STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALISADE HEALTHCARE CENTER	920 4TH ST , GARRETSON, South Dakota, 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
F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/17/25 through 11/19/25. Areas surveyed included quality of care related to a resident with skin wounds. Palisade Healthcare Center was found not in compliance with the following requirement: F684, with an Immediate Jeopardy violation at F684.	F0000	The resident identified in the deficiency statement is not currently in the center. 1) Nurse managers, including MDS nurse,wound care nurse, DNS and unit manager, completed head to toe skin evaluation on all residents, on 11/20/2025 to ensure no new wounds were found, and no worsening wounds were found and to identify any other potential deficient practice found. Any new issues found will be communicated to the provider and family and treatments to be received and placed on the TAR. Weekly wound evaluations were reviewed by Administrator, on 11/20/2025.MDS nurse, RCM, Regional nurse consultant and ED audited all MD orders and MARs to ensure that the orders were being followed for the residents with wounds, for the last 30 days, on11/20/2025. All weekly wound evaluations were reviewed to validate that weekly wound measurements were completed by Administrator/RN. 2) No staff will work their next scheduled shift without education. a. Educate nursing management on weekly wound assessments, on appropriate treatment and interventions, and provider, dietician and family notification and documentation of this being completed. b. Educate all licensed nurses on performing weekly skin assessments and documenting any issues identified during the skin assessment and notifying provider and family. Ensuring treatment order is initiated and placed on the TAR with correct start date.	
F0684 SS = SQC-J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint intake report review, record review, interview, and policy review, the provider failed to ensure staff provided quality care related to skin injury prevention and skin management processes including completing skin evaluations, accurate communication, accurate documentation, and implementing interventions and treatment orders for one of one sampled resident (1) who developed skin injuries to his left lower leg, left foot, and right lower leg and was hospitalized related to those wounds. Those failures put all residents at potential risk for serious injury or harm. Immediate Jeopardy (IJ) at F684 began on 11/18/25 when the provider failed to evaluate resident 1's left lower leg, left foot, and right lower leg wounds and implement appropriate follow-up procedures.	F0684		

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 reverse for further 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
Carolyn Riggs	Administrator	12/12/2025

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F0684 SS = SQC-J	Continued from page 1 *Administrator A was notified of the IJ on 11/18/25 at 4:03 p.m., and a removal plan was requested. *The IJ was removed on 11/19/25 at 1:00 p.m. as confirmed by onsite verification by the survey team. *After the IJ removal, the severity of non-compliance remained at a E. *Current census was 46. Findings include: 1. Review of the 11/12/25 SD DOH complaint intake report regarding resident 1 revealed: *Resident 1 went to his scheduled wound clinic appointment for treatment of his pressure ulcer (skin and/or underlying tissue injury caused by prolonged pressure) on his coccyx (tailbone), where it was determined that he needed to be transferred to the emergency room for further evaluation because of the condition of his left foot and left and right lower leg wounds. *The nursing home where resident 1 resided was aware and concerned of the left foot and both leg wounds and planned to move up his wound care treatment appointment to be seen earlier, but that did not occur. *The vascular physician indicated that resident 1's left foot and both leg wounds should have been treated sooner. *Resident 1 was admitted to the hospital on 11/4/25 with wounds to his left lower leg, left foot, and right lower leg. 2. Review of resident 1's electronic medical record (EMR) revealed: *He admitted to the nursing home on 8/29/25 with a pressure ulcer on his coccyx. That pressure ulcer was categorized as unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed) by licensed practical nurse (LPN) D on 9/2/25. *His 8/29/25 Brief Interview for Mental Status (BIMS) assessment score was 7 which indicated his cognition was severely impaired.	F0684	c. Educate C.N.A's on notifying the licensed nursing staff, by using the clinical alert tab/stop and watch, of any abnormal skin findings such as redness, foul smelling odor, and new skin impairments. d. Education provided by Administrator to nursing management team. They, in turn, will educate all nursing staff prior to their next working shift. 3) DNS, RCM/ADON and MDS nurses will audit random residents to validate preventative measures are in place, weekly wound assessment completed, treatments done as ordered and changed if no improvement in wound noted per provider direction, family notification, physician notification, and dietician notification with assessment and knowledge of staff of who has wounds on their unit. a. These audits will be completed weekly on all residents with wounds X 4 weeks then monthly X 2 months or until substantial compliance is met. All audits will be brought to monthly QAPI for review and recommendation Ad hoc QAPI completed with regional ops and regional nurse, Medical Director, Administrator and DON on 11/20/2025	11/20/25

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F0684 SS = SQC-J	Continued from page 2 *His diagnosis included chronic diastolic (congestive) heart failure, peripheral vascular disease (arteries narrow, restricting blood flow to the limbs), unspecified protein calorie malnutrition, and Brown-Sequard syndrome (damage to one half of the spinal cord that causes weakness and paralysis). Resident 1's current care plan (personalized plan that addresses a resident's care needs, goals, and interventions) revealed: *He was dependent on staff members to reposition him. *He required the use of a full body lift (a mechanical lift and sling used to lift a person's full body) for transferring. *He had actual impaired skin integrity related to his pressure injury to his coccyx and wounds (revised on 10/30/25) on his left heel, left inner ankle, left medial foot, and bilateral shins. Interventions last updated on 9/30/25 in that impaired skin integrity care plan area included: *"Administer treatments as ordered and monitor for effectiveness." *"Air mattress to bed." *"[Name redacted] wound clinic as scheduled or as needed." *"Inspect skin while providing care, notify nurse of any new skin conditions." *"Pressure reducing cushion to wheelchair." *"Use draw sheet to pull resident up in bed with two staff to prevent shearing." *"Wound vac [a device that uses negative pressure to remove excess fluid and debris from a wound to promote wound healing]. Make sure this keeps a charge and is running at 125 mmHg." Review of resident 1's physician's orders included: *On 8/29/25, "Heel boots on while in bed. Reposition frequently with wedge. Every day and night shift." *On 9/3/25, "Weekly Skin Audit every day shift every Wed [Wednesday] Nurse initials = Head to Toe Skin	F0684		

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F0684 SS = SQC-J	Continued from page 3 Evaluation completed. If new skin impairment is found, document in Progress Notes, notify Medical Provider, and initiate Weekly Skin Evaluation." *On 9/26/25, “Wound vac dressing changes every MWF [Monday, Wednesday, and Friday] to coccyx." *On 10/28/25, “Wound treatment to left foot. Apply foam dressing to left heel, left lateral foot and inner ankle. Change every 3 days and prn [as needed] if loose/soiled." *On 10/30/25, “Wound care to bilateral shins: Cleanse with Vashe [skin cleanser], cover with dry dressing, change every day. Do until healed." Review of resident 1's treatment administration record (TAR) indicated: *His weekly skin audit was completed every Wednesday from 9/1/25 through 11/4/25. *LPN F completed resident 1’s left foot treatment on 10/28/25 and his bilateral shin treatment on 11/1/25, 11/2/25, and 11/3/25. *LPN D completed resident 1’s left foot and bilateral shin treatment on 10/31/25. *Registered nurse (RN) L completed resident 1’s left foot and bilateral shin treatment on 11/3/25. Resident 1's nursing progress notes indicated: *A late entry note created on 11/6/25 by LPN D for 10/22/25 stated, "Charge nurse [RN K] brought this writer in to see resident's left inner ankle. Pressure wound noted. Upon evaluation of foot noted there also to be a SDTI [Suspected Deep Tissue Injury] to left heel and left medial foot. Risk management completed and fax sent to MD for foam dressing treatment. Charge nurse stated that the Wound/Wound Vac smelled so bad we need air freshener or peppermint oil to put in his room. She asked why he wasn't on IV antibiotics. I asked her to call the wound clinic to get an appointment sooner than 11/4. She stated she called [name redacted] wound clinic but they have not returned call yet. Son [name redacted] is here visiting and he was notified of new wounds on left foot." *On 10/26/26 RN/MDS coordinator C documented, "Resident noticed to have an open [area] on his left medial [inside] ankle. Looks to be a stage 2 [open wound or blister with partial-thickness skin loss] pressure	F0684		

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F0684 SS = SQC-J	Continued from page 4 ulcer. Also has a open area to inner medial foot. Son and PCP [primary care provider] notified nurse treated with betadine [topical antiseptic], foam dressing, and kerlix [gauze bandage]." On 10/22/25 LPN D faxed resident 1's physician that resident 1 had three wounds on his right foot, he had an appointment at the wound clinic "next week," and requested orders to cover the wound with foam for protection and change it every three days. *The physician replied "yes" to those requested orders on 10/22/25. On 10/28/25 LPN D faxed resident 1's physician that the previous order was incorrect, and it was resident 1's "left foot" that had wounds. *She requested to change the ordered wound dressing to be completed daily due to increased drainage. *She informed the physician that resident 1 also had wounds to his right and left shins and requested orders to cleanse those with Vashe brand wound cleanser, and cover with a dry dressing daily. *The physician replied "yes" to the requested order on 10/29/25. Resident 1's weekly skin evaluations indicated: *On 8/29/25 resident 1 had a pressure ulcer on his coccyx, a skin tear on his right and left forearms, and red areas on his right and left heels that staff were to monitor. *On 9/23/25 the wound care nurse documented that resident 1's right and left heel wounds had healed and his pressure ulcer on his coccyx was a Stage IV (open wound with full-thickness skin and tissue loss that may have visible bone, muscle, or tendon). *From 9/30/25 through 10/21/25, resident 1's Stage IV pressure ulcer on his coccyx was his only documented skin injury. *On 10/27/25, his Stage IV pressure ulcer was evaluated and no other skin concerns were included in that evaluation. *On 10/28/25, resident 1's wounds on his left foot were evaluated. The wound to his left outer foot was 8.5 cm long, 3.0 cm wide, and was "slightly open" in the center of the wound. The wound to his left inner ankle	F0684		

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F0684 SS = SQC-J	Continued from page 5 was open, 4.0 cm long, 4.0 cm wide, and had heavy drainage. The wound on his left heel had "purple intact tissue," was 4.5 cm long, and 3.7 cm wide. He was bathed on 8/29/25, 9/3/25, 9/10/25, 9/17/25, 9/24/25, 10/1/25, 10/8/25, 10/15/25, 10/22/25, 10/29/25, and 11/4/25 with no documented skin concerns. Resident 1 went to the wound clinic on 9/10/25, 9/24/25, and 10/7/25 for care of his coccyx pressure ulcer and his next wound clinic appointment was scheduled for 11/4/25. 3. Review of the 11/4/25 wound clinic appointment notes regarding resident 1 indicated: *The nursing home asked the wound clinic to examine resident 1's left foot due to a new ulcer on that foot. *Resident 1's skin wounds were labeled as: "Wound #1 coccyx," "Wound #2 left foot," "Wound #3 left lower leg," and "Wound #4 right, medial lower leg." *Wound #2's (left foot) measurements and observations were: "8 cm [centimeters] length x 13 cm width x 0.2 cm depth, with an area of 104 sq [square] cm and a volume of 20.8 cubic cm. Adipose [fat tissue] is exposed. There is a small amount of sero-sanguineous [both blood and the liquid part of blood (serum)] drainage noted which has a mild odor." *Wound #3's (left lower leg) measurements and observations were: "12 cm length x 3.5 cm width x 0.2 cm depth, with an area of 49 sq cm and a volume of 9.8 cubic cm. Adipose is exposed. There is a small amount of sero-sanguineous drainage noted which has no odor…The periwound (area of skin immediately surrounding a wound) skin exhibited edema [swelling] and erythema [redness]. The temperature of the periwound skin is warm. Periwound skin presents with s/s [signs and symptoms] of infection. Local pulse is absent." *Wound #4's (right, medial lower leg) measurements and observations were: "1.5cm length x 1 cm width x 0.2 cm depth, with an area of 1.5 sq cm and a volume of 0.3 cubic cm. Adipose is exposed. There is a small amount of sero-sanguinous drainage noted." *The wound clinic called the nursing home and inquired about resident 1's new left foot, left lower leg, and right lower leg wounds. The nursing home was unsure when those wounds developed, but believed they were	F0684		

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F0684 SS = SQC-J	Continued from page 6 caused by how resident 1 positioned his legs. *The wound clinic consulted with podiatry who agreed resident 1 should be admitted to the hospital for the severity of his left foot, left leg, and right leg wounds. 4. Interview on 11/17/25 at 8:45 a.m. with certified medication aide (CNA) G revealed: *If she saw a new skin impairment on a resident, she would alert a nurse. *Resident skin audits were scheduled on the TAR, and some residents' audits were to be completed daily. *LPN D was the wound care nurse, and she evaluated residents skin impairments once a week. *If a resident had a skin wound, it was checked daily. 5. Interview on 11/17/25 at 2:15 p.m. with director of nursing (DON) B revealed: *LPN D was the facility's designated wound care nurse. *Weekly skin evaluations were to be completed by the floor nurses on duty on residents' bath days. *She expected the bath aides to notify the nurse if they saw something unusual about a resident's skin or noticed if a wound appeared worse. *She expected the nurse to notify the physician, family, and the wound care nurse about a new or worsening wound. *She expected that the nursing staff would have continued to follow up with the physician or wound care clinic to arrange for resident 1 to be seen sooner. *She believed there was an oversight in care because there were policies and procedures in place, but something was missed, as there were four days which nothing was done for resident 1's leg wounds. *She verified that LPN D had incorrect information in the fax sent to the provider on 10/22/25 and had not implemented treatment for resident 1's left foot and both leg wounds until 10/28/25.	F0684		

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F0684 SS = SQC-J	Continued from page 7 6. Interview on 11/18/25 at 9:35 a.m. with LPN F revealed: *He remembered resident 1 had a wound on his tailbone where the bone was visible. *Resident 1 had a wound vac for the majority of his time at the facility. *LPN D was the nurse who showed him how to change resident 1's wound vac, and he had changed it many times. *He did not know how resident 1 had got the wounds on his legs. *He did not remember performing wound care treatment on resident 1's left foot or both legs. 7. Interview on 11/18/25 at 10:02 a.m. with CNA I revealed: *She was a bath aide and knew resident 1 had skin wounds on his left foot and both legs. *Bath aides did not document skin changes on bath days. If the staff saw a new skin impairment, they would inform LPN D or the floor nurse on duty. *The wounds on resident 1's left foot were always covered, and the wounds on his shins looked scabbed over. *Resident 1's left foot and both legs were covered with bandages when she bathed him on 11/4/25 before he left for his wound clinic appointment. 8. Interview on 11/18/25 at 10:28 a.m. with administrator A revealed: *She believed there was a breakdown in their processes because RN K did not document resident 1's new skin impairment on his left foot and both legs on 10/22/25 and should have completed a skin evaluation, contacted the family and the resident's healthcare provider, and made efforts for him to be seen at the wound clinic sooner. *She thought they could have addressed his left foot leg wounds sooner and prevented them from worsening. *She expected the nursing staff to follow physicians'	F0684		

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F0684 SS = SQC-J	Continued from page 8 orders. 9. Interview on 11/18/25 at 11:10 a.m. with LPN D revealed: *She confirmed she was the facility's designated wound care nurse. *She expected RN K to take care of resident 1's left foot and both leg wounds when they were discovered on 10/22/25 and complete a skin evaluation. *A weekly skin assessment was to be completed every Wednesday for residents by the floor nurse on duty, and resident 1's skin wounds on his left foot, left lower leg, and right lower leg was not identified until 10/22/25. *RN K did not document about resident 1's new skin wounds on his left foot or both legs, so she (LPN D) created a late entry note on 11/6/25 to document that the resident's new skin wounds was identified. *She believed there was a communication breakdown and that more should have been done for resident 1's skin wounds. *She completed all her skin/wound evaluations on Tuesdays for residents who had current skin impairments. *She verified that she entered the physician's 10/29/25 order regarding resident 1's wound treatment incorrectly in the EMR system. 10. Interview on 11/18/25 at 12:00 p.m. with RN E revealed: *If a resident was observed with a new skin impairment, the nurse would place a checkmark in the resident's EMR under "skin audit." *The nurse was to document the new skin impairment in a progress note, and perform a skin evaluation, but many staff just informed LPN D. 11. Interview on 11/18/25 at 12:19 p.m. with RN/MDS coordinator C revealed: *A floor nurse notified her on 10/26/25 about resident 1's new left foot and both leg wounds.	F0684		

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F0684 SS = SQC-J	Continued from page 9 *RN/MDS coordinator C documented what she observed and did for resident 1 in a nursing progress note. *Every day, management held an early morning meeting to review residents' progress notes, and identify new skin impairments. LPN D would be notified of any new skin impairments to add them to her list to complete those residents' skin evaluations. *She felt all staff knew that LPN D completed the skin evaluations and that the staff were expected to alert LPN D if they saw a new skin impairment. 12. Interview on 11/18/25 at 12:29 p.m. with DON B revealed: *She expected that the nurse who identified a new skin impairment was to complete a skin evaluation that day and document in the resident's nursing progress notes, any actions taken, and who was notified. *In any of the resident's EMR with weekly skin audits, the EMR would prompt a nurse who found a new skin impairment to complete a skin evaluation. 13. Interview on 11/18/25 at 3:46 p.m. with RN K revealed: *She noticed resident 1 had missing skin with yellow or white discharge on his left foot wound. *She did not document anything about his foot wound because she did not work at the facility often and did not know where to document about wounds, so she alerted the wound care nurse, LPN D. *RN K stated she dressed resident 1's wounds on his left foot with a foam dressing and ensured his pressure ulcer prevention boots were on all day on 10/22/25. *She explained that she called and faxed the wound care clinic that day (10/22/25), but never heard back, and felt she did not work at the facility often enough to follow up on that. 14. Interview on 11/19/25 at 10:53 a.m. with resident 1's son revealed: *He visited his father on 10/18/25 and left early on	F0684		

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F0684 SS = SQC-J	Continued from page 10 10/22/25, so he had not seen him that day. *When he arrived, his father's left ankle was wrapped up, and there were visible red areas on the skin of his legs. *He notified the nurse, who told him they were monitoring it and planned to move up his wound care appointment. *The wound clinic called him on 11/4/25, informing him that resident 1's wounds were a potential amputation situation. *The vascular surgeon, had taken care of his father for years, informed him that if the facility had acted sooner, the situation could have been corrected. 15. Review of the provider's updated July 2025 Skin Integrity policy revealed: *"In an effort to maintain the resident's optimal level of skin integrity and promote healing of skin ulcers/pressure ulcers/wounds, the facility has a systemic approach and monitoring process for evaluating and documenting skin integrity. In the event that a resident is admitted with or develops a skin ulcer/pressure ulcer/wound, care is provided to treat, heal, and prevent, if possible, further development of skin ulcers/pressure ulcers/wounds." *"The resident's skin is inspected daily with completion of ADL's [activities of daily living] (unless [the] resident is independent in ADL completion). Changes in the resident's skin are reported to the Licensed Nurse (LN)." *"Ongoing evaluation continues weekly with the LN completing a full body skin audit. Completion of the skin audit is documented on the treatment administration record (TAR) with their initials." *"If skin impairment is noted after admission (in addition to the above steps), the LN: a. Initiates alert charting. b. Completes (and documents) notifications to the medical provider and resident or resident representative. c. Implements new interventions as needed. Documents on the resident's care plan.	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALISADE HEALTHCARE CENTER	920 4TH ST , GARRETSON, South Dakota, 57030

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F0684 SS = SQC-J	Continued from page 11 d. Notified Food and Nutrition Services Manager (FANS) and/or Registered Dietitian of new pressure injury or worsening wound condition for nutritional needs evaluation. e. Notifies Director of Nursing Services (DNS) of skin impairments that indicate a potential significant change in condition (Stage II or greater Pressure Ulcer, surgical wound dehiscence, hematoma, or bruise on an area of the body not usually vulnerable to trauma (e.g. head, breasts, inner thighs, groin). f. The DNS and/or designee complete a comprehensive review of the resident's medical record to evaluate if the pressure injury was avoidable or unavoidable. This evaluation is documented in the nurse's notes."	F0684		