| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435115 | A. BUILDING<br>B. WING | 09/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| F0000 | INITIAL COMMENTS<br><br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/8/26 through 9/10/26. Palisade Healthcare Center was found not in compliance with the following requirements: F641, F761, and F812.<br><br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/8/26 through 9/10/26. Areas surveyed included resident safety regarding a resident's elopement and the quality of care and treatment regarding family notifications for change in condition. Palisade Healthcare Center was found in compliance. | F0000 | | |
| F0761<br>SS = E | Label/Store Drugs and Biologicals<br><br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br><br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) 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.<br><br>§483.45(h)(2) 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 | F0761 | 1. North medication refrigerator identified with a temperature outside of the acceptable range was immediately assessed. Medication refrigerator temperature was returned to the appropriate range and medications stored within the refrigerator were reviewed to ensure appropriate storage and integrity.<br><br>2. All medication refrigerators within the facility were audited to ensure temperatures were within the appropriate range. Medications requiring medication administration were reviewed to ensure they were stored according to manufacturer and pharmacy requirements.<br><br>3. The medication refrigerator temperature monitoring and alert process was reviewed to ensure appropriate monitoring and notification when temperature falls outside of the acceptable range.<br>DON will be educated by Administrator on medications refrigerator temperature requirements, documentation expectations, response to temperatures outside of the acceptable range, and appropriate notification/follow-up when an out-of-range temperature is identified. All education will occur by 9/18/2026. | 9/24/2026 |

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 |
|---|---|---|
| Chloe Robinson | LNHA | 9/29/2026 |

| 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 09/10/2026 |
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| PALISADE HEALTHCARE CENTER | 920 4TH ST , GARRETSON, South Dakota, 57030 |

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| F0761 SS = E | Continued from page 1<br>package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, record review, and policy review, the provider failed to ensure that temperature-sensitive medications and biologicals were stored within the required temperature range of 36°F to 46°F and failed to ensure that appropriate temperature-monitoring practices were implemented for one of two observed medication refrigerators, with temperature recordings outside the safe storage range.<br><br>Findings include:<br><br>1. Observation on 9/10/26 at 2:51 p.m. in the north medication room revealed that the medication refrigerator's internal manual thermometer displayed a temperature of 50 degrees Fahrenheit (F). The refrigerator contained multiple refrigerated medications (Lantus, Levemir, Humalog, Novolog, Tresiba, Actemra syringes, Ozempic, Trulicity, Mounjaro, Zepbound), influenza vaccines, and an emergency insulin kit.<br><br>A paper temperature log was posted on the refrigerator; however, further review showed the facility was not using the manual log to record temperatures. A sign posted on that refrigerator stated it was "continuously monitored via a micro temperature sensor."<br><br>2. Interview on 9/10/26 at 2:51 p.m. with contracted travel registered nurse (RN) L revealed that the staff did not manually check or record the medication refrigerator temperatures and relied on the internal temperature sensor to log temperature readings. Contracted travel RN L was instructed that the medication refrigerator did not require manual temperature logging because the internal sensor recorded the temperatures to an application on director of nursing (DON) B phone.<br><br>3. Observation and interview on 9/10/26 at 4:48 p.m. with DON B in the north medication room revealed she was removing all refrigerated medications from the north medication-room refrigerator. DON B acknowledged that the medication refrigerator was not maintaining the correct temperature and that she was relocating the medications to the south medication-room refrigerator, which had temperature readings within the acceptable range of 36 degrees F to 46 degrees | F0761 | 3. DON/Administrator/Designee will audit medication refrigerator temperatures and temperature monitoring documentation 3x a week for 2 weeks, 1x a week for 4 weeks, 1x per month for 2 months to ensure temperatures remain within the appropriate range and any out-of-range temperatures are appropriately identified and addressed.<br>Results of this audit will be discussed by DON/ Administrator/Designee at the monthly QAPI meeting with IDT for analysis and recommendations for continuation, discontinuation or revision of audits based on finding<br>5. Date of Compliance 9/24/2026 | |

| 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 09/10/2026 |
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| F0761 SS = E | Continued from page 2<br>F.<br><br>4. Interview on 9/10/26 at 4:48 p.m. with administrator A confirmed that, "based on the [temperature] logs," the north refrigerator temperatures were out of range. On 9/8/26, the facility experienced a power surge that caused portions of the building, including the refrigerator in the south medication room, to lose power. As a result, staff moved refrigerated medications from the south medication room refrigerator into the north medication room refrigerator.<br><br>5. Review of the 9/8/26 through 9/10/26 digital temperature log for the north medication refrigerator revealed that on 9/8/26, the refrigerator reached temperatures as high as 70.70 degrees F and as low as 20.08 degrees F.<br><br>On 9/9/26, from 1:12 a.m. to 1:05 a.m., the temperature ranged from 46.62 degrees F to 72.16 degrees F.<br><br>On 9/10/26, from 12:08 p.m. to 3:58 p.m., the temperature ranged from 12.19 degrees F to 35.60 degrees F.<br><br>6. Review of the provider's January 2018 Medication Storage policy revealed, "Medications and biologicals are stored safely, securely, and properly, following the manufacturer's recommendations or those of the supplier." The policy further stated, "All medications are maintained within the temperature ranges noted in the United States Pharmacopeia (USP) and by the Centers for Disease Control (CDC)... Refrigerated at 36°F to 46°F with a thermometer to allow temperature monitoring." | F0761 | | |
| F0641 SS = D | Accuracy of Assessments<br><br>CFR(s): 483.20(g)(h)(i)(j)<br><br>§483.20(g) Accuracy of Assessments.<br><br>The assessment must accurately reflect the resident's status.<br><br>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>§483.20(i) Certification.<br><br>§483.20(i)(1) A registered nurse must sign and certify | F0641 | 1. The MDS assessment for resident 5 was reviewed and corrected immediately to accurately reflect the resident's medication use.<br>2. Current resident MDS assessments were audited to ensure anticoagulant and anticonvulsant medication coding accurately reflected the resident's current medication regimen. Any inaccuracies identified were corrected as appropriate.<br>3. MDS Coordinator/Designee will be educated by DON/ Administrator/Designee on accurate completion of the MDS assessment, with emphasis on medication coding and verification of medication classifications against the resident's medical record prior to completion of the assessment. Education will occur by 9/16/2026. | 9/24/2026 |

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| F0641 SS = D | Continued from page 3<br>that the assessment is completed.<br><br>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>§483.20(j) Penalty for Falsification.<br><br>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, interview, and Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 review, the provider failed to ensure one of five sampled residents' (5), reviewed for unnecessary medications, Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessment was accurately coded for the area of anticoagulation medication use related to the resident's use of aspirin.<br><br>Findings include:<br><br>1. Review of resident 5's electronic medical record (EMR) revealed she admitted to the facility on 5/6/25. She had a 7/28/26 physician's order for Aspirin 81 milligrams twice daily for blood clot prevention, which was discontinued on 8/25/26. Her 8/3/26 significant change MDS assessment, section N (medications) N0415E1 was marked "yes", and N0415E2 was marked "yes", which indicated she was taking anticoagulant (blood thinner) medications during that assessment's look-back period (a specific timeframe in the past that government agencies, employers, or businesses review to check compliance, eligibility, or past history). | F0641 | 4. DON/Administrator/Designee will audit 5 completed MDS assessments for accuracy of medication coding 3x a week for 2 weeks, 1x a week for 4 weeks, 1x per month for 2 months to ensure medication coding accurately reflects the resident's medication regimen.<br>Results of this audit will be discussed by DON/ Administrator/Designee at the monthly QAPI meeting with IDT for analysis and recommendations for continuation, discontinuation or revision of audits based on finding.<br><br>5. Date of Compliance: 9/24/2026 | |

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| F0641 SS = D | Continued from page 4<br>2. Interview and record review on 9/10/26 at 3:39 p.m. with registered nurse (RN)/minimum data set (MDS) coordinator C revealed she used the resident's physician orders, diagnosis, hospital records, and the CMS Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.2 October 2025 to complete the resident's MDS assessments. She agreed that aspirin was not an anticoagulant, and that she had marked anticoagulant in error on resident 5's 8/3/26 MDS assessment section N. She expected the residents' MDS assessment to be completed accurately for what the resident care needs were.<br><br>3. Interview on 9/10/26 at 3:48 p.m. with director of nursing (DON) B revealed she expected the resident's MDS assessments to reflect the care provided to the residents. She confirmed they referred to the CMS Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.2 October 2025 for guidance on how to complete the resident's MDS assessments.<br><br>4. Review of the CMS Long-Term Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed section N, "Code all high-risk drug class medications according to their pharmacological classification, not how they are being used. Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as N0415E, Anticoagulant. N0415E1. Anticoagulant (e.g. warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). No415E2 Anticoagulant: Check if there is an indication noted for all anticoagulant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days)." | F0641 | | |
| F0812 SS = D | Food Procurement,Store/Prepare/Serve-Sanitary<br><br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br><br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly | F0812 | 1. The cleaning supply closet and dry storage areas identified with sanitation concerns were immediately cleaned and organized. Identified sanitation concerns within the kitchen were corrected to ensure food storage, preparation areas and kitchen areas were maintained in a clean and sanitary manner.<br><br>2. All kitchen areas were audited for cleanliness and sanitation to include food preparation areas, dry storage, refrigerators/freezers, cleaning supply storage, equipment, floors, walls, shelving, and other food service areas. Any sanitation concerns identified during the audit were immediately corrected. | 9/24/2026 |

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| F0812 SS = D | Continued from page 5<br>from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on policy review, observation, and interview, the provider failed to follow food safety standards to ensure that the dry food storage area and the walk-in refrigerator of food items located in one of one kitchen was maintained in a clean condition according to the providers policy. Findings include:<br><br>1. Review of the provider's updated September 2019 Sanitation policy revealed that, "The food service area is maintained in a clean and sanitary manner. 1. Kitchen areas, and dining areas are kept clean, free from litter and rubbish, and protected from rodents, roaches, flies and other insects."<br><br>2. Observation and interview on 9/8/26 at 5:24 p.m. with cook K in the kitchen revealed the dry storage room had several food crumbs, two individual sugar packets, a strip of packing tape, and a used hairnet were on the floor of the dry storage room. Multiple bags of dry cereal and several cans of soup were stored on the wire rack shelves.<br><br>The walk-in refrigerator had several chunks of food crumbs spread across the floor under the wire shelving units that had food products stored on the shelves. Cook K stated she cleaned areas of the kitchen when she had time. She was unaware of any specific cleaning schedules for the kitchen staff to follow.<br><br>3. Interview on 9/9/26 at 2:48 PM with dietary manager H revealed she began the role as dietary manager at the beginning of July. She was working on creating cleaning schedules for the dietary staff to follow for cleaning the kitchen. She agreed that | F0812 | 3. Dietary staff will be educated by Dietary Manager/ Dietitian/Administrator/Designee on kitchen sanitation requirements, proper cleaning and storage practices, cleaning schedules, appropriate storage of food supplies, and maintaining food service areas in a clean and sanitary condition. All education will occur by 9/24/2026. Those not in attendance due to illness, vacation, or casual work status will be education upon returning to work their next scheduled shift.<br>Dietary Manager/Dietitian/Administrator/Designee will complete routine kitchen sanitation rounds utilizing a kitchen sanitation checklist to ensure kitchen, storage, food preparation, and cleaning supply areas are maintained in a clean and sanitary condition.<br><br>4. Dietary Manager/Administrator/Designee will complete kitchen sanitation audits 3x a week for 2 weeks, 1x a week for 4 weeks, 1x per month for 2 months. Any sanitation concerns identified will be corrected and appropriate follow-up completed.<br>Results of this audit will be discussed by DON/ Administrator/Designee at the monthly QAPI meeting with IDT for analysis and recommendations for continuation, discontinuation or revision of audits based on finding.<br><br>5. Date of Compliance: 9/24/2026 | |

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| F0812 SS = D | Continued from page 6<br>the walk-in refrigerator floor needed a thorough cleaning. She agreed that the floor in the dry storage room needed to be swept and cleaned.<br><br>4. Interview on 9/9/26 at 3:35 p.m. with consultant dietitian I and senior certified dietary manager K revealed they were helping dietary manager H implement a cleaning schedule for the kitchen staff. They agreed there were several areas of the kitchen that were not cleaned for a long time. They expected the kitchen staff to clean all areas of the kitchen.<br><br>5. Interview on 9/10/26 at 1:46 p.m. with administrator A revealed she was aware of the lack of cleanliness in the kitchen. Dietary manager H began her position in July. Administrator A expected the dietary staff to follow the cleaning schedules that were being implemented for the dietary department and to keep the kitchen clean. | F0812 | | |

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

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| E0000 | Initial Comments<br><br>A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 9/9/26. Palisade Healthcare Center was found in compliance. | E0000 | | |

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| Michael | Interim Administrator | 10/5/2026 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING | (X3) DATE SURVEY COMPLETED 09/09/2026 |
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| K0000 Bldg. 01 | INITIAL COMMENTS<br><br>A recertification survey was conducted on 9/9/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Palisade Healthcare Center was found not in compliance.<br><br>The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K223, K300, K321, and K363 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K0000 | | |
| K0223 S = D Bldg. 01 | Doors with Self-Closing Devices<br><br>CFR(s): NFPA 101<br><br>Doors with Self-Closing Devices<br><br>Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:<br><br>* Required manual fire alarm system; and<br><br>* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and<br><br>* Automatic sprinkler system, if installed; and<br><br>* Loss of power.<br><br>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation, testing, and interview, the provider failed to ensure two randomly observed corridor doors (south kitchen door and north conference room) were equipped with functioning positive latching hardware. | K0223 | 1.The South door from the kitchen to the dining corridor and the Administrator's Office were adjusted/repaired to ensure each door closes and latches automatically into the door frame. Both doors were tested following correction to verify proper operation.<br>2. The Maintenance Director completed a 100% audit of doors equipped with self-closing devices throughout the facility to ensure each door closes and latches into it's frame automatically. Any concerns identified during the audit were corrected.<br>3. The Maintenance Director was educated by the Administrator on 9/21/2026 on the requirement that all doors close and latch automatically into their frames. The Maintenance Director well ensure self-closing doors are routinely inspected and that identified concerns are promptly inspected.<br>4. The Maintenance Director/Designee will audit doors equipped with seld-closing devices 1x per week x4 weeks, then 1x per month x2 months to ensure doors close and latch automatically into their frames. Any identified concerns will be corrected immediately.<br>Results of this audit will be discussed by Maintenance Director/Administrator/Designee at the monthly QAPI meeting with IDT for analysis and recommendations for continuation, discontinuation or revisions of audits based on finding.<br>5. Compliance date: 9/24/2026 | 9/24/2026 |

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| Chloe Robinson | LNHA | 9/29/2026 |

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| 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 |
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| K0223 SS = D Bldg. 01 | Continued from page 1<br>Findings include:<br><br>1. Observation and testing on 9/9/26 at 11:58 a.m. revealed the south door from the kitchen to the dining area was equipped with a closer, but it was not automatically latching into the door frame. That door hit its frame upon closing and kept it from latching.<br><br>Interview with the maintenance supervisor at the times of the observations confirmed those findings.<br><br>2. Observation and testing on 9/9/26 at 4:10 p.m. revealed the corridor door from the administrator's office to the corridor was equipped with a closer, but it was not automatically latching into the door frame. That door hit its frame at the top corner upon closing and kept it from latching.<br><br>Interview with the maintenance supervisor at the times of the observations confirmed those findings.<br><br>Doors provided with closers are required to latch into their frames automatically.<br><br>Those deficiencies could affect 100% of the occupants of their smoke compartments. | K0223 | | |
| K0300 SS = D Bldg. 01 | Protection - Other<br><br>CFR(s): NFPA 101<br><br>Protection - Other<br><br>List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation, testing, and interview, the provider failed to maintain the fire-resistive rating for one of one randomly observed ninety-minute rated fire doors (adjacent to the nurse station).<br><br>Findings include:<br><br>1. Observation and testing on 9/9/26 at 11:17 a.m. revealed the south leaf of the ninety-minute, | K0300 | 1.The South leaf of the ninety-minute cross-corridor doors located at the end of the 100 wing adjacent to the nurse station was adjusted/repaired to ensure door properly closes and latches. The door was tested following correction to verify proper operation.<br>2. The Maintenance Director completed a 100% audit of fire-related and cross-corridor doors throughout the facility to ensure doors close and latch as required. Any concerns identified during the audit were corrected.<br>3. The Maintenance Director was educated by the Administrator on 9/21/2026 on requirements for fire-realted and cross-corridor doors, including ensuring doors close and latch as required to maintain their intended fire protection. The Maintenance Director will ensure these doors are routinely inspected and identified concerns are promptly corrected. Education will take place by 9/21/2026<br>4. The Maintenance Director will audit all fire-related and cross-corridor 1x per week x4 weeks and then 1x per month x2 months to ensure doors properly close and latch. Any identified concerns will be corrected immediately. Results of this audit will be discussed by Maintenance Director/ Administrator /Designee at the monthly QAPI meeting with IDT for analysis and recommendations for continuation, discontinuation or revision of audits based on finding.<br>5. Compliance Date: 9/24/2026 | 9/24/2026 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING | (X3) DATE SURVEY COMPLETED 09/09/2026 |
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| K0363 SS = D Bldg. 01 | Continued from page 5<br><br>2. Observation, testing, and interview on 9/9/26 at 11:56 a.m. revealed the north door to the kitchen had a kickdown door stop installed. That hold open device interfered with the ability to instantly close that door in case of a fire. Interview with the maintenance supervisor revealed that kickdown device was installed for the convenience of staff.<br><br>The deficiencies had the potential to affect 100% of the occupants of each of their respective smoke compartments. | K0363 | | |

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| K0363 SS = D Bldg. 01 | Continued from page 4<br>required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.<br><br>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br><br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation, testing, and interview, the provider failed to maintain impediment-free closing doors for two randomly observed corridor doors (300 wing tub room and north kitchen door) as required.<br><br>Findings include:<br><br>1. Observation, testing, and interview on 9/9/26 at 11:25 a.m. revealed the corridor door to the 300-wing tub/shower room had a kickdown door stop installed. That hold open device interfered with the ability to instantly close that door in case of a fire. Interview with the maintenance supervisor revealed that kickdown device was installed for the convenience of staff. | K0363 | 3. The Maintenance Director was educated by the Administrator on 9/21/2026 regarding corridor door requirements, including that kickdown door stops or other unapproved hold-open devices may not be installed or used in a manner that prevents required corridor doors from closing. Education will occur by 9/21/2026<br>4. The Maintenance Director/Designee will audit corridor doors 1x per month x3 months to ensure no kickdown door stops or other unapproved hold-open devices are present and corridor doors are able to close as required. Any concerns identified will be corrected immediately.<br>5. Date of Compliance: 9/24/2026 | |

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| K0321 SS = D Bldg. 01 | Continued from page 3<br>g. Laboratories (if classified as Severe<br>Hazard - see K322)<br>This STANDARD is NOT MET as evidenced by:<br>Based on observation, Testing, and interview, the provider failed to maintain three separate hazardous areas (wheelchair washout/kitchen storage room, core area storage room, And the housekeeping office/storage room) as required.<br>Findings include:<br>1. Observation and testing on 9/9/26 at 12:38 p.m. revealed the wheelchair washout/kitchen storage room was over 100 square feet and contained combustible items. The corridor door to that room was fire-rated and would not close and latch with the operation of the closer. Testing of that door revealed it would hit the doorframe causing it not to close and latch as required.<br>2. Observation and testing on 9/9/26 at 12:42 p.m. core area storage room adjacent to the boiler room was over 100 square feet and contained combustible items. The corridor door to that room was fire-rated and would not close and latch with the operation of the closer. Testing of that door revealed it would hit the doorframe causing it not to close and latch as required.<br>3. Observation and testing on 9/9/26 at 12:46 p.m. revealed the housekeeping office/storage room was over 100 square feet and contained combustible items. The corridor door to that room was fire-rated and would not close and latch with the operation of the closer. Testing of that door revealed it would hit the doorframe causing it not to close and latch as required.<br>Interview with the maintenance supervisor at the times of the observations confirmed those findings. | K0321 | | |
| K0363 SS = D Bldg. 01 | Corridor - Doors<br>CFR(s): NFPA 101<br>Corridor - Doors<br>Doors protecting corridor openings in other than | K0363 | 1.The kick down door stops identified on the corridor door to the 300-wing tub/shower room and the north door to the kitchen were removed immediately to ensure the doors can close without interference from the hold-open devices.<br>2. The Maintenance Director completed a 100% audit of the corridor doors throughout the facility to identify any additional kickdown door stops or other unapproved devices that could interfere with the ability of the doors to close. Any found devices were removed immediately. | 9/24/2026 |

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| K0300 SS = D Bldg. 01 | Continued from page 2<br>cross-corridor doors in the corridor, at the end of the 100 wing, adjacent to the nurse station was not latching. That door leaf must latch to maintain the ninety-minute fire-rating of the cross-corridor doors.<br><br>Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he was unaware that condition existed. He further stated this door had previously latched when he tested it during the fire drill in the previous month. | K0300 | | |
| K0321 SS = D Bldg. 01 | Hazardous Areas - Enclosure<br><br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br><br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br><br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br><br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br><br>a. Boiler and Fuel-Fired Heater Rooms<br><br>b. Laundries (larger than 100 square feet)<br><br>c. Repair, Maintenance, and Paint Shops<br><br>d. Soiled Linen Rooms (exceeding 64 gallons)<br><br>e. Trash Collection Rooms<br><br>(exceeding 64 gallons)<br><br>f. Combustible Storage Rooms/Spaces<br><br>(over 50 square feet) | K0321 | 1.The fire-rated corridor doors to wheelchair washout/kitchen storage room, core storage area room adjacent to the boiler room , and housekeeping office/storage room were adjusted/ repaired to ensure each door closes and latches automatically into the door frame. Each door was tested following correction to verify proper operation.<br>2. The Maintenance Director completed a 100% audit of hazardous areas throughout the facility to ensure required fire-rated doors properly close and latch with operation of the door closer. Any concerns identified during the audit were corrected.<br>3. The Maintenance Director was educated by the Administrator on 9/21/2026 on requirements for hazardous area enclosures, including requirements for fire-rated doors to close and latch as required. The Maintenance Director will ensure doors serving hazardous areas are routinely inspected and that identified concerns are promptly corrected. Education will take place by 9/21/2026.<br>4. The Maintenance Director/Designee will audit doors serving hazardous areas 1x per week x4 weeks, then 1x per month x2 months to ensure the doors close and latch as required. Any identified concerns will be corrected immediately.<br>Results of this audit will be discussed by Maintenance Director/Administrator /Designee at the monthly QAPI meeting with IDT for analysis and recommendations for continuation, discontinuation or revision of audits based on finding<br>5. Compliance Date: 9/24/2026 | 9/24/2026 |

South Dakota Department of Health

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|---|---|---|---|
| | 10623 | A. BUILDING: _____ B. WING _____ | 09/10/2026 |

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| S 000 | Compliance/Noncompliance Statement<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/8/26 through 9/10/26. Palisade Healthcare Center was found not in compliance with the following requirements: S206 and S236. | S 000 | | |
| S 206 | 44:73:04:05 Personnel Training<br><br>The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects:<br>(1) Fire prevention and response;<br>(2) Emergency procedures and preparedness;<br>(3) Infection control and prevention;<br>(4) Accident prevention and safety procedures;<br>(5) Proper use of restraints;<br>(6) Resident rights;<br>(7) Confidentiality of resident information;<br>(8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms;<br>(9) Care of residents with unique needs;<br>(10) Dining assistance, nutritional risks, and hydration needs of residents;<br>(11) Abuse and neglect; and<br>(12) Advanced directives.<br><br>Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section.<br><br>The facility shall provide additional personnel education based on the facility's identified needs. | S 206 | 1. Staff member F completed training/education regarding the topics of proper restraint use, confidentiality of resident information, care of residents with unique needs, dining assistance, nutritional risks, hydration and advance directives. staff member G completed training/ education regarding the topics of infection prevention and control, accident prevention safety procedures, resident rights, confidentiality of resident information, dining assistance, nutritional risks, hydration, and advanced directives.<br><br>2. All employees who have been employed by the facility for one year or longer were audited to ensure required annual training was completed and up to date. Any employee identified as having incomplete or overdue annual training was provided with the required education and training.<br><br>3. HR Director/Administrator/Designee will maintain an annual education tracking system to identify required annual training and ensure education is completed within the required time frame.<br>HR Director/Staff Development Coordinator will be educated on the requirements for tracking, completion, and documentation of required annual employee training. Employees will be provided required annual education by the facility and documentation of completion will be maintained in the employee file. | 9/21/2026 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chloe Robinson — TITLE: LNHA — (X6) DATE: 9/29/2026

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| | 10623 | A. BUILDING: _____ B. WING _____ | 09/10/2026 |

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| S 206 | Continued From page 1<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on record review and interview, the provider failed to ensure the required annual training was completed for two of three reviewed employees (F and G).<br><br>Findings include:<br><br>1. Review of employee F's personnel record revealed he was hired on 11/20/24 as a certified nursing assistant (CNA). He did not complete the required annual training regarding the topics of proper restraint use, confidentiality of resident information, care of residents' with unique needs, dining assistance, nutritional risks, hydration, and advance directives.<br><br>2. Review of employee G's personnel record revealed she was hired on 3/10/25 as a licensed practical nurse (LPN). She did not complete the required annual training regarding the topics of infection prevention and control, accident prevention safety procedures, resident rights, confidentiality of resident information, dining assistance, nutritional risks, hydration, and advance directives.<br><br>3. Interview on 9/10/26 at 11:55 a.m. with administrator A revealed she expected the staff's education to be completed within 30 days of their hire and annually after that. She agreed that employees F and G did not complete the annual training as required for the above topics.<br><br>A policy about the required annual staff training was requested but the facility only had a general orientation training agenda | S 206 | 4. Administrator/HR Director/Designee will audit employee education records for 5 random employees 2x per month for 4 months to ensure required training is completed and appropriately documented<br>Results of this audit will be discussed by Administrator/HR Director/Designee at the monthly QAPI meeting with IDT for analysis and recommendations for continuation, discontinuation or revision of audits based on finding.<br><br>5. Compliance Date: 9/21/2026 | |

South Dakota Department of Health

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| S 236 | Continued From page 2 | S 236 | 1. Staff member D Tuberculosis records were reviewed and appropriate TB screening/testing was completed. Staff member E is no longer an employee of Palisade Healthcare as of 9/21/2026 and has not worked any shifts since her hire orientation date.<br>2. All employees hired within the last 6 months were audited to ensure required TB screening/ testing was completed within the required time frame following hire. Any employee identified as not having TB screening/testing completed was provided appropriate follow-up screening/ testing.<br>3. HR Director/Administrator/Designee will maintain a new hire TB screening/testing tracking log to ensure required TB screening/ testing is completed within the required timeframe following hire.<br>HR Director will be educated on requirements for employee TB screening/testing upon hire, required completion timeframes, documentation requirements, and ongoing tracking of new employees.<br>4. Administrator/HR Director/Designee will review the new hire TB screening/testing tracking log monthly x4 months to ensure all newly hired employees have completed required TB screening/testing within the required timeframe. If no employees are hired during audit period, this will be reflected on the tracking log.<br>Results of this audit will be discussed by Administrator/HR Director/Designee at the monthly QAPI meeting with IDT for analysis and recommendations for continuation, discontinuation or revision of audits based on finding.<br>5. Compliance Date: 9/21/2026 | 9/21/2026 |
| S 236 | 44:73:04:12(1) Tuberculin Screening Requirements<br><br>Tuberculin screening requirements for healthcare personnel or residents are as follows:<br>(1) Each new healthcare personnel or resident shall receive an initial individual TB risk assessment and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. The qualified personnel must record the assessment and the test in the employee's record or the resident's medical record. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment is considered a two-step test. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin testing having been completed within the prior twelve months. Skin testing or a TB blood assay test is not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any new healthcare personnel or resident who has a newly recognized positive reaction to the skin test or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; | S 236 | | |

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| S 236 | Continued From page 3<br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on employee record review, interview, and policy review, the provider failed to ensure two of five reviewed employees (D, and E) had two-step tuberculin (TB) skin testing or a TB assay test completed within 21 days of their employment.<br><br>Findings include:<br><br>1.Review of employee D's employee record revealed she was hired on 12/10/25 as a licensed practical nurse (LPN). She received the TB skin tests on 2/16/26 and 2/23/26 which was outside the 21-day requirement.<br><br>2. Review of employee E's employee record revealed she was hired on 7/6/26 as a certified medication aide (CMA). She did not have TB skin tests or a TB assay test completed as of 9/10/26.<br><br>3. Interview on 9/10/26 at 11:55 a.m. with administrator A revealed she expected the staff to have TB skin tests completed within 21 days of their hire date.<br><br>4. Review of the provider's June 2025 Employee Tuberculosis Screening policy revealed "Employees are screened for tuberculosis (TB) infection and disease upon hire and prior to commencing work in the facility, in accordance with Centers for Disease Control (CDC) guidelines, and State requirements." | S 236 | | |