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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435115 | A. BUILDING _____ B. WING _____ | C 08/07/2024 |

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

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| F 000 | INITIAL COMMENTS<br><br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/6/24 through 8/7/24. Areas surveyed included allegations of resident neglect and provision of care related to medication administration, wound care, and dietary substitutions. Palisade Healthcare Center was found not in compliance with the following requirement: F760. | F 000 | | |
| F 760 SS=D | Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of the South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, observation, interview, and policy review, the provider failed to ensure one of one certified medication aide (CMA) (C) administered a medication (med) according to pharmacy directions for one of one sampled resident (1) who required the use of the med to stabilize phosphorus levels in his blood. Findings include:<br><br>1. Review of the 6/24/24 SD DOH FRI regarding resident 1 revealed:<br>*Facility staff "found dozens of medications stored in a Green Bay Packers mug and loose medications sitting on the top of the night stand drawer ..."<br>*The "Facility has a standing order to crush medications in applesauce and [the] physician was notified that this was implemented and why | F 760 | 1. For resident #1 medication order was revised to include "do not crush" instructions. All residents have the potential to be affected.<br><br>2. The ED and DNS reviewed the policy on Medication Administration which includes appropriateness of crushing/not crushing medications. The DNS or designee will educate all licensed staff on proper med administration and the pharmacy provided list of medications not to be crushed by 9/01/24. All staff not in attendance will be educated prior to their next working shift.<br><br>3. The DNS or designee will audit 4 random residents with crush medications orders weekly times four weeks and monthly times two months to ensure no medications are being crushed that are contraindicated. The DNS or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits. | 09/13/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| *Lourdes Parker* | *Executive Director* | *08/20/2024* |

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.

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| F 760 | Continued From page 1<br>(after the medications were found)."<br><br>Review of resident 1's electronic medical record revealed:<br>*His diagnoses included end-stage renal disease, dependence on renal dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood), Marfan Syndrome, other disorders of phosphorus metabolism, and diabetes mellitus.<br>*He received dialysis three times per week.<br>*A 6/24/24 physician's order indicated, "Crush all medications in applesauce. Ensure resident takes medications prior to leaving resident. every day and night shift."<br><br>Observation and interview on 8/6/24 at 2:15 p.m. with resident 1 revealed:<br>*He had opened the top drawer of his bedside table to remove a video game.<br>*There were three small medication cups in the top drawer of that bedside table with a light-yellow substance and one white plastic spoon containing the same-colored substance.<br>*He stated, "I don't know what that is," when asked what was in the corner of the drawer.<br>*He quickly shut the drawer.<br><br>Observation and interview on 8/6/24 at 3:19 p.m. with administrator A regarding resident 1 revealed:<br>*A physician's order was obtained on 6/24/24 to crush all medications for the resident after a staff member had found medications in his room.<br>-That was implemented to ensure he had taken the medications.<br>*Interventions implemented after the 6/24/24 FRI included educating the resident and the personnel who administered his medications that | F 760 | | |

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| F 760 | Continued From page 2<br>his medications were to have been crushed and that the personnel were to "stay while he takes the medication."<br>*The facility had not completed any audits to ensure his compliance with taking the medications as ordered.<br><br>Observation and interview on 8/6/24 at 4:24 p.m. with CMA C revealed she:<br>*Removed two white tablets from the medication card.<br>*Confirmed the medication she was preparing was Sevelamer HCL (medication used to control high blood levels of phosphorus in people with chronic kidney disease who are on dialysis) Oral Tablet.<br>*Placed the two tablets into a plastic sleeve and proceeded to crush the medication.<br>*Put a glove on her right hand and removed several small white pieces from the plastic sleeve.<br>-She placed the white pieces in the trash can on the med cart.<br>*Poured the remaining contents of the sleeve into a medication cup and continued to remove small white pieces from it.<br>*Showed one of the pieces to the surveyor that contained the letter A.<br>*Mixed the remaining white powder in the medication cup with apple sauce.<br>*Placed the medication cup on the top of resident 1's bedside table, waited for him to place the mixture in his mouth, and then exited the room.<br>-The resident had not swallowed the medication before she exited the room.<br><br>Continued observation and interview on 8/6/24 at 4:31 p.m. with CMA C at the medication cart after administering the medication revealed: | F 760 | | |

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| F 760 | Continued From page 3<br>*A medication card for Sevelamer Carbonate 800 MG (milligram) TAB (tablet) with the instruction "GIVE 2 TABLETS BY MOUTH THREE TIMES DAILY WITH MEALS (AM, NOON, PM)".<br>*She read out loud the blue sticker on the top left corner of the medication card that stated "Do not chew or crush. Contact pharmacist if you have questions related to this med."<br>-She confirmed she had crushed all his medications including the Sevelamer.<br>-She stated "It is ok as long as you do it carefully. That is why I picked out the coating."<br>*She confirmed that she had not discussed that direction with her supervisor.<br><br>Interview on 8/6/24 at 5:04 p.m. with director of nursing (DON) B revealed she:<br>*Confirmed that resident 1 took his medication crushed to "make sure he is taking them."<br>*Was unaware that staff were crushing the Sevelamer.<br>*Expected medications that contained a label stating "do not crush" would not have been crushed.<br>*Explained that Sevelamer was a medication prescribed for resident 1 because he was on dialysis.<br>-He had been prescribed the medication because his phosphorus levels had been too high.<br>*Considered crushing a medication that should not have been crushed as a significant medication error.<br><br>Review of the provider's January 2021 Medication Administration General Guidelines Policy revealed:<br>*"Medications are administered as prescribed in accordance with manufacturer's specifications ..."<br>*"Personnel authorized to administer medications | F 760 | | |

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| F 760 | Continued From page 4<br>do so only after they have familiarized themselves with the medication."<br>*"Long-acting, extended release or enteric-coated dosage forms should generally not be crushed; an alternative should be sought."<br>*"Medications are administered in accordance with written orders of the prescriber."<br>*"The resident is always observed after administration to ensure that the dose was completely ingested." | F 760 | | |