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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435115	A. BUILDING _____ B. WING _____	02/01/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 29354 A COVID-19 Focused Infection Control Survey was conducted by the South Dakota Department of Health Licensure and Certification Office on 2/1/21. Palisade Healthcare Center was found not in compliance with 42 CFR Part 483.80 infection control regulation: F880. Palisade Healthcare Center was found in compliance with 42 CFR Part 483.10 resident rights and 42 CFR Part 483.80 infection control regulations: F550, F562, F563, F583, F882, F885, and F886. Palisade Healthcare Center was found in compliance with 42 CFR Part 483.73 related to E-0024(b)(6). Total residents: 36	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880	***Directed Plan of Correction F880*** **Palisade Healthcare Center** **Corrective Action:** 1. *RN B reviewed the facility's polices about appropriate hand-hygiene and glove use. She completed a hand hygiene and glove use competency on 2/9/2021. -She reviewed the facility policy for conducting a blood glucose check and completed competency on 2/9/2021, demonstrating appropriate hand hygiene and glove use as well as appropriate use of a barrier. Continued on next page.	2/15/2021

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

Lourdes Parker | *Executive Director* | *2/18/2021*

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 880	Continued From page 1 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880	*Resident (2) room doors or barrier curtains for those identified as COVID-19 positive or suspected will be kept closed except when entering or leaving the room. All staff reviewed the facility policy for COVID-19 placement and have acknowledged review. All staff educated on 2/9/2021 and 2/12/2021. **Identification of Others:** 1. *All residents who have procedures such as blood glucose checks have the potential to be affected. All staff completing the assigned task have potential to be affected. All staff assigned the task were provided infection control education/re-education by ED, DNS, and resident care managers by 2/12/2021. *All residents with known or suspected COVID-19 have the potential to be affected. ALL facility staff completing their assigned tasks have potential to be affected. Policy education/re-education by DNS and resident care managers by 2/12/2021. Continued on next page.	

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F 880	Continued From page 2 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to implement appropriate infection control practices for: *One of one observed registered nurse (RN) (B) completing a blood glucose check for one of one sampled resident (1). *Ensuring a room door for one of one sampled resident (2) who was COVID-19 positive remained closed. Findings include: 1. Observation and interview on 2/1/21 at 12:30 p.m. outside of resident 1's room revealed: *RN B: -Came out of the room. -Said she dropped something. -Removed her gloves, discarded them into a garbage can, and without performing hand hygiene removed two gloves from a box on top of the medication cart. -Dropped one of those gloves on the floor. -Picked up that glove and discarded it in the garbage. -Put on gloves. -Picked up the glucometer and other items used	F 880	**System Changes:** 1. Root cause analysis answered the 5 Whys: 1.) RN had not had her blood sugar competency or Relias training on the protocol per the blood sugar policy. 2.) No proper education on the plastic barrier to the red zone that there was to be some form of zipper or Velcro to hold the barrier together when no one is entering or exiting the area. 3.) Resident #2 is noncompliant with Covid protocol by not wearing a mask properly or closing his door all the way. 4. Handwashing competency had not been completed with RN B at the time of survey. 5. Two staff did not attend training on Covid policy and outbreak strategy. The DON or ED or designee will ensure the staff assigned receive education/re-education and necessary training to perform appropriate hand hygiene and glove use with procedure task of blood glucose check.	

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F 880	Continued From page 3 to do blood glucose testing. -Entered her room and laid the above supplies on top of an overbed table without disinfecting it or laying down a barrier. -Checked her blood glucose. -Went out in to the hall and discarded the used supplies and wrapped the glucometer in a Micro Kill Bleach cloth. -Removed her gloves and did hand hygiene. Interview on 2/1/21 at 2:45 p.m. with interim director of nursing regarding the above observation of resident 1 revealed: *Hand hygiene should have been done after removing her gloves. *A barrier should have been placed on the overbed table before placing the blood glucose testing supplies down. *There were some missed hand hygiene opportunities. Review of the provider's 2017 Disinfecting Glucometer policy and procedure revealed: *"Procedure: -1. In the resident's room, provide a barrier between the glucometer and any surface the machine is placed on." Review of the provider's March 2018 Handwashing/Hand Hygiene policy revealed: *"7. Use an alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: -m. After removing gloves." 2. Observation on 2/1/21 at 2:25 p.m. at the end of the 100 hallway revealed: *There was a plastic barrier from the ceiling to the	F 880	The DON or ED or designee will ensure ALL facility staff are educated and aware of the policy about doors closed for those residents with known or suspected COVID-19. 4. The DNS or designee will audit a random sample of 4 staff weekly times four weeks and monthly times two months for hand hygiene performed per policy, compliance of mask wearing on a random sample of four residents weekly times four weeks and monthly times two months, audit a random sample of four residents in isolation for compliance with keeping the door closed weekly time four weeks and monthly times two months and audit that the plastic barrier to the covid unit remains closed at all times except when entering or exiting the unit weekly times four weeks and monthly times two months. The results of these audits will be brought to the QAPI committee monthly for further review and recommendation to continue or discontinue the audits.	

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F 880	Continued From page 4	F 880		

floor leading into the dedicated COVID-19 area.
-The plastic barrier had tape on it.
-It had an opening from the floor extending upward five feet with an open gap approximately fifteen inches at the widest.
-The tape on both sides of that plastic barrier were not secured.
*There were two staff members in that area.
*The door leading into resident 2's single room was open.
*He:
-Was sitting in his wheelchair with his coat on.
-Had just gotten back from dialysis.
-Had entered the facility through the exit door leading into the dedicated COVID-19 area at the end of the hall.
-Was not wearing a mask.

Review of resident 2's medical record progress note dated 2/1/21 at 1:39 p.m. revealed:
*"Received a call from [transit name] that they had resident out the back door.
-Instructed them to go to the west door and educated the driver that this is the door he will use for the next 7 days."

Interview on 2/1/21 at 2:45 p.m. with interim director of nursing A regarding the above observation revealed:
*He had tested positive for COVID-19.
*That was the second time he had been diagnosed with COVID-19.
*His door should have been closed.
*They encouraged him to wear a mask but he refused.

Review of the provider's 11/30/20 COVID-19 policy and procedure revealed:
*"E. Patient [resident] Placement:

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F 880	Continued From page 5 -3. Patients with known or suspected COVID-19 should be placed in a single-person room with the door closed. -12. Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized."	F 880		