| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435090 | A. Building<br>B. Wing | 01/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Five Counties Nursing Home | 405 6th Avenue West<br>Lemmon, SD 57638 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47780<br><br>Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), complaint report, record review, interview, and policy review, the provider failed to ensure:<br><br>*They had followed their policy after one of one sampled resident (1) who had fallen and was not referred to therapy after those falls.<br><br>*Assessments accurately reflected a resident's status for five of five sampled residents (2, 3, 4, 5, 6). Specifically, the provider failed to assess vital signs and ensure that vital signs were documented accurately on skilled nursing assessments.<br><br>Findings included:<br><br>1. Review of the provider's SD DOH FRI submitted on 1/7/25 at 12:38 p.m. regarding resident 1 revealed:<br><br>*Staff assisted the resident to the bathroom, gave her the call light, remindered her to ring the call light when she was done and left to help another resident.<br><br>*Staff had heard resident 1 calling for help and found her on the bathroom floor with her pants and incontinence pull-up down, sitting on her bottom with her right arm in the wheel of the wheelchair (wc) and her left arm behind her to support herself.<br><br>*Staff had moved the wc and did a quick assessment, then moved the resident to the wc where the registered nurse completed a full assessment.<br><br>-Redness noted to buttock where she was sitting on the floor, some redness noted to leftunderarm [left under arm] (resident states this is from bars on the side of toilet).<br><br>-Resident is c/o [complaining of] pain in left ankle. Mild redness noted there and some puffiness, much like the right ankle and CNA [certified nursing assistant] reports it may have been like that prior to fall.<br><br>*At 5:00 am, resident continues to complain of left ankle pain an ER [emergency room ] physician notified.<br><br>(continued on next page) |

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.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435090 | A. Building<br>B. Wing | 01/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Five Counties Nursing Home | 405 6th Avenue West<br>Lemmon, SD 57638 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | *Resident was transported to the clinic for a physician ordered x-ray which determined a non-displaced fracture.<br><br>Review of resident 1's electronic medical record (EMR) revealed:<br><br>*She was admitted to the facility on [DATE].<br><br>*Her diagnoses included: chronic systolic heart failure, diabetes, macular degeneration, hypertension, and muscle weakness.<br><br>*She had started physical therapy (PT) on 5/22/24. Her PT Assessment indicated:<br><br>-Her therapy diagnosed included: a history of falls, risk of falls, weakness, and imbalance.<br><br>-She required the use of a a sit-to-stand (mechanical lift used to assist from a seated to standing position) supervision or minimal assistance. For chair-to-bed or chair-to-chair transfers, she required moderate staff assistance. For toilet transfers, she required moderate staff assistance.<br><br>*She was discharged from PT servoces on 6/19/24.<br><br>*Her PT discharge assessment indicated:<br><br>-For the chair-to-bed or chair-to-chair transfers, she required staff supervision or minimal assistance. For toilet transfers, she required staff supervision or minimal assistance.<br><br>-She was to have restorative therapy for ambulation, transfers, and active range of motion (AROM) for upper and lower extremities, three to five times a week.<br><br>*Minimum Data Set (MDS) review note from PT on 8/22/24 stated: [resident 1] uses a w/c for mobility around the facility. She is refusing to ambulate. She is requires mod [moderate] assistance in transfers. She is on a walk-to dine and AROM. Restorative programs atthis [at this] time. No therapy indicated at this time.<br><br>*She had fallen on 8/27/24, 10/20/24 and 1/4/25.<br><br>*The falls event checklist related to her falls on 8/27/24 and 10/20/24 did not have the therapy department box checked as notified.<br><br>*After her 8/27/24 and 10/20/24 falls, there was no documention that indicated physical therapy was notified or a therapy referral was sent.<br><br>-Death in the facility on 1/19/25.<br><br>Interview on 1/22/25 at 10:45 a.m. with physical therapist C revealed:<br><br>*He was one of two physical therapist who were employed with the facility.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435090 | A. Building<br>B. Wing | 01/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Five Counties Nursing Home | 405 6th Avenue West<br>Lemmon, SD 57638 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | *He was unaware of any referrals sent to the physical therapy department for resident 1 after she had fallen on 8/27/24 or 10/20/24.<br><br>*He stated if the therapy department had gotten a referral there would have been documentation in the resident's chart.<br><br>-There was no documentation in resident 1's chart for a therapy referral or therapy services after she had fallen.<br><br>Interview on 1/22/25 at 2:05 p.m. with director of nursing (DON) B revealed:<br><br>*She was unaware a referral had not been sent to the therapy department after resident 1 had fallen on 8/27/24 and 10/20/24.<br><br>*She was not sure why the therapy department was not notified.<br><br>*She confirmed the therapy department notifiation box on the falls event checklist for resident 1's falls on 8/27/24 and 10/20/24 were not check marked.<br><br>Review of the provider's reviewed December 2024 Fall policy revealed:<br><br>*Purpose: To provide a safe living environment for residents and to protect them from injury.<br><br>*Post-Fall Management:<br><br>-PT will be notified of each fall as it occurs. Referrals for evaluation made as indicated.<br><br>51816<br><br>2. Review of SD DOH complaint report submitted on 1/15/25 at 4:53 p.m. revealed:<br><br>*The complainant wished to remain anonymous.<br><br>*The complainant reported concerns with the accuracy of resident assessments and timeliness of the documentation of resident assessments at the facility.<br><br>3. A review of resident 2's electronic medical record (EMR) revealed:<br><br>*Her diagnoses included secondary hypertension (high blood pressure from an underlying medical condition), hyperlipidemia (high cholesterol), chronic obstructive pulmonary disease (COPD), anemia, peripheral vascular disease (progressive circulation disorder caused by narrowing, blockage, or spasms in a blood vessel), and essential hypertension (the most common type of high blood pressure).<br><br>*Previous vital signs were documented instead of having checked and documented her current vital signs each day. From 10/4/24 to 11/12/24, her:<br><br>- Blood pressure was checked on 33 out of 41 days.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435090 | A. Building<br>B. Wing | 01/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Five Counties Nursing Home | 405 6th Avenue West<br>Lemmon, SD 57638 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - Pulse was checked on 24 out of 41 days.<br><br>- Temperature was checked on 25 out of 41 days.<br><br>- Respirations were checked on 24 out of 41 days.<br><br>-Oxygen saturation was checked on 26 out of 41 days.<br><br>4. A review of resident 3's EMR revealed:<br><br>*Her diagnoses included COPD, atrial fibrillation (a condition that causes an irregular heartbeat), secondary hypertension, weakness, and essential hypertension.<br><br>*Previous vital signs were documented instead of having checked and documented her current vital signs each day. From 10/1/24 to 10/29/24, her:<br><br>- Blood pressure was checked on 11 out of 29 days.<br><br>- Pulse was checked on 11 out of 29 days.<br><br>- Temperature was checked on 10 out of 29 days.<br><br>- Respirations were checked on 11 out of 29 days.<br><br>- Oxygen saturation was checked on 12 out of 29 days.<br><br>5. A review of resident 4's EMR revealed:<br><br>*Her diagnoses included severe chronic kidney disease, heart failure, essential hypertension, Type 2 Diabetes, peripheral vascular disease, and chronic myeloproliferative disease (rare blood cancers).<br><br>*Previous vital signs were documented instead of having checked and documented her current vital signs each day. From 11/26/24 to 12/24/24, her:<br><br>- Blood pressure was checked on 20 out of 29 days.<br><br>- Pulse was checked on 20 out of 29 days.<br><br>- Temperature was checked on 19 out of 29 days.<br><br>- Respirations were checked on 20 out of 29 days.<br><br>- Oxygen saturation was checked on 20 out of 29 days.<br><br>6. A review of resident 5's EMR revealed:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435090 | A. Building<br>B. Wing | 01/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Five Counties Nursing Home | 405 6th Avenue West<br>Lemmon, SD 57638 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | *Her diagnoses included dementia, adult failure to thrive, acute kidney failure, heart failure, muscle weakness, and other specified disorders involving the immune mechanism.<br><br>*Previous vital signs were documented instead of having checked and documented her current vital signs each day. From 9/18/24 to 10/17/24, her blood pressure, pulse, temperature, respirations, and oxygen saturation were checked on 13 out of 29 days.<br><br>7. A review of resident 6's EMR revealed:<br><br>*His diagnoses included essential hypertension, diabetes mellitus due to underlying condition, and 2-part displaced fracture of surgical neck of left humerus (upper part of the left humerus bone near the shoulder has fractured into two pieces that are significantly displaced).<br><br>*Previous vital signs were documented instead of having checked and documented his current vital signs each day. From 12/13/24 to 1/20/25, his blood pressure, pulse, temperature, respirations, and oxygen saturation were checked on 26 out of 38 days.<br><br>8. Interview with Nurse Executive/Director of Nursing (DON) B revealed she agreed that a current set of a resident's vital signs needed to be a part of a skilled nursing assessment. She stated, I assume it is just pulling from the last documented vital signs if they aren't entering current vitals.<br><br>9. Review of the provider's undated How to Chart on Medicare A Residents policy revealed:<br><br>* What do you need?<br><br>- Full set of vitals on the resident (BP, Pulse, Temp, O2 Sat, RR [respiratory rate]).<br><br>* How Often Do I need to do this charting?<br><br>- For Medicare to reimburse us for services, we need to do this charting every 24 hours. |