

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

ORIGINAL

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030	
(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: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/3/14 through 2/5/14. Palisade Healthcare Community was found not in compliance with the following requirements: F281, F323, F431, and F441.	F 000	Addendums noted with an asterisk per 02/12/14 telephone to facility DON. PE/SDDOH/MF	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure: *Medications during the preparation process remained within the nurses sight for 1 of 16 sampled residents (8). *Physician's orders were followed for 2 of 3 liquid medications for 1 of 1 sampled resident (8). *Placement of a feeding tube had been assessed prior to medication administration for 1 of 1 sampled resident (8). *Insulin syringes for medication administration were maintained in a safe manner for 3 of 4 sampled residents (7, 11, and 12). Findings include: 1. Observation on 2/4/14 from 9:00 a.m. to 10:00 a.m. of licensed practical nurse (LPN) B and registered nurse (RN) D revealed: *LPN B prepared medications for administration	F 281	A. Resident # 8's medication dosages were clarified w/ the physician &/or pharmacy on February 4 th 2014. *Nurse was educated on giving insulin to residents 7, 11 and 12. PE/SDDOH/MF B. All residents are potentially at risk from the practices noted. C. The Director of Nursing (DON) or designee will complete education w/ the nurses on or before 3/27/14 on medication dosages / accuracy, insulin administration and tube feeding administration. The DON or designee will complete written audits weekly x 4, then monthly x 2 on the areas noted in the 2567. *including placement. PE/SDDOH/MF D. Results of the written audits will be presented to the facility QA & A committee by the DON or designee monthly x 3 for review and recommendations.	* 3/27/14 PE/SDDOH/MF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Ledie Smith, LWA

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.

12/25/14
MAR 10 2014
If continuation sheet Page 1 of 20
SD DOH L&C

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 281	<p>Continued From page 1</p> <p>by a feeding tube (tube inserted directly into the stomach for food and medication administration) for resident 8.</p> <p>*RN D monitored the above preparation process.</p> <p>*During three separate occasions RN D retrieved four of the medication cups that LPN B had prepared at the medication cart in the hallway.</p> <p>She:</p> <ul style="list-style-type: none"> -Placed medication cups in resident 8's room on his bedside table and returned to the medication cart. -Left medications unattended in resident 8's room while the resident, maintenance supervisor, and an unidentified staff person had been present in the room. <p>Interview on 2/5/14 at 9:35 a.m. with the director of nurses (DON) confirmed the medications should not have been left unattended.</p> <p>Review of the provider's 1/1/13 Pharmacy Services and Procedure manual revealed staff should not have left medications unattended.</p> <p>2. Observation on 2/4/14 at 9:30 a.m. of LPN B revealed:</p> <ul style="list-style-type: none"> *She prepared medications for administration by a feeding tube for resident 8. *She retrieved a bottle of liquid acetaminophen (pain reliever) and poured some into a medication cup. *The amount she poured into the cup had been just over 15 milliliters (ml). The medication administration record (MAR) revealed resident 8 was to have received acetaminophen 15.63 ml twice a day (BID) by his feeding tube. The order date on the MAR had been 9/25/13. *She retrieved a bottle of liquid sodium chloride and poured some into a medication cup. 	F 281			

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030	
(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 281	<p>Continued From page 2</p> <p>*The amount she poured into the cup had been just over 5 ml. The MAR revealed resident 8 was to have received sodium chloride 5.4 ml BID by his feeding tube. The order date on the MAR had been 9/25/13.</p> <p>Interview on 2/4/14 at the time of the above observation with LPN B revealed she had not known how to accurately measure the amounts of liquid medications required. She could not confirm the correct amounts had been poured into the medication cups. That had always been her usual practice.</p> <p>Interview on 2/4/14 at the time of the above observation with RN D revealed: *The 9/25/13 date on the MAR had been the original order date for the medications. *She would have poured the medications directly into the medication cups. *She would have estimated the amounts to be delivered. *She had not considered using a syringe to ensure resident 8 had been receiving the exact amounts of medication ordered by the physician. *That had always been her usual practice. *She had not considered contacting the physician to clarify the dosages were correct.</p> <p>After the above interviews RN D preceded to deliver the amounts dispensed in the medication cups by LPN B to resident 8. Neither LPN B nor RN D had attempted to remeasure the liquids in the medication cups to ensure the correct dosage had been delivered.</p> <p>Interview on 2/5/14 at 9:40 a.m. with the DON revealed the orders should have been clarified with the physician. The staff should have been</p>	F 281		

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 281	<p>Continued From page 3</p> <p>using a syringe to ensure proper dosage had been delivered.</p> <p>Review of the provider's July 2013 Medication Administration policy revealed: **When in doubt about dosage or effect of a medication, always refer to the Drug References on nursing unit or to the pharmacist. If any question, withhold the medication and consult the nurse in charge or the physician." *Always follow the five rights of medication administration which included the right dose.</p> <p>3. Observation on 2/4/14 at 10:00 a.m. of RN D revealed she had not checked for placement of the feeding tube prior to administering medications.</p> <p>Review of the provider's March 2013 Checking Placement of a Stomach Tube policy revealed "The purpose of this procedure is to check proper placement of the tube prior to medication, flush or liquid feeding administration."</p> <p>Interview on 2/5/14 at 9:40 a.m. with the DON confirmed the placement of the feeding tube should have been done prior to medication administration.</p> <p>4a. Observation on 2/3/14 at 12:15 p.m. of RN A revealed she had: *Retrieved supplies for insulin administration. *Drew up the correct dose of insulin. *Walked across the hall to resident 7's room to administer the insulin. *Left the needle of the insulin syringe exposed while she walked across the hall and into resident 7's room.</p>	F 281		

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030	
(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 281	Continued From page 4 b. Observation on 2/3/14 at 12:20 p.m. of RN A revealed she prepared insulin administration for resident 11. She had done the exact same procedure for administration of the insulin by a syringe as stated above. c. Observation on 2/3/14 at 12:25 p.m. of RN A revealed she prepared insulin administration for resident 12. She had done the exact same procedure for administration of the insulin by a syringe as stated above. d. Interview on 2/5/14 at 9:45 a.m. with the DON confirmed RN A should have covered the needles of the syringes after drawing up the correct doses of insulin and prior to administration. She further confirmed that had been an unsafe practice. Review of the provider's undated Insulin Administration policy revealed no procedure or direction for staff to cover the needle prior to administration of the medication.	F 281		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy	F 323	F323 A.No specific residents are cited in the deficiency. All listed bottles have been appropriately labeled and/or discarded. B. All residents are potentially at risk C. The facility will be free of unlabeled containers. The DON or designee will complete education to all facility staff on or before 3/27/14 regarding accident hazards related to unlabeled bottles. Facility policies	* 3/27/14 PEISDDH/MF

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 323	<p>Continued From page 5</p> <p>review, the provider failed to maintain proper labeling of chemicals in three of three whirlpool tub rooms (Southeast, Southwest, and North), in two of two soiled utility rooms (Southwest and North), and one of two activity rooms (North). Findings include:</p> <p>1a. Observation on 2/3/14 at 10:30 a.m. in the soiled utility room on Southwest hall revealed a spray bottle located on top of the hopper (a special type of sink). The bottle had a taped label and the typed word "EcoLab Stain Blaster" (a stain remover).</p> <p>b. Observation on 2/3/14 at the same time as the above in the whirlpool tub room on Southwest hall revealed: *Two full plastic twelve ounce (oz) bottles contained an unknown light green liquid. *The bottles' labels contained no information regarding the contents. *The bottles were located on a chair next to a spray bottle of disinfectant, a white brush, and a bottle of hair conditioner. *Six, twelve oz spray bottles in a cupboard each had handwritten "Periwash" (a personal cleanser) in black marker on the bottle.</p> <p>c. Observation on 2/3/14 at 3:55 p.m. in the whirlpool tub room on Southeast hall revealed: *Two, twelve oz bottles contained an unknown light orange liquid located on: -The handsink. -Top of the whirlpool tub. *One spray bottle contained an unidentified yellow liquid.</p> <p>Interview on 2/3/14 at 4:00 p.m. with certified nursing assistant (CNA) E and CNA F in the</p>	F 323	<p>labeling will be included in the education. The facility DON &/or Housekeeping supervisor or designees will complete written audits on labeled bottles in the facility. The audits will be completed weekly x 4, then monthly x 3.</p> <p>D. Results of the written audits will be presented to the facility QA&A committee by the DON monthly x 3 for review and recommendations.</p>		

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 323	<p>Continued From page 6</p> <p>whirlpool tub room on Southeast hall regarding the unlabeled bottles revealed: *They were unsure what the light orange liquid was. *The spray bottle that contained the yellow liquid was diluted whirlpool disinfectant cleaner.</p> <p>d. Observation on 2/3/14 at 4:15 p.m. in the whirlpool tub room on North hall revealed one, twelve oz bottle contained an unknown light orange liquid and was located on the top of the handsink.</p> <p>e. Observation on 2/3/14 at 4:20 p.m. in the soiled utility room on North hall revealed a spray bottle located on top of the hopper with a taped label and the typed word "EcoLab Stain Blaster."</p> <p>f. Interview on 2/3/14 at 5:35 p.m. with the housekeeping and laundry supervisor regarding the unmarked bottles revealed: *In the whirlpool tub rooms on Southeast, Southwest, and North halls she: -Was unsure what the bottles contained. -Stated the bottles were not used or filled by housekeeping. -Thought the nursing department had used and filled the bottles. *In the soiled utility rooms on Southwest and North halls she stated she: -Had made labels for the Stain Blaster that had contained only the name of the product. -Had needed more information on the labels including any warnings for its use.</p> <p>Interview on 2/3/14 at 5:55 p.m. with the administrator, director of nursing, and nurse consultant in the whirlpool tub rooms on Southeast and Southwest halls regarding the</p>	F 323			

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 323	Continued From page 7 unmarked bottles revealed the bottles should have been properly labeled with the contents and any warnings for their use. g. Observation and interview on 2/4/14 at 9:30 a.m. with the housekeeping and laundry supervisor of an unlocked cupboard in the activity room on North hall revealed: *A one-eighth full spray bottle contained a handwritten label "Rubbing Alcohol" in black marker. *The bottle had not been properly labeled with the contents and any warnings for its use. Review of the provider's 2/4/14 Chemical Labeling Requirements policy revealed labels on purchased chemicals included: *The common name of the chemical. *The name, address, and emergency phone number of the company responsible for the product. *An appropriate hazard warning. Review of the provider's 2/4/14 Tips for Handling Chemicals policy revealed: *Never to have used a chemical that was not clearly labeled. *The chemical could have been volatile (could change and evaporate into the air) if mixed with the wrong chemicals unknowingly. *A bottle not clearly marked was not to have been used.	F 323			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431	F431 A.No specific residents are listed in the deficiency. B. All residents are potentially at risk		

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2014	
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 431	<p>Continued From page 8</p> <p>controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Preceptor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure: *A double-locked location was available for storage for a received controlled substance for</p>	F 431	<p>C. The facility DON or designee will complete education with facility nurses and medication aides on the appropriate storage of medications.</p> <p>The facility pharmacy provider was consulted on 2/4/14 regarding areas cited w/ the emergency drug kit in the facility. The emergency drug kit was replaced by the contracted pharmacy on 2/5/14 to assure e-kit was appropriately checked by a pharmacist (as required monthly)</p> <p>The facility DON or designee will complete written audits on storage of medications and the facility E-kit weekly x 4, then monthly x 3.</p> <p><i>* outdated medications and</i></p> <p>D. Results of the written audits will be presented to the facility QA&A committee by the DON monthly x 3 for review and recommendations.</p> <p><i>Nurse was educated on receipt of narcotics to be double locked at all times. and on policy and procedure on receipt of medications.</i></p>	<p><i>2/18/14</i> <i>PE/SDD/HMF</i></p>

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 431	<p>Continued From page 9</p> <p>one of three medication carts. *One of one emergency drug kit (E-kit) did not contain expired medications. Findings include:</p> <p>1. Observation on 2/5/14 at 10:30 a.m. of the medication cart of the Southeast and Southwest wings with the director of nursing (DON) revealed: *A medication bubble pack was tucked along the side of the controlled substance locked box. *The bubble pack had ten tablets labeled hydrocodone-APAP 5-325 milligrams (mg) and was dated 2/4/14. *Tablets in the spaces numbered six and seven had the foil backing broken, and then had been taped shut with transparent tape. *One white tablet remained in each of the first ten numbered spaces. *No notation had been made as to the reason the two spaces for medication had been opened and then taped shut. *No sign out sheet had been placed in the notebook for counting of narcotics. *No delivery sheet documenting the hydrocodone had been delivered to the facility had been found.</p> <p>Interview on 2/5/14 at 10:30 a.m. with the DON revealed: *She agreed there was no way to know the hydrocodone had been delivered due to: -There was no sign out sheet for the hydrocodone placed in the notebook used to track controlled substances. -Medication bubble pack had not been locked in the narcotic locked box but had been tucked on the side of the box not in a plain or obvious site. - Delivery sheet had not been available for review.</p>	F 431			

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 431	<p>Continued From page 10</p> <p>*She had no idea why the two foil backs were broken, and then had been taped shut.</p> <p>*The resident for which the medication bubble pack had been prepared had not received any hydrocodone during the night shift when the bubble pack was received.</p> <p>Review of the proof of delivery form obtained from the pharmacy by the DON revealed certified nursing assistant G had initialed the form during the previous night shift (2/4/13 to 2/5/14).</p> <p>Review of the provider's 1/1/13 Delivery and Receipt of Routine Deliveries and Documents policy revealed: *Staff should have taken responsibility of the medication and provided proper storage upon delivery. *Receiving staff should have notified the pharmacy of any damage to packages within twenty-four hours. *Staff should have placed the medication in the appropriate location for storage and use after it had been delivered. *Staff should have immediately logged controlled substances into the provider's controlled medication inventory system and should have placed a sign out sheet in the controlled substance tracking notebook. *Staff should have stored the controlled medication in compliance with applicable law (double-locked system).</p> <p>Surveyor: 32355 2. Observation on 2/4/14 at 4:30 p.m. of the medication room on the Southwest and Southeast wings with the DON revealed: *An E-kit that had two labels on top of the lid. *One of the labels had been dated 8/9/13.</p>	F 431			

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 431	Continued From page 11 *The other label had "Avelox expires 11/30/13" on it. *The E-kit contained: -Two Avelox pills that had expired on 11/30/13. -Three cephalexin (medication for infections) 250 milligrams that had expired on 12/30/13. Interview on 2/4/14 with the DON at the time of the above observation revealed: *The 8/9/13 date indicated the last time the pharmacy had checked the E-kit. *Registered nurse D checked the E-kit monthly. *She had assumed the pharmacy had been checking the E-kit when they came to the facility every month. Review of the provider's 1/1/13 Pharmacy Services and Procedures Manual revealed any emergency systems or kits should have been exchanged with the pharmacy representative or courier as necessary. Review of the provider's 11/15/96 Emergency Medication Systems policy revealed: **Pharmacies will supervise and oversee the use of these emergency medication systems as needed and as required by law and regulation." ***The contents of emergency medication systems located in facility settings should be audited to ensure that the contents match the designated inventory for each medication and that no expired medications or items are present."	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		* 2/27/14 PERSON/ME	

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 441	<p>Continued From page 12 to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure</p>	F 441			

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 441	<p>Continued From page 13</p> <p>appropriate infection control practices were maintained for:</p> <p>*Five of five observed residents (3, 6, 7, 11, and 12) with blood sugar monitoring.</p> <p>*Three of four observed residents (7, 10, and 11) with insulin administration.</p> <p>* [REDACTED] PEISDDH/ME</p> <p>*One of one resident (8) who received a dressing change.</p> <p>*Completion of task for one of one resident (1) following catheter care.</p> <p>Findings include:</p> <p>1a. Observation on 2/3/14 from 12:07 p.m. through 12:25 p.m. of registered nurse (RN) A regarding residents 3, 7, 11, and 12 revealed:</p> <p>*She sanitized her hands and put on a pair of gloves.</p> <p>*With those gloves on she:</p> <ul style="list-style-type: none"> -Opened the medication administration record (MAR). -Reached into her pocket and retrieved the keys to unlock the treatment cart. -Retrieved supplies for checking the resident's blood sugar. -Placed all of the supplies directly on top of the treatment cart without a barrier. -Closed the drawer and locked the treatment cart. -Took all of the supplies into the resident's room and placed them directly on top of the bedside table without a barrier. -Used alcohol to wipe the resident's finger, poked the finger with the lancet (device to draw blood), and drew a sample of blood. -Returned to the treatment cart. -Placed the glucometer directly on top of the treatment cart without a barrier. -Retrieved a Super-Sani Cloth Germicidal (kills 	F 441	<p>* A. Action for residents #'s 3,6,7,11, and 12 noted in the 2567 are unable to be corrected at this time. Nurse was educated on correct procedure for completing blood glucose.</p> <p>B. All diabetic residents are potentially at risk.</p> <p>C. The facility DON or designee will complete education with facility nurses and MA's on or before 3/7/14 regarding appropriate procedures for blood sugar checks. The facility DON or designee will complete written audits weekly x4 then monthly x3.</p> <p>D. Results of the written audits will be presented to the facility QA&A committee by the DON monthly x3 for review and recommendations.</p> <p>PEISDDH/ME</p>		

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 441	<p>Continued From page 14</p> <p>germs) disposable wipe and cleansed the glucometer. -Placed the glucometer back on top of the treatment cart without a barrier. -Removed her right hand glove and retrieved a pen out of her pocket. -Opened the MAR with her left gloved hand and charted the blood sugar level. -Closed the MAR and removed the glove from her left hand. -After removing her glove she sanitized her hands. *She followed the same procedure above for each resident.</p> <p>b. Observation on 2/3/14 at 5:15 p.m. revealed RN C prepared to test the blood sugar of resident 6. *She opened the treatment cart drawer and retrieved supplies for checking the resident's blood sugar. *She placed all of the supplies directly on top of the treatment cart without a barrier. *She closed the drawer and locked the treatment cart. *She sanitized her hands and put on gloves. *With those gloved hands she: -Took all of the supplies into the resident's room and placed them directly on top of her bedside table without a barrier. -Used the glucometer to measure the resident's blood. -Returned to the treatment cart. -Placed the glucometer directly on top of the treatment cart without a barrier. -Retrieved a Super-Sani Cloth Germicidal disposable wipe and cleansed the glucometer. -Placed the glucometer back on top of the treatment cart without a barrier.</p>	F 441			

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 441	<p>Continued From page 15</p> <p>-Removed her gloves and sanitized her hands.</p> <p>c. Review of the provider's undated Glucometer Use, Cleaning, and Disinfecting policy revealed: *The glucometer would be wiped down in the resident's room with an EPA (Environmental Protection Agency) approved germicidal, such as Super-Sani Cloths. *If the supplies had been taken into the resident's room in a caddy they could have been placed directly on the bedside table. *No procedure had been mentioned for placement of the supplies in the resident's room or on top of the treatment cart without a caddy.</p> <p>Interview on 2/5/14 at 9:15 a.m. with the director of nursing (DON) and the nurse consultant revealed: *The above observations had not been appropriate infection control practices and sanitary conditions had not been maintained. *They had no information available to ensure education and auditing had occurred following the 12/19/12 survey when similar observations were cited.</p> <p>2a. Observation on 2/3/14 at 4:10 p.m. revealed RN A had been preparing to administer nebulizer treatments to residents 13 and 14. Without performing hand hygiene or putting on a pair of gloves RN A: *Carried both nebulizer treatments into the shared room of residents 13 and 14. *Retrieved the nebulizer mask for resident 13. *Opened the medication (med) canister on the nebulizer and placed the medication in it. *Adjusted and placed the nebulizer mask on resident 13's face. *Retrieved resident 14's nebulizer mask, opened</p>	F 441	<p>* A. Action for resident #'s 13 and 14 noted in the 2567 are unable to be corrected at this time. Nurse was on educated on correct glove use and hand washing.</p> <p>B. All residents receiving nebulizers are potentially at risk.</p> <p>C. The facility DON or designee will complete education with facility nurses and MA's on or before 3/7/14 regarding appropriate procedures for correct hand washing and glove use for nebulizer treatments. The facility DON or designee will complete written audits weekly x4 then monthly x3.</p> <p>D. Results of the written audits will be presented to the facility QA&A committee by the DON monthly x3 for review and recommendations.</p> <p>A. Action for resident 8 noted in the 2567 is unable to be corrected at this time. Nurse was educated on correct dressing change techniques.</p> <p>PE/SDDOH/ME</p>		

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 441	<p>Continued From page 16</p> <p>the med canister on the nebulizer, and placed the medication inside.</p> <p>*Left the room to find resident 14.</p> <p>*Had not washed her hands between set-up of the residents' nebulizer treatments nor upon exiting the room.</p> <p>b. Observation on 2/3/14 at 4:40 p.m. revealed RN A prepared to disconnect the nebulizer masks from residents 13 and 14. Without performing hand hygiene or putting on gloves RN A:</p> <p>*Touched resident 13 on the top of her head while removing the nebulizer mask.</p> <p>*Took apart the nebulizer mask and canister.</p> <p>*Rinsed the nebulizer parts with water and placed them on a paper towel on resident 13's bedside table. The paper towel had been saturated with water.</p> <p>*Went over to resident 14 to remove her nebulizer mask.</p> <p>*Touched resident 14 on the top of the head while removing the nebulizer mask.</p> <p>*Took apart the nebulizer mask and canister.</p> <p>*Rinsed the nebulizer parts with water and placed them on a paper towel on resident 14's bedside table. The paper towel had been saturated with water.</p> <p>*Left the room and charted on the treatment MAR.</p> <p>*Sanitized her hands.</p> <p>c. Interview on 2/5/14 at 9:20 a.m. with the DON and the nurse consultant confirmed the above observation had not been a sanitary practice. There had been potential for cross-contamination. Gloves should have been worn and hand hygiene performed between each resident.</p>	F 441			

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 441	<p>Continued From page 17</p> <p>Review of the provider's September 2010 Medication Administration via Nebulizers policy revealed: *Hand hygiene should have been performed prior to administration of the nebulizer medication. **When the equipment is completely dry, store in a plastic bag." *Hands were to have been washed at the end of the nebulizer treatment.</p> <p>Review of the provider's 12/1/07 pharmacy General Dose Preparation and Medication Administration policy revealed: **Prior to preparing or administering medications, authorized and competent Facility staff should follow Facility's infection control policy (e.g., handwashing)." **Facility staff should only prepare medications for one resident at a time."</p> <p>3a. Observation on 2/4/14 at 10:30 a.m. revealed RN D prepared to perform a dressing change to resident 8's feeding tube (a tube inserted directly into the stomach). *She retrieved the following supplies for the dressing change from the treatment cart: -Two unwrapped cotton-tipped applicators. -A package containing gauze dressings. -A package of hydrocortisone ointment. -A roll of tape. *She was summoned to another room for an emergency. *She laid the resident's dressing supplies directly on the sink counter top in the room she had been summoned to. *She had asked licensed practical nurse (LPN) B to continue with the dressing change.</p> <p>b. Observation on 2/4/14 at 10:35 a.m. of LPN B</p>	F 441	<p>* B. All residents requiring a dressing change could be affected. C. The facility DON or designee will complete education with facility nurses on or before 3/7/14 regarding appropriate procedures for dressing changes. The facility DON or designee will complete written audits weekly x4 then monthly x3. D. Results of the written audits will be presented to the facility QA&A committee by the DON monthly x3 monthly.</p> <p>PE/SDDH/ME</p>		

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 441	<p>Continued From page 18</p> <p>revealed she:</p> <ul style="list-style-type: none"> *Had been asked by RN D to continue with resident 8's feeding tube dressing change. *Retrieved the supplies from the counter top. *Placed the supplies directly on resident 8's bedside table. *Washed her hands, put on a pair of gloves, and then she: <ul style="list-style-type: none"> -Removed the old dressing from the resident's feeding tube site. -Opened the gauze package and placed the dressings on top of the package. -Placed the cotton-tipped applicators on top of the dressings. -Applied ointment with one of the cotton-tipped applicators to the site of the feeding tube. -Retrieved the dressing from on top of the package and applied it to the feeding tube site. -Taped the dressing in place. *Removed her gloves and washed her hands. <p>Resident 8 picked up the roll of tape and laid it on a hand towel that had been laying on his lap during the dressing change. LPN B picked up the roll of tape, placed it in her pocket, went to the treatment cart, and placed the roll of tape on top of the cart.</p> <p>Interview on 2/5/14 at 9:25 a.m. with the DON and nurse consultant revealed the above observation had not been a sanitary practice and there would have been potential for cross-contamination.</p> <p>Review of the provider's November 2013 Dressing Change policy revealed:</p> <ul style="list-style-type: none"> *The staff were to have cleaned the bedside table prior to placing supplies there. *Gloves should have been removed after removal of the old dressing and hand hygiene performed. 	F 441			

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2014
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
(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 441	Continued From page 19 Surveyor: 33265 Preceptor: 32355 4. Observation on 2/4/14 at 3:15 p.m. of certified nursing assistant (CNA) H after catheter care for resident 1 had been completed revealed she: *Placed a soiled towel directly on the top of the bedside stand. *Bagged the trash with her soiled gloves on. *Removed the gloves and placed the soiled gloves on the bedspread near the lower end of bed. *Squeezed the air out of the bagged laundry before closing it. *Picked up the soiled gloves and placed them inside of the garbage bag. *Closed the garbage bag. *Washed her hands. *Picked up the trash and soiled linen bags and left the room. No cleaning of the top of the bedside stand where the soiled towel had been placed was completed. No changing of the bedspread where the soiled gloves were placed had been completed. Interview on 2/4/14 at 3:30 p.m. with CNA H revealed she considered everything completed and was finished with the catheter care for the resident.	F 441	* A. Action for resident 1 noted in the 2567 is unable to be corrected at this time. CNA was educated on correct procedure for catheter care. B. All residents with a catheter could be affected. C. The facility DON or designee will complete education with facility CNA's on or before 3/7/14 regarding appropriate catheter care procedure. The facility DON or designee will complete written audits weekly x4 then monthly x3. D. Results of the written audits will be presented to the facility QA&A committee by the DON monthly x3 monthly. <i>PE/SDDCH/MF</i>		

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

ORIGINAL

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030
--	--

(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	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/5/14. Palisade Healthcare Community was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **02/25/14**

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.

ORIGINAL

PRINTED: 02/18/2014
FORM APPROVED

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10623	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH STREET GARRETSON, SD 57030
--	--

(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	<p>Initial Comments</p> <p>Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/3/14 through 2/5/14. Palisade Healthcare Community was found in compliance.</p>	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Redie Smith, LPHA

TITLE

(X6) DATE

02/05/14

