

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

ORIGINAL

PRINTED: 03/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/18/2016
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NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030
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F 000	<p><i>*Addendums noted with an asterisk per 3/31/16 per email with facility administrator. ML/SDDOHEL</i></p> <p>Surveyor: 35121 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/16/16 through 2/18/16. Palisade Healthcare Community was found not in compliance with the following requirements: F252, F280, F309, F323, F371, F441, and F520.</p>	F 000	<p>Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.</p>	
F 252 SS=D	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, and policy review, the provider failed to maintain a homelike environment due to lack of odor control for one of three (200) resident wings. Findings include:</p> <p>1. Observation on the initial tour of the 200 wing on 2/16/16 at 3:10 p.m. revealed a strong odor of urine throughout most of the hallway that contained twelve resident rooms. That odor seemed strongest around resident 11's room.</p> <p>Observation on 2/17/16 at various times from 9:00 a.m. through 6:00 p.m. of the above hallway revealed the same lingering strong urine odor.</p> <p>Observation on 2/18/16 at various times from</p>	F 252		<p><i>*F252 ML/SDDOHEL</i></p> <p>1. Resident Wing 200 has been cleaned and odor has cleared. All residents are at risk. <i>*A mattress and a resident's catheter bag were identified as the source of the odor. ML/SDDOHEL</i></p> <p>2. The Administrator will educate staff no later than March 16, 2016 on reporting any odors in the facility. Those who are not in attendance during education <i>*ML/SDDOHEL</i></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ron Woods, Adm.</i>	TITLE	(X6) DATE <i>3-10-16</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 252	<p>Continued From page 1</p> <p>8:00 a.m. through 11:00 a.m. of the above hallway again revealed a lingering strong urine odor.</p> <p>Observation and interview on 2/18/16 at 10:00 a.m. with the head of housekeeping revealed: *The odor came from resident 11's room. *That resident would urinate in different places in the room and bathroom. *She had replaced the mattress with a new one a month ago. *Housekeeping would clean the room and bathroom frequently up to "several times a day". *The bathroom had old tile in it, and the urine would get under the loose tile. "It was difficult to keep clean."</p> <p>Interview on 2/18/16 at 1:30 p.m. with a resident's family member who wanted to remain confidential revealed: *Their family member lived in the 200 wing. *The family member stated the urine smell in that hallway seemed to be an ongoing problem.</p> <p>Interview on 2/18/16 at 3:25 p.m. with the administrator revealed she agreed the odor in the 200 wing was a problem.</p> <p>Review of the provider's January 2014 Quality of Life-Homelike Environment policy revealed: "The facility staff and management shall minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include: [among other things] Institutional odors".</p>	F 252	<p>meeting will receive education prior to working their next scheduled shift.</p> <p>3. The Administrator or designee will do walking rounds four times a week for four weeks to ensure the facility is free from odors. Audit will be discussed by the Administrator in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations of continuation/discontinuation of monthly audit.</p> <p>4. April 5, 2016</p> <p>(Cont: from prev page)</p> <p>*The mattress has been replaced and will be monitored weekly by housekeeping staff. The identified residents catheter bag will be changed daily. Housekeeping policies were reviewed and no changes were made.</p> <p>ML/SDROHJEL</p>	4-5-16
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

for 3 months ML/SDROHJEL

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F 280	<p>Continued From page 2</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, interview, record review, and policy review, the provider failed to ensure 2 of 12 sampled residents' (3 and 6) care plans were reviewed and revised as changes in care needs occurred. Findings include:</p> <p>1. Observation and interview on 2/16/16 at 3:00 p.m. with resident 3 revealed she was crying in the hallway as she looked for her room. She explained she was upset about a possible family decision to move her to another facility.</p> <p>Interview at that time with licensed practical nurse (LPN) C revealed resident 3 frequently cried and</p>	F 280	<p>F280</p> <p>1. Residents 3 and 6 have had their care plan updated. All residents are at risk. <i>*NO Other residents were identified with this problem.</i></p> <p>2. The Administrator, Director of Nursing (DON), social services and Interdisciplinary Team have reviewed the Care Plan policy and reviewed the cited deficiency. The DON or designee will educate all staff on care plans and ensuring they are kept accurate and up to date with each resident's individual needs, including psycho-social needs and preferences by March 16, 2016. Those not in attendance will be educated prior to their next scheduled shift. <i>team to ensure...</i></p> <p>3. DON or designee will audit 4 care plans per week to ensure that the care plan reflects the care and services provided to the resident. This audit will be done weekly for 4 weeks and then monthly thereafter. Audit will be brought to QAPI by the DON for review and recommendations for continuation or discontinuation of the audit.</p> <p>4. April 5, 2016</p> <p><i>→ The interdisciplinary team will be responsible for updating the care plans as needed.</i></p>		

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F 280	<p>Continued From page 3 might not always know why she was crying.</p> <p>Observations of resident 3 and interview with certified nursing assistant (CNA) D on 2/17/16 at 10:00 a.m. revealed:</p> <ul style="list-style-type: none"> *The resident had been sleeping was still in bed. -The resident liked to sleep in. *She had not been up for breakfast. *The resident was now awake, and the CNA assisted her in getting out of bed and being toileted. *After the resident went to the bathroom the CNA was going to take her to the shower room to do her weekly shower. *After the shower the resident would 'just hang around' until her lunch at noon. *When asked if the resident was having any breakfast, CNA D said she could go and get her a piece of toast. -Hot breakfast in the dining room was from 7:00 a.m. until 9:00 a.m. and that had already ended. -She repeated she could get her some toast. <p>Random review of resident 3's meal intake records revealed from 1/20/16 through 2/17/16 revealed there was infrequent documentation she had received a breakfast meal. There was nothing documented to reflect she had refused her breakfast on those days.</p> <p>Review of resident 3's weight records from 8/13/15 through 12/9/15 revealed her weight had increased from 200.4 pounds (lb) to 214 lb.</p> <p>Review of resident 3's 12/18/14 Daily Lifestyle, Habits and Routines Questionnaire revealed:</p> <ul style="list-style-type: none"> *She liked to get up between 6:00 a.m. to 7:00 a.m. *Her breakfast preference included oatmeal, 	F 280		
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F 280	<p>Continued From page 4 eggs, tea, and fresh fruit. *It had been completed at the time of admission and had been reviewed and signed by the facility social worker at that time. -It had not been updated since admission.</p> <p>Review of resident 3's entire medical record revealed she had received psychological counseling in October, November and December of 2015 but there was not any record of that counseling after 12/22/15.</p> <p>Review of resident 3's 1/8/16 care plan revealed: *Focus: "I am displaying signs of depression. I am exhibiting these signs of depression: -Frequent crying. -I have a diagnosis of depression with anxiety. *Goal: "I will demonstrate a decrease in crying as evidenced by staff observation over the next quarter." *It did not address: -Specific interventions to address the depression. -What caused the incidents of crying. -The counseling services, and what goal they were working on with the resident. -Interventions to address the depression. *Focus: "I have diet restriction related to diagnosis of CHF [congestive heart failure] hypertension (high blood pressure), and edema (fluid retention)." -There were no interventions to address her sleeping in and how they would accommodate her breakfast meal. -It did not address she refused breakfast. -It did not address she had gained weight.</p> <p>Interview on 2/17/16 at 5:00 p.m. with the social services director (SSD) regarding resident 3 revealed:</p>	F 280		

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F 280	<p>Continued From page 5</p> <ul style="list-style-type: none"> *The resident frequently cried. *She frequently visited with the resident but did not document her conversations with her. *She was unaware who had actually completed the Daily Lifestyle form but wondered how accurate it was of the resident's preference. -She had always slept in during the morning and did not necessarily think that reflected her being depressed. *She confirmed the care plan did not reflect any specific interventions to address the depression. *The resident had been receiving counseling services for the depression, but she could not say if that had occurred recently. -They were having problems with getting the reports from the agency that provided the counseling despite their efforts to increase communication. *She agreed they did not have any specific goals for the resident, and to decrease crying was not an appropriate goal. <p>2. Interview on 2/16/16 at 5:00 p.m. with resident 6 and her husband revealed they were planning for her to go home as soon as possible. He had been coming at supper time and was assisting her with the meal. She ate in her room as it was a quieter environment with fewer distractions.</p> <p>Interview on 2/17/15 at 5:00 p.m. with the SSD confirmed they were working with resident 6 on the goal of being discharged home. The expectation was he would take her home when she resumed eating without a the tube feeding.</p> <p>Observation of resident 6 on 2/17/16 at 12:00 noon revealed she sat at the side of the dining room and refused to eat when her meal was served. Interview at that time the dietary manager</p>	F 280		
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F 280	<p>Continued From page 6</p> <p>revealed they had recently attempted to have her eat most of her meals orally as part of their plan for her to go home. It had not gone very well. She frequently would not eat anything at the noon meal.</p> <p>Observation on 2/17/16 at 3:30 p.m. revealed resident 6 walked with the restorative aide. A second aide followed behind with the wheelchair.</p> <p>Review of resident 6's 2/3/16 progress notes revealed the SSD and nurse manager met with resident and her husband and confirmed their goal was for her to return home.</p> <p>Review of resident 6's 1/8/16 care plan revealed: *Focus: I plan to stay here long term. -It did not address their desire for her to be discharged home. *Focus: My husband visits almost daily. -It did not address the assistance he gave at mealtime. *Focus: "I am on a Tube feeding via Peg Tube. I am on a regular diet." -It did not address that she frequently refused to eat. -It did not address when they had done a trial of her eating only orally. -It did not address what they had done to reduce the distractions at meals, so she could focus on eating. *Interventions: "I need extensive assistance of 2 staff with mobility, transfers and ambulation." -It had not been updated when she progressed to needing one assistance with ambulating.</p> <p>3. Interview on 2/18/16 at 10:30 a.m. with the director of nurses and Minimum Data Set coordinator (E) confirmed residents 3 and 6's</p>	F 280		

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F 280

Continued From page 7
care plans had not been updated as changes had occurred.

Review of the provider's undated care plan policy revealed "The care plan must be updated as there are changes in the resident's condition. Changes may be health related, mood and behavior related, ADL [activity of daily living] functioning related, activities related, dietary related, medication related, etc."

F 309
SS=D

483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

Surveyor: 26180
Based on observation, interview, record review, and policy review, the provider failed to ensure 1 of 12 sampled residents (3) received the necessary care and services addressing depression and preferences for daily routine. Findings include:

1. Observation and interview on 2/16/16 at 3:00 p.m. with resident 3 revealed she was crying in the hallway as she looked for her room. She explained she was upset about a possible family decision to move her to another facility.

F 280

*2. The social worker was educated on identifying, getting services needed and documenting on care plans for residents with depression. ML/SDDOHEL

F309

1. Resident 3 is receiving the care and services for her depression and her preferences for daily routine are included on her plan of care. All residents are at risk. *NO other residents were identified with this problem. ML/SDDOHEL

F 309

The Administrator, Director of Nursing (DON), social services and Interdisciplinary Team have reviewed the assessment policy and reviewed the cited deficiency. The DON or designee will educate all staff on completing assessments and identifying psychosocial needs and individual preferences by March 16, 2016. Those not in attendance will be educated prior to their next scheduled shift.

*#3
ML/SDDOHEL

*#4
ML/SDDOHEL

The DON or designee to review four social service assessments each week to ensure psycho-social needs and individual preferences are identified and included in the plan of care. Audits will continue for four weeks and then monthly thereafter. Audits will be brought to QAPI by the DON for review and recommendations of continuation or discontinuation of audit.

4. April 5, 2016

*for 3 months
ML/SDDOHEL

4.5.16

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F 309	<p>Continued From page 8</p> <p>Interview on 2/16/16 at 3:03 p.m. with licensed practical nurse (LPN) C revealed resident 3 frequently cried. She might not always know why she was crying.</p> <p>Review of resident 3's 12/6/15 Minimum Data Set (MDS) assessment revealed she had no mood issues.</p> <p>Observations of resident 3 and interview with certified nursing assistant (CNA) D on 2/17/16 at 10:00 a.m. revealed:</p> <ul style="list-style-type: none"> *The resident had been sleeping and was still in bed. -She liked to sleep in. *She had not been up for breakfast. *The resident was now awake, and the CNA assisted her in getting out of bed and being toileted. *After the resident went to the bathroom the CNA was going to take her to the shower room to do her weekly shower. *After the shower the resident would 'just hang around' until her lunch at noon. *When asked if the resident was having any breakfast, CNA D said she could get her a piece of toast. -Hot breakfast in the dining room was from 7:00 a.m. until 9 a.m. and that had ended. -She repeated she could get her some toast. <p>Random review of resident 3's meal intake records revealed from 1/20/16 through 2/17/16 revealed there was infrequent documentation she had received a breakfast meal. There was nothing documented to reflect she had refused her breakfast on those days.</p> <p>Interview on 2/18/16 at 9:00 a.m. with LPN C</p>	F 309		
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F 309	<p>Continued From page 9</p> <p>revealed resident 3 had a lot of candy in her room that she ate. That might have explained her weight gain.</p> <p>Review of resident 3's weight records from 8/13/15 through 12/9/15 revealed her weight had increased from 200.4 pounds (lb) to 214 lb.</p> <p>During an interview about life in the home on 2/17/16 at 10:30 a.m. with a group of residents who wished to remain confidential they shared: *They worried about resident 3 because she cried a lot. *They also voiced they felt the residents tried to help her more than the staff when she was sad.</p> <p>Review of resident 3's 12/18/14 Daily Lifestyle, Habits and Routines Questionnaire revealed: *She liked to get up between 6:00 a.m. to 7:00 a.m. *Her breakfast preference included oatmeal, eggs, tea, and fresh fruit. It had been completed at the time of admission and had been reviewed and signed by the facility social worker at that time. *It had not been updated since admission.</p> <p>Review of resident 3's entire medical record revealed she had received psychological counseling in the past but there was not any record of that counseling after 12/22/15.</p> <p>Review of resident 3's 1/8/16 care plan revealed: *Focus: "I am displaying signs of depression. I am exhibiting these signs of depression: -Frequent crying. -I have a diagnosis of depression with anxiety." *Goal: "I will demonstrate a decrease in crying as evidenced by staff observation over the next</p>	F 309		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 10 quarter."</p> <p>*It did not address:</p> <ul style="list-style-type: none"> -Specific interventions to address the depression. -The counseling services, was not part of the plan. -The social worker did not address interventions to address the depression. -The excessive sleeping in the morning was not addressed as a possible symptom of depression. <p>*Focus: "I have diet restriction related to diagnosis of CHF [congestive heart failure] hypertension (high blood pressure) and edema (fluid retention)."</p> <ul style="list-style-type: none"> -There were no interventions to address her sleeping in and how they would accommodate her breakfast meal. <p>Review of resident 3's 3/20/15 through 2/17/16 social service progress notes revealed there were no notes regarding her mood. There was no interventions to address any sadness or crying.</p> <p>Interview on 2/17/16 at 5:00 p.m. with the social services director (SSD) regarding resident 3 revealed:</p> <ul style="list-style-type: none"> *The resident frequently cried. *She frequently visited with the resident but did not document her conversations with her. *She was unaware who had actually completed the Daily Lifestyle form but wondered how accurate it was of the resident's preference. -She had always slept in during the morning and did not necessarily think that reflected her being depressed. *She confirmed the care plan did not reflect any specific interventions to address the depression. *The resident had been receiving counseling services for the depression, but she could not say if that had occurred recently. 	F 309			

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F 309	<p>Continued From page 11</p> <p>-They were having problems with getting the reports from the agency that provided the counseling despite their efforts to increase communication.</p> <p>*She agreed they did not have any specific goals for the resident, and to decrease crying was not an appropriate goal.</p> <p>Interview on 2/17/16 at 2:30 p.m. with the dietary manager revealed she would have expected resident 3 to have been offered a cold breakfast since she slept in during the morning. That was their policy.</p> <p>Review of the provider's undated meal time policy revealed "Hot breakfast is served from 7 am - 9 am, after 9 am a cold breakfast is served to those residents that chose to sleep in. Cold breakfast consists of cereal, toast, yogurt, and fresh fruits. Milk, coffee, and a variety of juices are also offered."</p> <p>Review of the provider's April 2013 Social Services Director job description revealed: *"Duties and responsibilities included: Assist residents in achieving and maintaining their maximum psychosocial functioning and independence. *Essential Functions: -As a member of the interdisciplinary team identify and seek ways to support resident's individual needs, preferences, customary routines, concerns and choices through the assessment and care planning process. -Assist resident in dealing with feelings about grief, depression, disability, death, dying or other emotional mental environmental, or physical limitations.</p>	F 309		
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<p>F 323 F 323 SS=E</p>	<p>Continued From page 12 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121</p> <p>Surveyor: 26180 Based on observation, interview, and policy review, the provider failed to ensure the security of one of one randomly observed residents (13) by giving the security code for the alarmed door to the resident. Findings include:</p> <p>1. Observations on 2/16/16 at 6:00 p.m. and on 2/17/16 at 1:00 p.m. revealed: *The front door to the building had a security system requiring a security code to be entered to prevent an alarm from going off. *As the surveyors were attempting to exit the building for the evening and for lunch, they did not know the code. *Resident 13 was seated in the front lobby watching TV and came to the door. *She entered the security code so the surveyors could exit the building. -She had the code written on a piece of paper she kept in her purse.</p> <p>Interview on 2/17/16 at 5:00 p.m. with the social</p>	<p>F 323 F 323</p>	<p>F323</p> <p>1. The door code was changed upon discovery of the deficient practice. No residents have door security code. All residents are at risk. <i>*including resident 13.</i></p> <p>2. The Administrator will in-service all staff no later than March 16, 2016 on the door policy and safety of our residents, including not sharing the code with residents. Those not in attendance will receive education prior to their first shift worked. <i>MYSDOCH/EL</i></p> <p>3. The Administrator or designee will audit four random residents each week to ensure they do not know the door code. Audits will continue for four weeks and then monthly thereafter. The Administrator will bring results of audits to the monthly QAPI meeting for review and recommendation on continuing or discontinuing the audit. <i>*for 3 months MYSDOCH/EL</i></p> <p>4. April 5, 2016</p> <p><i>*The door code was changed upon discovery on 2/17/16. Immediate education was provided to staff onsite at that time. Education was provided to staff on all shifts until all staff were trained. All staff were educated on or prior to March 5, 2016.</i></p>	<p><i>4-5-16</i></p>
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F 323	<p>Continued From page 13</p> <p>services director regarding resident 13 revealed: *She acknowledged the resident had the code for the front door. *She thought the resident had just seen so many people put the code in she remembered it. *The resident 13 had a traumatic brain injury.</p> <p>surveyor 35121 Interview on 2/17/16 at 5:50 p.m. with the administrator regarding the above and resident 13 revealed she: *Had not known the resident had the security code for the front door written down. *Agreed it was a safety risk for the resident to have the security code for the front door.</p> <p>Interview on 2/18/16 at 11:00 a.m. with resident 13 revealed: *She had been given the security code by the "waitresses." *Upon further clarification she said she had been given the code about two months ago by the nursing assistants. *She had lived there about two months.</p> <p>Interview on 2/18/16 at 3:45 p.m. with the administrator and the director of nurses regarding resident 13 revealed: *They were unsure who had given the code to the resident. *The resident had been a resident there for much longer than two months and explained she did have some memory issues. *They had other residents who had the code to the doors and would have to change their process.</p> <p>Review of the provider's January 2014 Safety and Supervision of Residents policy revealed:</p>	F 323		
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F 371	<p>Continued From page 15</p> <p>1. Observation on 2/16/16 from 3:05 p.m. through 3:25 p.m. in the kitchen revealed:</p> <ul style="list-style-type: none"> *Tuna salad in a four quart (qt) container with a handwritten label "Tuna Salad 2/9/16" on the side. <ul style="list-style-type: none"> -The above container contained approximately one qt of tuna salad. *Ham salad in a two qt container with a handwritten label "Ham Salad 2/11/16" on the side. <ul style="list-style-type: none"> -The above container had approximately one-half qt of ham salad. *Two salad dressings (ranch and thousand island) in opened, repackaged, and undated squeeze-type plastic containers. *Applesauce in an opened gallon pitcher-type container was undated and unmarked. <ul style="list-style-type: none"> -The above container had approximately two qt of applesauce. <p>Observation and interview on 2/16/16 at 5:20 p.m. with the dietary manager (DM) in the kitchen revealed:</p> <ul style="list-style-type: none"> *The tuna salad had: <ul style="list-style-type: none"> -A foul odor when the container had been opened. -A watery-type separation on top of it. -Been seven days old. *The ham salad had been five days old. *Those above food items needed to have been discarded after three days. <p>Observation and interview on 2/17/16 at 8:20 a.m. and at 8:35 a.m. with the DM in the kitchen revealed.</p> <ul style="list-style-type: none"> *The two above salad dressings had not been dated. <ul style="list-style-type: none"> -Those salad dressings should have been dated. *The above applesauce had not been labeled or dated. 	F 371		

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F 371	<p>Continued From page 16</p> <p>*That applesauce should have been labeled and dated.</p> <p>*She had been unsure on when the dressings and the applesauce had been opened.</p> <p>*She confirmed those above items needed to have been properly labeled and dated.</p> <p>Interview on 2/17/16 at 6:20 p.m. with consultant registered dietitian B regarding the above revealed:</p> <p>*The leftover policy for the tuna salad and ham salad had should have been followed.</p> <p>*Food items should have been properly labeled and dated.</p> <p>Review of the provider's undated Leftover Food Handling Procedures policy revealed:</p> <p>*Leftovers were to have been stored in a safe and sanitary manner.</p> <p>*Those leftovers were to have been used within an appropriate time frame to have maintained food quality and safety.</p> <p>*Leftovers were to have been utilized within seventy-two hours or discarded.</p> <p>*All leftovers were to have been labeled and dated.</p> <p>2. Observation on 2/17/16 at 11:50 a.m. in the kitchen storage room revealed a moderately large accumulation of dust and lint on the ceiling vent directly above stored disposable dishes and utensils.</p> <p>Interview on 2/17/16 at 12:00 noon with the DM regarding the above vent revealed:</p> <p>*The maintenance manager was responsible for cleaning the vent in the kitchen storage area.</p> <p>*She agreed the vent was over an area where the disposable dishes and utensils were stored.</p>	F 371		

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F 371	Continued From page 17 *She agreed that vent had not been cleaned. *She was unaware of a cleaning schedule for that vent. Interview on 2/17/16 at 1:15 p.m., 2/18/16 at 9:30 a.m., and on 2/18/16 at 11:20 a.m. with the maintenance supervisor in the kitchen storage area revealed he: *Agreed the vent had not been cleaned and needed to have been cleaned on a more frequent basis. *Had no specific cleaning schedule on cleaning of that vent. *He had no policy on cleaning of that vent. Interview on 2/18/16 at 1:10 p.m. with the administrator in the kitchen storage area revealed: *The kitchen staff had been responsible for cleaning the vent in the above area. *Agreed the vent had not been cleaned and needed to have been cleaned on a more frequent basis. *Confirmed the provider had no policy on cleaning of that vent.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	F441 1. The whirlpool tub is being disinfected per manufacturer's recommendations. All residents are at risk. 2. The DON will in-service nursing staff no later than March 16, 2016 on proper disinfection of whirlpool tub. Those not in attendance will receive education prior to their first shift worked. 3. The DON or designee will observe four whirlpool disinfections for proper procedure each week for four weeks and then monthly thereafter. Results of audit will be discussed by DON at monthly QAPI meeting for recommendation on continuation or discontinuation of audit. 4. April 5, 2015	4-5-16

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F 441	<p>Continued From page 18 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) 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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on observation, interview and policy review, the provider failed to ensure disinfection of one of one observed whirlpool cleanings by one of one certified nursing assistant (CNA) A. Findings include:</p> <p>1. Observation and interview on 2/18/16 from 10:53 a.m. to 11:05 a.m. with CNA A regarding the disinfection of the whirlpool tub revealed she</p>	F 441		

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F 441	<p>Continued From page 19</p> <p>had:</p> <ul style="list-style-type: none"> *Added two ounces of disinfectant to the water in the whirlpool tub. *Filled the whirlpool tub with water to above the intake valve. *Scrubbed the surfaces of the whirlpool tub with a scrub brush while the jets were running at 10:59 a.m. *Drained the water from the whirlpool tub at 11:02 a.m. *Referred to the whirlpool cleaning instructions that were posted on the wall several times. *Stated she had "No idea" how much water was in the whirlpool tub. *Confirmed: <ul style="list-style-type: none"> -She added two ounces of disinfectant to the water in the whirlpool tub. -She referred to the whirlpool cleaning instructions that were posted on the wall. -Those instructions stated to add two ounces of whirlpool disinfectant to each gallon of water. -The whirlpool surfaces were to have remained wet for ten minutes. -She had been giving whirlpool baths to residents since May 2015. -She had been trained to disinfect that whirlpool by another CNA. -No further whirlpool disinfecting training had been provided. <p>Interview on 2/18/16 at 11:15 a.m. with infection control nurse E confirmed:</p> <ul style="list-style-type: none"> *The whirlpool cleaning instructions that were posted on the wall by the whirlpool was their whirlpool cleaning policy. *The above whirlpool cleaning had not followed their whirlpool cleaning policy. <p>Review of the provider's undated Whirlpool</p>	F 441			

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F 441	Continued From page 20 Cleaning policy revealed: *Two ounces of disinfectant was to be added to each gallon of water. *Whirlpool surfaces were to remain wet with the disinfectant solution for ten minutes.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on interview, record review, and policy	F 520	F520 1. The Medical Director will attend QAPI meeting no later than March 16, 2016. All residents are at risk. 2. The facility has contracted with a new Medical Director and he is aware of the requirement to attend QAPI meetings at least quarterly. 3. The Administrator or designee will ensure the Medical Director is aware of each monthly QAPI date and that he attends at least quarterly. Physician attendance will be recorded on meeting minute notes. 4. April 5, 2015	4-5-16

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F 520	<p>Continued From page 21</p> <p>review, the provider failed to maintain quality assessment and assurance (QAA) quarterly meetings with a physician in attendance at those meetings. Findings include:</p> <p>1. Interview on 2/18/16 at 9:00 a.m. with the administrator and the director of nursing (DON) revealed: *A QAA meeting had been held on 4/8/15, 5/13/15, 6/9/15, 7/15/15, 8/12/15, 9/10/15, 10/20/15, 11/20/15, 12/9/15, 1/13/16, and 2/10/16. *The QAA meetings were currently being held monthly each year. *A physician never attended the QAA meetings.</p> <p>Review of the April 2015 through February 2016 monthly QAA meeting attendance records revealed a physician was not in attendance at any of the above listed QAA meetings.</p> <p>Interview on 2/18/16 at 9:10 a.m. with the administrator and the DON regarding QAA meetings revealed: *Monthly meetings had been held. *The meetings did not have a physician in attendance. *Both had been aware and agreed the physician needed to have been in attendance on at least a quarterly basis.</p> <p>Review of the provider's 2014 Quality Assurance and Performance Improvement (QAPI) Purpose, Guiding Principles, and Scope for QAPI policy revealed: *Facility leadership would have ensured the medical director was actively engaged in QAPI. *The medical director was to have attended QAPI meetings quarterly with monthly attendance</p>	F 520			

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F 520	Continued From page 22 preferred. *The facility administrator with assistance from the DON was responsible for leading and directing the QAPI program.	F 520			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/17/2016
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NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS Surveyor: 25107 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/17/16. Palisade Healthcare Community was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies upon correction of the deficiency identified at K072 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 25107 Based on observation and interview, the provider failed to maintain two of eight emergency exits (300 wing and therapy room) clear and unobstructed to a public way. The deficient practice affected two of six smoke compartments. Findings include: 1. Observation and interview with the administrator and the head of maintenance on 2/17/16 at 9:30 a.m. and at 9:55 a.m. revealed: *The entire length of the side walk (approximately 40 feet) from the emergency exit was covered	K 072	K072 1. The sidewalks from the two emergency exits were cleared of snow. All residents are at risk. 2. The Maintenance Director was educated on the requirement to continuously maintain paths of egress at the time of survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paul Woods, Adm.</i>	TITLE	(X6) DATE <i>3-10-16</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 03/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/17/2016
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030		
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K 072	<p>Continued From page 1 with several inches of snow. *The entire length of the side walk (approximately 120 feet) from the therapy room emergency exit was covered with several inches of snow. *The administrator was aware those sidewalks were to remain clear and unobstructed. She had not informed the head of maintenance of that requirement. *The head of maintenance confirmed he was not aware that all sidewalks were to remain clear and unobstructed. *He had been the head of maintenance for three weeks and had been employed as a certified nursing assistant prior to this position.</p> <p>This deficiency had the potential to affect all residents in the 300 wing and all residents attending therapy to exit the building safely in an emergency. At the time of the observation there were fifteen beds in the 300 wing with four of those beds being occupied by residents. The therapy room was occupied with four staff and four residents.</p>	K 072	<p>3. The Administrator or designee will audit all exit doors weekly to ensure that the means of egress is continuously maintained and free of all obstructions and impediments to allow for full instant use in case of emergency. Audits will continue for four weeks and then monthly thereafter. The Administrator will bring results of audits to the monthly QAPI meeting for review and recommendation on continuing or discontinuing the audit.</p> <p>4. April 5, 2016</p>	4-5-16	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10623	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/18/2016
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NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030
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S 000 Compliance/Noncompliance Statement
**Addendums noted with an asterisk per Surveyor. 3/31/16 per email with facility administrator. ML/SDDO/HJL*
 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/16/16 through 2/18/16. Palisade Healthcare Community was found not in compliance with the following requirement: S236.

S 236 44:73:04:12(1) Tuberculin Screening Requirements
 Tuberculin screening requirements for healthcare workers or residents are as follows:
 (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;

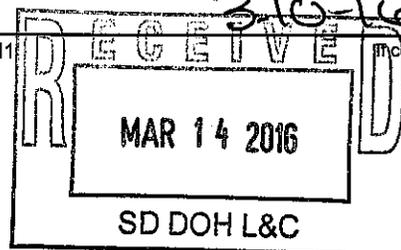
S 000
 Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance
**because the 2 step TB testing was completed on resident 6 on 11/18/15 and 12/1/15 and both were negative. ML/SDDO/HJL*
 No immediate correction could be taken for Resident 6 and 8's second missing Tuberculin screening test. Resident 8 has been assessed for any symptoms of TB and MDs contacted to see if they want 2 step test repeated. All residents are at risk. **NO other residents were identified with this problem. ML/SDDO/HJL*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Paul Woods, Adm.

TITLE

(X6) DATE



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10623	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/18/2016
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NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030
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S 236	<p>Continued From page 1</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure 2 of 12 sampled residents (6 and 8) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of admission. Findings include:</p> <p>1. Review of resident 8's medical record revealed: *An admission date of 3/16/15. *A one-step TB skin test had been completed on 3/16/15. *The two-step TB skin test had not been completed fourteen days after admission.</p> <p>Interview on 2/18/16 at 12:00 noon and at 1:25 p.m. with the director of nursing (DON) regarding the TB screening for resident 8 revealed: *There was a documented one-step TB skin test on 3/16/15. *She had no documentation that a two-step TB skin test had been given. *She confirmed the resident had been admitted on 3/16/15. *She agreed she had not had a two-step TB skin test within fourteen days of her admission. *The nursing staff were responsible for the resident's TB skin tests to have been given in a timely manner.</p> <p>Surveyor: 26180 2. Review of resident 6's entire medical record revealed:</p>	S 236	<p>2. The DON will in-service all licensed nurses on the requirement of 2 step Tuberculin test no later than March 16, 2016. Those not in attendance will receive education prior to their first shift worked.</p> <p>3. The DON will audit all new admissions after 14 days to ensure they have received a 2 step tuberculin test. Audits will be weekly for four weeks and then monthly thereafter. The DON will bring results of audits to the monthly QAPI meeting for review and recommendation on continuing or discontinuing the audit.</p> <p>4. April 5, 2016</p>	4-5-16

for 3 months M/S/D/O/H/E/L

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10623	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/18/2016
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NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030
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S 236	<p>Continued From page 2</p> <p>*She had been admitted on 5/8/15. *The one-step TB test was administered on 11/18/15. *The second-step of the TB test was administered on 11/26/15. -That was six months after her admission.</p> <p>Interview on 2/18/16 at 10:00 a.m. with the DON and the Infection Control nurse revealed resident 6's TB tests had not been completed within the fourteen day requirement.</p> <p>3. Review of the provider's December 2013 Tuberculosis Prevention and Control Program policy revealed "A resident's clinical record must contain a report of the two-step method of Tuberculin skin test (TST) to establish a baseline within 14 days of admission to a facility."</p>	S 236		
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 35121 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 2/16/16 through 2/18/16. Palisade Healthcare Community was found in compliance.</p>	S 000		