

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

ORIGINAL

PRINTED: 09/06/2016
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 C 08/24/2016
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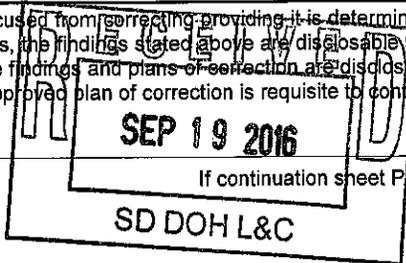
NAME OF PROVIDER OR SUPPLIER PALISADE HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 920 4TH ST GARRETSON, SD 57030
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F 000	<p><i>*Addendums noted with asterisk per 10/3/16 per telephone with facility DON. SB/SDDOH/EL</i></p> <p>Surveyor: 32332 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 8/24/16. Areas surveyed included resident quality of care/treatment with regard to safety, patient neglect in regard to pressure sores, resident assessment, and death. Palisade Healthcare Community was found not in compliance with the following requirement: F281.</p>	F 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.	
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on record review, interview, and policy review, the provider failed to follow professional nursing standards for one of one resident (1) regarding: *Identifying one stage one pressure ulcer and one suspected deep tissue injury (DTI) as an immediate concern. *Notifying the physician of a stage one pressure ulcer and a suspected DTI in a timely manner. *Reporting a stage one pressure ulcer and a suspected DTI to other healthcare staff members for continuation of care. *Identifying a stage one pressure ulcer and a suspected DTI on an initial care plan. Findings include: 1. Review of resident 1's medical record</p>	F 281	<p><i>* All residents with pressure ulcers and staff notification, physicians orders</i></p> <p>F281 were checked for timelines of physician and staff notification, physicians orders</p> <p>1. No correction could be made for Resident 1 as she has been discharged from the facility on 4/1/16. <i>provider treatment, and pressure ulcer care plan SB/SDDOH/EL</i></p> <p>2. All residents are at risk. ←</p> <p>3. The Administrator, Director of Nursing, and interdisciplinary team</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rae Wells, Adm</i>	TITLE	(X6) DATE 9-15-16
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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 281	Continued From page 1 revealed: *She was admitted on 3/24/16 from another nursing facility with a neck fracture after a fall. *A Comprehensive Evaluation of Skin Inspection and Risk Factors (revised) form with an effective date listed as 3/24/16. Licensed practical nurse (LPN) A had signed the evaluation on 3/25/16 and documented: -A Braden score for the risk factor of pressure ulcers as 20, indicating no risk. -A Stage one pressure area to her coccyx (tailbone) measuring thirteen millimeters (mm) long by nine mm wide with no depth. -A suspected DTI on her coccyx measuring four mm long by 2 mm wide. No depth was documented. -The resident had been transferred to an emergency room due to a status change on 4/1/16 and had not returned to the facility. Review of the above skin inspection form had an Analysis of Risk Factors and Interventions section. That section of the form indicated: *"RN [registered nurse] ANALYSIS OF RISK FACTORS AND INTERVENTIONS Include Date. SKIN NEEDS TO BE INSPECTED WITHIN 2 HOURS OF ADMISSION/READMISSION AND WEEKLY FOR 4 WEEKS." *No analysis of risk factors or interventions had been documented on the form. *No RN signature was documented. *LPN/Minimum Data Set assessment coordinator B had signed the Analysis of Risk Factors and Interventions section on 3/29/16. Review of a Weekly Wound Documentation form dated and signed by LPN/MDS coordinator B on 3/30/16 indicated: *The same measurements to the stage one	F 281	have reviewed procedures on documentation and notification to physician and the cited deficiency. The LPN scope of practice has also been reviewed. The DOC (Director of Clinical), and DON (Director of Nursing) will educate nurses on Professional Standards and Pressure Ulcers, including identification [REDACTED] →*, staging of pressure ulcers and physician notification. The LPN scope of practice will be reviewed with nurses at this time. Education will occur no later than 9/21/2016. Those not in attendance will be educated prior to their next shift. 4. DON or designee will audit the following: - Wound is staged correctly and assessment is completed timely - Providers are being notified of skin issues when they are discovered →* (see next page) - RN is signing all wound assessments. Audits will be completed weekly for four weeks and then monthly for three months. The DON or designee will bring the results of the audits to the monthly Quality Assurance Process Improvement meeting for review and →* reporting abnormal skin concerns to on-call staff and implementing care plans to address skin concerns. SB/SPD/H/E/L	

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F 281	<p>Continued From page 2</p> <p>coccyx pressure ulcer and the suspected coccyx DTI areas.</p> <p>*There was no change in the status of the ulcers.</p> <p>*There was no signature in the RN Signature area.</p> <p>Review of the Braden Scale assessmetn dated and signed by LPN/MDS coordinator B on 3/30/16 indicated:</p> <p>*A score of 18 indicating mild risk for pressure ulcers.</p> <p>*The resident had a pressure-relieving mattress on her bed and a cushion in her wheelchair.</p> <p>Review of the interdisciplinary progress notes from 3/24/16 through 4/1/16 revealed:</p> <p>*There was no documentation of the presence or treatment of the pressure areas until 3/30/16 when the physician had asked RN D about the area on the resident's coccyx.</p> <p>*On 3/31/16 RN D updated the physician by phone regarding "The condition of skin on the coccyx and placement of mepilex dressing."</p> <p>*No dietary documentation.</p> <p>Review of an undated and unsigned All About Me form had indicated:</p> <p>*On the skin conditions section neither pressure ulcer nor skin tear had been circled.</p> <p>*An area below the above section marked Location was documented as NA (not applicable).</p> <p>Review of the physician's orders section of the medical record had included the following physician's orders:</p> <p>*On 3/29/16 a fax physician communication form was sent to resident 1's physician stating:</p> <p>- "Resident has a pressure ulcer that is deep purple and is 4x2 unstageable and red</p>	F 281	<p>recommendations on continuing or discontinuing the audit.</p> <p>5. October 10, 2016.</p> <p><i>*charge nurse notifies staff of an abnormal skin assessment at the time of discovery.</i></p> <p><i>- Skin concerns are care planned at time of discovery.</i></p> <p><i>SB/SDDO/H/EL</i></p>	10-10-16

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F 281	<p>Continued From page 3</p> <p>unblanching area around it that is 13x9 - do you want orders for treatment?"</p> <p>-The physician response area had indicated the response had been addressed in a phone call on 3/30/16 and was signed by RN D.</p> <p>*A 3/30/16 phone communication from the physician to RN D stated "Make sure patient sits upright when in chair to help reduce pressure on coccyx."</p> <p>Interview on 8/24/16 at 3:30 p.m. with RN C revealed when asked about a licensed practical nurse performing the skin evaluation for resident 1 revealed:</p> <p>*She agreed LPN A had done the initial skin evaluation.</p> <p>*The LPNs could document the initial evaluation of the resident's skin.</p> <p>*After that evaluation was done the LPN would notify the RN of skin concerns.</p> <p>*The RN would perform the skin assessment within the next week.</p> <p>*LPN B and RN C (both MDS coordinators) worked as a team to monitor skin and perform the skin assessments.</p> <p>*RN/MDS coordinator C would sign all MDS assessments completed for both LPN/MDS coordinator B and RN C.</p> <p>*She agreed LPN B had signed the Comprehensive Evaluation of Skin Inspection and Risk Factors form and Weekly Wound Documentation form, but she had not signed the evaluation forms.</p> <p>*Her expectation was the RN would sign all Comprehensive Evaluation of Skin Inspection and Risk Factors forms and Weekly Wound Documentation forms.</p>	F 281		

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F 281	<p>Continued From page 4</p> <p>Interview on 8/24/16 at 4:12 p.m. with LPN A revealed:</p> <ul style="list-style-type: none"> *She had evaluated resident 1's skin on the day of her admission. *She had documented the stage one pressure ulcer and the suspected DTI on the Comprehensive Evaluation of Skin Inspection and Risk Factors form. *She had not notified the physician, the registered nurse, or other primary staff members of the skin issues. *She stated "I guess it was an oversight. We were busy. I documented it, but I didn't notify anyone." *She stated she did not believe the physician needed to have been notified, because the pressure ulcer and suspected DTI were not open areas. <p>Interview on 8/24/16 at 5:00 p.m. with the director of nursing (DON) and LPN/MDS coordinator B revealed:</p> <ul style="list-style-type: none"> *A skin evaluation was done for resident 1 at the time of admission, but the findings were not communicated to the physician or other provider staff at that time. *The admitting nurse should have notified other provider staff of the identified skin concerns. *Resident 1's physician had standing orders for treatment of pressure ulcers, so they felt he did not need to be notified of the skin concerns at that time. *The All About Me form was the initial care plan. *The initial care plan should have: <ul style="list-style-type: none"> -Been signed and dated. -Included the identified skin concerns and treatment plan for those concerns. *The DON was not sure if the dietitian had been notified of the pressure ulcer issues. 	F 281			

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F 281	<p>Continued From page 5</p> <p>*The resident should have had dietary interventions for the skin concerns.</p> <p>*The DON stated:</p> <ul style="list-style-type: none"> -The resident had been admitted from another provider. -The transfer papers had not included skin concerns. -She did not know the pressure areas had not been identified by the previous provider. <p>*The provider used their own policies for making decisions on professional standards.</p> <p>Review of the provider's April 2016 Skin Program policy revealed:</p> <ul style="list-style-type: none"> *The purpose was to promote healing of pressure ulcers/wounds that were present, and to prevent development of additional pressure ulcers/wounds. *On admission a baseline assessment of the resident's skin status would have been completed within twenty-four hours of admission. *A temporary plan of care would have been put in place for residents that were identified at-risk for skin breakdown. *Nursing personnel would utilize the results of the exam and pressure ulcer assessments to determine an individualized pressure ulcer prevention program for each at-risk resident including: <ul style="list-style-type: none"> -Skin protection against pressure, friction, shear, and moisture. -Optimum nutrition and fluid intake. -Education to staff, residents, and families. -Training front-line caregivers. -Immediate prevention plan instituted when potential area was identified. *When a pressure ulcer was identified a comprehensive wound assessment would have been completed including: 	F 281		

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F 281	Continued From page 6 -Wound measurements. -Treatment of the ulcers. -"Type of the skin ulcer (MD is asked to identify type of ulcer...and provide treatment orders." *Skin checks were to be completed weekly by the licensed nurse. Review of the provider's physician's Standing Orders revealed: **"Pressure Ulcer Protocol per dietitian recommendations." *No standing physician's orders for pressure ulcer dressings or other skin treatment. No Physician's Standing Orders policy had been provided when requested from the DON.	F 281			