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 _____	C 03/08/2023

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

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 3/5/23 through 3/8/23. Palisade Healthcare Center was found not in compliance with the following requirements: F657, F658, and F678. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 3/5/23 through 3/8/23. Area surveyed included abuse. Palisade Healthcare Center was found in compliance.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657	See next page	

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

Lourdes Parker | Executive Director | 3/27/2023

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 657	Continued From page 1 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the following: *Three of sixteen sampled residents (9, 26, and 32) care plans had been updated to include the most current medical status of the residents. *Seven of sixteen sampled residents (9, 10, 14, 16, 19, 21, and 28) care plans included their current code status. Findings include: 1. Review of resident 26's medical record revealed: *He was admitted on 2/13/23. *He had diagnoses that included: Major depressive disorder and severe protein-calorie malnutrition. *On 2/13/23 he weighed 136.2 pounds (lbs) and on 3/01/23 he weighed 131.0 pounds which was a 3.82 % loss. Review of the 2/20/23 nutrition/hydration committee meeting minutes revealed resident 26 had been reviewed for a diagnosis of malnutrition and failure to thrive. He had lost weight since his admission despite interventions that had been put in place. He had been reviewed due to his weight loss. Resident's current weight of 128 lbs. is down 8# from his admission weight of 136 lbs.. body max index "BMI" was 17.9. Eating 75-100% of	F 657	1. Residents 9,26, and 32 care plans updated to reflect current medical status. Residents 10,14,16,19,21,and 28 care plans updated to include advanced directive. All resident care plans reviewed for accuracy. All residents have the potential to be affected. 2. The DNS or designee will educate the interdisciplinary team and licensed nurses on ensuring an accurate and timely care plan is in place for all residents by 3/30/23. All those not in attendance will be educated prior to their next working shift. 3. The DNS or designee will audit four random care plans weekly times eight weeks for accuracy and timeliness. The DNS or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	4/14/2023

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F 657	Continued From page 2 meals on a regular diet with regular textures. The resident had been getting 2 ounces (oz) calorie-dense Med Pass supplement three times a day 4 oz of the house supplement two times a day to support weight gain. Review of resident 26's care plan problem for nutrition and hydration initiated on 3/5/23 revealed: *Goals that included: -"No unplanned significant weight loss or gain." -"Resident to consume 50% of each meal." -"Resident to consume > [more than] 75% of fluids provided at meals." *Interventions included: -"Encourage to eat 50 percent or more of meals." -"Meal Monitor. If intake 50 percent or less, offer substitute or supplement." -"Offer liquids (including thick liquids) between meals" *The care plan had not included the supplements he was to have received since the 2/20/23 nutrition/hydration committee recommendations. *No list of what his food likes and dislikes were. 2. Review of resident 32's medical record revealed he: *Had started to receive hospice services on 11/12/22. *Had a terminal diagnosis of abdominal cancer. *Had 11/28/22 and 2/13/23 care conferences. -The only notation for hospice was under additional comments and stated that he was being followed by hospice. No members of his hospice care team had been documented that they had been present at those meetings. Review of resident 32's 11/12/22 care plan for hospice services revealed:	F 657		

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F 657	Continued From page 3 *Problem: "I have a terminal prognosis r/t [related to] abdominal malignancy and currently have services with [name of provider] Hospice." *Goals included: "-Comfort will be maintained." -"Dignity and autonomy will be maintained at highest level." -"The resident will be free of depression and anxiety." *Interventions included: -"Consult with physician and Social Services to have Hospice care for resident in the facility." -"Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met." *There were no interventions to describe what extra services hospice would provide. A copy of the hospice care plan for resident 32 was requested from director of nursing (DON) B and the following was provided: *A 11/12/22 home visit schedule revealed a registered nurse would make two visits a week and as needed, the social worker would make two visits a month and as needed, a nurse aide would visit four times a week (Monday through Friday), and chaplain services would make two visits a month and as needed. *Review of the hospice care plan summary for the plan period 11/12/22-2/9/23 revealed no documentation of his long-term care living status or what his needs might have been. Interview on 3/8/23 at 10:00 a.m. with administrator A, DON B, and regional nurse consultant C revealed: *The care plans for the residents had not accurately reflected their current status.	F 657		

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F 657	Continued From page 4 *Agreed the care plans needed to have been more resident-centered. *Care plans were not consistently updated when a resident's care needs changed. *Agreed resident 32's care plan had not documented what services hospice had provided to the resident. Review of the provider's September 2017 Hospice - Provision of Care by Outside Providers revealed: *The hospice agency and care center would communicate, establish, and agree upon a coordinated plan of care to reflect the individual needs of the resident. *The plan of care would have included the following: pain management, care and services the care center and hospice agency provided in order to have been more responsive to the unique needs of the resident. 3. Observation on 3/6/23 at 8:26 a.m. of resident 9 in his room revealed that he had a pressure-relieving boot on his left foot. Interview on 3/6/23 at 9:17 a.m. and again at 1:52 p.m. with resident 9 revealed: *He confirmed he had a pressure injury on his left heel about the size of a 50-cent coin. *His doctor had said it could have developed from laying on his back for an extended period of time. *Staff were cleaning the wound and changed the bandages on a regular basis. *He thought it was getting better. *He was receiving a nutritional supplement. Review of resident 9's care plan revealed: *There were two problem areas relating to	F 657		

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F 657	Continued From page 5	F 657		

pressure injuries.
-"I currently have a pressure injury to my right heel and I also have a history of heel ulcers, and pressure ulcers to the ear."
--"Date Initiated: 06/07/2020"
--"Revision on: 11/30/2022"
--There was an intervention of "Keep shoe off of right heel," which was initiated on 8/30/22.
-"I have a pressure injury to my left heel r/t [related to] NEUROLEPTIC INDUCED PARKINSONISM, DM2 [type 2 diabetes], COPD [chronic obstructive pulmonary disease], and tight shoes ...I have a new area to the left heel."
--"Date Initiated: 01/11/2023"
--"Revision on: 01/20/2023"
--There was an intervention documented of "Keep shoe off of left heel. Wear heel boot to left heel at all times."

Interview on 3/8/23 at 10:54 a.m. with administrator A and DON B about resident 9's care plan revealed:
*Care planning was a team effort.
*They confirmed resident 9 had a pressure injury on his left heel only.
*Administrator A indicated that the pressure injury on his right heel was added to the care plan in 2020 and had not been removed from the care plan when the pressure injury had resolved.
*DON B confirmed that his care plan reflected a pressure injury to his right heel.
-Neither of them were aware of this documentation on the care plan.

4. Review of residents 9, 10, 19, and 21's care plans revealed there were no descriptions of their current code statuses.

5. Review of resident 14, 16, and 28's care plans

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F 657	Continued From page 6 revealed a statement of "See Advance Directive binder located at the nurse station," with no other description of their code statuses. On 3/8/23 at 8:10 a.m. a care plan policy was requested. Administrator A confirmed they had no care plan policy.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure two of two nurses (F and G) administered eye drops according to the provider's policy for two of two residents (12 and 45). Finding include: 1. Observation on 3/7/23 at 9:39 a.m. of licensed practical nurse (LPN) G administering eye drops revealed she: *Did not perform hand hygiene or wear gloves prior to preparing eye drop medications (Brimoindine 0.15% and Dorzolamide 2.23%) for resident 45. *Placed the drops from approximately two inches above the resident head directly into both eyes without making a "pouch" with the lower eyelid. *Did not perform hand hygiene after picking up the tissues and wiping the resident's face and shirt after administering eye drops. 2. Observation on 3/7/23 at 4:36 p.m. of LPN F	F 658	1. Unable to correct deficient practice noted during survey. All residents have the potential to be affected. 2. The ED, DNS and clinical management team have reviewed the policy on eye drop administration. The DNS or designee will educate all licensed staff that administer eye drops on proper administration per policy by 3/30/23. All staff that have not received education by 3/30/23 will be educated prior to their next working shift. 3. The DNS or designee will audit a randdom sample of 4 residents weekly times four weeks and monthly times two months to ensure eye drops are administered per policy. LPN F and G to be included in the audits. The DNS or designee will bring the results of the audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	4/14/2023

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F 658	Continued From page 7 administering eye drops to resident 12 revealed had not: *Performed hand hygiene prior to administering the eye drops. *Worn gloves while administering the eye drops nor did she perform hand hygiene. Interview on 3/7/23 at 4:30 p.m. with LPN F revealed she was unsure if the provider's policy indicated to wear gloves or not while administering resident eye drops. Interview on 3/8/23 at 9:09 a.m. with DON B revealed she was unsure of the correct procedure for administering resident eye drops without looking up the policy. Review of the provider's May 2016 "7.11 Eye Drop" policy revealed: *"3. Perform hand hygiene." *"8. With a gloved finger, gently pull down lower eyelid to form "pouch," while instructing resident to look up. Place other hand against resident's forehead to steady. Hold inverted medication bottle between the thumb and index finger, and press gently to instill prescribed number of drops into "pouch" near outer corner of eye. Do NOT let tip of dropper touch the eye or any other surface. If resident blinks or drop lands on cheek, repeat administration. "	F 658		
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's	F 678	See next page	

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F 678	Continued From page 8 advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to involve resident physicians in the advanced directive process and obtain physician orders for seven of sixteen sampled residents (9, 10, 14, 16, 19, 21, and 28) who had a signed do not resuscitate (DNR) form. Findings include: 1. Review of the provider's code status binder for the 100 and 200 hallways revealed the following residents had a signed DNR form on file: *Residents 9, 10, 14, and 21 had marked "No CPR [cardiopulmonary resuscitation]" on the "CPR/DNR Directive" form and had signed the form themselves. *The "CPR/DNR Directive" forms for residents 16, 19, and 28 were marked "No CPR" and signed by their family members. *There was no documentation that any of the residents physicians had reviewed or signed the forms. Interview on 3/7/23 at 4:15 p.m. with social services designee D about advanced directives revealed: *When residents were admitted the nurse manager educated residents and their families about the provider's "CPR/DNR Directive" form. *She was not aware if the form was sent to the resident's physician to review and sign as an order. *It was not the facility's practice to include code status in the resident's electronic medical record as a physician's order. *The "CPR/DNR Directive" forms were kept in the code status binder.	F 678	1. The physician has reviewed the code status for residents 9,10,14,16,19,21, and 28. The physicians have reviewed the code status for all other residents. All residents have the potential to be affected. 2. The DNS or designee will educate all staff assisting with code status that the physician must review and sign off on the code status by 3/30/23. All staff not in attendance will be educated prior to their next working shift. 3. The DNS or designee will audit all new admissions and residents with a code status change weekly times four weeks and monthly times two months to ensure a physician has reviewed the code status. The DNS or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	4/14/2023

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F 678	Continued From page 9 Interview on 3/7/23 at 4:32 p.m. with resident care manager E about the residents advanced directives revealed: *During the admission process she educated residents and their family members about the advanced directives, MOST (medical orders for scope of treatment) or POLST (physician's orders for life-sustaining treatment) forms, and the "CPR/DNR Directive" form. *She confirmed that the "CPR/DNR Directive" form was not communicated with the resident's physician. *If a resident decided to change their code status on the "CPR/DNR Directive" form it was not communicated to their physician. *If a resident had a DNR code status it was not included as a physician's order in the residents electronic medical record. -She confirmed that when a resident's physician reviewed their current medications and orders as scheduled, the resident's code status was not included in that review. -It was the provider's policy to have the residents code status in the code status binder, but not in the resident's electronic medical record as a physician's order. *They review the residents code status at quarterly care conferences. *If a resident had to be transferred out on an emergency basis, a copy of the resident's "CPR/DNR Directive" form was sent with them. Interview on 3/8/23 at 11:02 a.m. with administrator A, director of nursing services B, and regional nurse consultant C about the advanced directives revealed: *Residents and their families were educated on advanced directives and code status upon	F 678		

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F 678	Continued From page 10 admission, reviewed quarterly, and signed/updated annually. *It was the provider's policy to not include a resident's code status in the physician's orders. *Regional nurse consultant C confirmed they did not have the resident's physician involved in reviewing the "CPR/DNR Directive" form. 2. Review of resident 9's "CPR/DNR Directive" form revealed: *He filled out and signed the form on 3/8/22. *There was an "X" marked next to the option "NO CPR/NO RESUSCITATIVE MEASURES." *The resident's physician had not signed the form. 3. Review of resident 10's "CPR/DNR Directive" form revealed: *She filled out and signed the form on 1/4/22. *There was an "X" marked next to each of the following options: -"NO CPR/NO RESUSCITATIVE MEASURES" -"LIMITED TREATMENT" --"Other/Comments" ---A handwritten comment of "no blood" was added. *The resident's physician had not signed the form. 4. Review of resident 14's "CPR/DNR Directive" form revealed: *He signed the form on 9/30/22. *There was an "X" marked next to the option "NO CPR/NO RESUSCITATIVE MEASURES." *The resident's physician had not signed the form. 5. Review of resident 16's "CPR/DNR Directive" form revealed:	F 678		

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F 678	Continued From page 11 *Her son had filled out and signed the form on 2/17/23. *There were an "X" marked next to the following options: -"LIMITED TREATMENT" --"No CPR" --"DNI - Do Not Intubate" --"No Tube Feedings" --"No Intravenous Fluids" --"Do Not Hospitalize" --"No Antibiotics" --"Other Comments" ---A handwritten comment of "Comfort Care Only" was added. *The resident's physician had not signed the form. 6. Review of resident 19's "CPR/DNR Directive" form revealed: *Her husband had filled out and signed the form on 11/16/21. *There was an "X" marked next to the option "NO CPR/NO RESUSCITATIVE MEASURES." *The resident's physician had not signed the form. 7. Review of resident 21's "CPR/DNR Directive" form revealed: *He had filled out and signed the form on 9/6/22. *There were checkmarks next to the following options: -"LIMITED TREATMENT" --"No CPR" --"DNI - Do Not Intubate" --"No Tube Feedings" *The resident's physician had not signed the form. 8. Review of resident 28's "CPR/DNR Directive"	F 678		

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form revealed:
*Her son had filled out and signed the form on 7/11/22.
*There was a checkmark next to the option "NO CPR/NO RESUSCITATIVE MEASURES."
*The resident's physician had not signed the form.

Review of the provider's "CPR/DNR Directive" form revealed:
*At the top of the form, there was space to write the resident's name, their medical record number, their physician's name, and the date.
*There were three options for code status:
-"CPR/FULL RESUSCITATIVE MEASURES: Emergency measures will be taken to sustain and prolong life. Such measures may include cardiopulmonary resuscitation in the event of a cardiac arrest. Hospital admissions may also be necessary."
-"NO CPR/NO RESUSCITATIVE MEASURES: In the event of a cardiopulmonary arrest, there would be no resuscitation efforts. Therapeutic care will be provided for any other medical conditions."
-"LIMITED TREATMENT: Medical and nursing care ordered by the physician which contributes to the Resident's comfort, hygiene, and dignity will be delivered. Specific orders include, but are not limited to the following:"
--"No CPR"
--"DNI - Do Not Intubate"
--"No Tube Feedings"
--"No Intravenous Fluids"
--"Do Not Hospitalize"
--"No Antibiotics"
--"Other Comments:___"
--"***See Resident's medical record for documentation and other orders."

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 _____	C 03/08/2023

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 678	Continued From page 13 *There was a statement below the options that read: "THESE DIRECTIVES ARE THE EXPRESSED WISHES OF THE RESIDENT AND/OR THE RESIDENT'S RESPONSIBLE PARTY/PROXY, ARE MEDICALLY APPROPRIATE AND ARE DOCUMENTED IN THE RESIDENT'S MEDICAL RECORD." *The form had not included a section for the physician to review and sign as an order. Review of the provider's August 2010 "Advanced Directive" policy revealed: *"1. Upon admission, the Admissions Director or designee:" -"a. Asks each resident, or the resident's responsible party, if an advanced directive has been prepared." --"Each resident who has prepared an advance directive is asked to provide a copy of the document for placement in the resident's medical record." --"Each resident is asked to indicate in the 'Admission Agreement' whether an advance directive was provided to the Center." -"b. Informs each resident in writing of his or her right to make his or her own healthcare decisions including the right to accept or refuse medical treatments, to prepare an advance directive, and to complain about the Center's advance directive policy to the state survey agency." -"c. Gives each resident or the resident's responsible part a 'Resident Handbook' containing the 'Advance Directive Notice' and information on advance directive resources, and obtains written acknowledgement of the receipt of such information in the 'Admission Agreement.'" *"2. For each resident who does not have an advance directive and wishes to prepare one, the Admissions Director or designee may explain in	F 678		

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F 678	Continued From page 14 general terms the purpose of an advance directive." *"3. Under no circumstances may the Center's employees assist a resident in preparing an advance directive. Likewise, the Center's employees may not serve as a healthcare decision maker for any resident (unless the resident is a family member) nor may any of the Center's employees witness the signing of a resident's advance directive." *There was no documentation in the policy that a physician's order was to have been obtained for a DNR status.	F 678		

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

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	435115	A. BUILDING _____ B. WING _____	03/08/2023

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

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 3/5/23 through 3/8/23. Palisade Healthcare Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lourdes Parker
TITLE: Executive Director
(X6) DATE: 3/27/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2023**

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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/6/23. Palisade Healthcare Center was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K324 and K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through	K 324	1. Electrical work scheduled. All residents have the potential to be affected. 2. Midwest alarm system will electrically connect the fan by 4/14/2023. Maintenance will be educated by ED prior to 3/30/23 on reviewing reports and addressing noted issues. 3. The maintenance director will bring all inspection reports to the ED for further review and recommendations to correct noted issues ongoing as inspections occur.	4/14/2023

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

Lourdes Parker | *Executive Director* | *3/27/2023*

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2023**

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K 324	Continued From page 1 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the provider failed to follow through regarding inspection documentation from the kitchen hood semi-annual inspection. Findings include: 1. Document review on 3/6/23 at 2:00 p.m. of the kitchen hood fire suppression system records indicated the inspections had been performed on 10/24/22. The documentation of the inspection included a comment saying the fan needed to have been electrically connected in order to comply with code. The connection had not been scheduled. Interview with the maintenance director and the administrator on 3/6/23 at 3:15 p.m. confirmed the finding, and that the repair had not been scheduled. This deficiency affected one of numerous kitchen hood fire suppression system requirements.	K 324		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are	K 353	See next page	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 2 maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition at the facility (out-of-date sprinklers and overdue internal pipe inspection). Findings include: 1. Record review on 3/6/23 at 2:15 p.m. revealed the annual fire sprinkler inspection report dated 8/25/22 stated the quick response sprinklers in the facility were dated 2002. Quick response sprinklers must be tested and approved for use or replaced every twenty years. 2. Record review on 3/6/23 at 2:20 p.m. revealed the annual fire sprinkler inspection report dated 8/25/22 stated an internal pipe inspection was past due. 3. Interview with maintenance director on 3/6/23 at 3:00 p.m. confirmed those conditions. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire.	K 353	1. Sprinkler system work scheduled. All residents have the potential to be affected. 2. Building Sprinkler Systems will inspect the sprinklers by 3/28/2023. Maintenance will be educated by ED prior to 3/30/23 on reviewing reports and addressing noted issues. 3. The maintenance director will bring all inspection reports to the ED for further review and recommendations to correct noted issues ongoing as inspections occur.	4/14/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2023**

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K 353	Continued From page 3 The deficiency affected two of numerous requirements for the automatic sprinkler system.	K 353		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10623	A. BUILDING: _____ B. WING _____	03/08/2023

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

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/5/23 through 3/8/23. Palisade Healthcare Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/5/23 through 3/8/23. Palisade Healthcare Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lourdes Parker

TITLE: Executive Director

(X6) DATE: 3/27/2023

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