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 09/17/2025

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 9/16/25 through 9/17/25. The area surveyed was resident safety related to the use of mechanical lifts to transfer residents. Palisade Healthcare Center was found not in compliance with the following requirement: F689.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, observation, interview, record review, and manufacturer's operator's instructions review, the provider failed to ensure: *The safety of one of one sampled resident (1) who fell from a total body lift (a mechanical lift and sling used to lift a person's full body) and sustained a hematoma (an injury that causes a localized collection of blood under the skin) while being transferred by one of one licensed practical nurse (LPN) (C) and one of one certified medication aide/certified nursing assistant (CMA/CNA) (F). *The sling sizes for eight of eight sampled residents (1, 2, 3, 4, 5, 6, 7, and 8) who used a total body lift for transfers were assigned according to the sling's manufacturer's instructions.	F0689	1. All residents have the potential to be affected. 2. Resident #1's sling was immediately changed on 9-12-25, to her size based on her weight. 3. Audit was completed on all residents who use slings, to ensure correct sizing was completed by ED. Slings sized and marked to show ownership. Sign posted in resident's room to identify the size used. 4.On 9-17-2025, 6 new slings were purchased from EZ Way. Slings given to residents ob 9-18-25. Guldmann chart used to size gold slings for residents who chose to use those. Care plans updated with preferences. 5. Nursing staff, who use the equipment, was educated on roles and responsibilities when utilizing the mechanical lifts and who is responsible for sizing the slings, on 9.18.25. Non-nursing staff will be notified of process at the staff meeting, held on 9-26-2025. All staff not in attendance, will be educated prior to their next scheduled shift.	9-18-25

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
Lourdes Parker	*Administrator*	*10-17-25*

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 09/17/2025

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F0689 SS = G	Continued from page 1 Findings Include: 1. Review of the provider's 9/12/25 SD DOH FRI regarding resident 1 revealed: *On 9/12/25 at 11:20 a.m. LPN C and CMA/CNA F had been transferring resident 1 from her wheelchair to her bed. *CMA/CNA F had reported “that resident [1] fell out of the [full-body lift] sling,” and “stated all 4 [four] sides of the sling were hooked up to the metal bar of the mechanical lift.” *LPN C had stated that he didn’t know “how the sling slipped off the hook.” *Resident 1 had stated, “I was in the sling. I was being lifted up and the next thing I knew I was cracking my head but not from hitting it on the bar from hitting it really hard on the floor.” *LPN C reported that resident 1 had “a hematoma behind her left ear.” *Resident 1 had neck pain and was transferred to the hospital for evaluation and returned later that same day. A “hematoma to the back of the left ear was noted on the evaluation” at the hospital. *”The sling [used during that transfer] was noted to be an XL [size extra-large].” *”[An] Audit was done 9/12/2025, to assess all sizes of slings to those residents who utilize them, and appropriate sizes are in place.” 2. Review of resident 1's electronic medical record revealed: *Resident 1 was admitted on 9/3/25. *Her diagnosis included osteochondrodysplasia (a genetic condition where there is a defect in the development of cartilage and bone, leading to skeletal abnormalities and disproportionate growth), anterior displaced Type II dens fracture (a fracture of the second cervical vertebra where the fractured fragment is moved forward), and quadriplegia (partial or complete loss of movement and/or sensation in the upper and lower parts of the body). *Her 9/3/25 Brief Interview for Mental Status (BIMS)	F0689	6. DNS or designee will audit 5 samples, weekly times four weeks, then monthly times two months to ensure residents has the correct size sling and applying the loops to the machine correctly. 7. DNS or designee will bring the audits to the next QAPI committee meeting for further review and recommendations to determine if audits will be continued or can be discontinued.	9-18-25

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F0689 SS = G	Continued from page 2 assessment score was 15, which indicated her cognition was intact. *Her 9/3/25 care plan indicated that she required the assistance of two staff members and the use of a full-body mechanical lift for transfers. -There was no documentation of what size lift sling she used at that time. -A care plan intervention added on 9/14/25 indicated: “I require a full body small sling for transfers with the mechanical lay down lift. I have one assigned to me with my room number on the tag. Ensure the loops [of the sling] are completely inside of the metal rings on the lift bar.” *A 9/13/25 physician's order indicated “wear the [cervical] collar whenever up out of bed.” *Her 9/15/25 weight was 147.9 pounds (lbs). Review of resident 1's 9/4/25 Physical Therapy Evaluation revealed: *Resident 1 “requires the Hoyer lift [a brand of full-body mechanical lift] for all transfers,” and included that transfers with resident 1 using that lift had not been tested during that evaluation. *There was no documentation that the full-body lift sling size had been assessed during that evaluation. Review of resident 1’s 9/12/25 hospital discharge summary indicated: *On 9/12/25, resident 1 “sustained a head injury” when she was transferred with the full-body mechanical lift, and she “hit her head on the bed frame and then on the floor.” *She reported “mild discomfort.” *A 9/12/25 Computed Tomography (CT) scan (a medical imaging test) showed an “occipital scalp [back of the head] hematoma without underlying fracture,” and changes “since February 2025 though [the changes] may have been present on the August 2025 MRI (MRI) (a medical test to create highly detailed images inside the body).” *”There is clinical concern for new cord injury.	F0689		

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F0689 SS = G	Continued from page 3 Consider MRI." *"Neurosurgery (a medical specialty focusing on the brain and spinal cord) did review and thought no acute recommendations aside from the collar to be worn while out of bed." 3. On 9/16/25 at 10:00 a.m., a resident census list, indicating which residents used mechanical and non-mechanical transfer lifts, a transfer policy, a resident safety policy, and instruction manuals or policies regarding the use of mechanical lifts and their slings was requested. Review of the facility provided documentation revealed: *The provider indicated they did not have policies regarding resident safety, resident transferring, or mechanical lift sling use. *The provider referred to the EZWay Classic Lift Operator's Instructions for all guidance on the use of the full-body mechanical lifts and the lift slings. *The provider's census indicated 12 residents required the use of a full-body mechanical lift. 4. Observation and interview on 9/16/25 at 11:36 a.m. with resident care manager (RCM)/registered nurse (RN) D and CNA J while assisting resident 7 to transfer using the full-body mechanical lift revealed: *Each resident who used a full-body mechanical lift for transferring was to have their own sling that remained in the resident's room or wheelchair. *There were different-sized slings, and they would know which sling size was to be used for each resident by checking the resident's weight in their EMR and referencing that with the size chart in the manual attached to the EZWay full-body mechanical lift. *That size chart was the EZWay Sling Sizing Chart. *They thought that resident 7 used an extra-large sling, because it was in his room. RCM/RN D and CNA J transferred resident 7 with that extra-large sling and the full-body mechanical lift. Observation and interview on 9/16/25 at 11:55 a.m. and again on 9/17/25 at 7:48 a.m. with resident 1 and her husband revealed:	F0689		

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F0689 SS = G	Continued from page 4 *On 9/12/25, LPN C and CMA/CNA F were assisting her to transfer from her wheelchair onto her bed with the full-body mechanical lift and sling. They had raised her in the sling and had begun to turn her in the sling to align her body to the bed when she fell onto the floor. *Resident 1 thought the lift strap had come unhooked and caused her to fall. *When she fell, she hit her head on the floor, had pain in the back of her head and in her neck, and waited on the floor for the ambulance to arrive because she was afraid that if staff moved her, she would have had a more serious neck injury. *She was told at the hospital that she had a hematoma on the back of her head, and she was relieved that the hospital tests showed that there was no more serious injury. *She had constant pain before the fall and since, but she did not think that she had more pain than she did before the fall as long as she avoided lying on one specific spot on the back of her head. *The staff used the same lift sling that she fell out of since she was admitted on 9/3/25. *After that fall on 9/12/25, the staff used a smaller lift sling. *The sling in her room was a blue, Direct Supply full-body size small. That sling was marked with the date 9/12/25 and her room number. *Resident 1 chose not to wear the physician-ordered neck collar unless she was in therapy. Observation and Interview on 9/16/25 at 2:36 p.m. with LPN C regarding resident 1's 9/12/25 falling incident revealed: *CMA/CNA F was assisting him in transferring resident 1 from her wheelchair to the bed with the mechanical full-body lift and a yellow-colored sling. *He thought that the sling strap had come unhooked from the lift and caused resident 1 to fall from the lift when the resident was raised above her wheelchair. *He demonstrated with the mechanical full-body lift and	F0689		

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F0689 SS = G	Continued from page 5 a sling what he thought had occurred that day. He did not think that the sling used for resident 1 when she fell was the wrong size. *He thought resident 1 hit her head on the bed, and then her body hit the floor. *After resident 1 fell, he immediately assessed resident 1's vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) and pain, had the staff call the ambulance, and remained with resident 1 until the ambulance arrived because resident 1 had a previous neck injury and she was scared. *Resident 1's husband was outside of the room when resident 1 fell and was very upset about what had happened. Observation and interview on 9/16/25 at 2:50 p.m. with LPN/RCM E regarding resident 1's 9/12/25 fall revealed: *CMA/CNA F alerted LPN/RCM E that resident 1 fell out of the lift sling when CMA/CNA F and LPN C transferred the resident. *LPN/RMC E went to resident 1's room to assist, notified resident 1's husband, and called the ambulance. *LPN/RMC E confirmed that a yellow-colored sling had been used to transfer resident 1 the day resident 1 fell, and that sling was too large for resident 1. *Education had been conducted with all nursing staff on 9/12/25, after resident 1's fall, which included that staff were to check the resident's weight in the EMR and to determine the correct sling size to use by referencing the EZWay sling size guide that was located on the mechanical full-body lift. *Any nursing staff, including CNAs, were able to look up the resident's weight and determine the correct sling size to use by referring to the EZWay sling size guide. Interview by phone on 9/16/25 at 2:59 p.m. with CMA/CNA F regarding resident 1's 9/12/25 fall revealed: *She was assisting LPN C in transferring resident 1 from her wheelchair to the bed with the mechanical full-body lift and a yellow-colored sling.	F0689		

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F0689 SS = G	Continued from page 6 *She fastened the bottom two straps to the mechanical full-body lift, and LPN C fastened the top two sling straps that were closest to resident 1's head. *Resident 1 fell out of the left side of the sling. She thought that all four straps remained fastened after resident 1 fell from the sling. *She thought that the sling used to transfer resident 1 had been a size large. *That yellow-colored sling was in resident 1's room, and she thought that was the right sling size because the staff person who brought it to resident 1's room should have checked that it was the right size. *When she would bring a sling to a resident's room, she would check the resident's weight in the EMR and pick the sling size that the EZWay manual on the lift indicated the resident would need. Observation and interview on 9/16/25 at 3:07 p.m. with resident 1, LPN C, and CMA/CNA I revealed: *LPN C and CMA/CNA I used the mechanical full-body lift and a blue size small Direct Supply sling to transfer resident 1 from her bed to her wheelchair. *CMA/CNA I indicated that she had used resident 1's weight and the EZWay sling size guide to determine which size sling resident 1 needed. *She confirmed that the sling she had used was not an EZWay sling and was unsure if the Direct Supply sling had a different sizing guide. She was unsure if the Direct Supply sling size could be correctly determined using the EZWay sling size guide. Observation and interview on 3/16/25 at 3:10 p.m. with director of nursing (DON) B in the laundry room revealed: *Slings were washed and stored in the laundry room between resident uses. *The provider had at least four different brands and different sizes of mechanical lift slings. *She was unaware if there were size guides for the four brands of mechanical lift slings found in the laundry room.	F0689		

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F0689 SS = G	Continued from page 7 *She expected the CNAs to use the residents' weights found in the EMR to select the correct sling size for all of the different brand lift slings based on the EZWay sling size guide, and to ensure the resident fit between the top and bottom of the sling and that the sling was not too narrow for the resident's body. Interview on 9/16/25 at 3:27 p.m. with CMA/CNA I regarding the lift slings revealed: *She ordered the facility's resident care supplies and ordered the size small Direct Supply sling about a year ago for a previous resident. She thought it would be the correct size sling for resident 1 because "she was a tiny gal", and it was the only size small sling that the facility had in stock. *She would look to see if she could locate a sling sizing guide for the Direct Supply lift sling that she had ordered last year. *There was an EZWay sling size chart taped to the nurses' station counter to help the CNAs when selecting the correct size slings to use. Interview on 9/16/25 at 3:40 p.m. with administrator A regarding the use of mechanical lift slings revealed: *The provider had several different brands and sizes of mechanical lift slings. *She thought that the lift sling sizing was universal and that all slings could be used with the EZWay brand lifts. *She expected the nursing staff to use the EZWay lift sling size guide when they determined which size sling the resident required for all of the brands of slings. *She did not have sling size guides for the four brands of slings that were in the laundry room and available for use. *She confirmed that the lift slings were stored in the laundry room between resident uses, and she expected the CNAs to select the correct size lift sling based on the resident's weight using the EZWay lift slings. Interview on 9/17/25 at 7:15 a.m. with administrator A revealed she:	F0689		

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F0689 SS = G	Continued from page 8 *Printed the sling size guides for three of the most commonly used brands of slings that they used. *Had been unaware that each brand of sling had its own sizing guide and that not all of them used the resident's weight as a basis for the size sling a resident required. *Ordered seven EZWay brand slings on 9/16/25 that were recommended for use with the EZWay mechanical full-body lift that they used. *Spoke with the EZWay representative when she purchased those full-body mechanical lifts several years ago and had been told she could use any brand sling with the lifts. *Was considering discontinuing the use of the yellow Guldmann lift slings because those slings used three different resident body measurements in determining the sling size a resident would require, and not the resident's weight. *She agreed that they had not completed a resident assessment of those body measurements. Observations on 9/17/25 of the resident's mechanical full-body lift slings revealed: *At 7:38 a.m., resident 2 had a Direct Supply size large split-leg mechanical lift sling in her wheelchair. *At 7:45 a.m. LPN/RCM E and CMA/CNA G confirmed that resident 3 had used a blue mesh lift sling with a green trim on the edge for showering that morning. The label on the sling was illegible, and LPN/RCM E confirmed that she did not know the size of the sling. LPN/RCM E and CMA/CNA G had used the Guldmann size large sling to transfer resident 3 from his bed to his wheelchair. *At 7:57 a.m. CNA H confirmed that she used a Guldmann size large sling to transfer resident 8 from her bed to her wheelchair. *At 8:07 a.m., CNA K confirmed that resident 4 was seated in her wheelchair on a Guldmann size large sling *At 8:47 a.m., LPN/RCM E confirmed that resident 6 had used a Guldmann sling to get out of bed for breakfast, and that sling was removed from resident 6's wheelchair while she was up and was on her bed. The lift sling on	F0689		

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F0689 SS = G	Continued from page 9 her bed was a Guldmann size large. *At 8:52 a.m., resident 5 stated that staff used the lift sling in her wheelchair to get out of bed for breakfast. That lift sling was a Guldmann size extra-large. Interview on 9/17/25 at 9:09 a.m. with administrator A revealed: *She had been unaware that each mechanical lift sling manufacturer had a different size guide to determine the correct size sling a resident required for the use of the full-body mechanical lifts. *The therapy department assessed the resident for their correct transfer status and the equipment they required for transferring. The therapy department did not assess the resident for the correct size lift sling. *Administrator A conducted an investigation and interviews with staff on 9/12/25, and determined that resident 1 was not placed in the correct lift sling size when she fell on 9/12/25, but she felt that the correct sling size the staff were currently using to assist her with transferring was correct. *The provider primarily used the yellow Guldmann brand lift sling that required three body measurements to determine the correct size. Those measurements had not been completed when determining the correct lift sling size to use when transferring residents. *She was unaware that six of the eight residents would have been on the wrong size lift sling using the EZWay size chart. The lift sling size for those residents could not be determined because the three body measurements had not been completed. *She agreed that the Direct Supply, Guldmann, and SMT Volaro lift slings could not be accurately determined using the EZWay lift sling size guide. *A licensed staff member had not completed a resident assessment to determine the correct size lift sling that residents 1, 2, 3, 4, 5, 6, 7, and 8 would need when transferring with the mechanical full-body lift. 4. A request was made to administrator A and DON B on 9/17/25 at 7:34 a.m. for policies related to resident assessment, resident care planning, resident equipment, and resident falls. Review of the policies provided	F0689		

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F0689 SS = G	Continued from page 10 revealed they did not include assessing a resident for the use of the mechanical full-body lift or sling, who was responsible for completing that task, or what resident information was expected to be included in the resident's comprehensive care plan related to the use of mechanical lifts. 5. Review of the 11/28/18 EZWay Classic Lift Operator's Instructions revealed: “EZWay slings are made specifically for the EZWay Lifts. For the safety of the patient and caregiver, only EZWay slings should be used with EZWay lifts.” *”As patients [residents] do vary in size, shape, weight and temperament, these conditions must be taken into consideration when deciding which EZWay Sling is suitable for each patient’s needs.” *”There are a variety of slings available in various sizes.” *”Attaching the sling to the lift…Make a final check of all four loop attachment points to ensure each loop is sufficiently attached to the respective hook of the hanger bars.” *”Lifting the patient…Push the UP button on the hand control to initiate the upward motion of the lift. Continue the upward motion until there is tension on the legs of the sling, make sure all the loops on the sling are securely hooked on the hanger bars.” *”Users must accept full responsibility for checking the condition of all slings and harnesses before each and every use on the patient.” *”It is recommended that slings be replaced after one year or if the sling shows any sign of damage or wear.” *The “Sling Sizing Chart” had a color-coded chart that indicated which color correlated to which size. There was also a guide that correlated sling size with “Weight of Patient” and “Maximum distance from patient’s tailbone to base of neck. **Does not apply to Belted Mesh or Multi-Purpose slings**.” That chart indicated: -Gray was size S (small), for patients 70 – 100 lbs. (pounds) with a maximum distance from tailbone to base of neck of 21” (inches). -Beige was size M (medium), for patients 90 – 220 lbs.	F0689		

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 09/17/2025

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
F0689 SS = G	Continued from page 11 with a maximum distance from tailbone to base of neck of 24”. -Burgundy was size L (large), for patients 190 – 320 lbs. with a maximum distance from tailbone to base of neck of 26”. -Green was size XL (extra-large), for patients 280 – 450 lbs. with a maximum distance from tailbone to base of neck of 29”. -Black was size XXL (extra, extra-large), for patients 400-600 lbs. with a maximum distance from tailbone to base of neck of 36”. -Brown was size XXXL (extra, extra, extra-large), for patients 600+ lbs. with a maximum distance from tailbone to base of neck of 37”. *”NOTE! The size/weight designations are merely estimates and basic guidelines. A proper fit will depend on factors other than weight measurements, including the height and girth of the patient. A proper fit will involve the judgement of the caregiver.” Review of the requested Direct Supply Slings size guide revealed: *There were five different total body lift sling models, each had a different size and “Recommended user weight.” -Some sling models came in five sizes, extra small through extra-large, and others came in three sizes, one model size was indicated by weight only, 125-200 lbs., 175-300 lbs., and 275 – 500lbs. *”Our multi-brand slings have passed rigorous compatibility testing standards for use with leading models of lift equipment. So even if you have multiple brands of lifting equipment in your community, you can depend on one affordable sling brand to help keep your staff and residents safe during transfers.” Review of the requested Guldmann full body lift sling size guide revealed: *There were 12 different total body sling models. *The sling sizes were determined by the measurement of the residents' hip width, chest width, and seated height from the bone to the top of their head. The resident's weight was not considered.	F0689		

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 09/17/2025

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F0689 SS = G	Continued from page 12 *There were five “Kids” sizes and nine additional sizes that ranged from XS (extra small) to 5XL. 6. Review of the provider’s March 2025 Charge Nurse Job Description revealed: *”Evaluates resident care as related to individual resident needs, family involvement, and the physician’s plan of care for the resident.” *”Provides clinical supervision to nursing assistants.” Review of the Certified Nursing Assistant Job Description revealed: *”Under general supervision performs a combination of following duties in caring for residents…consistent with…established long-term care standards…” *”Reports to the Licensed Nurse directing and overseeing resident care on assigned unit.” 7. Review of a 9/16/25 email communication between administrator A and the EZWay Safety Program Coordinator revealed, “If an item is purchased to be used with another brand product, EZWay will not be held liable for any issues resulting from usage with non-EZWay equipment.	F0689		