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 _____	05/06/2021

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 Surveyor: 40788 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 5/4/21 through 5/6/21. Five Counties Nursing Home was found not in compliance with the following requirements: F578 and F758.	F 000	This Plan of Correction is submitted as required under Federal and State regulation 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 agreeement 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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the	F 578	F578: The Administrator, Director of Nursing and the Interdisciplinary team will review and revise policies and procedures to ensure that the Advance Directive policy and procedure reflects the wishes of the individual resident. All residents are potentially affected by this deficiency. The DON will update policies and procedures by May 24th, 2021. The Administrator, IDT Team and the nursing staff will be updated on the policy and procedure by May 24th, 2021. The DON or designee will ensure that all Advance Directives are signed by the physician within 24 hours of admission and that a two-nurse signature is required for ensuring that the Advance Directive is accurate on the medical record chart and the electronic chart. The DON or designee will audit each new admission or readmission's Advance Directive for accurate code status and a physician signature within 24 hours. This will be monitored for the next 3 months. The DON or designee will report to QAPI monthly for review and recommendations until the committee determines the goal has been met.	May 24th, 2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacy Drayton | TITLE: Administrator | (X6) DATE: 05/17/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING _____ B. WING _____	05/06/2021

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 578	Continued From page 1 time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on record review, interview, and policy review, the provider failed to ensure an advance directive matched the resident's preference for one of two sampled residents (31) who had admitted to the facility within the past ninety days. Findings include: 1. Review of resident 31's medical chart revealed: *She was admitted on 2/10/21. *Affixed to the "Alert Condition" divider tab inside the front of that chart was a pre-printed card that read: "DNR (do not resuscitate)-NO CODE (do not revive or sustain that person if a life-threatening event such as heart stoppage occurs)." Review of resident 31's electronic medical record revealed: *A 2/10/21 admission summary note that stated "At this time she wishes to be a full code..." *A 2/16/21 Brief Interview of Mental Status score of fifteen indicating her cognition was intact. Interview on 5/5/21 at 2:15 p.m. with director of	F 578		

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	435090	A. BUILDING _____ B. WING _____	05/06/2021

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 578	Continued From page 2 nursing (DON) B regarding resident 31's code status revealed: *She confirmed an advance directive form was signed by that resident on 2/11/21 identifying her preference for cardiopulmonary resuscitation (CPR) in the event she was found to have no pulse and was not breathing. -That form was in a notebook at the nurses' station expected to be signed by her physician when he rounded. *A copy of that form should have been in the resident's medical chart then replaced after the physician had signed the original form. Interview on 5/5/21 at 2:50 p.m. with licensed practical nurse (LPN) C regarding residents' code status revealed: *Resident code statuses were documented in their electronic medical record, on a list posted inside the chart storage cabinet, and in the resident's medical chart. *She confirmed resident 31's code status was listed as DNR in all three of those locations. -In the event of a life-threatening event measures would have been taken to sustain her life. *It was the responsibility of the charge nurse who admitted a resident to ensure a code status had been documented based on resident preference and input from that resident's physician. Follow-up interview on 5/5/21 at 3:18 p.m. with DON B revealed: *At the time of admission, it was the expectation the resident code status was verified. -Any discrepancy between the code status identified by the resident and the code status identified in records from a transferring facility was expected to be reconciled at the time of admission.	F 578		

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	435090	A. BUILDING _____ B. WING _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 578	Continued From page 3 *She confirmed the charge nurse who admitted resident 31 had not ensured the correct code status was documented in the electronic medical record, medical chart or the list inside the medical chart cabinet. *An admission checklist was completed within twenty-four hours of admission and placed in the medical chart for all new admissions. -It had included advance directive paperwork. -No one was assigned to review that checklist for completeness and accuracy. *She agreed the provider's processes that could have identified resident 31's conflicting advance directive had failed. Review of the provider's revised January 2021 Advance Directives policy revealed: *Procedure: -"As part of the admissions process the resident or resident representative will be provided with access to information outlining the individual's rights for making decisions concerning medical care." -"Authorized personnel will document in the medical record whether the patient (resident) has completed an advance directive..." -"The provider or the nursing home staff will have the responsibility to review any existing advance directive with the resident/resident's representative to validate its current status."	F 578	F758: The Administrator, Director of Nursing and the Interdisciplinary team will review and revise policies and procedures to ensure that PRN psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Psychotropic drugs will also be limited to 14 days and then reordered by the physician if indicated. All residents are potentially affected by this deficiency.	
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	F 758	F758: The DON will update policies and procedures by May 24th, 2021. The Administrator, IDT team and nursing staff will be updated on the policy and procedure by May 24th, 2021. The DON or designee will ensure that all psychotropic meds are reviewed every 14 days and either a gradual dose reduction is recommended, continuance or discontinuation of the medication by the physician. The DON or designee will audit 3 charts per week for the next 4 weeks and then 2 charts per month for the next 2 months. The DON or designee will report to QAPI monthly for review and recommendations until the committee determines the goal has been met	May 24th, 2021

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 _____	05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 4 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 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	F 758		

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F 758	Continued From page 5 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: Surveyor: 42558 Based on record review, interview, and policy review, the facility failed to ensure appropriate stop orders and clinical needs were in place for the use of as needed (PRN) psychotropic medication for one sampled resident (1) receiving a prn psychotropic medication. Findings include: 1. Review on 5/5/21 at 2:00 p.m. of resident 1's medical record revealed: *He had been admitted on 11/3/20 with diagnoses of unspecified dementia with behavioral disturbance, coronavirus infection (Covid 19), chronic obstructive pulmonary disease (COPD), malignant neoplasm of unspecified part of unspecified bronchus or lung, malignant neoplasm of prostrate, meniere's disease unspecified, type two diabetes mellitus with other diabetic neurological complication. *His brief interview of mental status (BIMS) was a two, indicating severe cognitive impairment. *His code status was listed as do not resuscitate (DNR). *On 2/13/21 at 13:31 p.m. an order was received from the on-call physician to "Initiate comfort cares, three times a day for initiate comfort cares per (power of attorney) POA and On call physician." -The provider's undated "Physician Standing Orders-Comfort Cares" included an order for "Ativan (Lorazepam) 0.5 milligram (mg) intramuscular (IM) or by mouth (PO) every (Q) 6 hours as needed for agitation."	F 758		

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	435090	A. BUILDING _____ B. WING _____	05/06/2021

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 758	Continued From page 6 -Documentation in the nursing progress notes on 2/13/21 at 14:05 p.m. stated resident had "remained lethargic and non responsive." -There had not been any prior documentation since 2/11/21, when resident received his second dose of COVID 19 vaccine. 2. Review of resident 1's February through May 2021 medication administration record (MAR) revealed: *Resident 1 received one dose of lorazepam 0.5mg by mouth on 2/14/21 at 07:30 a.m. -Over nine hours later at 4:34 p.m. on 2/14/21, the MAR follow up reflected "effective." -In resident 1's nursing progress notes there was no documentation why he had needed the as needed medication such as behaviors exhibited or communication indicating anxiety or agitation. *The as needed order for lorazepam had an "indefinite" end date. -The 2/14/21 dose was the only dose the resident had received. -The order had remained on the MAR for four calendar months with no documented need noted. 3. Interview on 5/5/21 at 4:14 p.m. with licensed practical nurse (LPN) (C) revealed: *She was unaware psychotropic medications needed reviewed by the MD and a new order received every 14 days. *She stated resident 1 had not needed this medication in quite some time. "The resident had a difficult time in February, but he has been doing good lately." 4. Interview on 5/5/21 at 4:38 p.m. with director of nurse's (DON) (B) revealed: *Their consulting pharmacist reviews resident's	F 758		

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 _____	05/06/2021

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F 758	Continued From page 7 medications every month. -He would give them a monthly list of gradual dose reduction or discontinue suggestions on psychotropic medications. *She was aware of the fourteen day discontinue or evaluation rule on prn psychotropic's. *She stated the lorazepam standing order should have been entered into the computerized MAR as a "one time only" dose. -She did not understand how this order had been missed for so many months as their standing orders specifically state all psychotropic's should be reviewed by the MD every 14 days. *Their standing order policies are reviewed yearly. It was not done in 2020 due to the Covid pandemic emergency. 5. Review of resident 1's 2021 monthly consulting pharmacist review showed the prn lorazepam dose had not been addressed during the months of February through May of 2021 6. Review of resident 1's physician visit order summary dated 2/22/21 by his primary physician shows the prn lorazepam order had not been addressed. -The physician had not been in to see the resident since this date. 7. Review of the provider's January 2021 Medication Drug Review Policy revealed in part: *"1. The drug regimen of each resident will be reviewed at least monthly by a licensed pharmacist and the pharmacist will report any irregularities to the attending physician, the facility's medical direct [sic] and the director of nursing and theses [sic] reports will be acted upon." -"2. Irregularities include, but are not limited to,	F 758		

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	435090	A. BUILDING _____ B. WING _____	05/06/2021

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F 758	Continued From page 8 any drug that meets the following criteria: a. Excessive dose (including duplicate drug therapy); or b. Excessive duration; or c. Without adequate indication for its use; or d. In the presence of adverse consequences which indicate the dose should be reduced or discontinued e. Any combinations of the reasons above." -"3. This review will include a review of the resident's medical chart" 8. Review of the provider's 2019 Physicians Standing Orders, page 3 related to psychotropic medications, stated: *"Discontinue prn orders for antipsychotic medications after 14 days and call provider with an update." *"Unless a longer duration is specified, discontinue prn orders for antidepressants, anxiolytics and hypnotics after 14 days and call provider with an update."	F 758		

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 _____	05/06/2021

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

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E 000	Initial Comments Surveyor: 40788 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 5/4/21 through 5/6/21. Five Counties Nursing Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacy Drayton
TITLE: Administrator
(X6) DATE: 05/17/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/04/2021

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

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/4/21. Five Counties Nursing Home (building 01) was found not in compliance with 42 CFR 483.70 (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 5/6/21 upon correction of the deficiency identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 225 SS=C	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by:	K 225		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacy Drayton
TITLE: Administrator
(X6) DATE: 05/17/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/04/2021**

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

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K 225	Continued From page 1 Surveyor: 18087 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 5/4/21 at 1:15 p.m. and record review of the previous survey report dated 5/15/19 revealed the first floor door swung into the southwest stair enclosure. That door in the open position restricted the egress to 17 inches measuring from the latch side of the door leaf to the stair newel post. The building meets FSES. Please mark an "F" in the completion date column.	K 225		
K 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: Surveyor: 18087	K 374		F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/04/2021**

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 Based on observation and record review, the provider failed to maintain clear door widths of at least 32 inches for one randomly observed smoke barrier located on the first floor of the original building (between the original building and the 1962 addition). Findings include: 1. Observation on 5/4/21 at 2:30 p.m. revealed the cross-corridor doors between the original building and the 1962 addition were only 30 inches wide and did not provide a clear opening width of 32 inches. Review of the previous survey report dated 5/15/19 revealed those doors were the original doors. The building meets the FSES. Please mark an "F" in the completion date column.	K 374		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	435090	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**5/4/2021**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 918	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 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: Surveyor: 18087 Based on record review and interview, the provider failed to document generator battery conductivity monthly (no testing was being done in the past year). Findings include: 1. Record review on 5/4/21 at 1:45 p.m. revealed there was not any documentation of the battery conductivity in the monthly maintenance logs for the generator. Interview with the director of support services at the time of the record review confirmed that finding. He stated he was unaware of the monthly battery conductivity documentation requirement. The deficiency affected 100% of the building occupants.

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

The above isolated deficiencies pose no actual harm to the residents

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 02 - BUILDING 02 B. WING _____	05/04/2021

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 Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/4/21. Five Counties Nursing Home was found not in compliance with 42 CFR 483.70 (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 deficiency identified at K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacy Drayton
TITLE: Administrator
(X6) DATE: 05/17/2021

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 ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	435090	A. BUILDING: **02 - BUILDING 02** B. WING _____	**5/4/2021**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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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

The above isolated deficiencies pose no actual harm to the residents

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 _____	05/06/2021

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 Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/4/21 through 5/6/21. Five Counties Nursing Home was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 40788 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 5/4/21 through 5/6/21. Five Counties Nursing Home was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacy Drayton

TITLE: Administrator

(X6) DATE: 05/17/2021