about their occupancy, needs, and its ability to help, to the authority with jurisdiction in an emergency. *There was no method to share emergency plan information with residents and their families or representatives. *There were no policies and procedures about: -Sewage and waste disposal. -Documentation that protected confidentiality of resident information, security and maintenance as well as availability of records. -Use of volunteers or other emergency staffing strategies in an emergency. *Administrator A agreed not all necessary items had been identified, developed, and implemented.	E 001		

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 _____	11/02/2022

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 with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/2/22. Five Counties Nursing Home (building 01) was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 11/8/22. 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 K291, 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	K 225		F

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

ADMINISTRATOR 11-23-2022

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	11/02/2022

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 of 22 inches between the swing of the door and the newel post in one of three stairwells (southwest stair enclosure). Findings include: 1. Observation on 11/2/22 at 2:32 p.m. and record review of the previous survey report dated 5/4/21 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	291	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain battery pack emergency lighting for three randomly observed locations (at the generator, boiler room, and basement storage). Findings include: 1. Observation on 11/2/22 at 8:52 a.m. revealed the battery pack emergency light for the storage room in the basement would not illuminate. Interview with the administrator at the time of the observation confirmed that finding. 2. Observation on 11/2/22 at 9:45 a.m. revealed the battery pack emergency light for the generator located inside the generator enclosure	K 291	Maintenance Director will replace or repair the Emergency lighting in the storage room, generator room, and the electrical room by the boiler room by December 23, 2022. Maintenance Director will also check all other emergency lighting to ensure compliance with this requirement by December 23, 2022. Any lights not meeting this compliance requirement will be replaced or repaired. All residents have the ability to be affected by this deficiency. Maintenance will then check all emergency lights weekly for 3 months to ensure compliance with this regulation. Maintenance will report the compliance with this regulation monthly in Qapi for 6 months.	12/23/2022

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 _____	**11/02/2022**

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 291	Continued From page 2 would not illuminate. Interview with the administrator at the time of the observation confirmed that finding. 3. Observation on 11/2/22 at 12:10 p.m. revealed the battery pack emergency light for the electrical room located adjacent to the boiler room would not illuminate. Interview with the administrator at the time of the observation confirmed that finding. The deficiencies affected three of numerous requirements for the emergency lighting system.	K 291	321	
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)	K 321	The wedge that was placed under the fire door was immediately removed and disposed of. Maintenance Director will make necessary repairs to the soiled utility door to ensure compliance with this requirement by December 23, 2022. Maintenance Director will also test all other fire doors in the building for compliance with this requirement by December 23, 2022. Any repairs needed will be completed by December 23, 2022. All residents have the ability to be affected by this deficiency. Maintenance will check all fire doors weekly for 3 months to ensure compliance. Maintenance will then check doors monthly on a continued with the Preventive Maintenance Program. Maintenance will bring results to Qapi for review and recommendation.	12/23/2022

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 _____	11/02/2022

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 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (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 two randomly observed hazardous areas (second floor laundry room and soiled utility room) as required. Findings include: 1. Observation on 11/2/22 at 9:15 a.m. revealed the second-floor laundry room door was equipped with a closer as required, but that closer had been defeated with a wedge placed under the door. That door would not maintain the required fire-rating for laundry room openings in that position. 2. Observation on 11/2/22 at 12:45 p.m. revealed the corridor door to the soiled utility room would not close and latch under the power of the doors automatic closer. Corridor doors to hazardous areas are required to close and latch into their door frames. Interview with the administrator at the time of the observations confirmed those findings. The deficiencies affected two of numerous requirements for hazardous storage rooms.	K 321		
K 374 SS=C	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors	K 374		F

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 01 - MAIN BUILDING 01 B. WING _____	11/02/2022

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 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the provider failed to maintain clear door widths of 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 11/2/22 at 1:30 p.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 5/4/21 revealed those doors were the original doors. The building meets the FSES. Please mark an "F" in the completion date column.	K 374		

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 _____	11/03/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/31/22 through 11/3/22. Five Counties Nursing Home was found not in compliance with the following requirements: S157, S206, S210, and S301.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in four randomly observed locations (housekeeping closet, bathroom for resident room 110, bathroom for resident room 112, and the main bathing room). Findings include: 1. Observation on 11/2/22 at 9:01 a.m. revealed the exhaust ventilation for the housekeeping closet was not functioning. A janitor's floor sink was also located in that room. Testing of the ventilation grille with tissue paper at the time of the observation confirmed that finding. 2. Observation on 11/2/22 at 9:04 a.m. revealed the exhaust ventilation for the bathroom of resident room 110, was not functioning. Testing of the ventilation grille with tissue paper at the time of the observation confirmed that finding. 3. Observation on 11/2/22 at 9:05 a.m. revealed	S 157	S 157 The exhaust ventilation in housekeeping closet , bathroom in resident rooms 110 and 112, along with the exhaust ventilation in the main bathing room will be assessed and repaired or replaced by local electrician, Stocks Electric. Stocks was contacted on 11/22/2022 and will came to the facility on 11/23/2022. All residents have the ability to be affected by this deficiency. An all-staff meeting will be held on November 30, 2022, to reeducate about this requirement. The maintenance director will verify that the rooms with exhaust ventilations are functioning properly by December 23,2022. If any vents are found faulty then Stocks will replace or repair. Maintenance director will then test 5 exhaust vents weekly after that for 1 month. Maintenance director will then test 5 exhaust vents monthly after that for 2 months. Monthly testing will be continued on the Preventative Maintenance Program. Maintenance director will report results monthly to Qapi for review and recommendation.	12/23/2022

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

ADMINISTRATOR | 11-23-2022

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 _____	11/03/2022

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

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S 157	Continued From page 1 the exhaust ventilation for the bathroom of resident room 112 was not functioning. Testing of the ventilation grille with tissue paper at the time of the observation confirmed that finding. 4. Observation on 11/2/22 at 1:18 p.m. revealed the exhaust ventilation for the main bathing room was not functioning. Testing of the ventilation grille with tissue paper at the time of the observation confirmed that finding. Interview with the administrator at the same times as those findings confirmed them. He revealed he was unaware as to why the exhaust ventilation was not working at those locations. Those rooms were required to have exhaust ventilation directed to the exterior of the building.	S 157	S206 Employee K will receive training on fire prevention, emergency preparedness, confidentiality of resident information, resident rights, abuse, neglect, misappropriation of resident property, and mistreatment by December 23,2022. Employee L will receive training on fire prevention by December 23, 2022.	
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (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;	S 206	Business Office Manager and Administrator will review and revise policies/procedures to ensure all employees are in compliance with this deficiency. All residents have the ability to be affected by this deficiency. An all-staff meeting will be held on November 30, 2022 to reeducate about this requirement. Business Office Manager will then audit 5 staff files monthly to ensure compliance with all education requirements. Business Office Manager will bring results to Qapi for review and recommendation. Business Office Manager will monitor the attendance of the all staff meeting and give the department heads and Administrator a list of who didn't attend. Education will be given to the staff by the Department head and/or will be included in the employee's paystub to ensure compliance. Business Office Manager will bring results to Qapi for review and recommendation.	12/23/2022

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S 206	Continued From page 2 (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section. Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel record review, interview, and policy review the provider failed to ensure two of two staff (K and L) hired in 2022 had received upon hire and/or continued training the following education. Findings include: Review of employee K's personnel record revealed: *He was hired 6/28/22 as an environmental services employee. -He had not received upon hire or to date, training in fire prevention, emergency preparedness, confidentiality of resident information, resident rights, abuse, neglect, misappropriation of resident property, and mistreatment. Review of employee L's personnel record revealed: *She was hired 1/18/22 as a registered nurse. -She had not received upon hire or to date, training in fire prevention. Interview on 11/1/22 at 5:05 p.m. with administrator A regarding training revealed:	S 206		

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S 206	Continued From page 3 *He was aware of the initial and ongoing training requirements. *He was not aware it had not been completed. Interview on 11/2/22 at 2:00 p.m. with business office manager I regarding employee training revealed: *She kept track of who had completed each training. *If an employee missed an in-person training, she would provide them written information on the topic. -They were required to read the information and sign an acknowledgement that they had done this. *She confirmed the above employees had not received the training. Review of provider's February 2020 personnel training policy revealed: *"Purpose: The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: -(1) Fire prevention and response." -(2) Emergency procedures and preparedness. -(3) Infection prevention and safety procedures." -"(6) Resident Rights." -"(9) Care of residents with unique needs. -(10) Dining assistance, nutritional risks, and hydration needs of residents." -(11) Abuse and Neglect/Dementia Management." Review of the provider's January 2021 revised pre-hire screening and education policy and procedure revealed: *"Policy: To ensure that every new	S 206		

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S 206	Continued From page 4 applicant/employee has been properly screened and trained prior to employment/assignment of duties." *"Procedures:" -"2. Staff training: --a. All new employees will be educated regarding the definitions of abuse, neglect and exploitation. They will be educated on signs and symptoms and who to report suspicious of abuse, neglect and exploitation." --"c. All new employees will have fire drill explanation and demonstration of what to do by Environmental Services Director. --d. All new employees will have an in-service with our Infection Control Preventionist regarding proper hand hygiene, PPE and ways to prevent infections. --"e. All staff will be annually trained through in-service on a variety of topics. If staff have an excused absence from the training, they will be required to review the materials with the department manager doing the training."	S 206	S210 Employee K and L will have their health evaluation completed by December 23, 2022. Business Office Manager and Nursing Director, and Administrator will review and revise policies/procedures as necessary to ensure all employees and future employees are in compliance with this deficiency. All employees have the abillty to be affected by this deficiency. An all-staff meeting will be held on November 30, 2022 to reeducate about this requirement. Business Office Manager will review all employees' files for compliance with this regulation by December 23, 2022. Business Office Manager will then audit 5 staff files monthly to ensure compliance with this regulation. Business Office Manager will bring results to Qapi for review and recommendation.	12/23/2022
S 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the	S 210		

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S 210	Continued From page 5 health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota Is not met as evidenced by: Based on personnel record review, interview, and policy review the provider failed to ensure two of three (K and L) recently hired employees had a health evaluation completed by a licensed health professional. Review of personnel records revealed: *Employee K had been hired on 6/28/22. *Employee L had been hired on 1/18/22. *There was not an employee health evaluation completed for either employee. Interview on 11/2/22 at 2:00 p.m. with business office manager I regarding employee health evaluations revealed: *She provided the health evaluation form to a nurse for new employees. -The nurse was to complete the form with the employee, sign it, and return it to her. *There was not a health evaluation completed for employees K and L. Review of the provider's Janaury 2021 revised health employee health program policy and procedure revealed: *"Policy: The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment.	S 210		

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S 210	Continued From page 6 -Procedures: --1. Health Questionnaire will be performed by a licensed nurse." --"4. After all forms completed, they will be kept in the employee's file in the Business Office."	S 210		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel record review, interview, and policy review, the provider failed to ensure annual education and training of dietary employees that included: *Five of five employees (C, D, E, M, and N) for food safety and serving and distribution of food. *Three of five employees (C, E, and M) for time and temperature controls of food. *Two of five employees (E and M) for sanitation. Findings include: Review of personnel records revealed: *Employees C, D, E, M, and N had not received food safety and serving and distribution of food training in the last year. *Employees C, E, and M had not received time and temperature controls of food training in the last year. *Employees E and M had not received sanitation	S 301	S301 Employees C, D, E, M, N will be reeducated on their required training for food safety and serving, distribution of food by December 23,2022. Employees C, E, M, will be reeducated their required training for time and temperature controls of food training by December 23, 2022. Employees E and M will be reeducated on their required training for sanitation by December 23, 2022. All residents have the ability to be affected by this deficiency. An all-staff meeting will be held on November 30, 2022, to reeducate about this requirement. Dietary Manager will complete a yearly Inservice schedule that will include the required topics. Dietary manager will report results of each monthly Inservice meeting including staff attendance in the next month's Qapi meeting. Dietary Manager will report results in Qapi by December 23, 2022.	12/23/2022

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S 301	Continued From page 7 training in the last year. Interview on 11/1/22 at 5:05 p.m. with administrator A regarding dietary training revealed: *The dietary manager had been responsible to ensure it was completed. *He was not aware it had not been completed. Interview on 11/2/22 at 8:31 a.m. with certified dietary manager F regarding training revealed she: *Was responsible to ensure the required initial and ongoing dietary training was completed. *Had not provided all the training due to being unavailable for medical reasons for the past two months. -No one else had provided the training. Review of provider's February 2020 personnel training policy revealed: *"Purpose: The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects:" -"(10) Dining assistance, nutritional risks, and hydration needs of residents." *The policy did not include the other required initial and annual dietary training topics. Review of the provider's Janaury 2021 revised pre-hire screening and education policy and procedure revealed: *"Policy: To ensure that every new applicant/employee has been properly screened and trained prior to employment/assignment of duties." *"Procedures."	S 301		

South Dakota Department of Health

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S 301	Continued From page 8 -"2. Staff training." --"e. All staff will be annually trained through in-service on a variety of topics. If staff have an excused absence from the training, they will be required to review the materials with the department manager doing the training." *The policy did not include the required initial and annual dietary training topics.	S 301		
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 10/31/22 through 11/3/22. Five Counties Nursing Home was found in compliance.	S 000		