

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435090	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/15/2025
NAME OF PROVIDER OR SUPPLIER  Five Counties Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  405 6th Avenue West 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and observation, the provider failed to ensure the safety of one of one cognitively impaired sampled resident (3), identified as being at risk for elopement, who eloped (left the facility without staff knowledge) and was outside of the building for an unknown amount of time after she entered the doorlock's key pad code and exited the building. Failure to adequately supervise and monitor the resident's location and to provide environmental controls (doorlock keypad code unknown to the resident) may have contributed to her elopement and placed the resident at risk for an accident and/or injury while she was out of the building and unsupervised.</p> <p>Findings include:</p> <p>1. Review of the provider's 4/12/25 SD DOH FRI revealed:</p> <p>*On 4/12/25 at 11:00 a.m. resident 3 exited the building through the [NAME] wing doors.</p> <p>-She stated she had entered the door code to unlock it and left as she was looking for her son.</p> <p>-The door locked behind her.</p> <p>*She went to the front door of the building and rang the front doorbell.</p> <p>*At 11:00 a.m., certified medication aide D opened the door for resident 3, and she came back into the building.</p> <p>*The report indicated resident 3's care plan would be reviewed on Monday [4/14/25] to revise for high-risk elopement.</p> <p>*The facility ordered AirTags [a tracking device] to assist in monitoring residents' location to ensure safety.</p> <p>*Resident 3 had refused to utilize the WearTech devices as she insinuates her watch is broken and does not like the emblem on it.</p> <p>2. Review of resident 3's electronic medical record revealed:</p> <p>*Her admission date was: 6/7/22</p> <p>(continued on next page)</p>

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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Her 3/3/25 Brief Interview of Mental Status assessment score was an 8, which indicated she was moderately cognitively impaired.</p> <p>*Her diagnoses included: dementia with agitation, Alzheimer's Disease, schizophrenia, , altered mental status, and heart failure.</p> <p>*Her 5/15/25 care plan indicated:</p> <p>-A 6/14/22 focus area of appropriate placement (a facility with a dementia unit) with a 4/29/25 initiated intervention of Resident high elopement risk, considering other options for a facility better suited for her needs.</p> <p>-A 6/14/22 focus area of is at moderate risk for wandering and high risk for elopement.</p> <p>--A 1/31/25 revised goal for this focus area was Resident will remain in facility unless staff present and have no attempts at elopement through the review date.</p> <p>--The current interventions for that focus area included:</p> <p>--A 9/9/24 initiated and 9/24/24 revised intervention is a moderate risk for elopement,</p> <p>--A 4/3/25 intervention Window alarm placed on 4/3/25 in resident room.</p> <p>--A 4/14/25 intervention is at high risk for elopement, efforts in place to look for a facility more suited to her needs.</p> <p>--A 4/29/25 intervention Air tag placed in soles of shoes.</p> <p>*Her 12/3/24 elopement risk assessment indicated she was at moderate risk for elopement.</p> <p>-Elopement precautions for her included: routine monitoring of her whereabouts, involve in psychosocial programs and activities programs, re-direction, care plan was updated, DON notified, and up-to-date photo in system.</p> <p>*Her 3/2/25 elopement risk assessment indicated she was at a low risk for elopement.</p> <p>-Elopement precautions for her included the same as indicated above.</p> <p>3. Review of the provider's undated Elopement, Risk Reduction Strategies, and Management of Missing Residents policy revealed:</p> <p>*The facility strives to promote resident safety and protect the rights and dignity of the residents. The facility maintains a process to assess all residents for risk of elopement, implement risk reduction strategies for those identified as an elopement risk, institute measures for resident identification at the time of admission, and conduct a coordinated resident search in the event of a missing resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Elopement is the ability of a cognitively impaired resident, who is not capable of protecting himself or herself from harm, to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way.</p> <p>*An elopement risk evaluation is completed on all residents on admission, and with a change in condition or mental status.</p> <p>*A facility approved risk evaluation tool (or scoring system) is utilized</p> <p>-a. The evaluation is based on various risk factors that may precipitate an elopement event</p> <p>-b. The risk score includes a defined parameter which, when reached, indicates an increased risk and prompts strategies, as described below.</p> <p>*The risk evaluation . addresses the resident's mobility and psychological, behavioral, physical, and cognitive functions. Specific risk factors include:</p> <p>-Any cognitive impairment which results in an inability of the resident to appreciate safety risks and an inability to protect himself or herself.</p> <p>-Interference with risk reduction strategies, including an expressed displeasure with a wander bracelet or an attempt to remove it.</p> <p>-Behavior problems, including those where the resident is not easily redirected or managed when he or she is agitated or aggressive.</p> <p>*Interventions that may be used for residents identified as high risk for elopement include:</p> <p>-Frequent monitoring of the resident's whereabouts to assure he or she remains in the facility.</p> <p>-Implementation of wander bracelet or other electronic alert systems.</p> <p>-Environmental controls such as:</p> <p>--The physical plant is secured to minimize the risk of elopement through: (a.) Functional alarm system . c. Safety locks or keypad entry that restrict access to dangerous areas.</p> <p>*Verification of control systems.</p> <p>-Door alarm codes are changed routinely.</p> <p>-Resident electronic monitoring sensors (e.g. bracelets/pendants) will be utilized as needed. They will be checked quarterly for placement and proper functioning and documented in the Care Plan.</p> <p>*When a resident has been found:</p> <p>-The resident's service plan [care plan] is updated, including:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>--Additional measures such as a wander bracelet if not in current use</p> <p>--15-minute safety checks or continuous observation if transfer to a more secure facility is determined</p> <p>--A Missing Resident form is completed, and all staff involved sign the form. The form is forwarded to the Administrator or Resident Services Coordinator.</p> <p>--The incident is reported to the state authorities as required.</p> <p>*All elopement attempts and events are documented in the resident record, including objective and factual statements regarding:</p> <p>-a. Circumstances and precipitating factors</p> <p>-b. Interventions utilized to return the resident to the unit</p> <p>-c. The resident's response to the interventions</p> <p>-d. Results of reevaluation upon the resident's return and the condition of the resident</p> <p>e. Care rendered</p> <p>f. Notification of police, physician, and family</p> <p>g. Physician orders following notification</p> <p>h. Additional risk reduction strategies implemented</p> <p>*Resident-specific safety concerns are noted on the resident care plan and interventions that address his or her needs. Interventions to reduce risk are reviewed by the interdisciplinary team on a quarterly basis, at least, or with a change in condition for effectiveness of risk reduction strategies. These measures include realistic measurable goals and avoiding statements such as 'will have no events or no injuries related to elopement'.</p> <p>*Elopement drills will be conducted annually. Each elopement will be considered a drill and evaluated to improve outcomes.</p> <p>4. Interview on 5/15/25 at 12:50 p.m. with licensed practical nurse C regarding resident 3 revealed:</p> <p>*Resident 3 was often exit seeking, and she was aware that resident 3 had recently eloped from the building.</p> <p>*She thought resident 3 also had an elopement in October 2024, but she was not certain.</p> <p>*She was not working when resident 3 eloped on 4/12/25, but she was aware of the elopement and the intervention at that time for redirecting resident 3 when she was exit seeking.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*She stated they had not had any elopement drills since she had started her employment.</p> <p>*She was not aware of a photo book or any other book at the reception desk for residents at risk for elopement.</p> <p>5. Observation and interview on 5/15/25 at 1:05 p.m. with resident 3 while she was in the activity room revealed:</p> <p>*She walked independently, without the use of an assistive device such as a walker.</p> <p>*She stated she did not like living at the facility as she was unable to see her family.</p> <p>*She did not respond to any additional questions.</p> <p>6. Interview and policy review on 5/15/25 at 2:43 p.m. with administrator A regarding resident 3's elopement revealed:</p> <p>*Resident 3 had eloped from the building on 4/12/25.</p> <p>*Administrator A could speculate that she [resident 3] walked with a visitor out [of the building].</p> <p>-There were no cameras that would have captured resident 3's elopement.</p> <p>*She confirmed there was no way to determine how long resident 3 was outside of the building.</p> <p>*When administrator A interviewed resident 3 after the elopement, resident 3 indicated she had overheard the code to unlock the doors and used it to unlock the door that day.</p> <p>*There was no signage posted that directed non-staff members to ensure residents did not follow them out of the building when they left.</p> <p>*Administrator A thought the door alarm codes were changed maybe quarterly.</p> <p>-The door alarm codes were change after resident 3's elopement on 4/12/25.</p> <p>-She stated she knew the [door] codes were changed when we have noticed increased wandering and when we heard family screaming out the code.</p> <p>-There was no documentation of when the door alarm codes were changed.</p> <p>*She stated staff members were given the code and somehow family and volunteers get a hold of it and then we change it.</p> <p>*Resident 3 had eloped from the facility more than once, but she was not certain of the dates of those elopements.</p> <p>*They did not routinely execute elopement drills, but every elopement is reviewed as a drill.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Regarding the provider's undated Elopement, Risk Reduction Strategies, and Management of Missing Residents policy</p> <p>-They did not annually photograph residents at risk for elopement.</p> <p>--She was not certain how often a resident's photograph was taken.</p> <p>-There was no photo book or any other book of at-risk for elopement at the receptionist desk.</p> <p>--The MDS Coordinator would be responsible to create and update this book.</p> <p>*Resident 3 currently wore AirTags in the soles of her shoes, and it was monitored through an iPad at the nurse desk.</p> <p>-She confirmed the device would only give resident 3's location and not if she had left the building without staff's knowledge.</p> <p>-She stated We would be able to track her [location] if she left and I can't speak to its accuracy, it is in the settings if she leaves.</p> <p>*Resident 3 previously wore a wear tech device, but that was agitating her.</p> <p>*Regarding resident 3's care plan, administrator A indicated:</p> <p>-Her care plan was updated to include she was at high risk for elopement, and previously indicated she was at medium risk for elopement.</p> <p>-The alarm on resident 3's window intervention was due to her threatening to throw her clothes out her window.</p> <p>*Administrator A confirmed their Elopement, Risk Reduction Strategies, and Management of Missing Residents policy had not been followed.</p> <p>*Administrator A confirmed:</p> <p>-Resident 3 had left the facility without staff knowledge through an alarmed door when the resident entered the keypad code that deactivated the alarm.</p> <p>-The facility was responsible for the safety and supervision of residents.</p> <p>-Resident 3 was at high risk for elopement and had eloped on several occasions.</p>		