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 _____	03/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/11/24 through 3/13/24 and again on 3/18/24. Palisade Healthcare Center was found not in compliance with the following requirements: F550, F578, F584, F658, F695, F812, F880, and F909.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550	1. Unable to correct deficient practice noted during survey for Resident #26. All residents have the potential to be affected. 2. The ED, DNS and interdisciplinary team reviewed Residents Rights per regulation. The ED or designee educated all staff on resident's right, specifically a right to dignity by 4/11/2024. The ED or designee will educate all staff not in attendance prior to their next working shift. 3. The ED or designee will audit 4 random residents weekly times four weeks and monthly times two months to ensure their residents rights are ackknowledged, and they are treated with dignity. The ED 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.	4/11/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lourdes Parker	*Executive Director*	*4/05/2024*

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 550	Continued From page 1 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure dignity was maintained for one of one sampled resident (26) who was parked in the middle of a hallway after requesting help to use the restroom by one of one social services designee (SSD) (C) and was told to wait for another staff member. The resident waited 20 minutes and in that time frame was incontinent. Findings include: 1. Observation on 3/12/24 from 9:06 a.m. to 9:28 a.m. with resident 26 in the 100-hallway revealed: *She was being transferred from her room by SSD C. *The resident was overheard saying, "I need to go to the bathroom." *SSD C brought the resident to the main hallway just outside her office and parked her there. SSD C said to the resident, "I will call another staff to help you." *SSD C radioed for a staff member to help resident 26 to the restroom. *Certified nursing assistant (CNA) D responded on the radio that she would come to help in a	F 550		

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F 550	Continued From page 2 minute when she was done helping another resident. *By 9:28 a.m., resident 26 was still sitting in her wheelchair in the middle of the hallway. -When asked if she still needed to use the restroom, she said, "Yes I do." *SSD C then re-radioed for assistance. *CNA D responded at that time and assisted resident 26 back to her room. 2. Interview on 3/12/24 at 9:40 a.m. with Minimum Data Set (MDS) Coordinator E revealed: *The resident usually never verbalized that she needed to use to the restroom. *She made nonsensical statements at times. *She was incontinent at all times. Interview on 3/12/24 at 9:49 a.m. with CNA D revealed: *She was assisting another resident when the call came over her radio and did not realize it would take as long as it did. *No other staff member was available to help her with resident 26 due to the resident requiring two staff members to transfer her with the mechanical lift. *Resident 26 was incontinent of urine before she could assist her to the restroom. Interview on 3/13/24 at 3:58 p.m. with the director of nursing (DON) regarding resident 26 revealed: *She heard the radio traffic asking for help with resident 26. -She indicated that she could have helped, but confirmed she did not provide help with this instance. *It was not acceptable that the resident continued to sit in a wet brief after staff had known she was incontinent.	F 550		

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F 550	Continued From page 3 *It was her expectation staff would ask for help if they were not able to perform a task in a reasonable time. 3. Review of resident 26's electronic medical record (EMR) revealed: *She was admitted on 12/22/23. *Her diagnoses included: dementia, anxiety disorder, hypothyroidism, psychotic disturbance, fracture to left patella, encephalitis, reflux disease, hypertension, reduced mobility, and other systemic atrophy. Review of resident 26's 12/28/23 Minimum Data Set assessment revealed: *Her Brief Interview for Mental Status (BIMS) assessment score was three indicating her cognition was severely impaired. *She required extensive assistance from staff for incontinent care. *She was frequently incontinent of urine. *She was not on a toileting program. Review of resident 26's care plan initiated on 12/22/23 revealed: *"The resident has an Activities of Daily Living (ADL) self-care performance deficit regarding to dementia." -"Toileting Transfer: the resident is dependent on staff for toileting transfer. Date initiated: 2/9/24. revision on: 2/9/24." -"Toileting Hygiene: the resident is dependent on staff for toileting hygiene. Date initiated: 2/9/24. Revision on: 2/9/24." Review of the provider's November 2016 Resident Rights Under Federal Law policy revealed: *"14. The resident has the right to a dignified	F 550		

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F 550	Continued From page 4 existence and self-determination." *"15. The resident has the right to be treated with respect and dignity." 3. Review of resident 26's electronic medical record (EMR) revealed: *She was admitted on 12/22/23. *Her diagnoses included: dementia, anxiety disorder, hypothyroidism, psychotic disturbance, fracture to left patella, encephalitis, reflux disease, hypertension, reduced mobility, and other systemic atrophy. Review of resident 26's 12/28/23 Minimum Data Set assessment revealed: *Her Brief Interview for Mental Status (BIMS) assessment score was three indicating her cognition was severely impaired. *She required extensive assistance from staff for incontinent care. *She was frequently incontinent of urine. *She was not on a toileting program. Review of resident 26's care plan initiated on 12/22/23 revealed: *"The resident has an Activities of Daily Living (ADL) self-care performance deficit regarding to dementia." -"Toileting Transfer: the resident is dependent on staff for toileting transfer. Date initiated: 2/9/24. revision on: 2/9/24." -"Toileting Hygiene: the resident is dependent on staff for toileting hygiene. Date initiated: 2/9/24. Revision on: 2/9/24." -" Encourage the resident to participate to the fullest extent possible with each interaction. Date initiated: 2/9/24. " Review of the provider's November 2016 Resident Rights Under Federal Law policy revealed:	F 550		

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F 550	Continued From page 5 *"14. The resident has the right to a dignified existence and self-determination." *"15. The resident has the right to be treated with respect and dignity."	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578	1. All Code Statuses removed from cheat sheet during survey. All residents have the potential to be affected. 2. The ED or designee will educate all staff on the location of the disaster recovery binder and location of code status within by 4/11/2024. The ED or designee will educate all staff not in attendance prior to their next working shift. 3. The ED or designee will audit all cheat sheets and 4 random staff knowledge of location of code status weekly times four weeks and monthly times two months to ensure no code status information is listed on the cheat sheet and staff are aware of the location of the code status and disaster recovery binder. The ED or designee will bring the results of the audits to the monthly QAPI for further review and recommendation to continue or discontinue the audits.	4/11/2024

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F 578	Continued From page 6 individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview, and policy review, the provider failed to ensure one of one sampled resident's (1) advance directive wishes were consistent between the resident's records, facility's code status binder, and the nursing staff's "cheat sheet" records. Findings include: 1. Review of resident 1's electronic medical record revealed: *There was a "CPR [cardiopulmonary resuscitation]/DNR [do not resuscitate] DIRECTIVE" form signed and dated by the resident and his power of attorney (POA) dated 1/17/24. *It had indicated "NO CPR/NO RESUSCITATIVE MEASURES." 2. Random observation on 3/18/24 at 9:43 a.m. in the 200 hallway nurses' station revealed: *There was a sheet of paper labeled "EAST HALL (200s)" that listed each resident in that hall including their code status. -Resident 1 was listed as "Full Code." *In the red code status binder: -The first page contained the sheet labeled "EAST HALL (200s)." -There was a copy of resident 1's "CPR/DNR DIRECTIVE" dated 1/17/24 that indicated "NO	F 578		

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F 578	Continued From page 7 CPR/NO RESUSCITATIVE MEASURES." 3. Interview on 3/18/24 at 9:48 a.m. with certified nursing assistant (CNA) H revealed: *If she had found a resident unresponsive, "I would get on the walkie or push the call button and ask for help." *She would have known if someone was a DNR or full code because it was listed on the sheet of paper she was provided. *The sheet of paper was labeled "EAST HALL (200s)". *She referred to the sheet as the "cheat sheet." *She stated, "If [resident 1] wasn't breathing I would do CPR." Interview on 3/18/24 at 9:52 a.m. with CNA G revealed: *The resident code status was kept on a sheet of paper at the nurse's station. *He provided a sheet labeled "EAST HALL (200s)". *He stated that each hall had a separate "cheat sheet". *He stated he had known the sheet was recently updated because it contained the newest resident room changes. *He stated that the nurses updated that form. Interview on 3/18/24 at 10:03 a.m. with licensed practical nurse (LPN) F revealed: *She had a "cheat sheet" with her on the medication (med) cart. *The sheet listed the code status for each resident. *The resident's code statuses were also kept in a code status book at the nurse's station. *She confirmed there might have been a discrepancy for the code status for resident 1.	F 578		

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F 578	Continued From page 8 *She indicated that code statuses changed at times when residents were admitted to the hospital. *Each resident had a code status signed by their physician and POA. *If she found a discrepancy she would then "go by the sheet in the book." *She did not specify which sheet in the book she would have referenced. Interview on 3/18/24 at 10:12 a.m. with director of nursing (DON) B revealed: *She confirmed the "cheat sheet" was updated after the new resident had arrived on 3/11/24. *She was not aware of the discrepancy with resident 1's code status. *Staff should not have been referring to the "cheat sheet." *The most recent code status for resident 1 was in the red binder. 4. Review of the April 2023 Advance Directive policy revealed: *"4. The Center follows each advanced directive that has been provided to it in accordance with State and Federal Law." *The policy provided no direction on the use of the code status binder or "cheat sheet."	F 578		
F 584 SS=F	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 584	See next page.	

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F 584	Continued From page 9 §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to provide a homelike environment that was free from excessive foul odors and large amounts of dust, dirt, debris, rust, and other cosmetic issues for all	F 584	1. All wall-mounted heating units to be audited. Units will be painted and mounted to the walls and placed back in functional working order. All toilets were audited for caulking repair needs. 200 hallway exterior outside door will be repaired. MJ Doors came in and did an quote for repairs. The 4 tiles in the men's public bathroom will be repaired. The sink will be replaced. Room 207 toilet repairs will be completed. Lobby sitting room: all areas of shelves were cleaned. Puzzles put in cabinet. Live plants discarded immediately. Health Care Service Group will bring a shampoo and shampoo the carpets in the front lobby. Items removed from the brown box and tossed to the garbage.Smoking area for residents: cigarette butts cleaned from the ground. All smokers and staff educated on using the red can for cigarette butts. The overhead will be repaired and maintenance will be assess the exterior door for the need of repairs. Dining room: piano was cleaned and will be removed from the property. Stereo cleaned. 5 tables will be repaired. Floor cleaned under the Culligan machine. All residents rooms were audited for chipped wood and wood filler was used to repair these areas. Far exterior door on West hallway: will be repaired. It has been tested on several other occasions and in working order. All vents were cleaned and repaired immediately and will be audited and cleaned.Room 301: arm pole removed immediately from the toilet. 300 hallway: all guard rails to be removed, sanded and painted. 303 was cited in the 2567 for items all over the floor but it is not and an occupied room. Room315 was cited in the 2567 and this room is ready for 2 LTC residents. No issues with this room. Room 313/314 has items that are being repaired and will be removed. All rooms were audited for repairs and will be addressed in order of priority. All skylights were cleaned and will be audited. SEE NEXT PAGE.	4/11/2024

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F 584	Continued From page 10 49 residents living at the facility. Findings include: 1. Observation and interview on 3/11/24 at 4:22 p.m. with resident 40 revealed: *The wall-mounted heating unit under the window was not attached to the wall and had fallen forward. *There was a box fan sitting on the floor in her room, and it was blowing air out the door. -She said her room "is too hot" and "is very noisy." *The bottom of the toilet was missing portions of caulking. The remaining caulking was brown in color. The original color was white. There was a foul odor in the bathroom. -She said her room "smells like poop and pee every morning and I can barely stand it." *She stated maintenance worker I "looked at the toilet but didn't do anything." Observation on the following dates and times of the 200 hall-way room revealed: *3/11/24 at 2:53 p.m. there was a strong odor of urine around rooms 205 to 208. *3/11/24 at 3:02 p.m. the exterior door outside room 212 was missing the lower portion of the door molding on the right side. The foundation was crumbling. -The door glass had a cloudy film between the layers of glass. -There were sharp rusty edges exposed. *3/12/24 at 1:26 p.m. the exterior door on 200 hallway was not closed tightly allowing visible gaps between the door and the door frame. *3/12/24 at 2:43 p.m. there was a strong odor of urine around resident rooms 206 to 208. *3/13/24 at 10:59 a.m. there was a strong odor of urine outside of resident room 202.	F 584	Soiled Utility room: area cleaned. Splash guard replaced. Spray hose to be replaced. Tiles surrounding the hopper sink will be re-paired. White film will be cleaned off. Bio-hazard grey bin removed and will be sent back to Stericycle. Therapy gym: white dry substance removed immediately. Ordered new parallel bars to replace old ones. Torn seat on the NuStep replaced. Stools will be removed from the facility and replaced. Room 210 bathroom door was repaired. 2. The ED or designee will educate all staff on how to communicate maintenance repair needs and logbook tools by 4/11/2024. Maintenance workers # I and J were educated on the importance of checking log-books, walking rounds and a safe and clean environ-ment by the ED by 4/11/2024.All smokers and staff educated on using the red can for cigarette butts by the ED by 4/11/2024. 3. The ED or designee will audit all areas identified in 2567 weekly times four weeks and monthly times two months to ensure a clean, safe and homelike environ-ment. The ED or designee will bring the results of these audits to the monthly QAPI committee for fur-ther review and recommendation to continue or dis-continue the audits.	

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F 584	Continued From page 11 Observation on 3/11/24 at 6:05 p.m. in the front men's public restroom revealed: *Four tiles were missing from the wall behind the toilet. -Plumbing pipes were exposed. -The tiles were sitting on the edge of the sink. *There was a package of opened wet wipes in the sink. *There was evidence of rusty water streaks in the sink basin and around the faucet. Interview on 3/12/24 at 9:10 a.m. with resident 7 revealed she stated: *"They have been cleaning the heck out of this place since you walked in. They were checking the rooms at 7:00 a.m. and looking at the bathrooms." *Her "bathroom smells of urine from the toilet." -She had questioned maintenance worker I and had asked if the seal was broken. -"They [maintenance] are aware of the problem, but they haven't fixed it." *"It's funny how corners of the building that haven't been touched in months are finally getting cleaned." *"They were even polishing the floors at 6 a.m." Observation on 3/12/24 at 1:28 p.m. in resident room 207 revealed: *The toilet seal at the base of the toilet was missing in the front. -There was a brown substance around the base of the toilet. *The baseboard molding in the bathroom was cracked and not a cleanable surface. *There was a bedpan sitting on the floor. Observation on 3/12/24 at 1:35 p.m. in the entry	F 584		

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F 584	Continued From page 12 lobby revealed: *The sitting room was to the east of the entrance. *There were unidentified brown stains in the carpet in the sitting room. *There was a puzzle area to the west of the entrance. *There was a layer of dust covering the bookshelves, an oxygen concentrator, and a table near the puzzle area. *Some of the plants had dropped dead leaves on the tables and carpet. Observation on 3/12/24 at 1:39 p.m. in the resident smoking area revealed: *Cigarette butts were lying on the ground and in the trash can. *The windows were covered with dirt and cobwebs *The overhead soffit (the material beneath the eave that connects the far edge of the roof to the exterior wall of the building) was peeling and dropping down. That was located directly above the resident smoking area. *The exterior door had peeling paint and was missing portions of the weather strip molding. Observation on 3/12/24 at 2:12 p.m. in the dining room revealed there was: *Salt and plant material on top of the piano. *A vent next to the piano that was rusted. *A layer of dust covering the stereo. *Five of the twelve dining room tables had areas where the surface had worn off. *An entanglement of extension cords between the stereo and the television. *Dust, dirt, and Nerf gun darts located under items on the north wall. *Food debris, dirt, dust, and paper items under	F 584		

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F 584	Continued From page 13 the ice machine on the south wall. Observation on 3/12/24 between 4:15 p.m. and 4:31 p.m. in the 100-hallway revealed: *Resident rooms 101 and 102 had chipped paint on the walls and chipped wood on the doors. *The far exit door was unable to be opened by one person. -It required both administrator A and regional nurse consultant K to push together quite hard to open it. --The bronze push bar was tarnished to a green color. *There were cobwebs above the door. *The air vent in front of the activities desk was not completely attached to the ceiling. *The large ceiling vent in front of resident's room 108 had a thick layer of dust. *The vent in front of resident room 102 was not completely attached to the ceiling on two sides with at least a one-half-inch gap. Observation on 3/12/24 at 4:41 p.m. in the 300-hallway revealed: 301: *There was a metal pole of a toilet arm (used to provide support for the residents) next to the back of the toilet tank and the toilet seat. -The rest of the safety rail was not present or connected to the arm. -The metal pole extended up approximately ten inches and was uncovered, there was a concern of a resident falling backward and causing skin harm. *The bathroom door had two gouges of unvarnished wood exposed. *A metal heater under the window beside the bed had fallen to the floor. 303:	F 584		

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F 584	Continued From page 14 *A one-by-one-foot area of the ceiling close to the ceiling light in the middle of the room was pulling away from the ceiling. *A corner by the closet had wall edging coming loose from the wall. *Paint was peeling from both sides of the bathroom door frame. *Chunks of missing wood and varnish were missing from the door. 304: *Paint was peeling off the bathroom door frame. *The entry door to room 304 had chunks of missing wood and varnish. 305: *The bathroom door was missing chunks of wood and varnish. *Paint was peeling off the bathroom door frame. *There were scrapes and scratches on the wall behind the recliner. *The bathroom heater had areas of missing paint. 307: *There was approximately 20-inch-by-three-inch area of the wall beside the bed where something had scraped the sheetrock away. *The north tub room had a sink with heavy rust on the faucet, levers, and drain. *Four holes had been placed in tiles beside the toilet. -They had not been filled. Observation on 3/13/24 at 10:08 a.m. in the 300-hallway revealed: *The skylight located between resident rooms 307 and 309 contained dirt, evidence of a water ring approximately five inches wide and 15 inches in length, and plant debris. *The ceiling vent across from 309 was coated with a significant dust build-up. *The door to resident room 313 was open and	F 584		

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F 584	Continued From page 15 contained the following: -An air mattress was lying on the floor. -A hospital bed was positioned on its side. -A second hospital bed without a mattress. -The bathroom contained the following: --An opened and used container of skin cleanser, a bottle of lotion, toothpaste, barrier cream, deodorant, and a toothbrush in a travel protector. --On the back of the toilet was an opened package of wet wipes. --There was no paper towels or toilet paper. *The door to resident room 314 was open, the light was on, and it contained the following: -A bed piled with a combination of what appeared to be resident belongings including: --Two suitcases, a plastic bag containing clothes, and boxes. -A bin containing wheelchair foot pedals. -Two mechanical lifts. -A furniture dolly. -A set of wall cabinets were sitting on the floor. -The bathroom contained a minimum of 15 cardboard boxes piled on the floor, sink and toilet and a resident four wheeled walker. -The closet contained over 25 boxes including COVID-19 tests, a continuous positive airway pressure (CPAP) cleaner, and gowns piled to the ceiling. *The door to resident room 315 was open and it contained the following: -Two unmade resident beds -A full trash can. -A room chair and a high-back wheelchair. -The bathroom was missing the toilet paper holder and there was no toilet paper. *The door to resident room 312 was labeled "This room is clean and ready for our new resident." It contained the following: -A toilet with no back lid.	F 584		

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F 584	Continued From page 16 -There were ceramic pieces located in the trash. -Personal care products unlabeled in the bathroom included a yellow plastic bin located in the sink. Observation on 3/13/24 at 10:40 a.m. of the therapy room revealed: *The hard folding divider curtain between the therapy room and the conference room had a large area of a dry white substance beneath it. The substance extended into both rooms. *There was a cloth chair with three nickel-sized red stains and a larger discolored stained area surrounding the red stains. *There were two mouse traps sitting on the floor in the far corner on both sides of the exit door. *There were five ceiling vents with darkened stained areas surrounding them. Interview on 3/14/24 at 9:53 a.m. with maintenance worker I and maintenance director J revealed: *Staff would notify them about something that needed fixing in person. *They confirmed there were maintenance request books at each nurse's station. -Staff usually wrote the requests in those binders if he was not able to address the concerns right away. *Maintenance worker I checked the maintenance request binders about once per week. *The management team discussed maintenance requests at the morning meetings. *Maintenance worker I performed rounds each morning around the building to check for leaks and any damages to the building such as holes in walls and broken doors. *Maintenance director J explained tiles were missing in the men's bathroom due to recent	F 584		

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F 584	Continued From page 17 plumbing work that had been completed. The tiles were replaced. *They explained that the nursing staff were responsible for keeping the resident's mechanical lift equipment clean. *They confirmed they did not keep track of all the maintenance fixes they performed throughout each day. Observation and interview on 3/14/24 from 10:18 a.m. to 10:40 a.m. with administrator A revealed: *The survey team walked her through the building to inform her of the identified concerns. *The bathroom door in room 210 was off its bottom hinge. The wood paneling was chipping away. -She was not aware of that. *It was her expectation that the dietary department should have kept the dining room clean. *She was aware of: -The state of the skylights. -The issues with the foundation crumbling. -The concerns with the deteriorating caulking around resident toilets. 2. Review of the provider's July 2015 "Homelike Environment" policy revealed: *"Policy Statement: Resident rooms are personalized and organized in a manner that promotes independence through a homelike environment." *There was nothing in the policy about shared resident spaces. Review of the provider's resident handbook, last updated December 2023, revealed: *Page 24, "3 - Community Life" -" ...Heating and Lighting. Staff members	F 584		

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F 584	Continued From page 18 maintain the heating and overall lighting throughout the center." -" ...Room Cleanliness and Maintenance. Our goal is to provide a clean environment in good working order for our residents. We replace light bulbs and repair plumbing issues as needed. If you have any concerns about the cleanliness of your room or working order of your bathroom, please alert center staff."	F 584		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of six nursing staff members (M) observed during medication administration had properly disposed of one of one sampled resident's (36) narcotic medication after it had been dropped on the medication cart tabletop. *One of two licensed practical nurses (LPN) (M) had properly disinfected an insulin pen before attaching the needle and primed the pen before administering one of one resident's (32) insulin. *Appropriate care was provided and documented for one of one resident (40) who was receiving an anticoagulant medication and experienced a nosebleed. Findings include: 1. Observation on 3/12/24 from 4:53 p.m. to 5:12 p.m. at the 200-hallway medication cart revealed:	F 658	1. Unable to correct narcotic destruction insulin administration and glucometer cleaning noted during survey. Anticoagulant monitoring placed on all residents including #40 during survey. All residents have the potential to be affected. 2. The ED or designee will educate all licensed nursing staff on glucometer cleaning and insulin administration, destruction of narcotics and anticoagulant monitoring by 4/11/2024. The ED or designee will educate all staff not in attendance prior to their next working shift. 3. The ED or designee will audit 4 random med passes to include medications, insulin administration and glucometer cleaning weekly time four weeks and monthly times to months to ensure appropriate med destruction if applicable, proper insulin administration and glucometer cleaning. The ED or designee will audit all anticoagulants weekly times four weeks and monthly times to months to ensure proper monitoring is in place. The ED 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.	4/11/2024

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F 658	Continued From page 19 *LPN M was preparing resident 36's scheduled dose of oxycodone. *As she popped the pill out of the card, it landed on the medication cart tabletop rather than into the medication cup. *LPN M picked up the pill with her ungloved hand, placed it into the medication cup, and delivered the medication to resident 36. -Resident 36 took that pill. *LPN M prepared resident 32's "Humalog KwikPen" insulin pen. -She did not disinfect the rubber seal on the insulin pen before attaching the needle. -She did not prime the insulin pen. *She administered the scheduled 12 units of insulin in the resident's right lower quadrant. Interview on 3/12/24 at 5:22 p.m. with LPN M about the above observations revealed: *She confirmed it was not the correct practice to use a pill that had been dropped on the medication cart tabletop. -She said she should have gone through the proper channels to waste the narcotic pill. -"It would have taken two nurses since it's a narcotic." *To her understanding, it was not a requirement to: -Disinfect the rubber seal on insulin pens. -Prime the insulin pen by dialing up two units of insulin, then wasting that insulin. Interview on 3/13/24 at 12:25 p.m. with LPN R revealed: *She was a nurse manager. *It was her expectation that: -Any pill should have been properly wasted if it was dropped. -To waste a narcotic medication, the nurse should	F 658		

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

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F 658	Continued From page 20 have first informed the pharmacy of the dropped medication and requested a replacement, then two nurses should have been present to account for the narcotic having been discarded in the medication destroyer bottle. -A pill that had been dropped should not have been administered to a resident. -All insulin pens should have been disinfected before attaching the needle. -Insulin pens should have been primed before administering the medication. -To prime an insulin pen, the nurse should have dialed up two units of insulin and pressed the injection button to waste the two units of insulin. -That step was to ensure insulin was present in the needle, and to ensure the insulin was able to pass through the needle. *She indicated LPN M was a travel nurse and they relied on competency and training records from the travel agency. -They held competency training, however some of the travel staff would not always attend. Review of the provider's December 2012 "Disposal of Medications" policy revealed: *"Policy: ...2. Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances (or those classified as such by state regulation) are subject to special handling, storage, disposal, and record keeping in the nursing care center in accordance with federal and state laws and regulations." *"Procedures: ...2. Controlled Substances listed in Schedules II, III, IV and V remaining in the nursing care center after the order has been discontinued are retained in the nursing care center in a securely double locked area with restricted access until destroyed as outlined by state regulation."	F 658		

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F 658	Continued From page 21 -"b. For the State of _____ [this part of the policy was not filled out by the provider to indicate the State of South Dakota], these controlled substances shall be disposed of by the nursing care center in the presence of appropriately titled professionals (check appropriate line):" [The following was not filled out by the provider to indicate what their practice was]. -"___ Licensed nurse employed by the nursing care center and a pharmacist." -"___ Two licensed nurses employed by the nursing care center." -"___ Administrator and licensed nurse employed by the nursing care center." -"___ Others as listed: ___ [nothing was listed]." *"3. If a controlled medication is unused, refused by the resident or not given for any reason, it cannot be returned to the container. It is destroyed as outlined above and the disposal is documented on the accountability record on the line representing that dose with the required signatures. This same procedure applies to unused portions of single dose ampules and doses of controlled substances wasted for any reason." *"7. Outdated medications, contaminated or deteriorated medications, and the contents of containers with no label shall be destroyed according to the above policy." Review of the provider's November 2017 "Medication Administration, Orals" policy revealed: *"Procedures: ...7. Pour the correct number of tablets or capsules into the medication cup, taking care to avoid touching and of the medication unless wearing gloves." Review of the provider's January 2022	F 658		

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F 658	Continued From page 22 "Medication Administration, Subcutaneous Insulin" policy revealed: *"Policy: To administer subcutaneous insulin as ordered and in a safe, accurate and effective manner." *"Procedures: ...5. ...Review manufacturer specific administration and storage instructions for pen devices." *"9. Prepare injection:" -" ...b. Prepare syringe/pen and safety needle. (See pen example)." -"c. Swab rubber cap of vial with antimicrobial agent." *"Always perform the safety test before each injection." -"A. Select the dose of units by turning the dosage selector." -"B. Select your required dose ... If you turn past your dose, you can turn back down." -" ...F. Press the injection button all the way in. Check if insulin comes out of the needle tip." Review of the manufacturer's guidelines for the "Humalog KwikPen" insulin pen revealed: *"Preparing your Pen" -"Step 1: Pull the Pen Cap straight off. Wipe the Rubber Seal with an alcohol swab." *"Priming your Pen" -"Prime before each injection." -"Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly." -"If you do not prime before each injection, you may get too much or too little insulin." -"Step 6: To prime your Pen, turn the Dose Knob to select 2 units." -"Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air	F 658		

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F 658	Continued From page 23 bubbles at the top." -"Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and '0' is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly." -"You should see insulin at the tip of the Needle." -"If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times." -"If you still do not see insulin, change the Needle and repeat priming steps 6 to 8." 2. Interview on 3/11/24 at 4:18 p.m. with resident 40 revealed she: *Had gotten "nose bleeds." *Was concerned she was receiving "too much blood thinner. *Reported she had "3 major ones [nosebleeds]" while at the facility. *Stated she "takes a blood thinner and baby aspirin." *Recalled having had a nosebleed "last Thursday [3/7/24] that lasted from 9:00 p.m. until 3:00 a.m." *Stated, "They gave me ice to get it [the nosebleed] to stop, but never came back. Interview on 3/13/24 at 2:15 p.m. with resident 40 revealed she: *Recalled LPN M: -Assisted her when she had the last nosebleed. -Had filled a glove with ice and wrapped it in paper towels. -Had placed the glove on her nose with her head down. *Stated the nosebleed lasted from 9:30 p.m. until 3:00 a.m. *Had known she was on "Eliquis and 81mg of aspirin." *Stated, "I talked to a couple of nurses including [LPN M] about the blood thinners because I get	F 658		

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F 658	Continued From page 24 these bloody noses." *Could not recall if she had discussed her concerns with DON B. *Was not aware if her concerns had been shared with her doctor. Interview on 3/13/24 at 3:25 p.m. with LPN M revealed she: *Agreed that she had provided ice to resident 40 when she had a nosebleed. *Could not recall if resident 40 was on a blood thinner. *Would have gone back to check on resident 40 "had the CNA told me the resident had rang her call light again." *Could not recall if she had shared the information in the report with the next shift. *Could not recall if she had documented the nosebleed. *Had not notified resident 40's physician of her nosebleed. Interview on 3/13/24 at 4:10 p.m. with DON B revealed: *She stated, "this is the first I am hearing of [resident 40's] nosebleeds." *She stated, "an anticoagulant assessment is completed on all residents on a blood thinner." *Her expectation was that the assessments would have been completed on all residents who were on anticoagulants. *She expected nurses would document and communicate with a supervisor or the physician when a resident was on an anticoagulant and experiencing bleeding or nosebleeds. Review of resident 40's electronic medical record revealed: *She had a Brief Interview for Mental Status	F 658		

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F 658	Continued From page 25 (BIMS) score of 15 that meant she was cognitively intact. *Her diagnoses included peripheral vascular disease, personal history of pulmonary embolism, and unspecified anemia. *The Minimum Data Set dated 2/15/24 indicated the use of anticoagulants. *An order for "Aspirin Oral Capsule 81 MG (Aspirin) Give 81 mg by mouth one time a day for blood thinner." *An order for "Ferrous Sulfate Tablet 325 (65 Fe) MG Give 1 tablet by mouth one time a day for Anemia." *An order for "Apixaban Oral Tablet 5 MG (Apixaban) Give 5 mg by mouth two times a day for DVT prophylaxis." *There was no documentation regarding the use of a blood thinner, anticoagulant, bleeding risk, or nosebleeds in the resident care plan updated 3/12/24. *There were no anticoagulant assessments in the Treatment Administration Record. Requested a copy of resident 40's anticoagulant monitoring assessment. The provider responded on the request sheet, "Don't have any assessments." Review of the providers July 2014 "Anticoagulation Therapy Policy" revealed: *"Policy Statement: Residents who are on anticoagulation therapy are monitored to deliver proper care and treatment. This includes monitoring ... resident for any sign or symptoms of complications from the medication(s) utilized."	F 658		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695	See next page	

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

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F 695	Continued From page 26 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review, and manufacturer's guideline review, the provider failed to ensure: *Four of four sampled resident's (6, 11, 34, and 38) oxygen concentrator machines were free from dust buildup. *One of one shared resident oxygen concentrator machine was free from dust and debris buildup. *One of one sampled resident's (34) oxygen tubing was managed in a way that minimized the risk of contamination. *Physician's orders were followed for continuous oxygen administration for one of one sampled resident (1). Findings include: 1. Observation on 3/11/24 at 4:39 p.m. in resident 6 and 34's room revealed: *Resident 6's oxygen tubing was labeled with a handwritten date of "12/21/23." *Resident 34's oxygen nasal cannula was lying on the floor. -He was in bed and was not wearing his oxygen. *There were no dates written on resident 34's oxygen tubing or humidifier. *The foam filters on the back of both resident 6's and 34's oxygen concentrator machines were covered with a layer of dust.	F 695	1. Resident's 6,11,34 and 38 were cleaned as well as all others in the center. Resident 34 oxygen tubing was replaced. Order for resident 6 was changed during survey to reflect current needs. All residents have the potential to be affected. 2. The ED or designee will educate all nursing staff on respiratory equipment policy and procedure for cleaning O2 concentrators and changing tubing as well as licensed nurses on oxygen orders and administration by 4/11/2024. The ED or designee will educate all staff not in attendance prior to their next working shift. 3. The ED or designee will audit all concentrators and tubing weekly times four weeks and monthly time two months to ensure they are clean and uncontaminated. The ED 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.	4/11/2024

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F 695	Continued From page 27 Observation on 3/11/24 at 5:00 p.m. revealed that resident 34 was now wearing the oxygen nasal cannula. Interview on 3/13/24 at 4:34 p.m. with LPN L about the above observations revealed she: *Confirmed resident 6's oxygen concentrator machine was dirty, and the foam filter was very dusty. *Thought the night staff had been cleaning the oxygen concentrator machines. *Denied that she put the oxygen tubing back on resident 34's face. *Was not aware if the nasal cannula had been cleaned or replaced after it had been sitting on the floor. Observation on 3/12/24 at 9:36 a.m. in resident 11's room revealed the oxygen tubing was labeled with a handwritten date of "12/22/23." Observation on 3/13/24 from 10:05 a.m. to 10:38 a.m. throughout the facility revealed: *In the front entrance room: -There was a multi-resident shared oxygen concentrator machine that was covered with a layer of dust, unidentified crumbs, and dead plant material. -There was a wall-mounted wooden podium. Inside the podium was a used oxygen tubing, tape, a thumb tack, dirt, and crumbs of unidentified food. *In resident 38's room, her oxygen concentrator machine and CPAP (continuous positive airway pressure) machine was covered in a layer of dust. -The foam filter on the back of the oxygen concentrator machine also had a layer of dust on it.	F 695		

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F 695	Continued From page 28 -There was moisture buildup in the oxygen tubing. -There was no date on the oxygen tubing. Interview on 3/13/24 at 4:37 p.m. with licensed practical nurse L revealed: *Cleaning of oxygen equipment was completed at night. *She stated: -"I don't know when it was last done or how quickly it gets dusty." -"Honestly, I don't look at it. I don't have time. Seriously, it's not a good excuse." Interview on 3/14/24 at 11:02 a.m. with director of nursing (DON) B revealed: *The night staff were responsible for changing the resident's oxygen tubing. *Her expectation was "if the staff see it's visibly dirty, to clean it. If you see a dirty surface, you clean it." *Other times she expected the oxygen tubing to have been changed including if the resident had been sick, or if the tubing was damaged. Continued interview on 3/14/24 at 3:32 p.m. with DON B revealed: *They used to have a hospitality aide that was assigned to clean the oxygen concentrator machines and change the tubing. -That hospitality aide was promoted to a certified nursing assistant (CNA) in December 2023. *She explained there may have been some miscommunication in job duties as that hospitality aide stopped maintaining the oxygen concentrator machines and changing the oxygen tubing after the promotion to a CNA. *The policy was to change a resident's oxygen tubing and to clean the oxygen concentrator	F 695		

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F 695	Continued From page 29 machines as needed. *She confirmed that resident 6's oxygen concentrator foam filter was especially dirty. Review of resident 6's electronic medical record (EMR) revealed: *There was a physician's order for "Change oxygen tubing. Clean oxygen filter," that was scheduled on the Treatment Administration Record (TAR) for each Saturday on the night shift. -The order started on 8/22/20. *The resident's TAR for January, February, and March of 2024 indicated that staff were documenting that the oxygen tubing was changed and the filter was cleaned as scheduled. -However, his oxygen tubing was dated 12/21/23 as mentioned above and the filter was very dusty. Review of resident 11, 34, and 38's EMR revealed there were no physician's orders to change the oxygen tubing or clean the oxygen filter. Review of the CPAP machine's "Patient Instructions" revealed the cleaning instructions on page eight indicated to "wipe the exterior of the device with a dry cloth" weekly. 2. Observation and interview on 3/12/24 at 10:11 a.m. with resident 1 revealed: *He was on 3.5 liters of oxygen. *He stated he wore his oxygen "all the time." *The humidifier bottle attached to the concentrator was empty. *There was no date on the oxygen tubing or humidifier bottle. *He stated he was not aware when staff had changed the oxygen tubing or the humidifier	F 695		

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F 695	Continued From page 30 bottle. Review of resident 1's EMR revealed: *A "Facsimile Transmission" to resident 1's physician dated 3/6/24 requested, "Can we get an order for 2-4L [liters] of continuous oxygen." -There was a reply of "yes" signed and dated 3/6/24 by the physician. *There was an order in the Treatment Administration Record (TAR) that indicated: -"Oxygen to maintain O2 Saturation levels to > = 90 every day shift for Oxygen related to ACUTE AND CHRONIC RESPIRATORY FAILURE WITH HYPOXIA (J96.21) -Start Date-03/07/2024." *There were no parameters for the flow rate being administered. *There were no physician standing orders for oxygen reflected on the TAR. *The care plan revised on: 02/14/23 indicated: -"I use oxygen therapy r/t COPD, and acute and chronic respiratory failure w/ hypoxia." -"Give medications as ordered by physician. Monitor/document side effects and Effectiveness." Interview on 3/14/24 at 11:10 a.m. with DON B revealed: *There were physician standing orders for the use of oxygen. *"If the doctor orders oxygen, the order would be written on the TAR with the parameters specified by the doctor." *Changing of the oxygen tubing and filling of the humidifier was done PRN [as needed] and was not on the TAR. *She expected staff to change the oxygen tubing and fill the humidifier "as needed."	F 695		

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F 695	Continued From page 31 -That task was "as needed and not assigned, not on the TAR, and therefore there would have been no documentation of when it had been completed." Review of the provider's November 2018 "Respiratory Care; Equipment Care and Handling" policy revealed: *The policy statement read, "Respiratory equipment is handled in a manner that maintains good working order and promotes proper infection control." *Under the "Oxygen Administration" section: -"1. Oxygen is administered in accordance with professional scope of practice, state and federal regulation, and physician's orders." -"4. Consider all disposable equipment as single patient use items." -"5. General equipment guidelines will be observed unless otherwise specified by regulation or physician order." *In the table that described "Recommended Change and Frequency:" -"Nasal Cannula or Face Mask, PRN [as needed], Discard and replace if heavily soiled." -"Tubing, PRN, if soiled, malfunctioning, or damaged."	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812	See next page	

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F 812	Continued From page 32 and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of one refrigerator in the kitchen storage room used for storing resident foods: -Was maintained for cleanliness. -The food stored in the refrigerator was monitored for outdated food items consistently. *Groceries delivered in cardboard boxes were not left on the floor of the pantry and the walk-in freezer. *Food items set up on kitchen carts for the next meal were covered until they were brought to the dinner table. *The following kitchen equipment and the surrounding environment was maintained in a clean and sanitary manner: -Two of two ovens, one convection, and one oven/range. -One-of-one stove hood filter panels. -One of one steam table. -One of one vegetable sink. -One stainless steel counter on the back wall holding a large mixer on the counter. -One of one shelf holding pans under a steel table in the serving area. -One of one toaster.	F 812	1. All areas identified in the 2567 will be cleaned and maintained on the new cleaning schedule. Maintenance will address the ceiling fixture and electrical plate covering. Ordered 2 new wire racks to replace the cooler racks. All other racks cleaned. Screen in the window was repaired and cleaned. The resident refrigerator was cleaned during survey. Activity department will be responsible for cleaning the resident's refrigerator weekly. Door to the Nutrition room will be fixed and new handle placed to latch. Window and screen cleaned. Unable to fix deficient practice noted during survey related to temperature logs. All residents have to potential to be affected. 2.The ED or designee will educate all dietary staff on the new cleaning schedules that have been revised and updated, food storage guidelines that will be available for the resident refrigerator, and that monitoring of the resident refrigerator will be added to the cleaning schedule. Dietary staff will be in-serviced on the following: cleaning schedules, cleaning of equipment both stationary and moveable, cleaning of floors, food Storage including label and dating, documenting of temperatures including freezer and refrigerators, prep of the fresh produce, cleaning of the vent hoods filters. All staff will be in serviced on resident food brought from the outside by 4/11/2024. The ED or designee will educate all staff not in attendance prior to their next working shift. 3. The ED or designee will audit all deficient areas weekly times four weeks and monthly times two months to ensure a clean, sanitized kitchen environment. The ED or designee will bring the results of the audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	4/11/2024

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F 812	Continued From page 33 *Two of two large ceiling vents *All kitchen area floors, including the following: -Kitchen storage room. -Serving and cooking areas. -Pantry. -Dishwasher area. -Below and behind the ice machine *The kitchen area walls: -Above and below the dishwasher table. -The walls and floors of one walk-in cooler and one of one walk-in freezer. -Behind the ovens. -Behind and below the stainless-steel counter on the back wall. -Behind and below the three-compartment sink and the hand sink. -All walls in the kitchen storage room. Findings include: 1. Observation on 3/11/24 at 3:15 p.m. during the initial tour of the kitchen revealed: *The dietary cook's daily cleaning list for 3/4/24 through 3/10/24 revealed the dates of 3/9/24 and 3/10/24 had no documentation of any cleaning on those dates. *The dietary aide's daily cleaning list for 3/4/24 through 3/19/24 revealed the date of 3/7/24 had no documentation for any cleaning on that day. *The toaster, tray, and the surrounding shelf had crumbs of bread. *One-of-one oven/range and one-of-one convection oven had: -Dark brown and black unidentified build-up on the walls, ceiling, and inside of the oven door. -The floors of the ovens were lined with aluminum foil that was covered with dark unidentified stains and food particles. -Both ovens had dark brown and black unidentified streaks of food on the inside walls	F 812		

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F 812	Continued From page 34	F 812		

and doors.
-The outside of the ovens were covered in grime that was sticky to the touch.
*Above the ovens was one large ceiling vent.
-The grate covering the vent was covered with grease, grime, and dust.
*The kitchen floors:
-Had heavy dust and dirt build-up under the ovens, the counter and vegetable sink at the back of the kitchen, and a heavy amount of dirt and brown/black stains at the back door (adjacent to the pantry).
-The floor under the back counter had a plastic bag and papers left under the counter.
-The floor under the three-compartment sink had dust and dirt build-up.

Interview at the above time with cook O and dietary aide N. When dietary aide N had been asked why the kitchen had not been cleaned she stated only two employees were working in the kitchen and there was no time for cleaning. Cook O stated that was the third day on her job.

Continued observation of the kitchen on 3/11/24 at 4:00 p.m. revealed the walk-in cooler had:
*Two food carts holding thirty-five uncovered fruit cups.
-There was no date indicating how long the food had been dished and left uncovered.
*One plastic container on a shelf.
-The container appeared to have some kind of deli meat.
-The container was not identified what it was or when it was placed in the cooler or a use-by-date.

Continued observation on 3/11/24 at 4:15 p.m. of the kitchen storeroom next door to the kitchen revealed:

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F 812	Continued From page 35 *The floor was littered with pieces of paper and a heavy amount of dust, dirt, and lint. -Two small containers of applesauce were sitting on the floor. *Two meal tray carts. -One of the carts had been placed under a large ceiling vent. -An opened cardboard box was placed under that vent. -The box contained plastic disposable glasses, bowls, and small containers with lids. -The ceiling vent contained a large amount of lint and dust. -Some of the vent dust was visible on top of the tray cart. *The window at the end of the room revealed: -The window screen had been placed inside the window. -The screen, windowsill, and trim had an accumulation of dirt, dust, grime, and cobwebs. -A metal shelving unit to one side of the window held the nursing department items for medication passes, such as supplement drinks, and applesauce. -The other side of the window there was a metal shelving unit holding the emergency supply of food. *A sign on the refrigerator in that room indicated it was to have been used for storing resident food items. -The thermometer indicated the temperature in the refrigerator was 40 degrees Fahrenheit. The temperature was to have been documented daily. The temperatures for the dates of 3/9/24 and 3/10/24 had not been documented. *The refrigerator was full of food, with the resident's food stacked on top of other resident food. -Some foods were in bags, while other foods	F 812		

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F 812	Continued From page 36 were in take-out boxes. *The inside of the resident's refrigerator had old, dried food stuck to the shelving and the door. Observation and interview with dietary manager (DM) P regarding the kitchen on 3/13/24 at 10:30 a.m. through 12:50 p.m. revealed: *When dietary manager P was asked about the unclean vegetable sink she stated the sink had not been used in three to four months because they rarely used fresh fruits or vegetables. -She served baked potatoes for lunch on 3/13/24. *Observation of the metal counter at the back of the room held the vegetable sink, and large mixer revealed: -A window above the vegetable sink had a screen on the inside of the window. --The screen was coated with dust, brown grit, leaf parts, and cobwebs. --The windowsill, and window trim also had brown grit, dust, and greasy grime. -A food processor sat on a shelf below the sink covered with dust. --When DM P was asked why the food processor was under the sink, she did not respond. -Beside the sink was an opened cardboard container holding paper baking sheets used for food going into the oven. -The countertop had grit, and dust, and was sticky to the touch. -Beside the container was a large, covered mixer. -The rest of the counter held random items not used for cooking or baking. *When asked about the counter area and lack of cleaning DM P stated: -The area was not used. -They did not use the mixer. --They used a large spoon and bowl to mix the food.	F 812		

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F 812	Continued From page 37 -The mixer had flour on its base. *The wall behind the back counter revealed brown and black stains and was sticky to the touch. *The oven hood filter panels inside the hood area and the fire suppression pipes on the hood had a build-up of greasy grime and thick dust. -DM P stated she had never cleaned the panels attached to the hood because she was told not to touch the hood. *The dishwasher area had brown and dark black stains: -On the wall against the dish table. -Below the dish table next to the floor. -The dishwasher had a heavy build-up of white mineral deposits sitting on the top. -The table beside the dishwasher had rust on the legs. Continued observation on 3/13/24 at 12:10 p.m. with DM P of the steam table area revealed: *A large flour bin with flour sat on a shelf below the coffee maker and beside the steam table. -The lid had been covered with dust that could be wiped away. *An approximately five-inch by two-inch piece of ceiling that was coming away from the wall in front of the steam table. *An electrical outlet on the wall in front of the steam table was missing the cover plate. -The sides of the table including the area with knobs used to turn it on and off were sticky to the touch from grease. Observation on 3/13/24 at 12:40 p.m. of the walk-in cooler and walk-in freezer revealed: *Five metal shelving units in the cooler and freezer had heavy rust. *A metal pipe attached to the wall of the cooler	F 812		

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F 812	Continued From page 38 had left rust stains on the wall. *Both the cooler and freezer floors had dirt, juice spills, and food particles on the floors with sticky build-up, especially in the doorways. Observation on 3/13/24 at 1:30 p.m. of the ice machine in the dining room revealed: *The ice chute had built-up mineral deposits as well as a build-up of juice splashes from drinks in their glasses when adding ice to their glasses. *The area behind and below the ice machine had dust, dirt, and papers on the floor. *The walk-in freezer and pantry had two towers of cardboard boxes filled with groceries. -The groceries were delivered on 3/12/24. -They remained on the floor of the walk-in freezer and pantry until 3/14/24. Observation and interview on 3/14/24 at 9:30 a.m. with DM P revealed: *When asked who was responsible for keeping the residents' refrigerator clean and monitoring the food DM P stated: -The residents or family were to take care of the food in the refrigerator. -She did not state who was responsible for keeping the refrigerator and the kitchen storage room clean and sanitary. Observation on 3/14/24 at 9:30 a.m. of the resident's food in the resident's refrigerator with DM P revealed the following foods were either beyond the expiration date or had no date to indicate how old the food was. *A burrito or sandwich wrap had no date on the container. *An undated container of Braunschweiger had no date on the container.	F 812		

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F 812	Continued From page 39 *One sandwich wrap had expired on 3/12/24. *One pancake and sausage meal had no date on the container. *Three containers of yogurt had expired on 12/28/23. *Several bags of shrunken blueberries in juice had no date. *One piece of bologna had no date. *One piece of cheese with no date. *Onion dip with no identified date. Interview on 3/14/24 at 10:15 a.m. with registered dietitian (RD) Q regarding the above kitchen findings revealed: *RD Q had only been consulting with the provider for one month. *He had been in the building on 3/8/24. *He had told DM P the area in front of the steam table needed to be cleaned. *RD Q discussed the findings from the survey and the lack of a sanitary environment and expired or undated food. *RD Q confirmed: -Kitchen and kitchen storage areas had not been maintained in a sanitary manner. -Opened items were to have use by dates. -Food items should have been covered until they were served. Interview on 3/18/24 at 2:15 p.m. with DM P regarding maintaining the kitchen in a sanitary manner confirmed: *The resident refrigerator: -Was not clean. -Had not been monitored for expired food or missing dates on food items. *Opened foods should have a use by date. *Prepared foods should have been covered until it was served.	F 812		

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F 812	Continued From page 40 *The cardboard boxes that held food items should not have been left on the floor of the pantry and walk-in freezer floor. *The ceiling vents in the kitchen and kitchen storage room were not cleaned. *The kitchen and kitchen storage room walls, floors, and windows had not been cleaned. -Metal shelves in the walk-in cooler and freezer, one wall of the cooler, and the legs of the dish table had rust. *Kitchen equipment (ovens, stove hood filter panels, steam table, vegetable sink, stainless steel countertop, and shelf, large mixer, shelf holding pans, tray carts, and a toaster should have been cleaned and maintained. DM P stated: *The provider had lost two cooks. *She had been working as a cook after they lost two cooks. *She normally did not work in the kitchen, spending her time in her office. *She was not aware that the kitchen had been so dirty. "I couldn't believe how bad it was." Review of the provider's August 2020 Resident Personal Refrigerators and Foods Brought into Center by Family/Visitors policy revealed: *Foods brought to a resident by family by family, or visitors may be stored in their refrigerator or designated refrigerator/freezer in the Center. *Non-perishable foods in the resident's room were dated and stored in containers with tight-fitting lids or sealable bags, except fresh fruit. *There was a designated refrigerator in the building to store resident foods. *The refrigerator containing the resident food items had thermometers and daily temperature	F 812		

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F 812	Continued From page 41 logs with temperatures documented. -Temperature standards for the refrigerator were 35-40 degrees Fahrenheit. -Temperatures outside of those standards were to have been reported to [DM P] or the Person in Charge. *Perishable foods were to have been covered, labeled, dated, and discarded following use-by-date guidelines. -Provider staff were responsible for educating the resident and family on food/fluid labeling and dating. -Provider staff, at their discretion, could discard food items that were not safe to eat, nor labeled after verbally notifying the resident or then responsible party. Review of the provider's September 2019 Sanitation Policy revealed: *The food service was to have been maintained in a clean and sanitary manner. *Kitchens, kitchen areas, and dining areas were to have been kept clean and free from litter and rubbish. *Utensils, counters, shelves, and equipment were to have been kept clean, and maintained in good repair, and free from breaks, corrosion, open seams, cracks, and chips. *Ice used in connection with food and drink was expected to come from a sanitary source and was to have been handled and dispensed in a sanitary manner. *Cleaning schedules were developed by the [DM P] or the person in charge. *The registered dietitian was to complete comprehensive summary reports. Review of the provider's October 2017 Food Storage Policy revealed:	F 812		

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F 812	Continued From page 42 *Food storage areas were to have been maintained in a clean, safe, and sanitary environment. * Food storage areas were to have been kept clean at all times. *Food or food items not requiring refrigeration were to have been stored on surfaces (shelves, racks, dollies, etc. a minimum of six inches above the floor to facilitate thorough cleaning, in a ventilated room, not subject to sewage or contamination. *Packaged food, canned foods, or food items stored were to have been kept clean and dry. *Dry bulk foods, such as flour were to have been stored in seamless metal or plastic containers with tight-fitting covers or bins. *Remove food from packing boxes upon delivery to minimize pests. *Foods were to have been dated with the month and year of delivery. *Cold foods were to be maintained at 41 degrees Fahrenheit. *Foods that were stored in walk-in refrigerators and freezers were to have been stored above the floor on shelves, racks, dollies, or other surfaces to facilitate a thorough cleaning. Do not line the shelving. *Opened items were to have use-by-dates. The use-by-date. The provider may indicate the date opened or the date prepared, if required from the survey agency. *The manufacturer's expiration date, when available, was the use-by-date for unopened items.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880	See next page	

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F 880	Continued From page 43 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880	1. Expired resident's supplies were removed, and supply room was cleaned. All boxes on the floor were removed. Dining room: cabinets items removed and cleaned. White basket thrown away and replaced with new. Sink cleaned. Linen closets: storage containers cleaned and will be audited. 210: toilet rust cleaned and privacy curtains changed out. Mechanical lift with rust cleaned and painted. White plastic shower chair broke and will be repaired or replaced. Remote ordered for the mechanical EZ Way lift. 300 hallway shower room faucet will be replaced. Cloth chairs cleaned. Disinfectant spray bottle replaced with a bottle with label. Enhanced Barrier Precautions signs placed on the residents doors and in care plans. All residents have the potential to be affected. 2. The ED or designee will educate all staff to sanitize all residents shared equipment after each use and as needed and Enhanced barrier precautions by 4/11/2024. All staff not in attendance will be educated prior to their next shift by the ED or designee.	4/11/2024

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 44 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the following: *Resident use items, such as mechanical lifts, therapeutic exercise machines, door handles, and handrails were maintained in a clean and sanitary manner. *Supply closets were maintained in a manner that prevented the accumulation of dust and trash, and ensured the supply of resident-use items were discarded after the expiration date. *Infection control guidelines were maintained during the following:	F 880		

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F 880	Continued From page 45 -Three of twenty-six medication administration observations by licensed practical nurse (LPN) M and LPN L. -Wound care performed by two of two LPNs (R and S) for two of two sampled residents (1 and 24) on enhanced barrier precautions (the practice of using gowns and gloves when performing certain high-contact cares for certain residents). Findings include: 1. Observation on 3/12/24 at 1:28 p.m. in resident room 207 revealed: *The toilet seal at the base of the toilet was missing in the front. -There was a brown substance around the base of the toilet. *The baseboard molding in the bathroom was cracked and was not a cleanable surface. *There was a bedpan sitting on the floor underneath the resident's bed. Observation on 3/12/24 at 1:35 p.m. in the lobby revealed: *There was a used oxygen nasal cannula tubing, not labeled, in a wooden lift-top podium attached to the wall under the window on the right side of the door. -Inside the box there were thumbtacks, chips, tape, assorted crumbs, and dust. -Those items in the podium box remained in the same condition throughout the survey, and were still present upon survey exit on 3/18/24 at 4:20 p.m. Observation on 3/12/24 at 1:39 p.m. of the facility's medical supply storage room located in between the dining room and the rehab wing revealed: *A cabinet containing a minimum of 12 catheters	F 880		

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F 880	Continued From page 46 with past expiration dates. *A sterile Foley insertion tray that had been opened. *A plastic three drawered bin containing an opened package of sterile gloves and two additional pair of sterile gloves with past expiration dates. *A shelf containing opened briefs loose on the top shelf. *At least six cardboard boxes sitting on the floor containing lotions and skin creams. -Three of the boxes were opened. *The shelving units and drawers in that room were covered in a layer of dust and unidentified debris. Observation on 3/12/24 at 2:12 p.m. in the dining room revealed: *A Kool-aid container and a Clorox wipes container was sitting on the same shelf in the cabinet. *A white plastic basket containing pudding/Jello cups, napkins, and other items with a moderate amount of dust and food crumbs. *A drawer in the dining room cabinets that included a drain snake, a dirty sponge, and a plastic handle slotted spoon. *The sink was dirty and stained. *The ice machine: -Chute had built-up mineral deposits. -The catch basin area had an unidentifiable built-up residue. -Had dust, dirt, and papers on the floor beneath it. *Five of the twelve dining room tables had worn areas on the tops exposing the unfinished particle board wood surface. Observation on 3/12/24 at 2:49 p.m. in the 200-hallway revealed:	F 880		

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F 880	Continued From page 47 *In the linen closet, there were several buckets of resident use items not in the original packaging: -Oxygen tubing. -Incontinence briefs. -There was a bottle of hand sanitizer that expired in December 2022. -There was a cheese stick wrapper in one of the buckets. *The door handle on the exit door at the end of the hallway was corroded with patina and not a cleanable surface. -Patina is a layer of a green substance that develops on metals such as copper, bronze, and brass as it oxidizes. *In room 212: -The caulking at the base of the toilet was corroded and had turned dark brown in color. The original color was white. -There was a strong scent of urine and feces near that toilet, potentially from the caulking as there was nothing in the toilet. -The metal heat register was not a cleanable surface as it was rusted with sharp edges exposed as it was not completely attached to the wall. *In room 210: -The plumbing on the back of the toilet was rusted. -The privacy curtains were stained with scattered unidentified brown and reddish smears. Observation on 3/12/24 at 4:15 p.m. in the 100-hallway revealed: *A white mechanical sit-to-stand aide in the utility room. -There was rust on the front of the footplate. -There was a layer of dirt and other unidentified debris that appeared to have been food crumbs in the footplate.	F 880		

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F 880	Continued From page 48 *A white plastic shower chair located in the shower room. -The blue seat had yellowed in color. -There was brown staining on the plastic. *An opened package of "Contour plus Bladder Pads" on the floor in the linen room. *The handheld controller for the blue "E/Z Way Classic Lift 500 lbs. Capacity" had discolored non-cleanable white tape wrapped around it. -There was rust and scratched paint on the top of the lift. *The push bar on the exterior door at the end of the 100-hallway was corroded with patina and not a cleanable surface. *In the "utility room," the spray hose in the hopper (a sink used to pre-clean soiled resident linens) was rusted and not cleanable. -The ceiling vent in that room had a thick layer of dust. Observation on 3/12/24 at 4:41 p.m. in the 300-hallway revealed: *In the tub room: -A sink with heavy rust on the faucet, levers, and the drain. -There were four holes in the tiles beside the toilet. Continued observation on 3/13/24 at 10:08 a.m. in the 300-hallway revealed: *The railings on both sides of the hallway were wooden. The varnish had corroded away exposing the wood grain, potentially causing the handrails to become uncleanable. *The dirty utility room: -Contained a hopper with the spray shield unattached and lying in the hopper. -The spray hose nozzle was missing. *The floor to the right of the hopper had:	F 880		

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F 880	Continued From page 49 -Loose and torn tiles. -Foot controls that were corroded with rust and mineral buildup. -A white buildup of overspray. *There was a gray trash can, to the right of the hopper, marked "regulated waste" with a significant amount of white splatter on it. *Two of the four ceiling light bulbs were not lit, and the protective light cover was missing. *There were two plastic three-drawer bins containing gowns and masks covered in dust. *There were two full boxes of biohazard sharps containers. Observation on 3/13/24 at 10:40 a.m. in the therapy room revealed: *There was a cloth chair with three nickel-sized red stains and a larger discolored stained area surrounding the red stains. *A NuStep located near the exit door had two rips approximately 4 inches long in the plastic seat. -The rubber handle was torn, and the coating was worn off. *Two black therapist stools had several tears around the entire perimeter exposing the under surface. *The therapy mat table was soiled with dirt, unidentified white flakes, and pieces of an unidentifiable substance. The front edge was worn. *The therapy parallel bars were painted white and gray and there was significant peeling of the paint with rust noted on all surfaces. *A second NuStep had a cracked center with a section missing exposing moving parts. -The hand and foot grips were visibly soiled. Observation and Interview on 3/13/24 at 10:49 a.m. with occupational therapy assistant (OTA) U	F 880		

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F 880	Continued From page 50 revealed: *She has been working there for four days. *Stated "There is a spray in the cabinet." -The spray was used between residents, -She "sprays it on and wipes it off after 30 seconds to one minute and then lets it air dry." *The spray in the closet was in a plastic spray bottle. -It was not labeled. -A cloth was set on top of the bottle for repeated use. *She used hand sanitizer between working with residents. Interview on 3/14/24 at 9:24 a.m. with certified nursing assistant T revealed: *She had let maintenance know in person or used a communication book located at the nurse's station to notify maintenance when problems were identified. *She stated, "[Maintenance worker I] is very prompt and usually addresses issues within one day or so." *Problems she would report to maintenance included a problem with a bed not working or a sink that was loose to the wall because a resident had used it to get up. *Housekeepers were there seven days a week. -Stated she had been able to communicate with housekeeping when issues needed to be addressed. Interview on 3/14/24 at 10:18 a.m. with administrator A revealed: *The health unit coordinator was responsible for monitoring when resident use equipment was out of date and keeping the central supply room clean and organized. -She explained that incontinence briefs, once	F 880		

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F 880	Continued From page 51 opened from its original packaging, should have been stored in the resident's room or enclosed in a plastic container. If not in either of those places, it should have been discarded. *It was her expectation that the dietary department should have kept the dining room clean. 2. Observation on 3/12/24 at 5:08 p.m. of LPN M during medication administration revealed: *She did not disinfect a resident's insulin pen before attaching the needle. *When she brought resident 32's diabetic supplies (his insulin pen, the shared resident glucometer, alcohol swabs), she placed the supplies directly onto his overbed table. -Resident 32 had a plastic urinal bottle with urine in it located on his overbed table. -LPN M used the back of her wrist to push the urinal out of the way. -She set the above-mentioned supplies on the resident's table without using a barrier or disinfecting the table surface. *After she had completed checking the resident's blood sugar and administering his insulin, she brought the supplies back to the medication cart. -She did not disinfect the insulin pen before placing it back into the medication cart. All the resident insulin pens were stored together in a drawer organizer divider. -She briefly wiped the shared resident glucometer with a bleach wipe for about five seconds and placed it back into the drawer. -She did not follow the manufacturer's guideline for a minimum of three minutes of contact time to properly disinfect the glucometer. Interview on 3/12/24 at 5:22 p.m. with LPN M about the above observations revealed:	F 880		

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F 880	Continued From page 52 *To her understanding: -It was not a requirement to disinfect the rubber seal on insulin pens or disinfect the insulin pen before placing it back in the drawer. -There was no policy or practice to place a barrier on the resident's bedside table when placing medical supplies such as a glucometer or the insulin pen. -She thought that using the back of her wrist to push the urinal out of the way was acceptable. -She was not aware of any contact time with cleaning the glucometer. Observation on 3/13/24 at 11:51 a.m. of LPN L revealed: *She brought a blood pressure cuff to the medication cart and wiped it off with a bleach wipe for about five seconds. She then brought it directly to a resident's room to measure their blood pressure. *After she brought it back again, she wiped the device off again with a bleach wipe for about five seconds and set it back on the medication cart. *She did not allow the minimum three-minute contact time for full disinfection per the manufacturer's guidelines. Interview on 3/13/24 at 12:25 p.m. with LPN R revealed: *She was the nurse manager. *She confirmed that all resident insulin pens were stored in the same cubby in the top drawer of the medication cart. *It was her expectation that: -All insulin pens should have been disinfected before attaching the needle. -Staff should scrub the durable medical equipment, such as the shared glucometers and blood pressure cuffs, with a bleach wipe first,	F 880		

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F 880	Continued From page 53 then come back with a second bleach wipe to wrap the equipment to ensure the equipment remained wet with the bleach wipe for the full contact time. -She confirmed that LPN L and M should have done that. -Staff should have used a barrier if placing durable medical equipment on a resident's overbed table. Review of the provider's May 2015 "Cleaning and Disinfecting Resident Care Items and Equipment" policy revealed: *"Policy Statement: Resident care equipment, including reusable items and durable medical equipment, are cleaned and disinfected according to current CDC [Centers for Disease Control and Prevention] recommendations for disinfection and the OSHA [Occupational Safety and Health Administration] Bloodborne Pathogens Standard." *"Procedure: 1. The following categories are used to distinguish the levels of sterilization/ disinfection necessary for items used in resident care: a. Critical items consist of items that carry a high risk of infection if contaminated with any microorganism. b. Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin. Such devices should be free from all microorganisms, although a small number of bacterial spores are permissible. c. Non-critical items are those that come in contact with intact skin but not mucous membranes. i. Non-critical resident-care items include bed pans, blood pressure cuffs, crutches and computers. ii. Most non-critical reusable items can be	F 880		

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F 880	Continued From page 54 decontaminated where they are used ... d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). ...3. Durable medical equipment (DME) is cleaned and disinfected before reuse by another resident. 4. Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturers' instructions." Review of the provider's February 2017 "Disinfecting Glucometer and PT/INR Machine" policy revealed: *"The Center disinfects the multiuse glucometer and PT/INR between each resident use with [CDC] approved chemo sterilizer agent ...utilizing appropriate infection control practices during the disinfecting process." *"Procedure: 1. In the resident's room, provide a barrier between the glucometer or PT/INR machine, and any surface the machine is placed upon. ...3. Disinfect the glucometer per manufacturer's instructions. a. Multi-resident use glucometers are cleaned/disinfected with appropriate bleach product following product recommendations between residents, and when visibly soiled." 3. Observation on 3/14/24 at 2:06 p.m. with resident 1, LPN S, and LPN R revealed: *No posted notice regarding precautions or use of personal protective equipment (PPE) was on or near the room entrance door. *Resident 1 was in bed. *LPN S and LPN R completed wound care and	F 880		

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F 880	Continued From page 55 changed the dressing resident 1's left torso. *Resident 1 had an irregularly shaped wound, covered by a dressing on his left torso approximately 12 inches by 10 inches with 3 small dime-sized areas that appeared to have been open. *LPN S and LPN R wore gloves and completed hand hygiene between glove changes. *Neither LPN S nor LPN R wore a gown. *LPN S flushed resident 1's catheter without donning a gown. *LPN S performed hand hygiene and returned to the medication cart, then entered another resident's room. Observation on 3/14/24 at 2:46 p.m. with resident 24, LPN S, and LPN R revealed: *No posted notice regarding precautions or use of PPE was on or near the room entrance. *Resident 24 was in bed. *LPN S and LPN R completed wound care on resident 24's left heel. *Resident 24 had an irregularly shaped open wound, covered by a dressing and wrapped with a gauze on her left heel approximately four inches by five inches. *LPN S and LPN R wore gloves and completed hand hygiene between glove changes. *Neither LPN S nor LPN R wore a gown. *LPN R performed hand hygiene upon exiting the resident 24's room and stated, "I will be right back I need to take this lift and help toilet another resident." Interview on 3/14/24 at 1:55 p.m. with certified nursing assistant (CNA) T revealed: *It was her understanding that CNAs were not required to wear gowns when providing any care to resident 1.	F 880		

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F 880	Continued From page 56 *The care that she provided to resident 1 included repositioning, dressing, and emptying his urinary drainage bag. Interview on 3/14/24 at 3:10 p.m. with LPN S revealed: *She confirmed that resident 1 and resident 24 were both on Enhanced Barrier Precautions (EBP). *She explained that EBP was used when someone had an open wound. *She stated, "we have to wear gloves and a gown if the resident has MRSA [Methicillin-resistant Staphyloccus aureus]." *There was supposed to have been signage posted by the resident's door that explained the proper EBP personal protective equipment (PPE). *She stated for resident 1 and resident 24 the required PPE was "just gloves when providing cares, wound cares, or brief changes if it involves touching them." Interview on 3/14/24 at 3:20 p.m. with LPN R revealed: *EBP were "used with residents with an open wound, an ostomy, [gastrostomy-tube], catheter or other pathway for bacteria to enter their system." *Resident 1 and resident 24 were on EBP due to having open wounds. *EBP meant "staff needed to wear [gowns] and gloves when doing wound care." *EBP was recorded in the treatment administration record (TAR). *She expected the staff to wear gowns and gloves when completing wound care with any resident on EBP. *Gowns were stored in the laundry room on the unit.	F 880		

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F 880	Continued From page 57 *She did not wear a gown when providing wound care to resident 1 and resident 24 because "I just forgot." Interview on 3/14/24 at 3:37 p.m. with DON B revealed: *EBP was noted in the TAR and in the resident care plan. *She expected nurses to wear gloves and a gown when completing wound care on a resident with EBP. *Gloves were stored in each resident's room and gowns were stored on each unit. Review of resident 1's electronic medical record (EMR) revealed: *He had a wound to his "right side" described in his weekly skin evaluation dated 3/5/24, was 12.0 centimeters in length, 13.0 centimeters in width, and less than 0.1 centimeters in depth. *There was a physician's order for wound care "To wound on right side: Cleanse with wound cleanser, apply Venelex and foam dressing. [Every] day shift for skin integrity." -The start date was 2/14/24. *There was a physician's order that stated, "Resident is on Enhance Barrier Precautions. All direct/prolonged cares are preformed wearing gown and gloves. [Every] day and night shift for Suprapubic [catheter], nephrostomy tubes, wounds." -The start date was 10/11/23. -Documented on the day shift as "y" or "yes" nine out of 17 days in March. --Documented "NA", "n" or "x" eight out of 17 days in March. -Documented on the night shift as "y" seven out of 17 nights in March. --Documented ad "NA" or "n" 10 out of 17 nights	F 880		

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F 880	Continued From page 58 in March. *Resident 1's care plan did not mention EBP. Review of resident 24's EMR revealed: *She had an irregularly shaped left heel wound described in her weekly skin evaluation dated 3/12/24, as "chronic stage 3 pressure injury, slough in wound bed [with[necrotic tissue noted at wound edge. Slight odor, moderate drainage," 4.9 centimeters in length, 5.0 centimeters in width, and 0.2 centimeters in depth. *There was a physician's order for wound care that stated, "Treatment to Left heel: wash with Vashe [a brand of wound wash solution], apply Santyl ointment, apply ABD [an extra thick dressing pad used for draining wounds] and wrap with Kerlix. [Every] day shift for treatment to left heel until 03/20/2024 23:59 -Start Date-03/14/2024." *There was a physician's order that stated, "Resident is on Enhance Barrier Precautions for wounds. Gown and gloves must be worn for all prolonged direct care. [Every] day and night shift." -The start date was 11/22/23. *Resident 24's care plan did not mention EBP. Review of the providers July 2022 Enhanced Barrier Precautions Policy revealed: *"Policy Statement: Enhanced Barrier precautions are initiated to reduce transmission of multidrug resistant organisms (MDRO's). Initiated for residents known to be colonized or infected with a MDRO or have open wound or indwelling medical devices." *"2. Enhanced Barrier Precautions require the use of gown and gloves during high-contact resident care activities ..." *"6. When Enhanced Barrier Precautions are implemented, the Infection Preventionist or	F 880		

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F 880	Continued From page 59 designee: b. Posts the appropriate notice on the room entrance door .... This Center's process for notification is signage. d. Places necessary equipment and supplies in the room that are needed during the period of Enhanced Barrier Precautions."	F 880		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, user manual review, and policy review, the provider failed to ensure for one of one sampled resident (1) with bedrails: *They were routinely inspected checking to make sure the mattress fit the bed frame properly limiting entrapment zones. *Documentation of those inspections that included the entrapment zones. Findings include: 1. Observation and interview on 3/11/24 at 3:09 p.m. with resident 1 revealed he: *Had a hospital-style bed with two half-bed rails in the raised position. *He stated that he used the bed rail "when they roll me over."	F 909	1. Resident #1 evaluation was edited during survey due to transcription error when initially completed. All residents have the potential to be affected. 2. The ED or designee will educate all staff on bed rails and entrapment risk by 4/11/2024. The ED or designee will educate all staff not in attendance prior to their next working shift. The entrapment risk was placed on the TAR for monthly measurement for all residents affected. 3. The ED or designee will audit 4 residents with a siderail or grab bar weekly times four weeks and monthly times two months to ensure there is no entrapment risk. The ED or designee will bring the results of these audits to the monthly QAPI for further review and recommendation to continue or discontinue the audits.	4/11/2024

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F 909	Continued From page 60 2. Review of resident 1's electronic medical record revealed: *He was admitted on 9/25/18. *He had a Brief Interview for Mental Status (BIMS) score of 14 that meant he was cognitively intact. *A "Device Evaluation" completed on 1/11/24 indicated: -Medical Condition/Symptoms: "Bilateral bed grab bars." -Measures Tried: "New Admit/no previous measures." -Devices: "Bilateral bed grabs [grab] bars." -Entrapment Evaluation: --"1. Mattress is snug against the perimeter of rail or transfer bar / between side rails ends with no opportunity to fall in between device and mattress?" ---The answer on that for was, "b. No." 2. Mattress is snug against head and foot of bed with no opportunity to fall in between?" --- The answer on that for was, "b. No" *There was no indication in the medical record that the fit of the mattress had been addressed. 3. Interview on 3/14/24 at 9:28 a.m. with maintenance worker I revealed he: *Was responsible for installing bed rails on the resident beds. *Had to consult with his supervisor on what measurements were taken when completing bed rail installations. *He was not aware of any zones to measure, and that the only measurement that he had performed was from the rail to the mattress. *Deferred questions to his supervisor. Interview on 3/14/24 at 9:53 a.m. with maintenance director J revealed:	F 909		

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F 909	Continued From page 61 *Maintenance did not keep a list of beds with bed rails installed. *Bed rails and mattresses "are standard in size and there is no additional measurements that are needed." *Maintenance did not make or keep track of any zone measurements. *They confirmed they did not have a regular bed maintenance schedule. Interview on 3/14/24 at 10:42 a.m. with DON B, administrator A, and regional nurse consultant (RNC) K revealed: *Resident 1 had purchased his bed. *Bed rail assessments were called "device assessments." *Device assessments were completed "when needed" by nurse managers. *It was the expectation that they answer only questions that pertain to the device. *DON B stated that it was her expectation that: - The device assessment was to have been completed accurately. - "Maintenance completes the zone measurements." -The zone measurements should have been done "when they are supposed to be." -"Maintenance keeps track of that information [measurements]." -Maintenance alerted her, "if it [measurements] was not correct." *There was no bed rail policy. 4. Review of the "Sizewise Alliance [hospital bed] User Manual" revealed: *Starting on page 40 under the "Proper Use of the Bed" section: -"Side Rails --Seven Zones of Bed Rail Entrapment	F 909		

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F 909	Continued From page 62 ---WARNING: Bed rail entrapment can result in serious injury or even death. Sizewise recommends the caregiver be mindful of the FDA guidelines relevant to bed rail entrapment. When using an Air Therapy system the caregiver is responsible for ensuring the mattress properly fits the bed frame. It is also the caregiver's ultimate decision whether or not to use bed rails with the patient." 5. Review of the provider's September 2017 "Devices" policy revealed: *"Policy Statement: In the event a resident's medical condition or symptom(s) warrants the use of a physical device, the least restrictive device is used after a comprehensive evaluation is completed." *The policy does not specifically address bed rail use, installation, inspection, monitoring, or zone measurements. 6. Review of provider's "Inspect Bed Rails" report printed 3/14/2024 revealed: *"Maintenance Check -Inspect Connectors on rail and tighten as necessary. -Remove any burs or rough edges to prevent injury. -Verify the function of the spring latch-knob assembly, if applicable. Ensure the latch is free of dirt and/or foreign material that could impair its function. -Ensure that the rails engage and lock as specified. -Tighten, adjust or replace any parts such as end caps, knobs, bolts, screws, etc. that are loose, show signs of wear or are missing." *Task completion: "Marked done on-time by [maintenance director] on 03/06/2024"	F 909		

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	435115	A. BUILDING _____ B. WING _____	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 909	Continued From page 63 *Indicated "no" under columns titled "Has Logs" and "Has Docs. *There was no documentation of inspection that the mattress fit the bed frame properly, that included zone measurements on beds that were known to have had bed rails.	F 909		

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E 000	Initial Comments 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 from 3/11/24 through 3/13/24 and again on 3/18/24. Palisade Healthcare Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Lourdes Parker | Executive Director | 4/5/2024

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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	435115	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/12/24. Palisade Healthcare Center was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K131, K222, K321, K351, K363, and K522 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 131 SS=D	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health	K 131	1. Both doors mentioned in 2567 scheduled to be repaired by contractor. All residents have the potential to be affected. 2. ED educated maintenance on proper door closure to ensure fire safety by 4/11/2024. 3. The ED or deisgnee will audit four random fire doors weekly times four weeks and monthly times two months to ensure proper closure. The ED 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.	4/11/2024

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Lourdes Parker | Executive Director | 4/5/2024

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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K 131	Continued From page 1 Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain the fire-resistive rating for two randomly observed ninety-minute rated fire doors (300-wing and outside of the administrator's office). Findings include: 1. Observation and testing on 3/12/24 at 9:16 a.m. revealed the north leaf of the ninety-minute, cross-corridor doors in the corridor, to the north of the 300-wing nurse's station was not latching. Testing of that door leaf revealed it would strike the west leaf at the top keeping it from latching into the door frame. That door leaf must latch to maintain the ninety-minute fire-rating of the cross-corridor doors. The deficiency could affect 100% of the occupants of the smoke compartments on either side of the cross-corridor doors. 2. Observation and testing on 3/12/24 at 9:45 a.m. revealed the east leaf of the ninety-minute, cross-corridor doors in the corridor, outside of the administrator's office was not latching. Testing of that door leaf revealed it would strike the west leaf at the top keeping it from latching into the door frame. That door leaf must latch to maintain the ninety-minute fire-rating of the cross-corridor doors.	K 131		

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K 131	Continued From page 2 The deficiency could affect 100% of the occupants of the smoke compartments on either side of the cross-corridor doors. Interview with the maintenance technician at the time of the above observations confirmed those findings. He stated he was unaware those conditions existed. He further stated those doors had previously latched when he tested them as part of his monthly maintenance the previous month.	K 131		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is	K 222	1. The doors need replacing, doors have been ordered and will be replaced by a contractor. All residents have the potential to be affected. 2. The ED educated maintenance on the importance of exit doors being operable and not requiring greater than 50 lbs. of pressure to open by 4/11/2024. 3. The ED or designee will audit 4 random exit doors weekly times four weeks and monthly times two months to ensure appropriate functionality. The ED 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.	4/11/2024

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K 222	Continued From page 3 protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain operable egress doors as required at two randomly observed exit door locations (dining room and southeast wing).	K 222		

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K 222	Continued From page 4 Findings include: 1. Observation beginning on 3/12/24 at 11:42 a.m. revealed the east-facing dining room exit door was unable to be easily opened. Testing of the door revealed it would not open without applying greater than fifty pounds of force in the direction of the path of egress. Interview at the time of the above observation with the maintenance technician confirmed that condition. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiencies affected 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K 222		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 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. Describe the floor and zone locations of	K 321	1. The linen storage and laundry room door closures were adjusted to close appropriately. All residents have the potential to be affected. 2. The ED educated maintenance on proper door closure by 4/11/2024. 3. The ED or designee will audit four random rooms with a door closure weekly times four weeks and monthly times two months to ensure proper closure. The ED or designee will bring the results of these audits to the monthly QAPI for further review and recommendation to continue or discontinue the audits.	4/11/2024

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K 321	Continued From page 5 hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain three separate hazardous areas (linen storage room, laundry room, the combined housekeeping office and storage room) as required. Findings include: 1. Observation and testing on 3/12/24 at 9:48 a.m. revealed the linen storage room was over 100 square feet and contained combustible items. The door from that room to the corridor was equipped with a closer but would not latch into the frame under the power of the closer. That room was considered a hazardous area and that door is required to automatically latch into the door frame. 2. Observation and testing on 3/12/24 at 10:13 a.m. revealed the laundry room was over 100 square feet and contained combustible items. The door from that room to the corridor was equipped with a closer but would not latch into the frame under the power of the closer. That room	K 321		

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K 321	Continued From page 6 was considered a hazardous area and that door is required to automatically latch into the door frame. 3. Observation and testing on 3/12/24 at 11:43 a.m. revealed the combined housekeeping office and storage room was over 100 square feet and contained combustible items. The door from that room to the corridor was equipped with a closer but would not latch into the frame under the power of the closer. That room was considered a hazardous area and that door is required to automatically latch into the door frame. Interview with the maintenance technician at the time of the observations confirmed those findings. Failure to provide separation from hazardous areas as required increases the risk of death or injury due to fire. The deficiencies affected 100% of the building occupants.	K 321		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes	K 351	1. The cooler was removed. All residents have the potential to be affected. 2. The ED educated maintenance on not blocking sprinkler heads by 4/11/2024. 3. The ED or designee will audit four random areas weekly times four weeks and monthly times two months to ensure sprinkler heads are clear. The ED or designee will bring the results of these audits to the monthly QAPI for further review and recommendation to continue or discontinue the audits.	4/11/2024

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K 351	Continued From page 7 closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain unobstructed space adjacent to the sprinkler deflector, so the water discharge was not interrupted in one randomly observed location (maintenance office and storage room). Findings Include: 1. Observation beginning at 9:10 a.m. on 3/12/24 revealed a sidewall sprinkler in the maintenance office and storage room on the north wall at the west end blocked by a red "Igloo" brand cooler. The sprinkler discharge pattern was completely blocked by the cooler and would not have been effective in the event of a fire. Interview with the maintenance technician at the time of the observation confirmed that finding. He stated he was unaware of the cooler's possible interruption of the sprinkler discharge pattern. The deficiency affected one location required to have been equipped with unobstructed fire sprinkler protection. Ref: 2012 NFPA 101 Section 19.3.5.1, 9.7.1	K 351		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than	K 363		

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K 363	Continued From page 8 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. 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. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to ensure four randomly observed	K 363	1. The doors were adjusted to close and latch appropriately. All residents have the potential to be affected. 2. The ED educated maintenance on proper door closure and latching by 4/11/2024. 3. The ED or designee will audit four random rooms with a door closure weekly times four weeks and monthly times two months to ensure proper closure and latching. The ED or designee will bring the results of these audits to the monthly QAPI for further review and recommendation to continue or discontinue the audits.	4/11/2024

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K 363	Continued From page 9 corridor doors (central bath, mop closet, clean utility room, dietary storage, and time clock room) were equipped with functioning positive latching hardware. Findings include: 1. Observation and testing on 3/12/24 at 9:16 a.m. revealed the door from the central bath in the 300-wing into the corridor was equipped with an automatic door closer but it was not automatically latching into the door frame. Testing of that door at that same time revealed it did not latch into the door frame on three of three attempts. 2. Observation and testing on 3/12/24 at 9:19 a.m. revealed the door to the mop closet next to the central bath in the 300-wing into the corridor was equipped with a closer but it was not automatically latching into the door frame. Testing of that door at that same time revealed it did not latch into the door fame on three of three attempts. 3. Observation and testing on 3/12/24 at 9:23 a.m. revealed the door to the clean utility room across from the central bath in the 300-wing into the corridor was equipped with a closer but it was not automatically latching into the door frame. Further observation at that same time revealed the door was missing a strike plate for the latch. Testing of that door at that same time revealed it did not latch into the door frame on three of three attempts. 4. Observation and testing at on 3/12/24 9:54 p.m. revealed the door to the dietary storage room into the corridor was equipped with a closer but it was not automatically latching into the door frame. Testing of that door at that same time	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/12/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 10 revealed it did not latch into the door frame on three of three attempts. 5. Observation and testing on 3/12/24 at 9:23 a.m. revealed the door to the time clock room across from the central bath in the 100-wing into the corridor was equipped with a closer but it was not automatically latching into the door frame. Further observation at that same time revealed the door was missing its latch. Testing of that door at that same time revealed it did not latch into the door frame on three of three attempts. Doors provided with closers are required to latch into their frames automatically. Interview with the maintenance technician at the time of the above observations confirmed those findings. He stated he was unaware of those conditions and the requirements for doors with closers. Those deficiencies could affect 100% of the occupants of their smoke compartments.	K 363		
K 522 SS=D	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere.	K 522	1. The metal plate was removed in the laundry room. All residents have the potential to be affected. 2. The ED educated maintenance and laundry on maintaining fresh air in the laundry room by 4/11/2024. 3. The ED or designee will audit the laundry for maintaining fresh air weekly times four weeks and monthly times two months. The ED or designee will bring the results of these audits to the monthly QAPI for further review and recommendation to continue or discontinue the audits.	4/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/12/2024**

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

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K 522	Continued From page 11 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain combustion (fresh) air in one randomly observed area (laundry). Findings include: 1. Observation of the three commercial natural gas-fired dryers in the laundry room on 3/12/24 at 9:52 a.m. revealed the following: a. There was dedicated combustion (fresh) air ductwork provided for the operation of the natural gas-fired commercial clothes dryers. b. The ductwork provided for combustion air had been blocked off by a sheet of metal. Interview with the maintenance technician at the time of the above observations confirmed those findings. The deficiency affected one of several requirements for fuel-fired devices.	K 522		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10623	A. BUILDING: _____ B. WING _____	03/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/11/24 through 3/13/24 and again on 3/18/24. Palisade Healthcare Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/11/24 through 3/13/24 and again on 3/18/24. Palisade Healthcare Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lourdes Parker

TITLE: Executive Director

(X6) DATE: 4/5/2024