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 ______	12/06/2023

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 12/4/23 through 12/6/23. Five Counties Nursing Home was found not in compliance with the following requirements: F625, F658, F678, F692, and F758 .	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 conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy	F 625	All residents have the ability to be affected by this deficiency. Resident #10 is back in the facility. All other residents out on a bed hold will be audited to ensure the bed hold notice was provided. Staff responsible for bed hold notices will be re-educated regarding the bed hold notice. Charge Nurse on Duty is responsible for obtaining bed holds upon transfer. DON or designee will ensure that the bed hold policy and form are introduced to the transfer packet to ensure compliance. DON or designee will conduct monthly audits for 3 months and will report findings at monthly QAPI meetings for review and recommendations.	01/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jordan Fish	Administrator	12/29/2023

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

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F 625	Continued From page 1 described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the bed hold notice was given upon the transfer on three separate dates for one of one sampled resident (10) to the hospital. Findings include: 1. Review of resident 10's electronic medical record (EMR) revealed: *On 3/30/23, he had been transferred to the hospital when staff was unable to keep his oxygen saturation levels above 90% on eight liters of oxygen. *On 4/6/23, he was transferred to the hospital at the request of his family representative when he had lost consciousness while transferring using a mechanical stand lift. *On 11/19/23, he was transferred to the hospital for intravenous (IV) antibiotics to treat cellulitis in his left leg. The bed hold forms were requested on 12/5/23 at 3:15 p.m. for the above three hospital transfers and the facility was not able to produce that documentation. Interview on 12/06/23 at 9:49 a.m. with interim director of nursing B revealed: *Her expectation would have been that all residents who were transferred out of the facility to an acute care provider would be given the bed hold policy and form by the nurse on duty at the time of transfer. *She would expect any resident that was unable to sign the bed hold policy at the time of the transfer, should have been given the bed hold policy and form to sign at the earliest possible	F 625		

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F 625	Continued From page 2 time, or the policy should have been given to the resident's representative to read and sign. Review of the provider's undated "BED HOLD POLICY" form revealed: *"POLICY" -"Five Counties will provide written information to the resident and a family member of legal representative of our Bed Hold Policy at the time of transfer to an acute care hospital or on therapeutic leave." *"PROCEDURE" -"The Charge Nurse at the time of transfer will provide a copy of the Bed Hold Policy to the resident or family member/responsible party."	F 625		
F 658 SS=E	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 observation, interview, record review, and policy review, the provided failed to ensure the following: *Post-fall monitoring was completed and documented in a timely manner for one of one sampled resident (26) who had fallen. *A physician's order was followed and suprapubic catheter cleaning and care at the insertion site was completed and documented for one of one sampled resident (11). *The use of a chair alarm was monitored and documented for one of one sampled resident (14) who required a chair alarm.	F 658	All residents have the ability to be affected by this deficiency. Resident #26 has made a full recovery. All other resident falls were audited since December 6, 2023 to ensure post fall monitoring was completed and documented in a timely manner. Staff responsible for post-fall monitoring will be re-educated on the post-fall monitoring requirements. Charge Nurse on Duty is responsible for post-fall monitoring. DON or designee will ensure compliance with post-fall monitoring and conduct weekly audits for 1 month, then monthly for 2 months. DON or designee will continue to report falls at monthly QAPI for review and recommendations.	01/20/2024

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F 658	Continued From page 3 Findings include: 1. Observation on 12/4/23 at 3:25 p.m. of resident 26 revealed she: *Was asleep on her bed. -Had multiple staples on the crown of her head. Interview on 12/5/23 at 10:00 a.m. with resident 26 revealed she: *"Turned wrong" and had fallen when she was returning to her bed from the bathroom a few weeks ago. *Was taken to the emergency room (ER) after the fall and required staples to close a cut on the top of her head that occurred as a result of that fall. Review of resident 26's electronic medical record (EMR) and paper chart revealed: *An 11/28/23 nurse progress note completed at 2:38 a.m. indicated the resident was found on the floor of her room after an unwitnessed fall. -She was taken to the ER for post-fall evaluation and treatment. *An 11/28/23 ER discharge report included the following post-fall instructions: -"Follow concussion guidelines that have been given to the patient on discharge, report back to ER/clinic for any concerning signs or symptoms as outlined in the handout." -Signs and symptoms included mental status and vision changes. *A nurse progress note dated 11/28/23 at 9:30 a.m. indicated the resident had returned to the facility from the ER. *The resident's Post Fall 72-Hour Monitoring Report for the 11/28/23 fall: -Included spaces for the following to have been documented: the resident's vital signs, orientation, skin condition, pain, range of	F 658	All residents have the ability to be affected by this deficiency. Resident #11 has been audited to ensure physician order is properly documented in the TAR and is receiving proper catheter cleaning and care. All other residents with catheters have been audited to ensure physician orders are properly documented in the TAR, and care is in compliance. Staff responsible for catheter cleanings will be re-educated on catheter care procedures to ensure proper catheter care is given. DON or designee will conduct audits on catheter care monthly for 3 months then as deemed necessary by QAPI committee. Findings of audits will be discussed at monthly QAPI meetings. All residents have the ability to be affected by this deficiency. Resident #14 has been audited and his chair alarm order documented. All residents who utilize a chair alarm will be audited to ensure physician orders for chair alarms are documented and monitored. Staff responsible for chair alarms will be re-educated regarding monitoring and documenting chair alarms. DON has revised the process of documentation on chair alarms and has incorporated chair alarm documentation on the TAR. DON or designee will conduct monthly audits for 3 months and will report findings at monthly QAPI meetings for review and recommendations.	

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F 658	Continued From page 4	F 658		

motion/extremity strength, and eye responses.
--That documentation was expected to have been initiated upon the resident's return from the ER then should have continued at the following intervals:
Every 15 minutes for the first hour after the initial assessment.
Every 30 minutes for the next hour.
Every hour for the following two hours then every 12 hours for the next three days.
*Resident 26's inital assessment was documented on her Post-Fall 72-Hour Monitoring Report at 7:35 p.m. on 11/28/23.
-That was nine hours after she had returned from the ER.
*Subsequent assessments were documented every 12 hours thereafter for three days.

Interview on 12/6/23 at 9:00 a.m. with interim director of nursing (DON) B regarding resident 26's post-fall assessments and documentation revealed:
*Licensed practical nurse (LPN) G was responsible for the documentation but had not initiated the Post Fall 72-Hour Monitoring Report upon resident 26's return from the ER on 11/28/23.
-That report should have been completed any time a rersident fall occurred.
*Completion of that report was important for any resident who had sustained a head injury.
-Her risk for a post-fall complication such as a brain bleed was high.

Review of the 10/23/23 Falls Event Checklist revealed the Post Fall 72-Hour Monitoring Report was expected to have been initiated and completed any time a resident fall occurred.
2. Observation and interview on 12/04/23 at 4:31

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F 658	Continued From page 5 p.m. with resident 11 revealed: *He had a urine drainage bag that was visible under his pant leg. -He had been in the hospital and had a suprapubic catheter placed at that time. *The certified nursing assistants (CNAs) emptied the urine drainage bag several times a day. *He could not remember if the nursing staff cleaned the suprapubic catheter insertion site or placed a dressing on the site. *He had a history of urinary tract infections (UTIs). Review of resident 11's EMR revealed: *He had a Brief Interview for Mental Status (BIMS) score of 13 indicating he was cognitively intact. *His diagnosis included benign prostatic hyperplasia (BPH) with lower urinary tract symptoms. *Review of his 10/12/23 revised care plan revealed: -He had a suprapubic urinary catheter placed on 10/11/23 related to BPH with obstructive uropathy. -He wore a urine drainage bag. -He required staff assistance for his suprapubic catheter care including a daily dressing change. *Review of active physician's orders related to his suprapubic catheter revealed: -A urinalysis (UA) was ordered on 12/4/2023 and the lab result indicated the resident had a UTI. -A 10/16/23 hospital discharge order: "Keep suprapubic catheter area clean and dry and change dressings as needed." *A 10/16/23 skin/wound note documenting a dressing was changed around the suprapubic site. -There was no documentation regarding other	F 658		

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F 658	Continued From page 6	F 658		

dressings or suprapubic catheter care at the insertion site in the EMR.
*Review of the October 2023 through December 2023 Treatment Administration Record (TAR) revealed:
-No physician's order for care of the suprapubic catheter insertion site.
-No care of the insertion site was documented.

Interview on 12/05/23 at 4:20 p.m. with LPN F regarding resident 11 revealed:
*He was hospitalized and had a suprapubic catheter inserted on 10/11/23.
*The suprapubic catheter was inserted due to his history of urinary tract infections and a urethral blockage that had caused trauma when a Foley catheter was inserted.
*He had a 12/4/23 UA and the lab results indicated the resident had a UTI.
*The CNAs emptied the resident's urine drainage bag each shift and as needed.
*The nursing staff was responsible to clean the suprapubic catheter and should have placed a split gauze at the insertion site.
*Suprapubic catheter care should have been performed and then documented on the TAR.
*The resident had not received suprapubic catheter care.
*The nursing staff should have followed the hospital discharge orders for the suprapubic catheter care and the nurse who entered the hospital discharge orders had not added that physician's order to the TAR.
*He agreed that not regularly performing suprapubic catheter care at the insertion site might have contributed to the resident's UTI.

Observation and interview on 12/05/23 at 4:33 p.m. with CNA G emptying resident 11's urine

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F 658	Continued From page 7 drainage bag revealed: *The CNAs empty his urine drainage bag each shift and as needed. *She reported any urine or catheter concerns to the nurse. *CNAs would not complete insertion site care for residents with suprapubic catheters. -The nurses were responsible for completing that care. Interview on 12/06/23 at 10:01 a.m. with interim DON B regarding suprapubic catheter care revealed: *She reviewed the suprapubic catheter care policy with the nursing staff, and provided education on suprapubic catheter care for the nursing staff when the resident returned from the hospital. *They received a 10/16/23 physician's order for suprapubic catheter care when the resident was discharged from the hospital, and that care was not documented on his TAR. *She expected nursing staff to follow the hospital discharge physician orders for suprapubic catheter care and the nurse who had received those orders enter them into the TAR. *She believed despite the suprapubic catheter care not being documented on the TAR the resident's suprapubic catheter care was being completed sporadically. *She had found only one skin/wound note dated 10/16/23 in the EMR that documented a "dressing was changed around the suprapubic site." *She agreed suprapubic catheter care at the insertion site was important in preventing infections. -She agreed the lack of suprapubic catheter care could have contributed to the resident's current UTI.	F 658		

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F 658	Continued From page 8	F 658		

Review of the provider's undated Suprapubic Catheter Care Policy and Procedure revealed:
*Policy: "To keep insertion site area clean and dry and prevent infection."
*"4. Clean area around catheter well with soap and warm water."
*"5. Clean catheter at insertion site."
*"7. Rinse and dry well."
*"8. Apply thin film of antiseptic ointment to edges of opening for suprapubic catheter as ordered."
3. Observation on 12/4/23 at 3:20 p.m. of resident 14 revealed:
*He was sitting in his wheelchair in the dayroom watching television.
*He had a chair alarm device connected to the back of his wheelchair.

Review of resident 14's EMR revealed:
*He was admitted on 12/21/2021.
*His 12/5/23 BIMS score was 5 indicating he had severe cognitive impairment.
*His diagnosis included vascular dementia with other behavioral disturbances.
*He was at high risk for falls and was an elopement risk related to cognitive limitations.

Review of resident 14's revised 12/5/23 care plan revealed:
*A chair alarm device was in place due to his high fall risk.
*Staff were to ensure the device was in place.

Interview on 12/6/23 at 10:03 a.m. with CNA M revealed:
*She was not aware when a resident would need a chair alarm device unless she checked the resident's care plan.
*She was not responsible for charting the use of

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F 658	Continued From page 9 the chair alarms in the EMR. -The nurses were responsible for the monitoring and documentation of the chair alarm devices. Interview on 12/6/23 at 10:10 a.m. with LPN F revealed he: *Would not have been aware that a resident needed a chair alarm device unless he checked the resident's care plan. *Would visually monitor the resident if they used a chair alarm device. *Had been unsure if there was a place to document the use or the monitoring of a chair alarm device in the EMR. Interview on 12/6/23 at 10:15 a.m. with interim DON B regarding resident 14's chair alarm device revealed: *The nurses were responsible for adding physician ordered chair alarms into the resident's TAR. -Monitoring the use and continued necessity of a chair alarm device was expected to have been documented daily on the TAR. *Her review of resident 14's December 2023 TAR revealed no documentation related to the chair alarm device. Review of the provider's 6/1/21 Miscellaneous Nursing Interventions policy revealed: *Chair alarm device documentation was expected to have been completed once each 12 hour shift on the TAR. -That documentation would have included the chair alarm device was used appropriately and if any falls had occurred.	F 658		
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3)	F 678	All residents have the potential to be affected by this deficiency.	01/20/2024

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F 678	Continued From page 10 §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, interview and policy review, the provider failed to have an acknowledged and signed code status that was easily accessible for three of three sampled residents (186, 32, and 33). Findings include: 1. Review of resident 186's electronic medical record (EMR) revealed: *He was admitted on 11/17/23. *There was no code status documented for the resident on the demographic section at the top of the EMR screen. *There was no physician's order located for a code status. Review of resident 186's care plan revealed: *He had signed an Advanced Directive that was in his EMR. *There was no documentation of his code status. Review of the provider's list of resident code status located at the nurse's station revealed that resident 186 was not on that list. Review of resident 186's paper chart revealed: *There was no indication of his code status on the outside of the paper chart binder. *The advanced directive/code status was not quickly accessible for staff in an emergency situation to find the resident's code status.	F 678	Residents # 186, 33, and 32's electronic medical records and paper charts have been audited to ensure proper documentation. All resident's electronic medical records and paper charts have been audited to ensure proper documentation of the resident's code status. Charge Nurse is responsible for obtaining and documenting code status' upon admission. Residents code status is documented in three areas for easy access for staff to identify which residents are DNR and full code. Code statuses are documented in residents Electronic Medical Record, paper chart, and have designated red sticker on outside of paper chart for DNR status. DON or Designee will be responsible for conducting monthly audits for 3 months and will report findings at monthly QAPI meetings.	

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F 678	Continued From page 11	F 678		

2. Review of resident 32's EMR revealed:
*She was admitted on 10/10/23.
*The code status in the profile section at the top area of her EMR screen was blank.
*There was no physician order for code status located in the EMR.

Review of resident 32's care plan revealed:
*She had signed an advanced directive that was in her chart.
*There was no documentation of her code status.

Review of the provider's list of resident's code statuses located at the nurse's station revealed her name was not on that list.

Review of resident 32's paper chart revealed:
*There was no documentation of her code status on the outside of the chart's binder.
*The advanced directive/code status form was not on the top page of her chart and in an emergency situation the chart would have to be gone through to find the resident's code status.

3. Review of resident 33's EMR revealed:
*She was admitted on 11/1/23.
*The code status in the profile section at the top area of her EMR screen was blank.
*There was no physician order for a code status located in her EMR.

Review of resident 33's care plan revealed:
*She had signed an advanced directive that was in her paper chart.
*There was no documentation of her code status.

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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 678	Continued From page 12 Review of the provider's list of resident's code statuses located at the nurse's station revealed her name was not on that list. Review of resident 33's paper chart revealed: *There was no documentation of her code status on the outside of the chart's binder. *The advanced directive/code status form was not the top page of her chart and indicated that in an emergency the chart would have to be gone through to have found the resident's code status. Interview on 12/5/23 at 10:24 a.m. with licensed practical nurse (LPN) F regarding resident's code statuses revealed he: *Was a contract travel nurse and had worked at the facility since 5/19/23. *Would have looked in the residents' EMR for a code status if there had been a resident emergency. *Agreed several resident EMRs did not have a physician's orders for their code statuses. *Would have looked at the provider's list of resident code statuses located at the nurse's station if there was no physician's order for a resident code status in their EMR. *Agreed the resident code status list was not up to date. *Was unsure who was responsible for updating that list or what the process was for updating the list. *Agreed if there was a resident emergency, he would have had to look at the resident's advanced directive form located in their chart at the nurse's station. *Stated the resident's advance directive form was located at the front of the chart. *Reviewed two resident charts and agreed their advanced directive forms were not located in the	F 678		

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front of their paper charts.
-One resident chart had the advance directive form located toward the front of the chart under the condition alert tab.
-The other chart reviewed had an advance directive form located under the advanced directive tab that was located farther back in the chart.
*Agreed the location of the advance directive form in the charts was inconsistent.
*Agreed the inconsistencies in the location of documented code status for residents could have led to errors and delays for residents in an emergency situation.

Interview on 12/5/23 at 10:47 a.m. with interim director of nursing B regarding resident code status revealed:
*She had been employeed for approximately two months.
*She agreed the location for the resident's documented code status was not consistent.
*There was no process for where a resident's code status was to have been documented and located, and that could have led to inconsistencies and delays in an emergency situation.

Review of the provider's revised May 2020 Advance Directives Policy revealed:
*"This policy is to provide an atmosphere of respect and caring and to ensure that each resident's ability and right to participate in medical and mental health decision making is maximized. Additionally, the purpose of this policy is to assure compliance with the Patient Self Determination Act (PSDA) in such a manner as to expand the patient, personnel, and community knowledge base regarding advanced directives and the

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F 678	Continued From page 14 process by which patient participation in medical decision making is carried out at Five Counties Nursing Home. *It is the policy of Five Counties Nursing Home to respect and encourage resident self-determination." "Residents will be encouraged to communicate their desires in regard to advance directives to their resident representative, to allow for guidance to health care providers following the resident's wishes should the resident become incapacitated, rendering them unable to make decisions." -The advance directive policy had no documentation regarding the location of the resident's advance directive or code status for immediate accessibility to staff in an emergency situation.	F 678		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692	All residents have the potential to be affected by this deficiency. Resident #26 is eating under observation. All residents who have nutritional orders and are at nutritional risk have been audited. Facility is currently seeking a consulting dietician. Dietary Manager or designee will conduct monthly audits on residents at nutritional risk for 3 months and report monthly findings at monthly QAPI meetings.	01/20/2024

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§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, job description review, and policy review, the provider failed to follow a process to thoroughly assess, implement, monitor, and revise interventions for one of one sampled resident (26) who was at nutritional risk. Findings include:

1. Observation on 12/4/23 at 12:30 p.m. of resident 26 in the dining room revealed:
*She fed herself the noon meal without observed chewing or swallowing difficulties.
*The texture of her food was the consistency of a regular diet.

Review of resident 26's electronic medical record (EMR) revealed:
*Registered dietician (RD) E's 5/25/23 initial dietary assessment indicated the resident was eating 100% of her meals, her weight was 141 lbs, and her nutritional status was "normal."
-There were no additional RD assessments or progress notes completed since that initial assessment.
*Dietary manager (DM) D completed two progress notes (PN) between 5/17/23 and 12/5/23.
-Her 8/17/23 PN: The resident's weight was "down 5% over the last 30 days" but that was planned due to an increase in her diuretic medication. There was no documentation of what her weight was. The resident ate 100% of her meals and was able to make her needs known.
-Her 11/16/23 PN: The resident's weight was 139 lbs. "This is a 10% [weight] loss that was

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F 692	Continued From page 16 unplanned." The resident had no trouble chewing or swallowing, continued to make her needs known, but her meal intake had declined to 76%. *Resident 26's unrevised 5/17/23 care plan included a dietary goal to "maintain weight and nutritional balance through the review date." *Interventions included: following her diet as prescribed, monitoring signs/symptoms of dysphagia, eating in an upright position, eating slowly, and chewing thoroughly. -There was no documentation that resident had weight loss or that any nutritional interventions had been implemented to address her weight loss. *Her weight on 12/4/23 was 134.5 lbs. Interview on 12/4/23 at 3:30 p.m. with DM D regarding nutritional interventions for residents with weight loss revealed: *Caloric supplements (usually in the form of juices or other beverages) were prepared several times a day by dietary staff and provided to the nursing staff to distribute to residents with weight loss. *The 10/25/23 "Supplement List" initialed by DM D was developed by her with input from the interdisciplinary team members (IDT). -Resident 26's name was not on that supplement list. *There was a resident "Snack List" that included different types of snacks beside some residents' names that were offered or provided to a resident when they had requested a snack. -"Cookie" was listed beside resident 26's name. *There was a list in the kitchen that included individual resident food likes and dislikes that was referred to by kitchen staff when preparing resident meals to encourage food/fluid intake. -Resident 26's food likes included orange juice	F 692		

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F 692	Continued From page 17 and hot green tea. *DM D and RD E had not collaborated on the development or use of information on the Supplement, Snack, or food preference lists. -DM D thought RD E "was mostly happy" with the interventions referred to above that she had implemented for residents with weight loss. Interview on 12/5/23 at 10:00 a.m. with resident 26 revealed she: *Knew she had lost weight since her admission on 5/17/23 but was not concerned because she "doesn't want to get fat." *Was not purposefully trying to lose weight but was more conscious of making healthier food choices. Interview on 12/5/23 at 10:15 a.m. with cook N regarding interventions used to add caloric value to food for residents with weight loss revealed she: *Sometimes added a fortified powder to a resident's coffee or oatmeal if she felt they "needed a little something extra" in terms of caloric intake. -There was no process in place if a resident was expected to have been provided fortified food. *Resident 26 was not receiving fortified food or fluids. Interview on 12/5/23 at 10:45 a.m. with DM D regarding RD E's consultations revealed: *She provided RD E with a form in preparation for her monthly consultation that listed all resident names, their room numbers, and their current weight. -If she made comments in the "concern" column next to a specific resident name that prompted RD E to review the resident's nutritional status.	F 692		

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F 692	Continued From page 18 *DM D relied on her judgment and input from the IDT to identify resident "concerns". -RD E was expected to respond to the "concerns" referred to above in the "recommendation" column of that form then complete a full progress note in the resident's EMR regarding her findings. *DM D had not retained a record of the original monthly RD reports. *Review of the November 2023 dietician consultation form revealed: -DM D had added no "concerns" for resident 26 on the November 2023 form even though she had known the resident had weight loss. Continued interview with DM D regarding resident 26's weight loss revealed: *Either her or RD E's PNs should have included information about if: -The resident had been interviewed regarding her intake goals or food preferences. -The resident had been observed during mealtimes for environmental or functional factors that impacted her weight loss. -Staff had been interviewed to gain mealtime or dietary-related information regarding her weight loss. -Specific dietary interventions had been implemented and whether or not they had or had not been effective in relationship to her weight loss. -The resident had new diagnoses or medication changes that may have affected her weight. -Her weight record, a review of nurse and physician progress notes, laboratory values had been evaluated. -The resident's medical provider had been made aware of the unplanned weight loss. *The resident's weight loss was discussed during monthly quality assurance and performance	F 692		

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F 692	Continued From page 19 improvement (QAPI) meetings. -She was responsible for reporting information related to residents who had lost 10% of their body weight and residents that had lost 5% of their body weight in the previous 30 days. *Review of DM D's weight loss data reported to QAPI revealed: -Between June 2023 through August 2023 resident 26 had not been discussed. -It was reported during the September 2023 the resident 26 had a 10% weight loss: "Resident 26 had a diuretic [medication] increase. She is eating meals over 76% and is able to inform staff of her wants or needs." Plan: "We will continue to monitor and encourage." -It was reported during the October 2023 the resident continued to be monitored for having lost 10% of her body weight. Plan: "Working with nursing on getting special snacks out to these residents daily and charted." *DM D agreed the data referred to above related to resident 26's weight loss had not: -Identified contributing factors to her weight loss, possible causes for her weight loss, or changes that had been made to address the possible causes for her weight loss. -Measured the success or failure of any changes that had been made. *RD E had not attended QAPI meetings and DM D had not discussed the quality of care measure referred to above that she was following and reporting to the QA team related to resident weight loss. *DM D thought her workload limited her ability to manage the overall operation of the kitchen which she felt was her primary work responsibility. *Some of her responsibilities seemed more appropriate for RD E to have carried out based on her clinical experience and educational	F 692		

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background.
-DM D had no RD job description to refer to for the RD's job duties.

Interview on 12/6/23 at 11:15 a.m. with administrator A and interim DON B revealed:
*Administrator A had been in her current position for a few weeks and interim DON B had been in her current position for a few months.
*They had known there were concerns regarding the process for managing resident weight loss because it was being discussed during monthly QAPI meetings.
*They were not aware that there was no job description for RD E but agreed without that job description:
-There had been a lack of collaboration between DM D and RD E regarding dietary-related expectations and services.
-DM D assumed dietary-related responsibilities that were not within the scope of practice for a DM to have carried out.
-RD E had not been accountable for ensuring the recognition, evaluation, monitoring, and documentation expectations for residents at nutritional risk had been followed.
*RD E had retired.
-They agreed her retirement created an opportunity to establish written job expectations and accountability expectations for the next RD that was hired.

Review of the 1/11/23 Maintaining Nutrition Status policy revealed: "It is the intent of Five Counties Nursing Home to prevent the unplanned weight loss, if unavoidable, in our residents by providing assessments for nutrition and hydration and applying interventions appropriate for individual resident needs."

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F 692	Continued From page 21 Review of the 10/30/15 Dietary Manager job description revealed duties included: *Managing food operations of the facility. *"Assures proper documentation of weights, intakes and any other dietary resident issues. *Utilizes the services of a clinical dietician to assist in management of the dietary department." *"Assures that the dietary department is in compliance with all state, federal and local regulations. *Conducts inservicing for the dietary personnel, facility personnel and monthly scheduling."	F 692		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758	All Residents have the potential to be affected by this deficiency. Resident #1 is no longer using a psychotropic PRN drug. All residents have been audited and no resident is currently using PRN psychotropic medications. Consultant Pharmacist and DON have revised and added a psychotropic addendum to current medication policy. Psychotropic PRNs are to be renewed by physician orders every 14 days. The Charge Nurse on duty and is responsible for ensuring the renewal of PRN psychotropic medications for residents. PRN psychotropic orders will be placed on the TAR. Education will be provided to the responsible staff regarding addendums to the medication policy.	01/20/2024

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F 758	Continued From page 22 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on review of the Consultant Pharmacist Review reports for 2023, record review, and interview, the provider failed to ensure a physician's order included a specific duration of time for an as needed (PRN) psychotropic medication for one of one sampled resident (1) who received a PRN psychotropic medication. Findings include: 1. Review of resident 1's electronic medical record (EMR) and paper chart revealed: *Consultant Pharmacist Review 2023 monthly notes completed by pharmacist H regarding his	F 758	DON or Designee will conduct monthly audits for 3 months and report finding at monthly QAPI meeting.	

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F 758	Continued From page 23 review of the resident's medical record for identification of medication irregularities. *His September 2023 review note was dated 9/30/23: -"MD [medical doctor] - Serax (a psychotropic medication) DR [dose reduction] request - now taking prn for insomnia (as of 10/31/23) - no need to send." *His October 2023 note was dated 10/31/23: -"No recommendations." *A Fax Communication to Provider form dated 10/31/23: "Resident was out of oxazepam [Serax] over the weekend. She reports that she did 'well without it' and is requesting it be changed to PRN. Resident noted to be well and in good spirits during evening hours at that time." *The physician responded to that fax on 10/31/23 with new orders to change the frequency of administering the Serax from once daily at night to PRN every 24 hours. -There was no end date for the duration of time that the medication was expected to have been administered. *Medication Administration Records revealed the resident had used that PRN Serax 18 of 30 days during November 2023 and twice between 12/1/23 and 12/3/23. Telephone interview on 12/5/23 at 3:30 p.m. with pharmacist H regarding the physician-ordered Serax frequency changes referred to above revealed he: *Had known PRN orders for the use of psychotropic medications were limited to 14 days unless the physician documented a rationale to extend the use of that medication. *Should have requested a standing order for re-evaluation of the use of that medication every 14 days or requested the medication to have	F 758		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 758	Continued From page 24 been administered on a scheduled basis. A PRN Psychotropic Medication policy was requested from interim director of nursing B (DON) on 12/5/23 at 3:00 p.m. On 12/6/23 at 9:00 a.m. Interim DON B stated the provider had no policy.	F 758		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 000	Initial Comments An emergency preparedness survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 12/4/23 through 12/6/23. Five Counties Nursing Home was found not in compliance with the following requirements: E006, E036, and E039.	E 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 conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.	
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:	E 006	All residents have the ability to be affected by this deficiency. The Administrator and the Emergency Preparedness Committee will meet to organize and review the Emergency Preparedness Plan. The facility is scheduled to participate in a community-wide drill in April 2024. Administrator will ensure that EP testing and training program is completed. Administrator or designee will conduct monthly audits for 3 months and report findings at monthly QAPI.	01/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jordan Fish
TITLE: Administrator
(X6) DATE: 12/29/2023

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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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 ______	12/06/2023

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

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E 006	Continued From page 1 (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on interview and review of an undated Emergency Preparedness Policy and Procedure (EPPP), the provider failed to include a	E 006		

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E 006	Continued From page 2 community-based risk assessment that utilized an all-hazards approach. Findings include: 1. Interview on 12/6/23 at 10:30 a.m. with administrator A and business office manager C revealed: *There were no community-based risk assessments performed. -They were unaware that a community-based risk assessment was required. Review of the provider's undated EPPP revealed: *There was no community-based risk assessment identified in the policy. -There was no process for completing a community-based risk assessment.	E 006		
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of	E 036	All residents have the ability to be affected by this deficiency. The Administrator or designee and the Emergency Preparedness Committee will develop an emergency preparedness training and testing program. The facility is scheduled for a community-wide EP drill in April 2024. The Administrator or designee and the Emergency Preparedness Committee will meet annually to review and revise the Emergency Preparedness training and testing.	01/20/2024

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E 036	Continued From page 3 this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this	E 036		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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E 036	Continued From page 4 section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and review of an undated Emergency Preparedness Policy and Procedure (EPPP), the provider failed to develop an emergency preparedness training and testing program based on their EPPP. Findings include: 1. Interview on 12/6/23 at 10:30 a.m. with administrator A revealed: *She had not developed a program to test their EPPP. -There had been multiple changes in their leadership positions which had delayed the development of an emergency preparedness training and testing program. *Administrator A had been hired two weeks ago. -She had not reviewed all the documents and requirements related to emergency preparedness. Review of the provider's undated EPPP revealed no emergency preparedness training and testing program was identified.	E 036		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).	E 039	All residents have the ability to be affected by this deficiency. The administrator or designee and the Emergency Preparedness Committee will meet annually to ensure Emergency Preparedness training and testing are in compliance with Emergency Preparedness testing requirements.	01/20/2024

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E 039	Continued From page 5 *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and	E 039	The facility will complete an annual community-based emergency preparedness drill and ensure proper documentation is acquired to ensure compliance. The facility is scheduled to participate in a community-wide EP drill in April 2024. Facility will complete an annual facility-based drill to ensure compliance. Administrator and Director of Maintenance will ensure documentation of all EP drills. Director of Maintenance will ensure compliance and audit Emergency Preparedness Training for 3 months and will present findings at QAPI meeting.	

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E 039	Continued From page 6 maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient	E 039		

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E 039	Continued From page 7 care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:	E 039		

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E 039	Continued From page 8 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or	E 039		

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E 039	Continued From page 9 (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or	E 039		

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E 039	Continued From page 10 (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of	E 039		

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E 039	Continued From page 11 the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the	E 039		

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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**

(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 039	Continued From page 12 emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.	E 039		

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 ____	12/06/2023

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 039	Continued From page 13 (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and review of an undated Emergency Preparedness Policy and Procedure (EPPP), the provider failed to fully implement and evaluate their plan by conducting emergency preparedness exercises and drills at least twice per year using emergency procedures. Findings include: 1. Interview on 12/6/23 at 10:30 a.m. with administrator A revealed no table-top, facility-wide, community-wide, announced or unannounced emergency preparedness exercises/drills occurred or were documented for the year 2023. Review of the provider's undated EPPP revealed: *There was no information in the policy to direct	E 039		

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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 ____	12/06/2023

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 039	Continued From page 14 the completion of any emergency preparedness exercises/drills. -There was no process for completing emergency preparedness exercises/drills identified in the policy.	E 039		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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 ______	12/05/2023

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 12/5/23. 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 12/7/23. Please mark an F in the completion date column for K225 and K374 deficiencies identified as meeting the FSES.	K 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 conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.	
K 225 SS=C	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the provider failed to maintain a minimum clear space of 22 inches between the swing of the door and the newel post in one of three stairwells (southwest stair enclosure). Findings include: 1. Observation on 12/5/23 at 2:15 p.m. and review of the previous survey report dated 11/2/22 revealed the first-floor door swung into	K 225		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jordan Fish
TITLE: Administrator
(X6) DATE: 12/22/2023

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 ______	12/05/2023

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 the southwest stair enclosure. That door in the open position restricted the egress to 17 inches measuring from the latch side of the door leaf to the stair newel post. The building meets FSES. Please mark an "F" in the completion date column.	K 225		
K 374 SS=C	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the provider failed to maintain clear door widths at least 32 inches for one randomly observed smoke barrier located on the first floor of the original building (between the original building and the 1962 addition). Findings include: 1. Observation on 12/5/23 at 1:40 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	K 374		F

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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	12/05/2023

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 374	Continued From page 2 width of 32 inches. Review of the previous survey report dated 11/2/22 revealed those doors were the original doors. The building meets the FSES. Please mark an "F" in the completion date column.	K 374		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING **02 - BUILDING 02** B. WING	**12/05/2023**

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 12/5/23. Five Counties Nursing Home (building 02) 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 upon correction of the deficiencies identified at K351 and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 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 conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by:	K 351	All residents have the ability to be affected by this deficiency. Director of Maintenance will schedule Quarterly Flow Inspection for February 2024. Director of Maintenance will ensure compliance and conduct monthly audits for 3 months. Director of Maintenance will report audit findings at monthly QAPI meetings.	01/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jordan Fish	Administrator	12/22/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING **02 - BUILDING 02** B. WING ______	**12/05/2023**

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 351	Continued From page 1 Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow testing not completed in 2023). Findings include: 1. Record review on 12/5/23 at 2:00 p.m. revealed no documentation of the required quarterly flow tests had been performed in 2023 prior to the annual inspection dated 11/28/23. Interview with maintenance supervisor at the time of the record review confirmed that condition. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required tests on the automatic sprinkler system.	K 351		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test	K 918	All residents have the ability to be affected by this deficiency. Director of Maintenance will document monthly conductivity reports for monthly generator reporting. Director of Maintenance will conduct monthly audits for 3 months and report audit findings at monthly QAPI meetings.	01/20/2024

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING **02 - BUILDING 02** B. WING ______	**12/05/2023**

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 918	Continued From page 2 under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to document generator battery conductivity monthly (no documentation was located for 2023). Findings include: 1. Record review on 12/5/23 at 2:15 p.m. revealed there was no documentation of the battery conductivity in the monthly maintenance logs for the generator for the calendar year 2023. Interview with the administrator at the time of the record review revealed the generator had a maintenance-free battery installed and it could not be tested for specific gravity. She stated she was unaware of the monthly battery conductivity documentation requirement. The deficiency affected 100% of the building occupants.	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING **02 - BUILDING 02** B. WING ______	**12/05/2023**

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

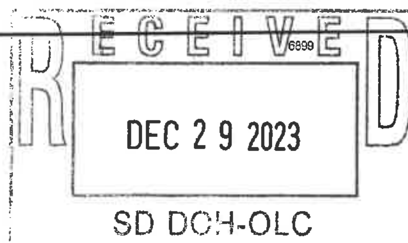
South Dakota Department of Health

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 ______	12/06/2023

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 12/4/23 through 12/6/23. Five Counties Nursing Home was found not in compliance with the following requirements: S130, S206, and S296.	S 000	This Plan of Correction is submitted as required under Federal and State regulations and statuses applicable to long term care providers. This Plan of Correction does not Constitute an admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.	
S 130	44:73:02:07 Food Service Food service shall be provided by a licensed facility or food service establishment that is inspected by a local, state, or federal agency. The facility shall meet the safety and sanitation procedures for food service in §§44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive, the Food Service Code. In addition, a mechanical dishwasher shall be provided in all facilities of 17 beds or more. The facility shall have the space, equipment, supplies, and mechanical systems for efficient, safe, and sanitary food preparation if any part of the food service is provided by the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain physical air breaks for two of two sinks used for vegetable preparation in the kitchen (single-compartment sink and the three-compartment sink). Findings include: 1. Observation on 12/5/23 at 1:45 p.m. revealed the single-compartment sink and the three-compartment sink in the kitchen had direct connections from the drains to the waste plumbing system. The kitchen did not have a two-compartment sink. Interview with the dietary manager at the time of the observations confirmed those findings. She revealed she either	S 130	The Director of Maintenance will ensure proper plumbing with physical air breaks is installed on the single-compartment sink and the three-compartment sink. The Director of Maintenance will audit all other sinks used in food preparation to ensure there are physical air breaks. The Director of Maintenance will complete audits monthly for 3 months on all food preparation sinks to ensure there are physical air breaks. The Director of Maintenance will present monthly audits at the monthly QAPI meetings for further consideration.	01/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jordan Fish — TITLE: Administrator — (X6) Date: 12/29/2023



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 ______	12/06/2023

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 130	Continued From page 1 of the two sinks might be used for vegetable preparation. According to ARSD 44:02:07:70, a designated prep sink or vegetable sink must be provided if food preparation procedures require washing, soaking, or rinsing of food items. Either a separate sink or the third compartment of the three-compartment sink may be utilized for this operation. The sink must be plumbed with a physical air break on the drain line. Further interview revealed she understood the air break was not required.	S 130		
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; (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	S 206	Employees #J,K,L,G and H have been required to complete annual trainings and will be in compliance. Business Office Manager is responsible for the completion of employee files per job description. Business Office Manager will audit all other employee files to ensure that all employees have completed the required trainings. Administrator or designee will streamline onboarding process to incorporate personnel training in the onboarding process and mandate completion. Business Office Manager will complete monthly audits for 3 months to ensure compliance with all education requirements. Business Office Manager will bring audit results to QAPI for review and recommendations.	01/20/2024

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 ______	12/06/2023

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 206	Continued From page 2	S 206		

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 file review, interview, and policy review, the provider failed to ensure:
*A formal orientation training program for two of two sampled employees (G and H).
*An annual training program with the eleven required training topics for three of three sampled employees (J, K, and L).
Findings include:

1. Review of employees G and H's personnel files revealed:
*Employee G was employed since 1/2/23.
-Her required orientation training had the following missing topics: emergency procedures/preparedness, proper restraint use, the confidentiality of resident information, or resident abuse, neglect, and mistreatment.
*Employee H was employed since 2/17/23.
-Her orientation training had the following missing topics: fire prevention/response, emergency procedures/preparedness, infection control and prevention, accident prevention, and safety procedures, the confidentiality of resident information, incidents/disease reporting, or dining assistance, nutritional risks, and hydration.

2. Review employees J, K, and L's personnel files revealed:
*Employee J was employed since 7/1/11.
-She had not received annual training for fire prevention/response, emergency

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 ____	12/06/2023

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 206	Continued From page 3 procedures/preparedness, proper restraint use, the confidentiality of resident information, or resident abuse, neglect, and mistreatment. *Employee K was employed since 1/15/14. -She had not received annual training for emergency procedures/preparedness, infection control and prevention, proper restraint use, incidents/disease reporting, care of residents with unique needs, dining assistance, nutritional risks, and hydration, or resident abuse, neglect, and mistreatment. *Employee L was employed since 1/5/18. -She had not received annual training for fire prevention/response, emergency procedures/preparedness, accident prevention and safety procedures, proper restraint use, resident rights, the confidentiality of resident information, incidents/disease reporting, care of residents with unique needs, dining assistance, nutritional risks and hydration, or resident abuse, neglect, and mistreatment. Interview on 12/5/23 at 4:15 p.m with business office manager C regarding the employee training program revealed she: *Was responsible for ensuring all employees completed an orientation training program and an annual training program that included the eleven required training topics. *Was aware that newly hired employees had incomplete orientation training documentation and existing employees had incomplete annual training documentation. *Had been the interim administrator since the spring of 2023 and fulfilled her business office manager responsibilities until about three weeks ago. -Had been unable to ensure that newly hired and existing employees had completed their expected training requirements during that time.	S 206		

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 ____	12/06/2023

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S 206	Continued From page 4 Interview on 12/6/23 at 9:45 a.m. with administrator A regarding the employee orientation and annual training program revealed she: *Was aware some employees had not completed the orientation training or the annual training for those eleven required training topics. *Was assuming responsibility for the employee training program from that point forward. Review of the revised February 2020 Personnel Training policy revealed: *"The facility shall have a formal orientation program and an ongoing education program for all personnel." -"Ongoing education programs shall cover the required (eleven) subjects annually."	S 206		
S 296	44:73:07:11 Director of Dietetic Services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the	S 296	Dietary Manager and one cook will pursue a current ServSafe Food Protection Program by January 31st, 2024. The Administrator or designee will audit compliance with acquiring a ServSafe Food Protection Certificate for the Dietary Manager and one cook monthly for 3 months. The administrator or designee will present audit findings at monthly QAPI meetings for review and recommendations.	01/20/2024

South Dakota Department of Health

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	10641	A. BUILDING: ______ B. WING ______	12/06/2023

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S 296	Continued From page 5 national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the residents shall be on duty daily over a period of 12 or more hours in facilities. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and job description review, the provider failed to ensure the dietary manager and one cook possessed a current ServSafe Food Protection Program certificate. Findings include: 1. Interview with dietary manager (DM) D revealed: *She had not completed the ServSafe Food Protection Program. *There was no staff cook who had completed the ServSafe Food Protection Program. *She thought the cost of completing that program was the employee's responsibility and that was not feasible. Interview on 12/6/23 at 9:45 a.m. with administrator A revealed she was not aware that DM D or a staff cook had no current ServSafe Food Protection Program certificate. Review of the dietary manager's job description revealed there was no requirement for her to	S 296		

South Dakota Department of Health

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S 296	Continued From page 6 have had a food sanitation certification.	S 296		
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 12/4/23 through 12/6/23. Five Counties Nursing Home was found in compliance.	S 000		