STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/5/25 through 8/7/25. Palisade Healthcare Center was found not in compliance with the following requirements: F582, F686, F725, F761, F804, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/5/25 through 8/7/25. Areas surveyed included potential resident neglect. Palisade Healthcare Center was found to have past noncompliance at F609.	F0000		
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F0582	1. Residents number 1 and 22, forms are beyond correction. All residents have the potential to be affected. 2. The ED educated, the MDS Coordinator, DON, and the BOM, on the Medicaid and Medicare coverage and liability notice, the correct forms, and how to complete the form by 8/11/2025. 3. The DON or designee will audit random resident's ABN or NOMNCs and ensure they are on the correct form and filled out entirely. The DON or designee will complete audits weekly times four weeks, then monthly times two months. The DON or designee will bring the results of the audits to the monthly QAPI committee for further review and recommendations to continue or discontinue audits.	8-11-2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lourdes Parker	*Administrator*	*9-1-2025*

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F0582 SS = D	Continued from page 1 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider failed to ensure the Medicare notice given to the resident and/or the representative was: *Provided on the current form and completed according to the form's instructions for one of two sampled resident (1) who had discharged from Medicare skilled part A services and remained in the facility. *Completed according to the form's instructions for one of two sampled resident (22) who had discharged from Medicare part A services and remained in the facility. Findings include: 1. Review of the Entrance Conference Worksheet completed by the provider on 8/6/25 revealed that two sampled residents (1 and 22) had been discharged from Medicare Part A skilled services and remained in the facility.	F0582		

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F0582 SS = D	Continued from page 2 2. Review of the Notice of Medicare Non-Coverage (NOMNC) form CMS-10123, with a revision date of July 2022, for resident 1 revealed: *His last covered day on Medicare Part A Skilled Service was 4/4/25. *The required information of "You have the right to get your information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY [teletypewriter for people with hearing or speech difficulties] users can call 1-877-486-2048" was not included on the form. 3. Interview on 8/7/25 at 3:05 p.m. with MDS/RN coordinator F regarding the NOMNC form for resident 1 revealed that she confirmed the form was outdated and did not include the non-discrimination clause above. 4. Review of the NOMNC with a revision date of December 2024, for resident 22 revealed: *Her last covered day for Medicare Part A Skilled Service was 2/19/25. *The "Sign below to show you received and understood this notice" was not signed or dated by the resident or the resident's representative. 5. Review of resident 22's 2024 Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055, with verbal notification given to resident 22's representative by telephone that was documented on 2/17/25 revealed: *The "Reason Medicare May Not Pay" section, which required a brief explanation to help understand why Medicare may deny payment, was marked as "Custodial Care" and did not include what Medicare services she had been receiving, as required. There was no signature of who had provided that verbal notice to her representative. 6. Interview on 8/7/25 at 2:20 p.m. with Minimum Data Set (MDS) coordinator/registered nurse (RN) F regarding SNF Beneficiary Notices for resident 22 revealed:	F0582		

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F0582 SS = D	Continued from page 3 *She agreed that the NOMNC provided was not signed or dated by the resident or their representative. *She agreed the SNF ABN form should have included the skilled nursing service that Medicare may deny payment for, and there was no identification of who had provided the verbal notice. *She was not available when that notification was given and was unable to determine who had given that notice. 7. Review of the January 2025 "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055" and "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123" revealed: *The SNF ABN Form Instructions included: -"Completing the SNF ABN" indicated in the "Reason Medicare May Not Pay" section, "the SNF must give ... a brief explanation of why the beneficiary's medical needs or condition do not meet Medicare coverage guidelines. The reason must be sufficient and specific enough to enable the beneficiary to understand why Medicare may deny payment." -Signature and Date indicated "If an authorized representative signs for the patient, write "(rep)" or "(representative)" next to the signature." -"Disclosure Statement: The disclosure statements in the footer of the notice are required to be included on the document." *The NOMNC Form's Instructions included: -"{Insert type}: Insert the kind of service being terminated, i.e., skilled nursing, home health, comprehensive outpatient rehabilitation service, or hospice."	F0582		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F0609	"Past Noncompliance - no plan of correction required"	

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F0609 SS = D	Continued from page 4 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, interview, and policy review, the provider failed to report an allegation of suspected neglect for one of one sampled resident (56). This citation is considered past non-compliance based on the corrective actions the provider implemented immediately following the incident. Findings include: 1.Review of the provider's 4/10/25 SD DOH FRI revealed: *On 4/3/25 certified nursing assistant (CNA)/certified medication aide (CMA)/activities director J reported via a grievance form that resident 56's incontinence product had not been changed on the night shift. *Resident 56 was noted to be very incontinent of urine. *Resident 56's diagnoses included: -Dementia (a group of symptoms affecting memory, thinking, and social abilities). -Congestive heart failure (heart does not pump blood as well as it should).	F0609		

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F0609 SS = D	Continued from page 5 -Chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). -Agitation (feeling of restlessness or nervous excitement). *Resident 56 was receiving end-of-life hospice care services. *On 4/9/25 a skin review was completed for resident 56, with no new identified areas of concern noted. *Resident 56's care plan was reviewed and updated. *Resident 56's family and primary care provider was notified of incident. *Staff education was started. *CNA X was suspended pending investigation. 2. Interview on 8/6/25 at 8:26 a.m. with CNA/CMA/activity director J regarding the reported 4/3/25 incident revealed: *She started her shift at 6:00 a.m. on 4/3/25. *Resident 56 was in her recliner in the same clothes she had worn the day before. *Resident 56 was wet with urine from her waist down. *She was told by CNA X that resident 56 had behavioral episodes during the night shift and had refused to get changed. *When she provided resident 56's incontinence care, she did not observe any skin areas that were open. *She had filled out a grievance form later that day on 4/3/25 and turned it in. Interview on 8/6/25 at 4:12 p.m. with licensed practical nurse (LPN)/resident care manager (RCM) I revealed: *CNA/CMA/activities director J had given her a grievance form regarding resident 56 on 4/3/25. *She reviewed CNA documentation and behavior documentation for resident 56.	F0609		

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F0609 SS = D	Continued from page 6 *She had notified director of nursing (DON) B and was unsure if it was neglect due to resident 56's behaviors of refusing toileting when she asked CNA X. *Resident 56's skin evaluation had been completed on 4/9/25 and there were no new areas of concern noted. *She had given the grievance form to either DNS B or administrator A after completing her investigation on 4/4/25. Interview on 8/7/25 at 9:48 a.m. with DON B revealed: *She was notified of the grievance form on 4/7/25 by LPN/RCM I. *Based on the information shared with her she did not consider the 4/3/25 incident to have been a neglect issue. *She was unsure when administrator A was made aware of the 4/3/25 incident. *She was aware that allegations or incidents of neglect or abuse of a resident DOH needs to be notified within two hours. Interview on 8/7/25 at 10:01 a.m. with administrator A revealed: *She was notified of resident 56's incident on 4/10/25 at approximately 10:00 a.m. *CNA X had worked shifts on 4/3/25, 4/5/25, 4/6/25 and 4/8/25. *She identified the incident on 4/3/25 as a neglect issue and reported it to DOH on 4/10/25. *She had been out to a conference when the incident happened, no one notified her until 4/10/25. *CNA X was suspended on 4/10/25 and an investigation was initiated. *CNA X's employment was terminated on 4/11/25 after being interviewed and admitting to not changing resident 56's incontinence products. Review of the provider's updated September 2017	F0609		

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F0609 SS = D	Continued from page 7 Grievance procedure Policy revealed: *"8. If the grievance involves abuse, neglect, exploitation, or misappropriation of resident property, the ED [Administrator] is notified immediately, and an investigation begins." Review of the provider's published September 2017 Abuse Reporting and Response Policy revealed: *"Policy statement: The center immediately reports all suspected and /or allegations of abuse, neglect, and exploitation of residents, misappropriation of resident property, mistreatment, and injuries of unknown source in accordance with state and federal law." *"4. The Executive Director or designee reports alleged violations to the state survey agency and other officials in accordance with state law (such as Adult Protective Services and local law enforcement) as follows: a. Immediately but no later than 2 hours-All allegations of abuse, neglect… b. Immediately but not later than 24 hours- All allegations, if the events that cause the allegation do not involve abuse and do not result in serious bodily injury." The provider's implemented systemic changes to ensure the deficient practice does not reoccur was confirmed after record review revealed the facility had followed their quality assurance process, education was provided to all direct care staff regarding reporting abuse and neglect, what to do when residents reject cares and how to deal with refusals such as incontinence cares and toileting, what is a reportable incident and who needs to be contacted and within what time frame they need to be contacted. Continued monitoring on all residents through clinical alert monitoring was being completed daily which advises the Interdisciplinary team of resident concerns, such as refusals of care, behaviors, self-transfers and falls. Audits were being completed on incidents that would be reportable to the SD DOH and brought to monthly QAPI meetings for review. Based on the above information, non-compliance at F609 occurred on 4/3/25, and based on the provider's 4/25/25 implemented corrective actions for the deficient practice confirmed on 8/7/25, the non-compliance is	F0609		

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F0609 SS = D	Continued from page 8 considered past non-compliance.	F0609		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review the provider failed to adequately identify and effectively implement pressure ulcer (skin and/or underlying tissue injury due to prolong pressure) preventative interventions for residents identified at risk for developing pressure ulcers for: *One of one sampled resident (3) who developed a pressure ulcer to her heel. *One of one sampled resident (27) who developed a pressure ulcer to her coccyx (tailbone). Findings include: 1. Observation on 8/5/25 at 9:10 a.m. of resident 3 in her room revealed: *There was a sign on the wall beside the entrance to resident 3's room that indicated she was on enhanced barrier precautions (personal protective equipment, such as gloves and a gown was to be worn with all close contact resident care). *She was sitting in a wheelchair near her bed. *She was wearing a Prevalon boot (a cushioned boot that floats the heel off the surface of the mattress, to	F0686	1. All residents have the potential to be affected. 2. The DON or designee will educate all staff on preventing pressure ulcers and staff responsibilities completed by 8/22/2025. Education included responsibilities of the nurse's initial admission evaluations such as skin review and Braden evaluations, nutrition and hydration, bathing, regular skin reviews, dressings, heel booties and offloading. 3. The DON or designee will educate all staff not in attendance prior to the next shift scheduled. 4. The DON or designee will start audits, to include resident numbers 3 and 27, to ensure preventative measures are started at admission and preventative measures are in place and used. The DON or designee will complete audits weekly times for four weeks, then monthly times two months. The DON or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue audits.	8-22-2025

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F0686 SS = G	Continued from page 9 help reduce pressure) on her left foot. *There was a second Prevalon boot on a chair at the foot of her bed. *She had an air mattress on her bed. *On the wall beside her bed was a sign that said, "heel boots on at all times while in bed." 2. Interview on 8/6/25 at 4:45 p.m. with certified nursing assistant (CNA)/certified medication aide (CMA) M revealed: *Resident 3 used Prevalon boots and an air mattress because she had a pressure ulcer on her heel. *Those interventions were put into place after resident 3's had developed that pressure ulcer. *Prior to the pressure ulcer being identified on resident 3's left heel, CNA/CMA M stated resident 3 had complained of pain to her heels. -When resident 3 reported the pain to CNA/CMA M she placed a pillow under resident 3's legs to float her heels off the mattress. *CNA/CMA M stated she was off for a few days after resident 3 reported pain to her heels. *When CNA/CMA M returned to work, she found blood on resident 3's bed sheet and the open area to the resident's heel was identified. 3. Review of resident 3's electronic medical record (EMR) revealed: *She was admitted on 6/16/25. *Her 7/23/25 Brief Interview for Mental Status (BIMS) assessment score was 4, which indicated she had severe cognitive impairment. *Her 6/16/25 and 6/30/25 Braden Scale for Predicting Pressure Score Risk assessment was 15, which indicated she was at risk [low risk] for the development of pressure ulcers. *Physician Y was notified of resident 3's left heel pressure ulcer on 7/21/25 and ordered the wound to be	F0686		

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F0686 SS = G	Continued from page 10 cleansed with a wound cleanser twice weekly and covered with a foam dressing until healed. *"Pro Heal Liquid Protein [a supplement that promotes wound healing] two times a day 30 cc [cubic centimeters] to aid in wound healing" was added on 7/24/25. Review of resident 3's 8/5/25 care plan revealed: *She did not ambulate. *She was dependent on the assistance of one staff for dressing and bed mobility. *She required assistance from two staff members and a mechanical lift for transfers. *The pressure ulcer was added to her care plan as a problem area on 7/21/25. -The heel boots and the air mattress were added to her care plan as interventions for the pressure ulcer on 7/29/25. *Prior to the identification of the pressure ulcer, resident 3's care plan the skin integrity interventions were, -"Educate the resident/family/caregivers as to causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning." -"Follow facility policies/protocols for the prevention/treatment of skin breakdown." -"Pressure Ulcer risk evaluation quarterly and as indicated." -"Weekly skin observations by charge nurse per protocol." *Within the 8/6/25 Clinically Unavoidable Review and Acknowledgement assessment licensed practical nurse (LPN)/ resident care manager (RCM) wound nurse l documented, "Based on the above clinical review of medical conditions and individual high risk factors in combination with all defined and implemented interventions the center has put forth, this IDT [interdisciplinary team] and Provider agree the specified skin impairment is determined to be unavoidable."	F0686		

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F0686 SS = G	Continued from page 11 -The assessment indicated the documentation was to be, "Defined and Implemented Interventions PRIOR to the Skin Impairment or Pressure Injury Development". --This assessment indicated interventions initiated after the pressure ulcer was identified included the medication review and recommendation on 7/22/25, the staff education on individual care planned skin prevention needs on 7/22/25, the nutritional supplement ordered on 7/24/25, and the registered dietician review and recommendation on 7/24/25, -Lab results were not included in the portion labeled Lab Results in that assessment. *A 7/15/25 at 5:50 a.m. progress note indicated, "Called to [the] residents [resident's] room during the night to look at her heels. Both heels are pink and spongy. Heel protectors [were] placed [on the resident] and will monitor. Will pass onto [the] oncoming nurse." *There was no documentation that the pressure ulcer had been identified in the progress notes. *There was no documentation that the resident's representative was notified of the change in her heel condition. *Resident 3's weekly skin evaluation on 7/22/25 at 2:11 p.m. indicated the area to resident 3's left heel measured 0.6 centimeters (cm) X (by) 0.6 cm and was identified as a stage II (2: open skin wound with partial thickness skin loss) pressure ulcer without drainage. *Resident 3's 7/28/25 Weekly Skin Evaluation indicated the pressure ulcer was "improving" and measured 0.8 cm X 0.7cm and was 0.1cm deep. -The stage of the pressure ulcer had advanced from a stage II to a stage III (3: open skin with full thickness skin loss. Fatty tissue may be visible). -The base of the wound was 100% slough (tissue that was not alive and could hinder the healing process) and moderate drainage. *On 7/29/25 at 2:36 p.m. an air mattress was placed on resident 3's bed. *Resident 3's 8/4/25 Weekly Skin Evaluation indicated the pressure ulcer was "improving" and measured, 1 cm X 1 cm and was 0.1 cm in depth.	F0686		

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F0686 SS = G	Continued from page 12 -It remained at a stage III. -It was 75 % slough and 25 % granulation tissue (new tissue formed in the healing process) without drainage. 4. Interview on 8/7/25 at 2:35 p.m. with LPN/RCM wound nurse I revealed: *She had received specialized training in wound care. *She was primarily responsible for residents' wound care and wound assessment documentation. *When asked what interventions were in place to prevent the development of pressure ulcers for resident 3, she stated she received skin checks weekly by the nurses, she had a Braden Scale assessment completed on admission which indicated she was at risk (low risk), and she was admitted from the hospital with heel protector boots. *Upon review of resident 3's progress notes LPN/ RCM wound nurse I verified the heel protector boots had not been provided to resident 3 until 7/15/25. *LPN/ RCM wound nurse I was not aware there was concern related to resident 3's heels prior to the identification of the pressure ulcer documented on the resident's 7/22/25 weekly skin evaluation assessment. * LPN/RCM wound nurse I completed the Clinically Unavoidable Review and Acknowledgement assessments and used her clinical judgement to determine whether a pressure ulcer was clinically avoidable or unavoidable. *She stated she had determined resident 3's pressure ulcer to her left heel was unavoidable due to resident 3's immobility, poor positioning related to her torticollis (muscle contractions causing the head to lean to one side), and having been dependent on one or two staff members for most of her care needs. * LPN/RCM wound nurse I agreed she had included interventions on the resident 3's clinically unavoidable review and acknowledgement assessment that were not implemented until after the development of the pressure ulcer. *She stated it was not her usual practice to include interventions on those assessments that were implemented after the pressure ulcer was identified.	F0686		

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F0686 SS = G	Continued from page 13 *She verified resident 3's heel pressure ulcer had been identified on 7/22/25 but the Clinically Unavoidable Review and Acknowledgement assessment was not completed until 8/6/25. *She stated she had not identified whether resident 3's shoe or the mattress that may have caused the pressure ulcer. Resident 3 was not to wear her shoes until the pressure ulcer had resolved and she had an air mattress. *LPN/RCM wound nurse I would document whether a pressure ulcer was improving or not based on a decrease in the size of the pressure ulcer or a decrease in exudate (drainage). *She agreed resident 3's weekly skin assessments indicated each the size of the pressure ulcer had increased each week. *LPN/RCM wound nurse I stated she had documented on resident 3's 7/28/25 weekly skin assessment the pressure ulcer was improving because there was no longer any exudate, even though the size of the wound had increased, and she advanced the pressure ulcer from a stage II to a stage III with 100% slough. *LPN/RCM wound nurse I stated she had documented on the 8/4/25 weekly skin assessment that the pressure ulcer was improving because there was granulation tissue present, even though the size of the wound had increased. *She verified she had not notified the physician of the increased size of the pressure ulcer. 5. Observation of resident 27's room on 8/5/25 at 11:39 AM revealed: *She was not in her room *Her heel boots were lying on the floor by her bed. *She had a sign on the wall located by the foot of her bed that stated she needed to wear heel boots in bed. *Her mattress appeared to be the facility's standard mattress. 6. Review of resident 27's EMR revealed: *She was admitted on 10/27/25. *Her most recent Braden scale score, completed on	F0686		

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F0686 SS = G	Continued from page 14 5/1/25, was 13, which indicated she was at moderate risk of developing pressure ulcers. *Her 5/30/25 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. *She had diagnoses of spinal stenosis (narrowing of the spinal cord), spondylosis (age-related wear and tear on the spinal discs (cushion between vertebrae) and bones), radiculopathy (disease of the nerve root in the spine), disease of the spinal cord, weakness, diabetes, and morbid obesity (excessive body weight that significantly impacts health and well-being). *Her 7/29/25, weekly skin evaluation indicated she had a new pressure ulcer on her coccyx (tailbone). It listed the measurements as 0.6cm long by 1.1cm wide by 0.1cm in depth. The pressure-reducing interventions in place included: a cushion in her chair, a pressure-reducing mattress, and heel boots. *A 7/30/25 physician's order instructed to: "clean open wound at coccyx with wound cleaner, pat dry, and apply foam dressing twice per week & PRN [as needed]." *Her 7/30/25 Clinically Unavoidable Review and Acknowledgement assessment was blank. *An 8/2/25 Nutrition Hydration Skin Committee review progress note indicated the interdisciplinary team (IDT) met about the resident's pressure ulcer discovered on 7/29/25. The pressure ulcer was a stage II the measurements noted in the 7/29/25 weekly skin evaluation were listed. The registered dietitian recommended adding the ProHeal supplement daily to aid in wound healing. The IDT staff members included regional dietitian G, DON B, and LPN/RCM, wound care nurse I. *8/3/25, she had received a doctor's orders for ProHealth, a liquid protein supplement. Take one ounce daily to aid in pressure ulcer healing. *Her 8/5/25, weekly skin evaluation noted the wound had improved and was smaller in size. 7. Observation of resident 27 on 08/05/2025 at 3:16 p.m. revealed: *She was lying in bed on her back. *Her heel boots were on the floor by her bed.	F0686		

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F0686 SS = G	Continued from page 15 *A pressure relief cushion was in her wheelchair. 8. Observation and interview with resident 27 on 8/5/25 at 3:20 p.m. revealed: *She had an open sore on her left buttock that sometimes caused her pain. -The nurse puts a patch on it. *The staff did not reposition her, and she would have liked to have been repositioned more. *She tried to reposition herself in bed sometimes, but would then slide. *The provider's staff had told her they did not want side rails used, but she thought she would be able to move herself more if she had them. *An air mattress was not on her bed. 9. Observation of resident 27 on 8/6/25 at 2:55 p.m., 4:24 p.m., and again at 4:54 p.m. revealed she had been lying in her bed, position on her back. 10. Interview on 8/6/2025 at 4:40 p.m. with certified nursing assistant (CNA) Q revealed: *To prevent pressure ulcers, the staff repositioned residents from side to side and placed heel boots on the residents. If the resident did not have boots, staff used a pillow or blanket to lift their feet off the bed. The staff would check on those residents more frequently. *For resident 27, the staff tried to reposition her every two hours. She stated resident 27 had "kinda" moved on her own, so they would ask her if she had repositioned herself. If resident 27 had said yes, they would not have repositioned the resident at that time. *Resident 27 was not physically able to reposition herself in bed from side to side. She had not refused to be repositioned. *They were not able to use side rails because they were considered a restraint. *The mattress type on resident 27's bed had been the facility's standard mattress that everyone used, except for the hospice residents. The hospice residents usually used an air mattress.	F0686		

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F0686 SS = G	Continued from page 16 11. Review of her current care plan on 8/7/2025 indicated: *She needed one staff member to assist her with bathing or showering, repositioning in bed, and two staff members to assist her with transferring. *She had been incontinent of bowel and bladder. *She was to have a pressure-reducing mattress on her bed. 12. Further review of resident 27's EMR revealed her 7/30/25 Clinically Unavoidable Review and Acknowledgement assessment was signed as completed by LPN/RCM, wound care nurse I on 8/7/25. *The assessment indicated she was at risk for developing pressure ulcers due to her history of pressure ulcers, poor alignment, impaired functional mobility, diabetes, incontinence, behavioral disturbances, and pain. *The assessment conclusion note stated: "Based on the above clinical review of medical conditions and individual high-risk factors in combination with all defined and implemented interventions the center has put forth, this IDT and Provider agree the specified skin impairment is determined to be unavoidable." 13. Interview on 8/7/25 at 11:51 a.m. with LPN/RCM wound nurse I revealed: *Resident 27 liked to lie in the same position in bed, and staff have reported they cannot get her to lie on her side. *She had a pressure ulcer in the past on her coccyx that had healed. *She shifted frequently in her wheelchair to get comfortable, which increased her risk for pressure ulcers related to friction. *After the development of a pressure ulcer, she expected the Clinically Unavoidable Review and Acknowledgement assessment was to have been done within 24 hours. *She was not sure why resident 27's 7/30/25 initial Clinically Unavoidable Review and Acknowledgement assessment was blank. She confirmed she completed the assessment today.	F0686		

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F0686 SS = G	Continued from page 17 *Resident 27 had been on and off the ProHeal supplement. She received it again when her coccyx pressure ulcer re-opened. *She stated resident 27 should have been repositioned routinely, every two to three hours. *She denied that resident 27 had declined being repositioned but stated the resident had preferred to be on her back. She confirmed that information was not included in her care plan. *She expected CNAs to document on the repositioning task intervention in the EMR each time the resident was repositioned. *She reviewed the resident 27's repositioning documentation for the past 14 days, which indicated resident 27 had only been repositioned one to three times each day. *She confirmed resident 27 was not repositioned as expected to help prevent her from developing a pressure ulcer. *She stated her mattress was the facility's standard mattress, which was considered pressure-reducing. *She would consider using an air mattress if her wound did not improve within two weeks. *The provider was a side rail-free building, and hers were zip-tied down. She was updated on the residents' request for grab bars. *She stated that, even with the resident not being repositioned routinely and based on her clinical judgment, she thought resident 27's pressure ulcer was unavoidable. 14. Interview with DON B on 8/7/25 at 6:08 p.m. revealed: *She expected pressure ulcer prevention interventions to be implemented for residents at high risk for developing pressure ulcers or if they had a history of pressure ulcers. -Those interventions included the use of heel boots and repositioning every two hours. *She stated the standard mattresses were pressure-reducing and she did not expect a resident to have an air mattress unless the resident's pressure	F0686		

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F0686 SS = G	Continued from page 18 ulcer was a stage III or IV (open wound with full-thickness skin and tissue loss. Bone, tendon, or muscle may be visible), depending on its severity. *She expected resident 27 not to be frequently lying on her back if she had a pressure ulcer on her coccyx. *She expected the Clinically Unavoidable Review and Acknowledgement assessment to be completed within 24 hours. *She stated she thought Resident 27's pressure ulcer was unavoidable, even though she was not repositioned as expected, and was frequently placed on her back. 15. Review of the provider's July 2025 Skin Integrity policy revealed: *"In an effort to maintain the resident's optimal level of skin integrity and promote healing of skin ulcers/pressure ulcers/wounds, the facility has a systemic approach and monitoring process for evaluating and documenting skin integrity. In the event that a resident is admitted with or develops a skin ulcer/pressure ulcer/wound, care is provided to treat, heal, and prevent, if possible, further development of skin ulcers/pressure ulcers/wounds." *"The nurse completed the Braden Scale/Skin Integrity Evaluation on admission, weekly for three weeks, and then annually." *"The nurse establishes a plan of care based on risk factors in an effort to limit their potential effects." *"If skin impairment is noted after admission (in addition to the above steps), the LN [licensed nurse]: -a. Initiates alert charting. -b. Completes (and documents) notifications to the medical provider and resident or resident representative. -c. Implements new interventions as needed. Documents on the resident's care plan. -d. Notified Food and Nutrition Services Manager (FANS) and/ or Registered Dietician of [the] new pressure injury or worsening wound condition for nutritional needs evaluation. -e. Notified Director of Nursing [DON] Services (DNS) of skin impairments that indicate a potential	F0686		

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F0686 SS = G	Continued from page 19 significant change in condition (Stage II or greater Pressure Ulcer, surgical wound dehiscence, hematoma, or bruise on an area of the body not usually vulnerable to trauma (e.g. head, breast, inner thighs, groin). -f. The DNS and/ or designee complete a comprehensive review of the resident's medical record to evaluate if the pressure injury was avoidable or unavoidable. This evaluation is documented in the nurse's notes. *"If a wound condition fails to improve after 2 weeks of treatment or the condition of the wound deteriorates, the Medical provider and Resident's Representative are notified. If a new treatment order is obtained the LN: - a. Re-evaluates [the] plan of care and resident's condition (e.g. off-loading pressure from [the] skin impairment area, nutritional intake, blood sugars, and lab values)."	F0686		
F0725 SS = E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F0725	1. Resident numbers 8 and 54 have been discharged. All residents have the potential to be affected. 2. The DON or designee will educate all staff on answering call lights in a timely manner, using their communication tools for assistance, and meeting resident needs by 8/22/2025. 3. The DON or designee will educate all staff not in attendance prior to the next shift scheduled. 4. The DON or designee will audit random residents, including residents 3,6,14,19 and 28, to ensure their needs are being met and call lights are being audited for timely answering. The DON or designee will complete audits weekly times for four weeks, then monthly times two months. The DON or designee will bring the results of the audits to the monthly QAPI committee for further review and recommendations to continue or discontinue audits.	8-22-2025

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F0725 SS = E	Continued from page 20 §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the provider failed to ensure staff responded timely to residents' call lights for 7 of 18 residents (3, 6, 8, 14, 19, 28, and 54) who expressed complaints regarding staff not responding timely to their call lights to address the residents' needs. Findings include: 1. Observation and interview on 8/5/25 starting at 11:00 a.m. with resident 19 in his room revealed: *At 11:00 a.m. resident 19's call light was on. *He stated he had turned his call light on about 10:30 a.m. *He stated there were times his call light was on for two hours before it was answered by the staff. *At 11:29 a.m. his call light was answered. Follow-up interview on 8/7/25 at 9:20 a.m. with resident 19 revealed: *At times he had felt like he was going to die by the time his call light was answered. *When he had to wait long periods of time for assistance, he felt degraded. Review of resident 19's electronic medical record (EMR) revealed: *He was admitted on 6/23/25. *His 6/23/25 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated he was cognitively intact. *He was a quadriplegic (paralysis that affects all four limbs) and required the assistance of one staff member for bed mobility, dressing, and eating, and the assistance of two staff members with the use of a mechanical lift for transfers. *He had a history of pressure ulcers related to his immobility.	F0725		

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F0725 SS = E	Continued from page 21 *He was incontinent of bowel and bladder. Review of resident 19's call light times between 7/24/25 and 8/7/25 for response wait times that were longer than 15 minutes revealed: *The call light was used in that resident's room 167 times. *Forty-two of those times were indicated as "Needs Improvement" according to the system selected filters. *On 7/24/25 the call light wait times were, 31 minutes and 25 seconds, 21minutes and 15 seconds, 33 minutes and 44 seconds, 23 minutes and 48 seconds, and 29 minutes and 26 seconds. *On 7/25/25 the call light wait times were, 27 minutes and 12 seconds, and 38 minutes and 31 seconds. *On 7/26/25 the call light wait times were, 18 minutes and 13 seconds, 20 minutes and 30 seconds, 21 minutes and 32 seconds, 44 minutes and 1 second, 36 minutes and 29 seconds, 20 minutes and 17 seconds, 40 minutes and 19 seconds, 37 minutes and 13 seconds. *On 7/27/25 the call light wait times were, 42 minutes and 34 seconds, 16 minutes and 49 seconds, and 28 minutes and 29 seconds. *On 7/28/25 the call light wait times were, 28 minutes and 15 seconds, and 16 minutes and 25 seconds. *On 7/29/25 the call light wait times were, 19 minutes and 31 seconds, and 25 minutes and 27 seconds. *On 7/30/25 the call light wait times were, 17 minutes and three seconds, 27 minutes and 15 seconds, and 24 minutes and 21 seconds. *On 7/31/25 the call light wait times were 33 minutes and 37 seconds, 16 minutes and 18 seconds, and 18 minutes and 4 seconds. *On 8/1/25 the call light wait times were 34 minutes and 28 seconds, and 16 minutes and 20 seconds. *On 8/2/25 the call light wait time was 30 minutes and 27 seconds. *On 8/3/25 the call light wait times were, 20 minutes and 54 seconds, and 33 minutes and 4 seconds.	F0725		

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F0725 SS = E	Continued from page 22 *On 8/5/25 the call light wait times were 16 minutes and 59 seconds, and 31 minutes and 50 seconds. *On 8/7/25 the call light wait time was 18 minutes and 37 seconds. 2. Interview on 8/5/25 at 3:12 p.m. with resident 28 revealed: *He stated that he had consistently waited about 45 minutes after he turned on his call light before he received assistance. *At times he wheeled himself out into the hallway and hollered for assistance because no one had answered his call light. *He stated that he could do most things by himself, but there were times he used his call light or hollered for staff assistance for his roommate, resident 19. Review of resident 28's call light times audit from 7/24/25 and 8/7/25 for call light response wait times that were greater than 15 minutes revealed on: *On 7/24/25 resident 28 used his call light one time with a wait time of 25 minutes and 38 seconds. *On 7/25/25 resident 28 used his call light two times. Those call light response wait times were 38 minutes and one second, and 26 minutes and 50 seconds. 3. Observation on 8/7/25 starting at 9:20 a.m. outside resident 3's room revealed: *Her call light was on at 9:20 a.m. *Housekeeper Z walked by the room multiple times and did not respond to the call light. *At 9:49 a.m. certified nursing assistant (CNA) P responded to resident 3's call light and told her she would return shortly. *CNA P returned to the resident 3's room with a gown and gloves at 9:50 a.m. Review of resident 3's electronic EMR revealed: *She was admitted on 6/16/25. *Her 7/23/25 Brief Interview for Mental Status (BIMS) assessment score was 4, which indicated severe cognitive impairment.	F0725		

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F0725 SS = E	Continued from page 23 *She did not ambulate. *She depended on assistance from one staff member for dressing and bed mobility and two staff members with the use of a mechanical lift for transfers. *She had a pressure ulcer on her left heel. 4. Review of the resident council meeting minutes from November 2024 through July 2025 revealed: *On 2/17/25 the documented resident concern communicated during resident council meeting was "CNA's-lack of respect and short staffed". *On 4/14/25 the documented concern communicated during the resident council meeting related to a long call light response time from a resident who was no longer in the facility. 5. Review of grievances from May 2025 through July 2025 revealed: *On 5/7/25 resident 6 reported having waited a long time for staff to respond to her call light. *On 5/8/25 a grievance was filed regarding a resident who waited a long time for staff to respond to her call light and her medications. That resident had discharged from the facility. *On 5/14/25 resident 8 reported she waited a long time for her call light to be answered. *On 5/19/25 a grievance was filed regarding a resident's call light not having been answered. That resident had discharged from the facility. *On 6/19/25 resident 54 reported having waited a long time for staff to respond to the resident's call light. 6. Interview on 8/6/25 at 4:46 p.m. with certified nursing assistant (CNA)/certified medication aide (CMA) M and licensed practical nurse (LPN) N revealed: *The expectation was for resident call lights to be acknowledged by a staff member within three to five minutes to determine what the resident needed and to communicate with the resident if there was going be a delay in providing what the resident needed. *Call light response times were generally longer after the breakfast meal.	F0725		

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F0725 SS = E	Continued from page 24 *CNA/CMA M stated all staff members were able to answer call lights, LPN N did not think the housekeepers could answer call lights. 7. Interview on 8/7/25 at 6:12 p.m. with administrator A revealed she did not know what system selected filters were used for the call light audits that determined if the timeliness of the staff's response to a call light was excellent, acceptable, or needs improvement. 8. Observation and interview with resident 14 on 8/5/25 9:44 a.m. revealed she: *Had to wait a couple of hours for help at times when she turned on her call light. *Stated she had wet her pants when she had to wait a long time for staff to help her, and that made her feel like she was abandoned. *Had a "call don't fall" sign taped to her wall to remind her to use her call light for assistance. *She stated she had fallen, but that had been a while ago. Review of resident 14's electronic medical record (EMR) revealed: *She was admitted on 12/2/24. *Her 5/23/25 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. *She had a diagnosis of depression, anxiety, diabetes, and irritable bowel syndrome (a bowel disorder that causes constipation or diarrhea). *She required extensive assistance from one staff member to use the bathroom and to transfer out of her wheelchair. *She had a history of falls. -A fall prevention intervention on her 8/7/25 care plan indicated staff were to "Be sure my call light is within reach and encourage the resident to use it for assistance. Staff [will] be prompt [in] response to all [of the residents'] requests for assistance."	F0725		

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F0725 SS = E	Continued from page 25 Review of resident 14's call light times between 7/24/25 and 8/7/25 for call light response wait times that were longer than 15 minutes revealed: *The call light was used in that resident's room 111 times. *Twenty-three of those times were indicated as "needs improvement" according to the system-selected filters. *On 7/24/25, call light wait times were 38 minutes and 2 seconds and 27 minutes and 14 seconds. *On 7/25/25, call light wait times were 18 minutes and 32 seconds, 16 minutes and 55 seconds, 21 minutes and 36 seconds, 43 minutes and 20 seconds, and 26 minutes and 42 seconds. *On 7/26/25, call light wait times were 25 minutes and 50 seconds, 1 hour and 37 seconds, 22 minutes and 15 seconds, and 16 minutes and 20 seconds. *On 7/27/25, call light wait time was 18 minutes and 54 seconds. *On 7/28/25, call light wait time was 15 minutes and 48 seconds. *On 7/29/25, call light wait times were 18 minutes and 46 seconds and 21minutes and 51 seconds *On 7/30/25, call light wait times were 24 minutes and 24 seconds, 1 hour 5 minutes and 3 seconds, and 1 hour 31 minutes and 54 seconds. *On 7/31/25, call light wait times were 25 minutes and 44 seconds, and 1 hour 58 minutes and 24 seconds. *On 8/1/25, the call light wait time was 21 minutes and 13 seconds. *On 8/2/25, the call light wait times were 16 minutes and 41 seconds and 21minutes and 22 seconds. 9. On 8/6/2025 at 1:30 p.m., a request for a call light response policy was made to director of nursing (DON) B. DON B stated they did not have a policy regarding call lights. 10. Interview on 8/6/2025 at 4:40 p.m. with CNA Q	F0725		

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F0725 SS = E	Continued from page 26 revealed she felt it was hard to answer the call lights in a "timely manner" with only one CNA working in each hall. 11. Interview on 08/07/2025 at 6:08 PM with the director of nursing services (DON) B revealed: *She expected call lights to be answered within five minutes and stated that ten minutes would be too long. *She completed call light audits weekly or more often if there were complaints or concerns. *When completing the audits, she reviewed the timeliness of staff response to the call lights, who was working, and which residents were involved to identify trends.	F0725		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the	F0761	1. All residents have the potential to be affected. 2. The DON or designee will educate nursing staff on ensuring insulin pens and eye drops are dated properly when opened by 8/22/2025. The DON or designee will educate the nursing staff to designate creams and powders to each resident, by 8/22/2025. All stock medications were removed immediately from the bath houses. All medication carts were audited to ensure the insulin pens were dated, immediately. 3. The DON or designee will educate all staff not in attendance prior to the next shift scheduled.	8-22-2025

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F0761 SS = E	Continued from page 27 provider failed to ensure: *Three of three medication carts were free from medications beyond the use by date after opening for six of six residents sampled. *Two of three shower rooms were free from medications that were intended for individual resident use and without access to staff that were not qualified to administer medications. *Drugs and biologicals are stored according to the facilities policy in two of three shower rooms and one of three medication carts. *Drugs and biologicals are free from access and administration by staff other than trained nurses and certified medication aides (CMAs). Findings include: 1.Observation on 8/6/25 at 2:53 p.m. of the 200 hallway medication cart revealed: *Resident 26s Lantus (long-acting insulin for blood sugar control) insulin pen did not have an open date listed. *Resident 7's Lantus insulin pen and Semglee (long-acting insulin) insulin pen did not have open dates listed on them. *Resident 5's Lispro insulin vial had an open date of 6/28/25 written on it. Review of the facility's Medications with Shortened Expiration Dates reference sheet revealed Lispro's expiration date was 28 days after the vial was opened. Residnet 5's Lispro vial that was opened on 6/28/25 expired 28 days later, on 7/26/25. 2. Observation on 8/6/25 at 3:00 p.m. of the 100 hallway medication cart revealed resident 28's two boxes of Lanaprost eyedrops (used to treat high pressure in eyes) did not have open dates documented on them. 3. Observation on 8/6/25 at 3:27 p.m. of the 300 hallway medication cart revealed: *Two boxes of Lanaprost eye drops. One was resident 53's and one was resident 24's. Neither eyedrop boxes had an open date documented on them. *Psyllium powder (for constipation) that is administered by mouth was being stored in the same plastic storage container as triad cream (wound healing product), meta honey (wound healing product), and nystatin powder (antifungal) that are administered topically.	F0761	4. The DON or designee will audit medications carts to ensure insulin pens and eye drops are dated. The DON or designee will audit bath houses to ensure stock medicated powders or creams are removed. The DON or designee will complete audits weekly times for four weeks, then monthly times two months. The DON or designee will bring the results of the audits to the monthly QAPI committee for further review and recommendations to continue or discontinue audits	

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F0761 SS = E	Continued from page 28 4. Observation on 8/7/25 at 2:13 p.m. of the shower room in the 200 hallway revealed: *An open shelving unit with plastic storage bins on the shelves. *Each bin had a resident's room number labeled on it. There were two bins labeled "STOCK". The "STOCK" bin contained one bottle of nystatin cream with an open date of 4/2/25 documented on it, one tube of bacitracin (antibiotic) ointment with an open date of 2/15/25 documented on it, and one tube of bacitracin ointment with an open date of 2/18/25 documented on it. 5. Interview on 8/6/25 at 3:12 p.m. with licensed practical nurse (LPN) N revealed: *She was not aware that some medications had shortened expiration dates after opening. *She acknowledged that all medications needed to have an open date listed on the container and opened medications should be thrown away if the open date could not be found. 6. Interview with LPN C revealed he was aware that some medications have short expiration dates. He stated if he would find a medication without an open date, he would not know when it would expire. He would discard the medication. 7. Interview on 8/7/25 at 5:49 p.m. with director of nursing (DON) B revealed: *She expected all staff to follow policy and procedures for medication storage and labeling, including documenting the open dates on all opened medications. *She was aware of medications with shortened expiration dates and recieved an updated list from the pharmacy. She tried to keep a current updated medication expiration dates list in the medication storage room. *Staff qualified to give medications included licensed nurses and certified medication aides. -That included physician ordered medicated creams such as antifungal, zinc, and antibiotic creams. *She acknowledged that licensed nurses or medication	F0761		

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F0761 SS = E	Continued from page 29 aides were the only ones who should have access to the medicated creams. 8. Review of the provider's January 2021 Medication Storage policy revealed: *"Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe [and] effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication." *"In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed to access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access." *"Internally administered medications are stored separately from medications used externally such as lotions, creams, ointments, and suppositories." *"Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used. The opened insulin vial may be stored in [a] refrigerator or at room temperature." *"Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists." 9. Review of the provider's January 2021 Medication Administration General Guidelines policy regarding medication administration revealed: *"Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medication do so only after they have familiarized themselves with the medication. " *"Check expiration date on package/container. No expired medications will be administered to a	F0761		

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F0761 SS = E	Continued from page 30 resident." *"Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date. *"The nurse shall place a 'date opened' sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened." *"Certain products or package types such as multi-dose vials and ophthalmic drops have specified shortened end-of-use dating, once opened, to ensure medication purity and potency." 10. Review of the provider's 2005 Medications with Shortened Expiration Dates list revealed: *Lispro insulin vials expire 28 days after opening. *Lantus insulin pens expire 28 days after opening. *Lanaprost eyedrop bottles expire 42 days after opening.	F0761		
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, record review, and policy review, the facility failed to ensure: *The food was appetizing and served at a satisfactory temperature. *Accurate menus were provided to residents. Findings include:	F0804	1. All residents have the potential to be affected. 2. The DON or designee will educate all staff on the policy for the food temperatures and delivering room trays in a timely manner, by 8/22/2025. 3. The DON or designee will educate all staff not in attendance prior to the next shift scheduled. 4. The DON or designee will audit food temperatures to ensure they are in the required range. The DON or designee will audit room tray food temperatures, to include residents' number 2,19, 28, and 37, for required temperatures. 5. The DON or designee will complete audits weekly times for four weeks, then monthly times two months. The DON or designee will bring the results of the audits to the monthly QAPI committee for further review and recommendations to continue or discontinue audits.	8-22-2025

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F0804 SS = E	Continued from page 31 1. Interview on 8/5/26 at 9:06 a.m. with resident 2 revealed: *She stated the facility's food service was fair to poor and unorganized. *If she did not like the food being served her alternate meal option was soup and a sandwich. *She felt it took a long time for her to be served her meal in the dining room. *She thought her table was always the last table to be served and by the time she received her meal the food was cold. 2. Interview on 8/5/25 at 10:58 a.m. with resident 18 revealed: *He ate all of his meals in his room. *He did not like the food he was served. *When he received his food, it was cold at times. *Staff used to bring a menu to his room, so he knew what was being served but that no longer happened. *He stated he would need to go down to the dining room to see what was on the menu. 3. Interview on 8/5/25 at 11:17 p.m. with resident 19 revealed: *He ate all of his meals in his room. *He stated the quality of his meals were "sub-par". *He felt his food was cold about 75 percent of the time. *Staff used to bring him a menu of the meals, but he no longer received one. 4. Interview on 8/5/25 at 11:36 a.m. with resident 37 revealed: *She stated the food was terrible. *She usually ate her meals in the dining room. *When she ate meals in her room the food was cold. Occasionally when she ate in the dining room, the meals were cold.	F0804		

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F0804 SS = E	Continued from page 32 *She used to receive a menu, but that no longer happened. *The food items listed on the menus often changed because those food items were unavailable. 5. Observation and interview with resident 2 during the meal service on 8/5/25 starting at 12:12 p.m. revealed: *Cook T was serving drinks to the residents, and stated there was no grape juice available for those residents who wanted it. *The staff began to serve the residents' meals at 12:35 p.m. *At 12:53 p.m. meals were served to the residents seated at resident 2's table. That was the last table to be served their meals. *Resident 2 stated the temperature of her meal was "medium". *At 12:54 p.m. with meal trays were sent to the 100-hallway followed by the 200-hallway. -The trays were brought into each hallway on an uninsulated cart with open shelves by the dietary staff, and left there until a nursing staff member passed the meal trays to the residents in their rooms. -The plates on the meal trays were covered by a plastic insulated plate cover. *All meal trays were delivered to the residents' rooms in the 100 and 200 hallways by 1:04 p.m. 6. Interview on 8/5/25 at 3:12 p.m. with resident 28 revealed: *He ate his meals in the dining room. *When he received his food, it was generally cold, so he would eat fast to prevent the food from becoming colder. 7. Interview on 8/5/25 at 3:40 p.m. with dietary manager S revealed: *He had a copy of the weekly menu available for the residents that wanted one on Fridays. *The residents were to come and ask him for the menu if	F0804		

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F0804 SS = E	Continued from page 33 they wanted one. 8. A test tray of the lunch meal served on 8/6/25 requested by the surveyors revealed: *It was delivered to the survey team at 1:25 p.m. *The meal tray was the last tray served off the steam table for that meal. *The temperature of the cubed potatoes was 132 degrees Fahrenheit (F). *The cubed potatoes felt cool when eaten. *The meat of the pulled pork sandwich was 135 degrees, and the bun felt cool to the touch. *The pulled pork was dry. *The temperature of the mixed vegetables was 147 degrees F. *The mixed vegetables were mushy, and overcooked. 9. Interview on 8/7/25 at 9:33 a.m. with certified nursing assistant (CNA)/ certified medication aide (CMA)/ medical records staff member U revealed: *Residents expressed frustration regarding the food to her at least weekly. *Most often those frustrations were about how the food tasted, but occasionally they had reported to her that the food was cold. *The facility used to pass out menus to all the residents but since a new contracted food service company started in the dietary department the menus are no longer passed out to the residents. *Residents have expressed to her that they would like to receive the menus. *She had witnessed times when the food items written on the menu board in the dining room were crossed out and substituted with another food item. 10. Review of the provider's July 2025 menu substitution record revealed: *On 7/2/25 for the dinner meal turkey was added to replace the baked potato taco with the reason for the change documented as "not enough potatoes".	F0804		

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F0804 SS = E	Continued from page 34 *On 7/7/25, for dinner, hot dogs, and green beans were added to replace the 4-cheese bake with the reason for the change documented as "short staffing due to no show". *On 7/8/25 for lunch BBQ, baked beans, and peas were added to replace hot dogs, tater tots, and a salad with the reason for the change documented as "did not have". *On 7/10/25 for lunch goulash and peas were added to replace turkey and Swiss sandwiches, chips and beets with the reason for the change documented as "did not have". Review of the provider's August 2025 menu substitution record revealed: *On 8/4/25 "changed but forgot to write down" was documented in the margin. *On 8/5/25 for breakfast bacon was added to replace sausage with the reason for the change documented as "running low". *On 8/5/25 for breakfast toast was added to replace pancakes with the reason for the change documented as "not enough mix". *On 8/5/25 for lunch chicken was added to replace turkey with the reason for the change documented as "do not have". *On 8/5/25 for lunch, macaroni and cheese was added to replace potatoes with the reason for the change documented as "not enough." *On 8/6/25 for breakfast, ham was added to replace bacon with the reason for the change documented as "not enough for everyone". *8/7/25 for lunch, turkey was added to replace smoked sausage with the reason for the change documented as the "delivery company did not have". 11. Review of the provider's resident council meeting minutes from November 2024 through July 2025 revealed: *On 11/18/24 the notes stated, "need to follow recipes" and "food not tasting good". *On 12/23/25 a resident requested the meal portions be increased and was told the facility needed to "go by cooperates [corporates] guidelines".	F0804		

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F0804 SS = E	Continued from page 35 *On 2/17/25 the dietary department received feedback from the residents that it had "slow service" and "short staffed". *On 4/14/25 the residents requested that menus be passed out on Fridays, and they wanted condiments on the tables and on the room trays. *On 4/14/25 the resident council minutes included a portion identified as Administrator session which revealed: -"Administrator reeducated on mealtimes and there have been complaints that the room trays are later and later due to residents slowly trickling in the dining room late. The expectation is that the dining staff serve at mealtimes and are completed with serving the dining room in 30 minutes and then room trays are done. Anyone who comes in late and did not request a room tray, will have their food served on a tray and aides can reheat the food if needed." -"Hard veggies" -"Likes/Dislikes are updated per residents' request". -"To spicy/salty/peppery". -"[residents] Like week 1 and 2 menus and now week 3, 4, 5 are not good". 12. Review of the provider's grievances from May 2025 through July 2025 revealed: *On 6/12/25 resident 32 reported she was unable to eat in the dining room because there was no room. -Residents 7, 32, and 37 asked to be provided a weekly menu. *Grievances filed by staff on 6/15/25 and 6/16/25 indicated there were no condiments for the food and on 6/16/25 the "meals were not out on time, slow staff". *On 6/28/25 a grievance was filed by residents 20 and 37 reporting that the meat was hard. *On 6/30/25 resident 5 was not served lunch. *On 7/9/25 resident 12 reported the meal was not what she ordered.	F0804		

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F0804 SS = E	Continued from page 36 13. Interview with resident 23 on 8/7/25 at 10:48 a.m. in his room revealed: *The menu he was given for week 8/4/25 to 8/8/25 had the dates "15-21" written on it. Resident 23 states he got the menu from the "head guy". *He used to get menus on a regular basis and stated he had to "beg" for this menu. *He said that the kitchen has all new staff and they are inexperienced. *He likes to have a copy of the menu in his room to refer to, so that he can bring his own seasonings to the dining room. *Tuesday's menu was listed as roast turkey and mashed potatoes. 14.Observation and interview on 8/7/25 at 10:48 a.m. with resident 23 revealed: *He stated that for the Tuesday lunch meal he was served macaroni and cheese with chicken strips. He did not eat the chicken strips. -He asked his table mate for some milk to add to the macaroni and cheese because it was too dry. *He stated, "Often the noodles are served tough and unchewable." *Resident 23 stated on Wednesday they were served mixed vegetables instead of broccoli. *He said the vegetables were served in warm water and not flavored. 15.Interview on 8/7/25 at 11:24 a.m. with dietary manager (DM) S revealed: *He was aware of the resident frustrations with the changing menu. *He attended the monthly resident council meetings where this has been discussed. *He tries to have the menu for the next week available to residents on the Friday before. *He expects the trays that are delivered to residents to be the same temperature as the plates that are served to the residents in the dining hall.	F0804		

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F0804 SS = E	Continued from page 37 16.Interview on 8/5/25 at 9:02 a.m. with resident 14 revealed she: *Did not always eat because she did not like the food she was given. *Did not know she could request something else if she did not like the food. *Was not asked by the staff what foods she liked. 17.Review of resident 14's EMR revealed: *She was admitted on 12/2/24. *Her 5/23/25 Brief Interview for Mental Status (BIMS) Assessment score was 15, which indicated she was cognitively intact. 18.Review of resident 14's August 7, 2025, care plan revealed: *She liked Pepsi and popcorn. *Staff were to monitor her for symptoms of low blood sugar. *Staff were to encourage her to eat 50 percent of her meals or more. If she ate less than that, the staff were to offer her a substitute or supplement. *She ate breakfast in her room, otherwise, she ate in the main dining room. 19.Review of the provider's October 2017 Food Temperatures policy revealed: *"Food Temperatures are taken and documented daily prior to meal service and monitored periodically throughout meal service." *"Corrective action is taken for food temperature outside of regulatory standard (hot food should be 140 degrees F or above, cold foods 41 degrees F or less). It is suggested hot foods not exceed 180 degrees F in the kitchen." Review of the providers' 2025 Facility Assessment revealed, "Build a relationship with [the] resident/get to know him/her, then engage [the]	F0804		

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F0804 SS = E	Continued from page 38 resident/representatives in conversation to find out what makes a good day for the resident, and what upsets him/her. Incorporate this information into the care planning process, ensure staff caring for the resident/representative have this information, and record and discuss treatment and care preferences.....stay open to requests and preferences and work to support those as appropriate."	F0804		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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 §483.71 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;	F0880	1. All residents have the potential to be affected. 2. The DON or designee will educate all nursing and non-nursing staff on Hand Hygiene and Enhanced Barrier Precautions by 8/22/2025. 3. The DON or designee will educate all staff not in attendance prior to the next shift scheduled. 4. All hand sanitizers pumps and hand soap pumps were assessed for proper functioning, by 8/22/2025. 5. Hand sanitizer refills were ordered to fill the pumps on 8/12/2025. 6. The DON or designee will complete audits to monitor staff for hand hygiene practices and audit staff to ensure they are donning and doffing PPE according to the EBP practices. The DON or designee will complete audits weekly times for four weeks, then monthly times two months. The DON or designee will bring the results of the audits to the monthly QAPI committee for further review and recommendations to continue or discontinue audits.	8-22-2025

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F0880 SS = E	Continued from page 39 (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 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 follow infection prevention and control processes to ensure: *Proper hand hygiene, glove use, and gown use, was performed by eight of eight observed staff members (certified nursing assistant (CNA) R, K, L, and O, licensed practical nurse (LPN) I, housekeeper Z, and registered nurse (RN) H) during resident care for four of four sampled residents (1, 3, 5 and 27). *Contact precaution protocols were followed by one of one observed LPN (C) during resident care activities and medication administration for one of one sampled resident (52) related to an infectious bacterial infection in her stool.	F0880		

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F0880 SS = E	Continued from page 40 *The mechanical lift was cleaned between resident use by four of four observed staff members (CNAs L, O, and P, and LPN N) during two of three missed opportunities. 1.Observation on 8/5/25 at 10:24 a.m. of RN H and LPN I while providing resident 1's wound care revealed: *RN H and LPN I performed hand hygiene then put on a pair of gloves and a gown. *They cleaned off the designated wound care table with a sanitizing wipe, placed a towel down as a barrier, and removed wound dressings from a plastic bag with the resident 1's name handwritten on it in marker. *With those same gloved hands, LPN I then removed a towel from under the resident's leg. That towel had visible blood on it. She removed the soiled gloves, performed hand hygiene (washed her hands), and put on a new pair of gloves. *LPN I then used a ruler to measure the wounds. She touched the resident's legs and wounds with the ruler. She then set the ruler down on the clean wound care table, removed her gloves, did not perform hand hygiene, and put on a new pair of gloves. *With those gloved hands, LPN I cut the clean dressing supplies to the wound size. She cleansed the wounds with a wound cleanser, then reached into the clean supply bag with those same gloved hands. She touched her personal glasses with the back of those gloved hands. LPN I then covered resident 1's leg with wound dressings. *LPN I then removed a roll of tape from the clean wound supply table with those same gloved hands. She wrote the date on the tape with a marker, then placed the marker on the clean dressing supplies. She then applied the dressing to the resident's leg. *RN H opened the bedside dresser drawer with gloved hands and pulled out a compression leg wrap. She gave the wrap to LPN I. That wrap was then applied to the resident's leg by LPN I with her same soiled gloved hands while RN H held that leg. RN H then removed her gloves, performed hand hygiene, and put on new gloves.	F0880		

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F0880 SS = E	Continued from page 41 *With those new gloves on, LPN I removed a dressing from the resident's left index finger and threw it away. A tube of bacitracin antibiotic ointment fell onto the floor. With her gloved hands, RN H picked up the ointment tube off the floor. LPN I opened a new wound dressing, then RN H applied the ointment to the dressing that was being held in LPN I's hand. LPN I then placed the wound dressing to resident H's index finger. LPN I and RN H did not perform hand hygiene or put on new gloves before the clean dressing was applied to resident 1's index finger. *With those same gloved hands, RN H picked up the unused supplies from the table and put them back into the plastic treatment bag labeled with resident 1's name. She removed her gloves and gown then threw them away. She performed hand hygiene. She then returned to the hallway and placed that bag of supplies into the treatment cart with other residents' treatment bags. Interview with LPN I on 8/5/25 at 11:04 a.m. regarding the above wound care observation revealed - she: *Acknowledged she had missed several opportunities to remove her gloves and to perform hand hygiene. *Agreed that caring for the resident's wounds then retrieving supplies from the clean supply field contaminated the clean supply field. *Acknowledged that placing the contaminated wound/treatment supply bag into the treatment cart with other residents' (wound/treatment) supplies may have contaminated the treatment cart and the supplies stored in it. 2.Observation on 8/5/25 at 4:46 p.m. with resident 5 in her room revealed: * CNA R and CNA K were at the bedside to help resident 5 off the bedpan. They both performed hand hygiene, then put on new gowns and gloves.	F0880		

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F0880 SS = E	Continued from page 42 *CNA R helped resident 5 roll onto her left side in bed. She removed the bedpan from under the resident. She then tied the plastic bedpan covering, and handed the bedpan to CNA K. CNA K then went into the bathroom and disposed of it. *CNA R and CNA K removed their gloves, performed hand hygiene, then put on new gloves. *CNA K placed a clean incontinence brief on the resident, assisted her in pulling up her pants, and placed a sling under the resident. CNA K then wiped her forehead with the back of her gloved hand. *With those same gloved hands, CNA K transferred resident 5 to her wheelchair with CNA R's assistance and the use of a mechanical lift. They removed the sling from behind resident 5. They took off their gloves and performed hand hygiene. 3. Observation on 8/6/25 starting at 8:09 a.m. during medication pass in the 300 hallway with LPN C revealed: *LPN C prepared medications at the medication cart for resident 52 at 8:09 a.m. *He entered residnet 52's room without performing hand hygiene (handwashing) or wearing gloves and a gown. There was a sign next to her door that read "CONTACT PRECAUTIONS". LPN C assisted resident 52 from the toilet to the recliner. He checked her vital signs (the body's basic functions such as temperature, blood pressure, pulse, and respiration rate) and gave her her medications. He did not perform hand hygiene when he left the resident's room. LPN C did not wear a gown or gloves at any time while in resident 52's room. *LPN C prepared medications for resident 36 at 8:25 a.m. He entered the resident's room without performing hand hygiene, gave the resident his medications, and did not perform hand hygiene after exiting the room. *LPN C prepared medications for resident 54 at 8:30 a.m. He performed hand hygiene at the medication cart. He entered the room, gave the medications to resident 54, then left the room without performing hand hygiene.	F0880		

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F0880 SS = E	Continued from page 43 Interview with LPN C on 8/6/25 at 8:44 a.m. revealed he: *Thought he did not have to wear any PPE if he did not have any direct contact with the resident. *Was aware that resident 52 has a diagnosis of Clostridium difficile (a contagious infection of the intestines and colon). He stated he did not wear a gown or gloves because "it's on all of our skin". *Was aware of the policy to wear a gown and gloves while assisting a resident on contact precautions when providing direct care. Record review of resident 5's chart revealed: *She was admitted on 7/28/25. *Her diagnoses included C. Diff and a stage IV 4 (4; an open wound with full thickness skin and tissue loss. Bone, muscle, or tendon may be visible) pressure ulcer (a wound that resulted from pressure to an area) to her sacral area (low back to buttocks region). *She had been in the hospital, where she was diagnosed with a recurrent C. Diff infection prior to her admission to the facility. *She had a current physician's order for "Fidaxomicin (an antibiotic used to treat C. Diff) Oral Tablet (Fidaxomicin) Give 200 mg [milligrams] by mouth one time a day every other day" that was to be administered until 8/10/25. *She had a wound vac (a medical device used to promote healing of wounds) that was to cover her stage IV 4 pressure ulcer. Review of resident 5's current care plan revealed:	F0880		

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F0880 SS = E	Continued from page 44 *She required the assistance of one staff member for bathing, repositioning in bed, dressing, personal hygiene, transfers, and toilet use. *She was on enhanced barrier precautions (EBP) (gown and gloves use when providing close contact cares) related to her stage IV 4 pressure ulcer She was on contact precautions (gown and gloves were to be worn when entering the resident's room to prevent the spread of infection through direct or indirect contact) related to her C. Diff. 4. Interview with RN H on 8/7/25 at 3:29 p.m. revealed: *She was the facility's designated infection preventionist. *She was aware that the hand sanitizer dispensers in the resident's shared bathrooms were not filled with hand sanitizer. She was told this is against the fire code, so they stopped refilling the dispensers. *Infection rates were tracked on a quarterly report by RN H. If a resident would get an infection, the resident's room would be highlighted on her report. The resident's antibiotics and lab cultures were discussed in the daily morning meeting. *She acknowledged that if a clean field was touched with a soiled glove, that field would be contaminated. *Clostridium difficile infection (C.Diff) rooms with a contact precautions sign would require staff to wear a gown and gloves at all times while in the room. *She acknowledged that their policy for regarding resident rooms where a resident with C. Diff infection resided indicated staff were to perform hand hygiene with soap and water before and after providing resident care and between glove changes. *Staff only need to wear a gown and gloves while in a resident's room who was on enhanced barrier precautions (EBP) room if they were providing any resident contact care.	F0880		

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F0880 SS = E	Continued from page 45 *Staff should be assisting residents to perform hand hygiene after using the bathroom and before eating. 5. Interview with DON B on 8/7/25 at 5:49 p.m. revealed her expectation was for staff members to follow all policies regarding hand hygiene, contact precautions including enhanced barrier precautions (EBP), personal protective equipment (PPE), and wound care practices. 6. Observation on 8/5/25 at 9:04 a.m. of resident 27's room revealed: An enhanced barrier precautions (glove and gown use when providing contact care) (EBP) sign from the Centers for Disease Control and Prevention (CDC), was hung outside the residents' door frame. That sign: *It had two stop signs at the top of the sign. *It stated, "EVERYONE MUST: -Clean their hands, including before entering and when leaving the room." *It stated, "PROVIDERS AND STAFF MUST ALSO: -Wear gloves and a gown for the following High-Contact Resident Care Activities. -Dressing -Bathing/Showering -Transferring -Changing Linens -Providing Hygiene -Changing briefs or assisting with toileting -Device care or use.... -Wound Care: any skin opening requiring a dressing." *At the bottom of the sign, it indicated, "Do not wear the same gown and gloves for the care of more than one person." *There were no gowns available for use observed inside	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

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F0880 SS = E	Continued from page 46 or outside of the room. Review of resident 27's electronic medical record (EMR) revealed: *She was admitted on 10/27/23. *Her 5/30/25 BIMS assessment score was 14, which indicated her cognition was intact. *She had diagnoses of spinal stenosis (narrowing of the spinal cord), spondylosis (age-related wear and tear on the spinal discs (cushion between vertebrae) and bones), radiculopathy (disease of the nerve root in the spine), disease of the spinal cord, weakness, diabetes, and morbid obesity (excessive body weight that significantly impacts health and well-being). *She needed assistance from staff members for repositioning in bed, dressing, changing of incontinence products, and transferring. *She was incontinent of bowel and bladder. *She had a pressure ulcer on her coccyx. *She was required to be on EBP, and gowns and gloves should be worn by staff members while providing her personal hygiene incontinent care and any direct, prolonged contact care. Observation and Interview on 8/5/25 at 3:38 p.m. with certified nursing assistant (CNA) L revealed: *She applied resident 27's heel protectors without wearing a gown or gloves, and she did not perform any hand hygiene. *Sometimes she would wear gowns and gloves when working with resident 27, but she did not work in that hallway very often. *Resident 27 was on EBP, but she was not sure why, as she thought EBP was only for residents who had catheters. *She had worked here at the facility for about a year. Observation on 8/5/25 at 4:15 pm in residents 27 and 29's room revealed: *Resident 29 was sitting in her room, slouched in her wheelchair.	F0880		

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F0880 SS = E	Continued from page 47 *CNAs L and O placed a sling under resident 27 without wearing gowns or gloves. *Without performing hand hygiene, CNA O repositioned resident 29 in her wheelchair. She failed to perform hand hygiene after assisting her. *CNAs L and O then transferred resident 27 with a mechanical lift (a mechanical lift and sling used to lift a person's full body) without wearing gowns and gloves. *CNAs L and O left the room without performing hand hygiene and did not sanitize the mechanical lift. 7. Observation on 8/5/25 at 9:55 a.m. between the 100 and 200 hallways revealed: *Resident 1 was sitting in a bath chair covered in a blanket with a liquid dripping on the floor beneath him. *He was missing the toes on his right foot. *CNA K wrapped a towel around the resident's right foot and held up the foot while the resident 1 was pushed in the bathchair to his room. *CNAs K and R then transferred the resident to his bed using a mechanical lift, and did not wear gowns. *CNA K took her gloves off, did not perform hand hygiene, and pushed the mechanical lift into the hallway. *Without performing hand hygiene, she put on one glove and sanitized the lift. 8. Interview on 8/5/25 at 10:04 a.m. with CNA K revealed: *She had worked at the facility for about a year. *Resident 1 had just finished with a shower, and he had a towel on his leg covering a wound. *Resident 1 did not need to be on EBP anymore because his wounds were closed. 9. Interview on 8/5/25 at 4:36 p.m. with CNAs L and O revealed: *They stated that gowns and gloves were supposed to be worn when changing resident 27's incontinence product,	F0880		

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F0880 SS = E	Continued from page 48 and if they came in contact with the open wound. *They did not know where the gowns were stored and stated they thought they were in the rooms of residents who were on EBP. *They would perform hand hygiene before and after providing resident care and when moving from a dirty to a clean task. *They stated there was no hand sanitizer in the resident 27's room, but there was soap and water. 10. Observation and Interview on 8/7/25 at 9:29 a.m. with CNA P revealed: *There was a mechanical lift in the utility room in front of the hopper (a specialized sink flushing device used to rinse soiled items and linens of bodily fluids) that was plugged into the outlet near the hopper. *CNA P stated the room was a utility room, and she used this room to charge the mechanical lift. *She reported using the hopper at times. *She stated the mechanical lift should be sanitized after it is taken out of this room before it is used for a resident. She stated the lift also needed to be sanitized after it was used on a resident. 11. Observation on 8/7/25 at 9:53 a.m. in resident 3's room revealed: * CNAs were seen in resident 3's room, who was on EBP. * They turned on the call light and LPN N answered the call light. * LPN N took the mechanical lift out of the utility room and brought it to that room without sanitizing it first. 12. Observation on 8/7/25 at 2:21 p.m. revealed housekeeper Z cleaned resident 3's room, who was on EBP, without wearing a gown. 13. Interview with DON B on 8/7/25 at 6:08 p.m. revealed: *If a resident was on EBP, they would have a sign on the outside of their doorway. *Staff had been trained on the policy and procedures of	F0880		

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F0880 SS = E	Continued from page 49 EBP. *She expected gowns and gloves to be worn when staff had high contact with a resident in his or her room who was on EBP, which included transferring the resident. *She expected staff to use the rolling personal protective equipment (PPE) storage cart, which was shared between two hallways, when they cared for a resident who was on EBP. She stated the third hallway had its own PPE rolling cart. *She expected hand hygiene to be performed before working with a resident and when they left the room, when moving from a dirty to clean task during resident care, and after removing PPE. *Staff do not have hand sanitizer available in the residents' room, but it was available in the residents' bathrooms. *She expected the hand sanitizers in resident bathrooms to work and the soap to be available in the residents' rooms. *She expected the mechanical lift to be stored and plugged in in an empty room or the utility room. *She expected the mechanical lift to be sanitized before using it for a resident. *She stated a performance improvement project (PIP) on staff performing hand hygiene had been started in June. 14. Observation on 8/5/25 at 9:10 a.m. of resident 3 revealed: *Near the entrance of her room there was a sign that indicated she was on EBP. *She had a Prevalon boot (a cushioned boot used to float the heel off the mattress) on her left foot. *There was no alcohol-based hand sanitizer (ABHS) dispenser in her room. *There was an ABHS dispenser in her bathroom that would not dispense ABHS. 15. Observation and interview on 8/5/25 at 11:14 a.m. with resident 4 in her room revealed: *Near the entrance of her room there was a sign that	F0880		

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F0880 SS = E	Continued from page 50 indicated she was on EBP. *She had a urinary catheter. *She stated staff wore a gown when they assisted her with her care needs, but she had not seen them wear a gown. *There was no alcohol-based hand sanitizer (ABHS) dispenser in her room. *There was an ABHS dispenser in her bathroom that would not dispense ABHS. 16. Observations on 8/5/25 from 11:44 a.m. through 11:49 a.m. of the 100-hallway revealed: *There were seven of thirteen observed resident rooms (105, 106, 108, 110, 111, 112, and 115) that did not have ABHS available in the residents' rooms or bathrooms to use to perform hand hygiene. *There was one resident room, 104, that did not have soap available in the resident room to perform hand hygiene. 17. Interview on 8/6/25 at 11:39 a.m. with environmental services account manager AA and environmental service district manager BB revealed: *Cleaning of a room with a resident who was positive for C-Diff would require the use of bleach to clean all surfaces. *The housekeeping staff were to clean the rooms of residents who have C-Diff for the last. *It was their expectation for housekeeping staff to wear a gown and gloves while in the room of a resident who had C-Diff. *The expectation for the cleaning of a resident's room who was on EBP was the same but did not require the use of bleach to clean environmental surfaces. *All staff members were responsible for replacing hand sanitizers and soap when empty or if they were not functioning properly. *It was on the list of daily duties for housekeepers to check if the hand sanitizers or soap dispensers needed refilling and to refill them as needed. *Verified that the hand sanitizers had not been	F0880		

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F0880 SS = E	Continued from page 51 refilled in seven rooms in the 100-hallway, and the soap dispenser had not been refilled in one room in the 100-hallway. *Environmental services account manager AA and environmental service district manager BB agreed that the housekeepers had not been routinely checking the soap and hand sanitizer dispensers due to the dispensers having remained empty throughout the survey since first observed on 8/5/25. 18. Interview on 8/7/25 at 9:33 a.m. with CNA/CMA/medical records U revealed: *She was aware that there was no ABHS available in the residents' rooms at times. *She stated that sometimes there was ABHS in the dispenser, but the dispenser did work. *She stated if she noticed an ABHS or soap dispenser was empty in a resident's room she would refill it or notify housekeeping staff. Review of the provider's May 2025s Handwashing/Hand Hygiene policy revealed: *"Policy statement: The facility encourages and facilitates compliance with hand hygiene practices in alignment with standard precautions and standard of practice as outlined by the…CDC. *Procedure: 1. Personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. Personnel follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene products and supplies (sinks, soaps, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use. 3. Residents…. 4. Hand washing with alcohol-based hand rub (ABHR) is preferential to soap and water in most clinical situations. Wash hands with soap (…) and water for the following situations: a….	F0880		

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F0880 SS = E	Continued from page 52 b. after provision of care for residents with known or suspected with infectious diarrhea including…c. difficile…. 5. Hand hygiene is performed… c. Before and after direct contact with residents…. d. Before and after assisting a resident with personal care activities…. l. Before and after dressing change/wound care. m… (e.g. when moving from potentially contaminated sites to clean sites). O…after contact with a resident with infectious diarrhea (soap and water). p. after handling common use equipment (ie…mechanical lifts, etc.) r…after removing gloves. t…Before and after entering transmission-based precaution settings…. 6. Hand hygiene is the final step after removing and disposing of personal protective equipment. 7.The use of gloves does not replace hand washing/hand hygiene…. *Washing Hands:…. *Using Alcohol-Based Hand Rubs:…." Review of the provider's 3/26/24 Enhanced Barrier Precautions policy revealed: *"Policy statement: Enhanced Barrier Precautions (EBP) are initiated to reduce transmission of multidrug resistant organisms (MDRO's) employing targeted gown and glove use during high contact resident care activities. Initiated for residents known to be colonized or infected with MDRO or have open wound or indwelling medical devices." *" Procedure:	F0880		

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F0880 SS = E	Continued from page 53 -…1. Enhanced barrier precautions are used in conjunction with standard precautions and expand the use of PPE to donning [putting on] of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. -…2. EBP are indicated for residents with any of the following: --…b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. -…6. Enhanced barrier precautions requires use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDRO's to hand and clothing of healthcare professionals. -…12. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: --…a. Dressing --…b. Bathing/showering --…c. Transferring --…d. Providing hygiene --…h. Wound care: any skin opening requiring a dressing -…14. When enhanced barrier precautions are implements, the infection preventionist or designee: --…a. Validates protective equipment is maintained near the resident's room so that everyone entering the room can access what they need.	F0880		

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F0880 SS = E	Continued from page 54 --…b. Posts the appropriate notice on the room entrance door and in the front of the resident's chart so that all personnel will be aware of precautions or be aware that they must first see a nurse to obtain additional information about the situation before entering the room. --…e. Ensures that an adequate supply of antiseptic soap and paper towels is maintained in the room during the isolation period." Review of the provider's 3/2025 Transmission-Based Precautions (Isolation) policy revealed: *"Policy statement: Transmission-based precautions (previously referred to as isolation precautions) are implemented for residents known to be, or suspected of being, infected with infectious agents." *"Procedure: -…1. Use transmission-based precautions in addition to standard precautions -…5. Communication of transmission-based precautions is accomplished with pertinent signage and verbal reports to personnel and visitors" *"Contact Isolation Procedures -…1. Contact, or touch, is the most common and most significant mode of transmission of infectious agents. Contact transmission can occur by directly touching the resident, through contact with the resident's environment, or by using contaminated gloves or equipment. --…a. Personnel having contact with the infected resident should wear gloves and a gown. --…b. Prior to leaving the resident's room, gown and gloves are removed and hand hygiene performed.	F0880		

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F0880 SS = E	Continued from page 55 --…d. Residents with wound drainage, fecal incontinence, or diarrhea, that cannot be contained, should be placed on contact precautions until a specific organism for the origin of the medical issue is identified." Review of the provider's 5/2025 Clostridiodes Difficile (CDI) policy revealed: *"Policy statement: Preventative measures are taken to prevent the occurrence of Clostridiodes difficile among residents and precautions are taken while caring for residents with C. difficile Infection (CDI) to prevent transmission." *"Procedure: -…1. Clostridiodes difficile (C.diff) is a spore-forming, Gram-positive anaerobic bacillus that is often the source of antibiotic-associated diarrhea and C.diff infection. -…6. Contact precautions are implemented when CDI is suspected or confirmed. --…a. Transmission-based precautions are implemented for symptomatic residents while evaluating the cause of their symptoms. --…b. Contact precautions for confirmed CDI are maintained until 48 hours after resolution of diarrhea at minimum." Review of the provider's 5/2025 Handwashing/Hand Hygiene policy revealed: *"Policy statement: The facility encourages and facilitates compliance with hand hygiene practices in alignment with standard precautions and standards of practice as outlined by the Centers for Disease Control and Prevention". *"Procedure:	F0880		

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F0880 SS = E	Continued from page 56 -...2. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff to use. -...4. Hand washing with alcohol-based hand rub is preferential to soap and water in most clinical situations. Wash hands with soap and water for the following situations: --...b. After provision of care for residents with known or suspected with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella, and C. difficile. -...5. Hand hygiene is performed as soon as feasible, after hands become contaminated and frequently during the working day/ Examples of situations include but are not limited to: --...e. Before and after meal assistance. --...l. Before and after dressing change/wound care.	F0880		

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	10623	A. BUILDING: _____ B. WING _____	08/07/2025

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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 8/5/25 through 8/7/25. 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 44:73, Nursing Facilities, was conducted from 8/5/25 through 8/7/25. Palisade Healthcare Center was found not in compliance with the following requirement: S301.	S 000		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by:	S 301	1. Dietary In service training for new hires and current staff will be completed by 8/22/2025, on the following: Food safety, Hand washing, Food handling and preparation techniques, Food-borne illnesses, Servicing and distribution procedures, Leftover food handling policies, Time and temperature controls for food preparation and service, Nutrition and hydration and Sanitation requirements. 2. New hire orientation packets have been updated to include in services. 3. The DON or designee will educate all nursing and non-nursing staff on the dietary in-service training for new hires by 8/22/2025. 4. The DON or designee will educate all staff not in attendance prior to the next shift scheduled.	8-22-2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Lourdes Parker* | TITLE: *Administrator* | (X6) DATE: *9-1-2025*

South Dakota Department of Health

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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 301	Continued From page 1 Based on employee personnel records review and interview, the provider failed to ensure three of four newly hired sampled dietary employees (T, V, and W) had received initial training on the required topic of food safety and foodborne illnesses. Findings include: 1. Review of employee personnel records revealed: *Dietary cook T was hired on 5/30/25, dietary cook V was hired on 2/17/25, and dietary aide W was hired on 4/30/25. *There was no documentation to support that those three employees had completed the required initial training on the topic of food safety and foodborne illnesses. 2. Interview on 7/7/25 at 11:55 a.m. with regional dietitian G revealed: *The initial training for dietary employees was to be completed when they were hired. -That training included online education and monthly in-person education. *The dietary manager was responsible for ensuring the training was completed. *There had been a change in dietary managers, and the training records were not found when that change had occurred. *She was unable to confirm that the orientation training for the above employees was completed within 30 days of their hire.	S 301	5. The DON or designee will complete audits to monitor staff personnel files for the appropriate dietary in service training. The DON or designee will complete audits weekly times for four weeks, then monthly times two months. The DON or designee will bring the results of the audits to the monthly QAPI committee for further review and recommendations to continue or discontinue audits	