

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

ORIGINAL

PRINTED: 11/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>10/27/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>PALISADE HEALTHCARE COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>920 4TH ST GARRETSON, SD 57030</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  Surveyor: 16385 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/26/15 through 10/27/15. Areas surveyed included accidents, resident safety, and abuse. Palisade Healthcare Community was found not in compliance with the following requirements: F226 and F279.	F 000	*Addendums noted with an asterisk per 12/7/15 per telephone with facility DON. DH/SDDOH/EL		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on record review, interview, and policy review, the provider failed to thoroughly assess and report one of one sampled resident (4) with extensive bruising to the South Dakota Department of Health (SD DOH). Findings include:  1. Review of resident 4's medical record revealed: *An admission date of 8/31/15. *A readmission date of 9/23/15. *Diagnoses of end stage renal disease (kidneys no longer functioning), anemia (low red blood cells), pulmonary hypertension (high blood pressure affecting the arteries in the lungs),	F 226	*F226 Develop/Implement abuse/neglect, etc. policies  1. All incidents of unknown origin will be reported to the SD DOH. *per guidelines, DH/SDDOH/EL 2. All residents are potentially at risk. *resident 4 has been discharged, DH/SDDOH/EL 3. All staff were educated on 11-5-2015 on the Abuse policy. All incident reports will be reviewed at the morning quality conference to determine if they are reportable to SD DOH. Audits will be done by the DON or designee daily x 4 weeks. *Quality Conference will review incidents daily. DH/SDDOH/EL 4. Results of the written audits will be taken to the facility QAPI committee monthly by the DON or designee for review and recommendations.		

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

TITLE

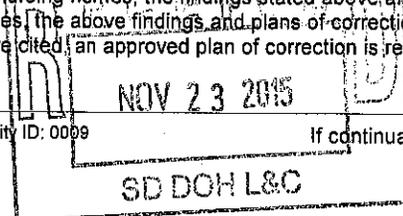
(X6) DATE

*Paul Woods*

*Adm*

*11-18-15*

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 226	<p>Continued From page 1</p> <p>thrombocytopenia (low platelet count), diabetes mellitus (uncontrolled blood sugar), cirrhosis of the liver (liver failure), and lymphodema (fluid). *She received dialysis (procedure used when kidneys not functioning properly) three times per week. *She received Opsumit (medication) for pulmonary hypertension.</p> <p>Review of the following Minimum Data Set (MDS) assessments revealed: *Admission 9/7/15 assessment: -A Brief Interview for Mental Status (BIMS; testing of thought process) score of three indicating severe mental confusion. -She required extensive to total assistance of staff for bed mobility (changing position), transfer, locomotion (getting around from place to place), dressing, toilet use, personal hygiene, and bathing. -She was not able to transfer herself without assistance from staff. -Used a wheelchair for mobility. -Had a fall within the last two to six months before admission. -Had received speech therapy (ST), occupational therapy (OT), and physical therapy (PT) services. -Received dialysis services. -Internal bleeding had not been marked. -The Care Area Assessment (CAA) summary recommended the following areas to review for the care plan: Cognitive loss/dementia (memory loss), urinary incontinence (loss of urine control), psychosocial well-being, behavioral symptoms, activities, falls, nutritional status, pressure ulcer, and psychotropic (mood altering) drug use. All of the above were indicated as having been placed on the care plan.</p>	F 226			

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F 226	<p>Continued From page 2</p> <p>The admission/five day medicare 9/30/15 MDS assessment revealed:</p> <ul style="list-style-type: none"> <li>*A BIMS score of 3 (indicating severe confusion).</li> <li>*She required extensive assistance of staff for bed mobility, transfer, locomotion, dressing, toilet use, and personal hygiene. She was not able to do transfers herself without assistance from staff.</li> <li>*Used a wheelchair for mobility</li> <li>*Had no falls.</li> <li>*Received dialysis services.</li> <li>*Had received speech therapy (ST), occupational therapy (OT), and physical therapy (PT) services.</li> <li>*Internal bleeding had not been marked.</li> </ul> <p>The fourteen day 10/10/15 MDS assessment revealed:</p> <ul style="list-style-type: none"> <li>*A BIMS score of 3 (indicating severe confusion).</li> <li>*She required extensive assistance of staff for bed mobility, transfer, locomotion, dressing, toilet use, personal hygiene.</li> <li>*Used a wheelchair for locomotion.</li> <li>*Had no falls.</li> <li>*Internal bleeding had not been marked..</li> <li>*Had received ST, OT, and PT services.</li> </ul> <p>Review of resident 4's 9/25/15 physician's order form revealed she had received Opsumit tablet 10 mg (milligrams) daily for pulmonary hypertension.</p> <p>Review of the current care plan revealed:</p> <ul style="list-style-type: none"> <li>*Transfer/bed mobility/ambulation: "I need extensive assistance of 2 staff with bed mobility, transfers and ambulation."</li> <li>--There was no documentation to use a mechanical lift (equipment used to move resident from one place to another).</li> <li>*"I will receive all medications from staff. Staff will deliver my medications as ordered. Staff will</li> </ul>	F 226		
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F 226	<p>Continued From page 3</p> <p>monitor for side effects of my medications." --There was no documentation the resident had received Opsumit, or any specific adverse side effects and monitoring to observe for.</p> <p>Review of the October 2015 medication administration record for resident 4 revealed she had received Opsumit daily. There was no documentation any monitoring of the medication had been done.</p> <p>Review of resident 4's progress notes revealed on:</p> <p>*10/12/15 at 1:05 p.m.: "Large bruise noted to L [left] side of L breast and underarm. Bruise is dark purple in color. No pain noted in area. Possibly cause is stand aide (type of mechanical lift used to transfer resident)."</p> <p>*10/14/15 at 7:27 a.m.: "Resident continues to have large red/purple bruise on left shoulder, left upper arm, left breast, left rib cage onto back, some swelling noted to left upper front shoulder and pain with movement."</p> <p>*10/14/15 at 8:24 a.m.: "Resident left shoulder assessed by nurse manager and MDS coordinator."</p> <p>*10/14/15 at 8:28 a.m.: "Dr. [physician name] nurse updated of resident condition."</p> <p>*10/14/15 at 8:47 a.m.: "Received call back from Dr. [name] office and nurse said to send her right away to [clinic] for evaluation by [physician]."</p> <p>*10/14/15 at 8:49 a.m.: "Resident is confused this AM and said something about a bear trying get her."</p> <p>*10/14/15 at 9:48 a.m.: "Son updated via [by] to [telephone call]."</p> <p>*10/14/15 at 12:57 p.m.: "Received call from [dialysis unit name] that patient is there."</p> <p>*10/14/15 at 14:09 p.m. [2:09 p.m.]: "Received</p>	F 226		
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F 226	<p>Continued From page 4</p> <p>call from clinic that resident had ecchymosis (discoloration of skin from bleeding underneath, typically from bruising) from simple trauma [injury] and to just let it resolve on its own. Labs [laboratory blood tests] were drawn."</p> <p>*10/14/15 at 15:18 p.m. [3:18 p.m.]: "Contacted residents son to let him know we had re-inacted the chair malfunctioning. It appears that when the chair was put backwards, the left side fell backwards and the nurse fell onto her left armpit in the chair. We relayed this message to the son and that we would continue to watch the bruising with his mom. We also stated we had thrown the chair away and were getting a new chair for her."</p> <p>*10/15/15 at 9:11 a.m.: "Administrator, DON [director of nursing], and nurse manager called son and relayed to him that his mom's bruising had gotten worse. He asked about her appointment from the previous day and we let him know that the dr [doctor] had said it was ecchymosis from trauma and it would resolve on its own. We stated that the lab values also looked a little off but we had gotten no new orders regarding this bruise. We felt that maybe resident should be sent in and asked [son] if he would like us to send her in. He stated he would talk to the rest of the family and call us back."</p> <p>*10/15/15 at 9:35 a.m.: "Resident's POA [power of attorney] wife called. Relayed that the family wished her to be sent to [hospital name]."</p> <p>*10/15/15 at 9:40 a.m.: "Note that bruising is now spread out from left shoulder to right shoulder and right chest; continues to be bright red/purple in color."</p> <p>*10/15/15 at 10:34 a.m.: "Late entry for 10/14/15 labs received via fax and reviewed by nurse; received call from [nurse' name] nurse at [clinic name], no treatment at this time just monitor ecchymosis and it will resolve itself."</p>	F 226		
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F 226	<p>Continued From page 5</p> <p>*10/15/15 at 15:13 p.m. [3:13 p.m.]: "Writer called [hospital name] for update on resident; ER [emergency room] staff, [staff name] indicated resident is being admitted inpatient for anemia and hematoma."</p> <p>*There was no further documentation by the nursing staff regarding the bruising.</p> <p>*There was not an incident report for the 10/12/15 bruise or the 10/14/15 broken chair incident in the resident's medical record.</p> <p>Review of resident 4's past medical record history revealed:</p> <p>*On 7/29/15 she had been admitted from an assisted living center to the hospital and had received Opsumit.</p> <p>*On 8/10/15 hemoglobin lab value was 7.6 (indicating anemia, normal level is 12 to 15).</p> <p>*On 9/8/15 she had been admitted to the hospital.</p> <p>*She had been started on Lovenox (anticoagulant medication, used to thin blood) subcutaneous (injection into the fat layer between skin and muscle).</p> <p>*The 9/16/15 certified nurse practitioner progress noted revealed:</p> <p>-The resident's "left upper arm was bruised, firm, swollen and left arm/hand with increased edema. Possibly from B/P (blood pressure) cuff. Pt (patient/resident) has nonfunctioning fistula in that left arm."</p> <p>-Hemoglobin 7.6.</p> <p>-Cirrhosis of the liver.</p> <p>*The 9/9/15 hospital physician's notes revealed:</p> <p>- "Has a history of liver cirrhosis."</p> <p>-Past medical history: severe pulmonary hypertension, anemia, thrombocytopenia (low platelet count, could be a side effect of taking certain medications. If very low dangerous internal bleeding could occur)."</p>	F 226		
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F 226	<p>Continued From page 6</p> <p>*The 9/25/15 primary physician's progress assessment notes revealed she continued with anemia, chronic kidney disease and pulmonary hypertension.</p> <p>*The 10/14/15 physician's clinic notes revealed: -She "presents today with large ecchymosis to her left chest and around to her back. She denies any injury and staff at the nursing home also deny any injury." -Hemoglobin is 9.2 (low). -Assessment plan: "Ecchymosis (bruising), Thrombocytopenia."</p> <p>Review of the monthly medication regimen (medications reviewed by the pharmacist) review by the consultant pharmacist revealed: *"9/15 [September, 2015]: In hospital during visit." Area where NI/See report for any noted irregularities and/or recommendations was "scratched out." *10/15 [October]: Area where "See report for any noted irregularities and/or recommendations" was checked. *There was no further documentation noted in the residents medical record.</p> <p>Telephone interview on 10/27/15 at 1:30 p.m. with the consultant pharmacist regarding Opsumit revealed the pharmacist requested the surveyor send an email to him and his supervisor regarding questions related to the medication Opsumit. An email was sent to the consultant pharmacist and his supervisor on 10/27/15 at 1:38 p.m. regarding the use of Opsumit and pharmacy recommendations.</p> <p>An email was received on 10/27/15 at 5:39 p.m. from the consultant physician regarding Opsumit that revealed:</p>	F 226			

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F 226	<p>Continued From page 7</p> <p>*The medication was approved for the treatment of pulmonary arterial hypertension.</p> <p>*The drug received approval from the U.S. Food and Drug Administration on October 13, 2013, making it not an "experimental medication."</p> <p>**"Low red blood cells may be noted at beginning of therapy along with slight transient liver function clearance. For that reason, CBC and AST/SLT (lab tests) are commonly done prior to therapy and occasionally during therapy."</p> <p>*The resident had received the medication for pulmonary hypertension, an approved indication, and had received the medication for six months prior to admission. She had more than satisfactory lab tests while she was at the facility on 9/12/15 and 9/15/15.</p> <p>Interview on the following dates and times with the DON regarding resident 4's 10/12/15 and 10/14/15 incidents revealed on:</p> <p>*10/27/15 at 10:30 a.m.:</p> <ul style="list-style-type: none"> <li>-The DON gave the requested documentation containing a four page hand written documentation. The documentation did not have dates, times, full names of what had occurred. The DON considered it her investigation of the above incidents.</li> <li>-The DON thought the above incidents had been reported to the South Dakota Department of Health (SD DOH) by someone.</li> <li>-She was unable to find documentation the above incidents had been reported to the SD DOH.</li> <li>-She had a telephone conversation with the facility nurse consultant if the above incidents needed to be reported and the nurse consultant had said the incident did not need to be reported to the SD DOH.</li> </ul> <p>*On 10/27/15 at 11:45 a.m.:</p> <ul style="list-style-type: none"> <li>-The DON had been on vacation and "in and out"</li> </ul>	F 226			

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F 226	<p>Continued From page 8 of the office during the above incidents.</p> <ul style="list-style-type: none"> <li>-Had written notes for her internal investigations after she had returned from vacation and "in and out."</li> <li>-No staff had been assigned to do any type of incident reports or investigations while she had been gone. All staff were involved with incidents and investigations.</li> <li>--She was informed at that time the incidents had not been reported to the SD DOH.</li> <li>-She had been unsure whether the above were reportable incidents.</li> <li>*On 10/27/15 at 1:10 p.m. regarding Opsumit:</li> <li>-Agreed the medication had not been on the care plan for monitoring.</li> <li>-She had researched the drug after the bruising had occurred with resident 4 and after she had spoken to the son.</li> <li>-The son had indicated the resident had been receiving the medication for six months.</li> </ul> <p>Interview on 10/27/15 from 2:00 p.m. through 2:30 p.m. with the administrator, DON, CNA A, RNs B, C, and D, and PT E regarding resident 4's incidents on 10/12/15 and 10/14/15 revealed:</p> <ul style="list-style-type: none"> <li>*On 10/12/15:</li> <li>-There had not been an incident report filled out.</li> <li>-The family and physician had not been notified of the bruising.</li> <li>-There had not been any follow-up documentation regarding the bruising.</li> <li>*On 10/14/15:</li> <li>-There had not been an incident report filled out.</li> <li>-The broken chair incident had occurred on 10/13/15 just before supper.</li> <li>-There was no documentation in the resident's medical record the family or physician had not been notified until 10/14/15.</li> <li>-Agreed an incident report should have been filled</li> </ul>	F 226		

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F 226	<p>Continued From page 9</p> <p>out, the physician and family contacted sooner, and the incidents reported to SD DOH. -Agreed the care plan had not included how to transfer the resident or monitoring of the medication Opsumit. *Agreed the care plan should have included how to transfer the resident and monitoring of the medication Opsumit.</p> <p>Interview on 10/27/15 at 2:30 p.m. with the occupational therapist revealed she had been working with the staff on using the stand-aid to transfer resident 4. She had previously been using the Hoyer lift for transfers.</p> <p>Review of the provider's revised October 2014 Abuse Prevention Plan policy revealed: *"The intent of this policy is to provide a safe living environment to all residents of the facility and to provide guidelines for investigation and reporting of suspected maltreatment." **F. 1. Facility will investigate all incidences such as falls, bruises, medication errors, resident complaints etc. -Facility will identify the staff member(s) responsible for: a. The initial report. b. Initiating the investigation. c. Reporting the results to the proper authority within the 5 day state requirement. The facility will accomplish this by all incident reports are to be filled out by licensed staff immediately following the incident."</p> <p>Review of the provider's revised June 2015 Incident Reporting - Resident policy and procedure revealed: *Policy: "To insure all incidents are reported in a timely manner. To insure that the appropriate</p>	F 226		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435115</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/27/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>PALISADE HEALTHCARE COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>920 4TH ST</b> <b>GARRETSON, SD 57030</b>		
(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 226	Continued From page 10 facility staff are informed of all resident incidents. To insure that resident care plans adequately reflect resident care needs." *Procedure: "A 'Resident Incident Report' is completely filled out on all "incidents" (an incident is defined as anything out of the ordinary, unusual happening, skin tear, falls, family concerns, allegation[a charge or claim] of abuse or neglect, altercation [disturbance] between residents, etc. [and so on)." **The DON will be responsible for the compliance of this policy." **The appropriate family members and physician are to be notified in a timely fashion of the incident."	F 226			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279			

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F 279	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on record review, interview, and policy review, the provider failed to ensure a care plan had been individualized and updated to reflect the current status for one of eight sampled residents (4). Findings include:</p> <p>1. Review of resident 4's medical record revealed: *The 9/30/15 and 10/10/15 Minimum Data Set (MDS) assessments indicated she: -Had two stage two pressure ulcers (open area or outer layer of skin missing due to injury usually from pressure and frequently over a bony area). -Required extensive assistance of staff for transfers (moving from one place to another). *The 9/25/15 physician's order for Venelex ointment to the buttock (one or both sides of the bottom) ulcer topically two times. *The current care plan had the following: -Skin: "I have a skin issue, open sore on my legs." --There was no documentation of any pressure ulcers to the buttock area. -Transfer/bed mobility/ambulation: "I need extensive assistance of 2 staff with bed mobility (repositioning in bed), transfers and ambulation." --There was no documentation to use a mechanical lift.</p> <p>Interview on 10/27/15 from 2:00 p.m. through 2:30 p.m. with the director of nursing, registered nurses B, C, and D regarding resident 4 revealed: *There was no documentation on the resident's care plan about a pressure ulcer or to use a</p>	F 279	<p><b>F279 Develop Care Plans</b></p> <p>1. Resident #4 is no longer at the facility, so care plan cannot be updated. All current residents care plans will be reviewed and updated as of Dec. 11<sup>th</sup>, 2015.</p> <p>2. All residents are potentially at risk</p> <p>3. The Interdisciplinary Team and nurses will be educated on or before Nov. 19, 2015 by the DON or designee on the care planning process.</p> <p>The DON or designee will complete written audits weekly x 4, then monthly x 3 on care planning of resident status. A minimum of 3 residents will be included in each audit.</p> <p>4. Results of the written audits will be taken to the facility QAPI committee monthly by the DON or designee for review and recommendations.</p> <p><i>*DK/SD/DH/E/L</i> <i>*Z/11/15</i> <i>DH/SD/DH/E/L</i></p>	
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F 279	<p>Continued From page 12 mechanical lift for transfers. *They agreed there should have been documentation on the resident's care plan to reflect a pressure ulcer and use of a mechanical lift for transfers.</p> <p>Interview on 10/27/15 at 2:30 p.m. with occupational therapist F revealed she had been working with the staff on using the stand-aid (mechanical lift where resident assists by standing) to transfer resident 4. She had previously been using the Hoyer lift (total lift using a sling resident sits in) for transfers with the resident.</p> <p>Review of the provider's revised August 2014 Care Planning policy revealed "Individual, resident-centered care planning be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence."</p>	F 279			