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 _____	08/25/2021

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: 26632 An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 8/17/21 through 8/19/21 and 8/23/21 through 8/25/21. Palisade Healthcare Center was found not in compliance with the following requirements: F550, F576, F582, F584, F600, F658, F678, F689, F729, F755, F835, F837, F865, F880, and F886.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550	1. All residents have the potential to be affected. Unable to correct deficient practice identified during survey for residents 20, 24 and 31. 2. Executive Director or designee will educate all staff on ensuring dignity is maintained for all residents. Education will be provided by 9/23/2021. All staff not in attendance will be educated prior to their next working shift. 3. Audits on ensuring dignity is maintained will be conducted weekly times four and monthly times two months by ED or designee. The ED or designee results of these audits will be taken to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	9/23/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lourdes Parker
TITLE: Executive Director
(X6) DATE: 9/20/21

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 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation and interview, the provider failed to ensure dignity was maintained for: *One of one randomly observed resident (24) with minimal clothing on due to the elevated room temperature. *One of one randomly observed resident (20) who was transported unclothed in a bathing chair by one of one certified nursing assistant/certified medication aide (CNA/CMA) (G) had been fully covered. *One of one randomly observed resident (31) who received personal care by two of two CNAs (J and K) with the residents door open. Findings include: 1. Observation on 8/17/21 at 3:12 p.m. of resident 24 revealed: *She was laying on her bed. *Her bed was positioned on the side of the room by the door. *She had an adult brief and top on. The top was	F 550		

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F 550	Continued From page 2 pulled up and exposed her stomach. *Her bed was positioned on the side of the room near the door. -The privacy curtain was pulled around the bottom of the bed. *When the door of the room was open she was able to be seen through a gap in the curtain and the door frame. *If a visitor entered the room to visit her or her roommate she would have been in this exposed condition. *She was observed like this during the survey on 8/18/21, 8/19/21, 8/23/21, and 8/24/21. Those observations were in the afternoon after lunch. Interview on 8/24/21 at 2:20 p.m. with resident 24 she stated she sleeps in a brief with her shirt pulled up and a fan on her. She stated the reason she sleeps this way is "It's just too damn hot." Interview on 8/25/21 at 1:00 p.m. with administrator A and interim director of nursing/divisional director of clinical operations B revealed: *They were not aware the curtain had not provided resident 24 privacy. *They were not aware resident 24 laid in bed with minimal clothing on. *They did not have a policy of how to maintain a residents dignity. Surveyor: 42477 2. Observation on 8/19/21 at 8:05 a.m. on the facility's 100 hallway revealed. *CNA/CMA G was transporting resident 20 out of the shower room and down the hallway. *Resident 20's unclothed backside was exposed as she was transported down the hallway. *There had been multiple staff members in the hallway as well as other residents.	F 550		

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F 550	Continued From page 3	F 550		

Interview on 8/19/21 at 8:45 a.m. with CNA/CMA G revealed:
*She had not noticed that resident 20's unclothed backside had been exposed.
*She usually tried to check to make sure that everything is covered before to bringing them out of the bathroom.
*She had not checked resident 20 to ensure she was covered.
Surveyor: 41088
3. Observation on 8/19/21 at 3:27 p.m. of CNA J and CNA K providing personal care for resident 31 revealed:
*CNA J exited her room with a mechanical lift.
*She had not closed the door behind her.
*Resident 31 had been seated in her wheelchair in full view from the hallway.
*She had been wearing a blouse and only an adult brief.
*CNA K had been standing beside her assisting her to straighten her blouse.
*The door remained open until CNA K noticed this surveyor walk by and then closed the door to the room.
*Other residents and staff had been in the hallway.
*Her room had been located near the nurse station.

Interview on 8/19/21 at 3:45 p.m. with CNA K revealed she:
*Normally had been more careful to ensure resident privacy.
*Agreed that the resident was exposed and she should have ensured resident 31 had been covered before the door was opened.
*Stated the door should have been closed.
*Agreed she should have closed the door to the

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F 550	Continued From page 4 room as soon as she noticed it had been left open.	F 550		
F 576 SS=F	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility	F 576	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey for residents 8, 11, 12, 15, 25, 35 and 36. 2. There is currently no hold time on mail delivery. The ED or designee will educate all staff that deliver mail on providing access to mail when it arrives at the facility by 9/23/2021. All staff not in attendance will be educated prior to their next working shift. 3. Audits ensuring proper mail delivery within 24 hours of delivery will be conducted weekly times four weeks and monthly times 2 months by ED or designee. The results of these audits will be taken to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	9/23/21

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F 576	Continued From page 5 (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, policy review, and Centers for Disease Control and Prevention (CDC) guidelines, the provider failed to ensure all residents received their mail with twenty-fours after it was delivered from the postal service. Findings include: 1. Observation on 8/17/21 at 2:00 p.m. in the front lounge revealed: *An open box that contained mail for the residents. *A sign by the box read "Mail must sit for 24 hours. Do not hand out mail until after the following date." *There was no date as to when the mail could have been delivered. *There was a newspaper in the box of mail with the date of 8/14/21. Interview on 08/18/21 at 10:12 a.m. with resident 12 revealed they are holding his mail for over twenty four hours. He does not always receive the mail within twenty-four hours. Mail is rarely delivered on Saturdays. The mail from Fridays and Saturdays is usually delivered on Mondays. Interview on 8/18/21 at 11:00 a.m. during the resident group meeting revealed seven of the ten residents present (8, 11, 12, 15, 25, 35, and 36) confirmed they did not get their mail within twenty-four hours. Sometimes the mail was only	F 576		

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F 576	Continued From page 6	F 576		

delivered a few days a week. They had been told the mail had to sit for twenty-four hours after it was delivered due to COVID-19.

Interview on 8/25/21 at 11:30 a.m. with activities coordinator M revealed:
*She was the person who always delivered the mail.
*Mail from the previous day would be delivered after it had sat for at least twenty-four hours due the COVID-19 pandemic.
*The mail delivered on Saturdays would be delivered by the nursing staff on Sundays.
*She was not aware residents had not received their mail within twenty-four hours.

Review of the provider's 5/18/20 COVID-19 Mail and Package Handling During the Pandemic revealed:
*"There is a very low risk of contracting COVID-19 from mail or cardboard packaging. Flower delivery carries a similar risk as other package deliveries; however, it is recommended that the following precautions are followed:"
Those recommendations included:
*"Set aside packages for 24 hours. Designate a corner or room for new packages and leave them isolated for at least 24 hours."
*"Wipe down packages and/or flower vases with disinfectant prior to delivery to residents."
*There was no direction for non-packaged mail.

Review of the CDC website revealed no guidance after 7/14/21 on the handling of mail or packages. https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html. The guidance included:
*"COVID-19 spreads when an infected person breathes out droplets and very small particles that

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F 576	Continued From page 7 contain the virus. These droplets and particles can be breathed in by other people or land on their eyes, noses, or mouth. In some circumstances, they may contaminate surfaces they touch. People who are closer than 6 feet from the infected person are most likely to get infected *"COVID-19 is spread in three main ways: -Breathing in air when close to an infected person who is exhaling small droplets and particles that contain the virus. -Having these small droplets and particles that contain virus land on the eyes, nose, or mouth, especially through splashes and sprays like a cough or sneeze. -Touching eyes, nose, or mouth with hands that have the virus on them."	F 576		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each	F 582	1. All residents have the potential to be affected. Unable to correct the deficient practice noted during survey for residents 1, 8, 15, 35 and 36. 2. Senior Dent contract has been cancelled as of 9/16/21 so there will be no further charges to the residents. All residents utilizing Senior Dent were informed of the contract cancellation. Residents utilizing Senior Dent will be offered dental services from a different provider. 3. ED or designee will audit a random sample of all residents to ensure they are satisfied with their dental services bi-weekly times four and monthly times 2 months. The ED or designee will take the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	9/23/21

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F 582	Continued From page 8 resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Surveyor: 42477 Based on interview and record review, the provider failed to ensure six of twenty-two	F 582		

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F 582	Continued From page 9 residents (1, 8, 15, 35, 36, and 37) were aware of charges for the dental plan. Findings include: 1. Interview on 8/17/21 at 2:27 p.m. with resident 37 revealed he: *Stated he was very upset. *Stated his account had been overdrawn $440. *Stated a sales representative from a dental company came in June and talked with the residents. *Had been asked if he wanted to partake in this dental coverage. *Had initially said yes. *Later found out they charge $175 per month to see a dentist in the facility. *Had refused his first visit due to the cost. *Had instructed social service designee H to have him taken out of the program at that time. *Stated since June he is still being charged $175 per month for a service he has not received. *Realized they had taken out two payments of $175 this month which resulted in his account being overdrawn. Interview on 8/18/21 at 8:34 a.m. with social service designee (SSD) H regarding the dental program revealed: *Residents were charged $175 per month for dental services. *The dental services were provided by a company that came into the facility. *The residents were to have been reimbursed by the state for $175. *She had been aware residents were confused and not happy about this. *She stated it takes some time for the reimbursement to come in from the state. Surveyor: 26632	F 582		

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F 582	Continued From page 10 The resident group interview on 8/18/21 at 10:30 a.m. revealed five of five resident's (1, 8, 15, 35, and 36) that attended the interview, stated they did not understand the dental program. They voiced concerns about the amount of money taken out of their accounts and how the reimbursement was handled. Review of resident 36's account revealed: *Her account had been overdrawn over $700. *She had not signed authorization for the $175 to be automatically withdrawn from her account. Surveyor: 42477 Phone interview on 8/18/21 at 1:42 p.m. with [dental company name] regarding the program revealed: *They provided dental services to residents residing in long-term care facilities. *They charged $175 for monthly service. *The provider was supposed to provide a deduction of "rent" for the amount of $175 per month. *This deduction would be completed by the facility. Review of resident 37's application for Individual Limited Benefit Dental Insurance revealed: *The monthly premium was listed as $129 per month. *The bill was to be sent to resident 37. *Resident 37 did not sign to authorize auto payments. *The application had not mentioned an amount of $175. Surveyor 42477 Further interview on 8/24/21 at 4:01 p.m. with SSD H revealed:	F 582		

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F 582	Continued From page 11 *Surveyors stated that we had been unable to see where all residents were being reimbursed for the $175 per month. -She had been unable to show the surveyors how the residents were reimbursed. *She agreed that had been confusing. *She had not been sure how the program exactly worked.	F 582	1. A statement: All residents have the potential to be affected. Residents 1, 10, 11, 12, 13, 15,17, 21, 24, 25, 35, 36 and 37 were offered window air and residents 1, 10, 11, 15, 17, 24, and 36 accepted a window unit and residents12, 13, 21, 25, 35, 7 and 37 refused. Resident 8 has discharged. All residents were offered a window unit. All new admissions will be asked about window AC. All residents will be asked yearly about window AC consent/decline. B statement: All unclean areas in the center were corrected with the exception of the nightstands which have an expected delivery date of 11/25/21 and the flooring that will be replaced in the 300 shower room prior to 12/ 31/21 by Carpet One.	9/23/21
F 584 SS=H	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each	F 584		

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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 584	Continued From page 12 resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 A. Based on observation, interview, record review, testing, resident group meeting interview, and policy review, the provider failed to maintain a comfortable room temperature for fifteen random residents (1, 7, 8, 10, 11, 12, 13, 15, 17, 21, 24, 25, 35, 36, and 37) Findings include: Surveyor: 26632 1. Review of the resident council minutes on: *4/5/21 documentation for maintenance/housekeeping/laundry department "A/C's [air conditioners] in rooms." *5/10/21 documentation for maintenance/housekeeping/laundry department "No window AC's." *6/25/21 documentation for other "No air conditioning - explained doors open, air comes thru [through] halls - if windows open, then doors need to be shut. *7/12/21 documentation for maintenance "Discussed air conditioning protocol thru out [throughout] the building. *There had been no further documentation of how this concern would have been investigated.	F 584	2. A base statement: The ED or designee educated all staff including contracted staff on maintaining a safe clean homelike environment and expectations of a clean environment and maintaining comfortable temperature for the residents whereas if the resident complains about temperature ED or maintenance will be notified by 9/23/21. B base statement: Contracted staff were educated on their cleaning policy through Learn Upon for the 5 and 7 step cleaning by 9/23/21. Contracted staff also attended the all staff by 9/23/21. All staff not in attendance will be educated prior to their next working shift. Work routines will be signed off by District manager for housekeeping supervisor by 9/23/21 or during next working shift. At present contracted company is providing supplemental coverage from other centers, district manager and director of operations until additional housekeeper can be hired. 3. The ED or designee will audit a random sample of 8 resident rooms/care areas for cleanliness, medication and treatment carts are clean, heat register in good repair, hand rails are in good repair and function, upholstered furniture is clean, fans/vents clear of dust and room temperature per resident, preference weekly times eight weeks and monthly times two months. The results of these audits will be taken to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	

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Surveyor:42477
Observation on 8/17/21 at 2:45 p.m. of the facility's 200 hallway revealed:
*The hallway had felt very warm.
*Thermostat on the wall stated the temperature was 77 degrees.

Observation and interview on 8/17/21 at 3:45 p.m. with resident 37 revealed:
*He had resided in the facility for the last couple of years.
*His room was even warmer than the hallway.
*They used to have air conditioner units in the windows of the residents rooms.
-He stated they took those out and sold them.
*They had put in rooftop air conditioning units, but none of the resident rooms had vents.
*He stated he cannot close his door because otherwise he will not receive any air.
*He was unable to close his door for privacy due to the temperature.
*Choose to wear a hospital gown due to the temperature inside of his room.

Observation and Interview on 8/18/21 at 11:38 a.m. with resident 36 revealed:
*Her room had been very warm.
*She stated she was unable to sleep last night because she was so hot.

Surveyor: 26632
Interview on 8/18/21 at 11:47 a.m. with resident 36 stated:
*They are not allowed to have a window A/C due to the hallway A/C.
*It is miserable when the temperature outside is high.
*I cannot rest properly and generally feel sick due

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F 584	Continued From page 14 to the heat. *The fans do nothing to bring cooler air in from the hallway. Interview on 8/17/21 at 4:15 p.m. and 8/24/21 at 2:15 p.m. with resident 17 revealed: *She does not like to come out of her room. *She ate all of her meals and did activities in her room. *The window air conditioning units had been removed last fall. *They had been told those air conditioning units had been sold when they fixed the air conditioning units on the roof. *The cool air never comes into the room. *Dreaded when the outside temperature went up. It just made her sick feeling and worn out. Surveyor: 26632 Interview on 8/18/21 at 11:00 a.m. during the resident group meeting revealed the ten residents present (1, 7, 8, 11, 12, 13, 15, 25, 35, and 36) stated the air conditioning had been brought up many times. They had been told they could not have window air conditioners as it would make the roof air conditioners not work correctly. They stated it was very uncomfortable in their rooms when it got really warm outside. Surveyor: 41088 Observation and interview on 8/24/21 at 9:51 a.m. with resident 21 regarding his room temperature revealed he: *Had quarantined in his room after his admission per facility policy. *Stated his room had no air conditioning. *Stated his room had been hot at times and he had developed a heat rash due to the excess temperature.	F 584		

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*His physician had prescribed a cream for his heat rash.
*Had voiced his concerns to staff and family members.
*Had been provided a fan after his family requested one to help keep the room temperature more comfortable.
*Thought his room had continued to be too warm at times.

Surveyor: 26632
Interview on 8/24/21 at 2:20 p.m. with resident 24 she stated she sleeps in an adult brief with her shirt pulled up and a fan on her. She stated the reason she sleeps this way is "It's just too damn hot."

Interview on 8/25/21 at 11:00 a.m. with licensed practical nurse (LPN)/staff development coordinator C revealed:
*The residents frequently complained about the heat in their rooms.
*If a resident is quarantined or on isolation the room door is closed.
*The room becomes very warm and uncomfortable for the resident, even with using a fan.
*She had been told the air conditioning units had been sold.

Interview on 8/25/21 at 1:30 p.m. with administrator A, interim director of nursing/divisional director of clinical operations B, and LPN/staff development coordinator C revealed they:
*Agreed the residents had asked about the window air conditioning units.
*Confirmed they had been sold when the roof air conditioning units had been repaired.

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F 584	Continued From page 16 *Were not aware some of the residents felt physically ill when it was hot in their rooms. *Agreed when a resident would be in quarantine or isolation the room would have been very warm without any air conditioning. B. Based on observation, interview, policy review, and checklist review, the provider failed to maintain a clean, homelike, and sanitary environment for all resident's who were residing in their facility. Findings include: Surveyor: 42477 1. Observation on 8/17/21 at 2:45 p.m. of the facility's 200 hallway revealed: *There was a medication cart and a treatment cart in the hallway. *The medication cart had what appeared to be crushed up pill residue spilled on the floor in front of it. *The treatment cart contained: -A nail clipper with debris inside of it. -Mustard and ketchup packets with their bleach wipes. -A lighter that was unsecured. -A plastic cup with mustard packets, batteries, paperclips, and a used nail file. *A fan in-between rooms 204 and 206 was on and contained a large amount of dust and lint particles. *A half-empty Poweraide bottle was on the handrail propped up against the wall. *The wooden handrails with metal attachment brackets were scraped and rusty, and were not a cleanable surface. Observation 8/17/21 at 2:58 p.m. of the whirlpool room on the 200 hallway revealed: *The door was unlocked.	F 584		

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F 584	Continued From page 17 *On top of a cart was a partially eaten plate of food. *Lying next to the partially eaten food was a comb with hair in it. *On the wall next to the soiled utility bin appeared to be fecal matter. Observation on 8/17/21 at 3:19 p.m. of a common area in between the 100 and 200 hallway revealed the trash was overflowing and there had been multiple pieces of trash on the floor. Observation on 8/17/21 at 3:45 p.m. of the provider's north conference/activity room revealed: *Chairs in the room contained visible stains on the cushions. *The floor was visibly dirty. *The trash had been overflowing. *That room was also used for resident activities. Observation on 8/19/21 at 2:00 p.m. of resident 2's room revealed: *Multiple large dried brown stains underneath a resident's bed. -Which appeared to be dried urine. *Many walls had areas of plaster showing. Observation on 8/19/21 at 2:05 p.m. of the soiled utility room on the facility's 200 hallway revealed: *There was a hopper, which contained a large smear of what appeared to be feces across the front of it. *Also appeared to be feces on the wall. *There were uncovered wheelchairs adjacent to the uncovered hopper. Observation on 8/19/21 at 2:10 p.m. of rooms 209 and 210 revealed:	F 584		

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F 584	Continued From page 18 *The floors in both rooms were visibly dirty. *The heat register in room 209 was partially hanging off of the wall. *Both rooms had areas where the plaster had been exposed. Review of the provider's admission packet revealed: *"Housekeeping staff endeavors to provide you with a clean environment. Everyday your room is cleaned, trash emptied, surfaces disinfected, the walls are spot cleaned, and the floors are vacuumed or mopped. We make sure your bathroom is properly cleaned and stocked with toilet paper, paper towels, and hand soap. In addition, housekeeping manages the cleanliness of common areas..." Surveyor: 26632 2. Observation on 8/17/21 at 3:00 p.m. of the 100 wing soiled utility and linen rooms revealed: *The soiled utility room had four - three drawer plastic containers stored by the sink. *The linen room had seven packages of adult incontinent briefs stored on the floor. Observation on 8/19/21 at 2:10 p.m. of the 100 wing resident rooms, hallway, soiled utility room, and linen room revealed: *Room 101: There were soiled paper towels laying by the sink. *Room 102: On the countertop by the sink there was a opened package of incontinence briefs and a sticky unknown substance. *Room 104: The bathroom fan had a large amount of dust and lint build-up. The nightstand next to the bed by the door had an uncleanable surface. The laminate top was cracked. *Room 105: Two-nightstands with uncleanable	F 584		

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F 584	Continued From page 19 surfaces. The laminate tops were cracked. *Room 107: Two-nightstands with uncleanable surfaces. The laminate tops were cracked. There was a soiled hand towel on the floor in the bathroom. The bathroom fan had a moderate build-up of dust and lint. There was an open package of incontinence briefs on the floor by the toilet. *Room 108: Two boxes of incontinence briefs on the floor by the bed closest to the door. The bathroom fan had a moderate build-up of dust and lint. *Room 112: There were opened wound care supplies on the top of the built-in dresser. Those wound care supplies included wound vac supplies. They were not in a covered container. Some of the supplies were laying directly on the counter. *Room 114: The bathroom fan had a moderate amount of dust and lint build-up. *The 100 wing handrails from room 101 to just before room 110 had the paint scraped off and was rough to the touch. This made it an uncleanable surface. *The vents in the charting alcove between the 100 and 200 hallways had a moderate build-up of lint and dust. Surveyor: 41088 3. Observation on 8/17/21 at 4:11 p.m. of 300 hallway shower room revealed: *A shower chair with hair on it. *An unlocked supply closet with: -Three rolls of used medical tape. -A roll of duct tape. -Three open bottles of body wash not labeled to a resident. -A soiled washcloth. -Two used body scrubbers. -A spray bottle of peroxide disinfectant.	F 584		

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F 584	Continued From page 20 *A locked supply cabinet contained: -An empty quat bottle with spilled contents all over the shelf. -A used roll of paper tape. *Floor with dirt particles and dark residue next to the edges of the room. *A resident identification tag under the soiled linen cart. *A room next to the shower room was used for storage and contained: -A cloth chair with stains and paper stuck to the arm. -4 cardboard boxes containing adult briefs directly on the floor. *A sink that had rust stains. -A toilet that had a dark stain throughout the bowl area. *A plastic zip-tie on the floor. -Various wheelchairs garbage receptacles and an electric wheelchair. -The floor had dust and dirt particles with a dark residue near the edges of the room. -It appeared that it had not been cleaned for some time. Observation on 8/18/21 at 9:46 a.m. of room 306 revealed: *Dark brownish spots that were on the floor beside the window and bed. *The floor appeared to not have been mopped. Observation on 8/18/21 at 1:34 p.m. of the 300 wing resident rooms revealed: *Room 301: A gouge in the corner of the wall next to the bathroom down to the drywall. *Room 302: -Overflowing garbage can. -Scraps of paper lying on the floor by the bed. -Used alcohol pad lying next to the doorway.	F 584		

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F 584	Continued From page 21 -Cracker crumbs on the floor by a chair near the door. -Dresser down to the bare wood and uncleanable. -Visible spots and lint particles on the floor. *Room 306: -Spots on the floor from the previous observation on 8/18/21 at 9:46 a.m remained unmopped. -Green plastic cap lying on the floor in the restroom. -Package of adult briefs lying directly on the floor. -Soiled shorts lying on the floor next to the bed. -Scrap of paper on the floor next to the doorway. *Room 307: -Overflowing garbage can. -Adult brief package stored directly on the floor. -Tube feeding nutrients in boxes directly on the floor. *Room 308: -A used surgical glove on the floor in the bathroom. -Worn off paint on the heating unit. -A gouge on the wall behind the recliner down to the drywall. Observation on 8/19/21 at 2:40 p.m. of shower room in 300 hallway revealed: *The zip-tie on the floor had not been moved from the previous observation on 8/17/21 at 4:11 p.m. *Toilet paper on the floor under the heating unit in the room used for equipment storage. *Two cardboard boxes of adult briefs directly on the floor of the storage room. *Cloth-covered chair in the same condition as the observation on 8/17/21 at 4:11 p.m. Observation on 8/19/21 at 3:23 p.m. of room 313 revealed: *Paint scraped off of the heating unit.	F 584		

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*A dresser by the doorway was worn down to bare wood and an uncleanable surface.
*An overflowing garbage can.
*Toilet paper on the bathroom floor.
*A C-PAP hose and mouthpiece hung over the top of the towel rack without a barrier.
*Crumpled paper on the floor next to her electric scooter.
*An open package of bladder control pads on the floor.

4. Observation and interview on 8/19/21 at 9:13 a.m. with district manager T for the contracted facility cleaning company revealed:
*She had previously been contracted to work for the facility for three years before moving to another district.
*She had filled in for the designated district manager and other cleaning staff at the facility when needed.
*She had been familiar with the facility and had last worked there in January 2021.
*She was now district manager over another group of contracted facilities.
*The district manager for this facility came on a weekly basis but had been out that day working at another location.
*She stated the facility had not been as clean as it used to when she was the district manager.
*She thought things had gotten worse with the current administration.
*Laundry/housekeeping manager R had been responsible for the daily cleaning operations of the facility.
-She had not been reliable about coming in to work as scheduled.
-She had currently been the only housekeeper on staff.
*A part-time housekeeper had just left their

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employment to return to school the week prior.
*Laundry/Housekeeping manager R filled in for laundry on her off days.
*Checklists were used to keep track of cleaning duties.
*Laundry/housekeeping manager R had been responsible for making sure the checklists had been completed.
*Administrator A completed monthly reports of the condition of the facility that she sent to their company.

Observation and interview on 8/19/21 at 10:52 a.m. with laundry/housekeeping manager R cleaning resident room 101 revealed she:
*Had not used the agency cleaning checklists to keep track of what she had completed.
*Stated she had been responsible for training the laundry and housekeeping staff and would expect them to use the cleaning checklists.
*Had not been tracking the checklists as she had been the only housekeeper on staff at that time.
*While cleaning room 101 she:
-Had sprayed the peroxide disinfectant cleaner on the toilet.
-Stated it had a three-minute wait time.
-Cleaned other areas of the restroom and then continued wiping down the toilet.
-Had not waited three minutes before wiping down the surface of the toilet.
-Had not made it a practice to use a timer and had just estimated the time.
-Used the same gloved hands she grabbed the mop and placed and clean mop head on it.
-Had not dust-mopped the floor before wet-mopping because she found it had been easier for her to gather the dirt as she wet-mopped.
-Wet-mopped the floor area and collected dirt on

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F 584	Continued From page 24 a pile in the center of the resident room. -Gathered the dirt on the pile using the wet mop-head she had removed. -Discarded the dirt into the garbage on her cart, then placed the mop-head into a plastic bag. *Agreed that her gloves should have been changed prior to using the mop. *Agreed that she should use a timer for the three-minute wait time. *Agreed she should have changed her gloves prior to touching the mop. *Agreed she had not followed the company policy or the room cleaning checklist. *Stated she had been "slacking" lately and had not cleaned the facility as well as it should have been. Further interview on 8/19/21 at 2:04 p.m. with laundry/housekeeping manager R revealed: *Her workdays had been long. *Her priority was to make sure the resident rooms were cleaned. *She was usually able to get all of the resident rooms cleaned each day. *If she had not completed all of the resident rooms she would start on those the next day. *She had not always had time to complete all tasks such as cleaning the shower/tub rooms or utility rooms. *Confirmation she had not used the cleaning checklists as was the policy of her agency. *She agreed she had not been able to keep up with all of her duties. *She was the only person doing housekeeping at that time and hoped they could get someone hired soon. *It had been difficult to find workers. Further interview on 8/24/21 at 8:56 a.m. with	F 584		

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F 584	Continued From page 25 district manager T revealed: *She had been filling in until another housekeeper could be hired to replace the part-time worker that went back to school. *She stated the laundry/housekeeping manager R had been scheduled to work at 7:00 a.m. that day but had not come in yet. *She stated this had been typical for her to come in late. *She thought laundry/housekeeper R had not understood the importance of her job. *They used their own policies and not the facilities for cleaning the building. *A copy of those policies had been requested but had not been received. Review of the 9/5/2017 contracted company's daily patient room cleaning checklist revealed: *A. Announce yourself at the door. *B. Do quick straighten up. *C. Follow 5-step room cleaning method: -1. Empty trash. -2. Horizontal dusting. -3. Spot clean with a cloth and disinfectant all vertical surfaces. -4. Dust mop the floor. -5. Damp-mop *When disinfecting, please be sure to use an EPA-approved solution and to allow for the recommended solution dwell time. Review of the high touch services log for August 2021 revealed: *It was to be completed three times daily, in the morning, noon and afternoons. *There had been blank entries for: -8/6/21 on the a.m. and afternoon times. -8/10/21 on the noon and afternoon times. -8/11/21 on the noon time.	F 584		

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F 584	Continued From page 26 -8/12 on the afternoon time. -8/17 all times. -8/18 all times. -8/21 all times. -8/22 all times. -8/23 afternoon time. Review of the laundry/housekeeping manager job description revealed: *Interviews, hires and orients, housekeeping, floor care, and laundry staff. *Communicates between various shifts to ensure completion of tasks. *Maintains proper staffing levels and schedules all environmental services staff. *Supervises, coordinates, and evaluates work of all environmental services employees. *Trains workers in housekeeping, floor care, and laundry methods and procedures and proper operation of equipment. *Daily inspection (quality control inspections) and follows through on all assignments, directives and projects to ensure task completion. Review of housekeeping services assessment reports submitted to the contracted cleaning company by administrator A revealed: *She had assessed housekeeping services for the following dates ranked on a scale of 1-70 points: *3/15/21 had given 58/70 points which was ranked as average to good services. *4/30/21 had given 61/70 points which was ranked as good to excellent services. *No report of May 2021. *6/29/21 had given 60/70 points which was ranked as good to excellent services. *7/29/21 had given 57/70 points which was ranked as average to good services.	F 584		

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F 584	Continued From page 27 Interview with administrator A on 8/23/19 at 5:33 p.m. revealed: *She stated she had not completed environmental audits of the building. *She expected her unit managers to do walk-throughs and to check for problems or cleanliness issues with the building or resident rooms. *All staff should be helping out to keep the areas clean and safe for residents.	F 584	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey for resident 30. Root Cause Analysis: Why: Nurse inexperienced in situation. Why: Lack of education on code status binder location and training on policy. Why: Facility did not provide training. Root Cause: Lack of training on CPR/ Code Status in new hire education and ongoing education. Had newly initiated Code drills and had not done them previously.	
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on interview, record review, policy review, job description review, the provider failed to provide necessary care and services resulting in neglect for one of one resident (30) who had needed life-saving interventions including cardiopulmonary resuscitation (CPR).	F 600	2. ED or designee will educate all licensed nursing staff on initiating CPR on a full code resident and the code blue policy and competency by 9/23/21. All licensed staff not in attendance will be educated/competencied prior to their next working shift. 3. The ED or designee will audit 4 random licensed staff to ensure they are proficient in practice regarding full code residents through scenario reinactment and procedure weekly times four weeks and monthly times two months. These audits to include nurse D, F and N. The ED or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	9/23/21

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F 600	Continued From page 28 Findings include: 1. Resident 30 had not been provided the necessary care to ensure his resuscitation choice had been followed. No nursing interventions that included: nursing assessment of abnormal vital signs, repositioning, suctioning. and oxygen administration had been provided. CPR had not been started when his respirations were absent and it was uncertain if he had a heart rate. Review of resident 30's August 2021 care plan revealed: *He had an alteration in his neurological status which was related to trauma. *Staff were to: -"If seizure activity occurs, place on side, maintain open airway. Remove obstacles to ensure safe environment." -"Monitor/document/report PRN [as needed] s/sx [signs and/or symptoms] of tremors, rigidity, dizziness, changes in level of consciousness, slurred speech." *He had a feeding tube related to swallowing difficulty from trauma, he was to not have anything by mouth. *Staff were to: -"Monitor for signs and symptoms of aspiration pneumonia such as SOB [shortness of breath], Tube dislodged, Infection at tube site, Self-extubation, Tube dysfunction or malfunction..." -"Observe for Signs or Symptoms of aspiration, respiratory infection and cardiovascular distress (paroxysmal coughing, fever over 100F[Fahrenheit] for 24 hr. [hour], chills, respiratory distress, dyspnea, wheezing, frothy non-purulent sputum."	F 600		

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F 600	Continued From page 29 2. Review of the provider's November 2016 Licensed Practical Nurse job description revealed: *"Under the direct supervision of the Director of Nursing Services, provides prescribed nursing care services to residents. Works collaboratively with members of the healthcare team. Maintains standards of professional nursing practice. Performs other duties as assigned by supervisor. Completes shift duties in an accurate and timely manner." *Essential functions included: -"Observes residents and reports adverse reactions to medication or treatment to medical personnel in charge." *Other duties included: -"Enforces Center policies and processes to promote quality of care and to assure resident safety." -"Other duties as assigned and appropriate to the position." *Knowledge, skills, and abilities included: -"Demonstrates knowledge of nursing process, particularly as it relates to geriatric residents, long-term care, and rehabilitation." 3. A neglect policy had been requested from administrator A. She stated they did not have one. Refer to F678, finding 2.	F 600		
F 658 SS=E	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.	F 658		

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F 658	Continued From page 30 This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, record review, job description review, and policy review the facility failed to ensure: *One of one sampled resident (34)'s continuous positive airway pressure (CPAP) Machine had been cleaned and accurately documented on the treatment administration record (TAR). *Two of two sampled residents (21 and 31) had dressing changes completed per physician orders. *Physician orders had been followed for one of two sampled dialysis residents (93). *Wound evaluations had been completed for one of five sampled residents (35) who had identified skin concerns. *Antibiotics had been administered per physician orders for one of one sampled residents (31) with a peripherally inserted central catheter (PICC) line. *One of three residents (26) who received nutrition and hydration via gastrostomy tube (g-tube) as ordered. Findings include: 1. Observation and Interview on 8/17/21 at 3:20 p.m. with resident 34 in her room revealed: *She had been admitted to the facility on 7/30/21 for rehabilitation services. *She had a C-PAP machine on the dresser next to her bed stating she used it at night and the staff had not cleaned the machine since she was admitted. *The C-PAP was surrounded by multiple personal items and papers on the dresser. -The mouthpiece of the C-PAP was resting on the bare top of the dresser. -There were two bottles of distilled water directly	F 658	1. All residents have the potential to be affected. Unable to correct deficient practice identified during survey for residents 34, 21, 35, 93 and 26. Residents 31 has discharged from the facility. 2. The ED or designee will educate all licensed nurses on cleaning of CPAP and documenting, dressing changes per order and documenting, completing the dialysis transfer form, weekly wound evaluations are completed and documented, administering medications and tube feedings timely per MD order by 9/23/21. All licensed staff not in attendance will be educated prior to their next working shift. 3. Audits will be conducted weekly times four and monthly times 2 on a random sample of 4 residents and 4 nurses to ensure CPAP cleaning, dressing changes, dialysis transfer forms, weekly wound evaluations, tube feeding and medications are completed timely all areas identified will be audited and documented by ED or designee. The ED or designee will bring the results of these audits to the monthly QAPI for further review and recommendation to continue or discontinue the audit.	9/23/21

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F 658	Continued From page 31 sitting on the floor next to the dresser. Observation on 8/18/21 at 10:44 a.m. of resident 34 in her room revealed: *Her C-PAP machine was placed on top of the dresser next to her bed. *The C-PAP mouthpiece had been resting on top of the dresser. *Two bottles of distilled water were in the same position as of 8/17/21 at 3:20 p.m. A review of resident 34's 7/30/21 physician orders revealed: *C-PAP per home settings daily at bedtime for obstructive sleep apnea. *Cleanse C-PAP mask and machine with a solution of half part vinegar and half part tap water 3 times per week, Monday, Wednesday and Friday during the day shift, and as needed with mild soap and water then let it air dry. Interview with licensed practical nurse (LPN) D on 8/19/21at 12:36 p.m. regarding resident 34's C-PAP machine revealed: *He had been an LPN since 2012. *Resident 34 had a C-PAP machine that she brought from home. *He had not cleaned the machine since she had been admitted to the facility. *He was unfamiliar with the process of cleaning the machine. *He did not believe she had used it since she admitted. *Because he believed she had not used the machine it had not needed to be cleaned. *He confirmed that the TAR had included his initials on 8/2, 8/4, 8/9, 8/13, 8/16, and 8/18/21 indicating he had cleaned the C-PAP machine. *Stated he understood that he should not have	F 658		

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initialed the TAR if he had not completed the task.
*Stated he was not sure how to document on the TAR that the C-PAP had not been used.
*Stated he must have just clicked completion by mistake.

Review of resident 34's TAR revealed:
*Nursing staff had initialed her use of the C-PAP machine each night during the month of August 2021.
*It had been signed off as cleaned on 8/2, 8/4, 8/6, 8/9, 8/11, 8/13, 8/16 and 8/20/21 as being cleaned by nursing staff.

Interview on 8/25/21 at 1:35 p.m. with LPN/Staff Development C regarding resident 34's C-PAP use revealed:
*She had been a unit coordinator for the facility and was familiar with resident 34.
*She had not been aware the TAR had been signed off by LPN D when he had not completed the task.
*Nursing staff were expected to follow the physician orders on the medication administration record (MAR) and TAR.
*She would expect that if the TAR had been signed off by nursing staff the task had been completed.

2. Observation and interview on 8/18/21 at 10:58 a.m. with resident 21 in his room revealed:
*He was admitted to the facility on 7/7/21.
*His BIMS score of 15 indicated he was cognitively intact.
*He was admitted with a stage 3 pressure ulcer on his right gluteal cheek.
*He had another wound on his sacrum where a penrose drain had been placed to removed fluid prior to his admission.

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*The two areas were to be cleaned and dressed daily and as needed (PRN).
*At times he felt the dressings had become saturated and had leaked into his adult brief.
*He thought the staff had not been changing the dressings as often as they should have.

Interview on 8/18/21 at 1:57 p.m. with the sister of resident 21 revealed:
*She had concerns about her brother's care at the facility.
*During family visits his room had been unclean and trash overflowing.
*In the last few days her brother had called with concerns that his dressings had become saturated and staff had not been changing them as often as needed.
*She contacted the facility and requested he be evaluated due to the increased drainage.

Review of resident 21's August 2021 TAR revealed:
*Nursing staff had not to changed the dressings as ordered on 8/4 and 8/19/21.
*There had been no indication PRN dressing changes for those two wounds had been completed any day in August 2021.
*There had been a missing entry on 8/21/21 for a nursing daily skilled evaluation related to his wounds.

Interview with LPN D on 8/19/21at 12:40 p.m. regarding documentation on the MAR/TAR record revealed he understood the documentation should be accurate and physician orders followed.

Interview on 8/24/21 at 3:38 p.m. with LPN/Staff development C regarding resident 21's wound

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F 658	Continued From page 34 dressing changes revealed: *She was familiar with resident 21. *She had been responsible for completing weekly wound assessments for the resident. *Scheduled nursing staff had been responsible for the daily assessments and dressing changes as needed. *She had been aware the resident had more drainage coming from the wound recently. *She had contacted the physician due to the increased drainage. *When his wound dressings had been saturated her expectation would be for the nursing staff on duty to assess, change the dressing, and document it on the TAR. *She had not been aware: -There had been missing entries for scheduled dressing changes on resident 21's August 2021 TAR. -His August 2021 TAR had no entries or documentation any PRN dressing changes had been completed. *She would expect nursing staff to follow physician orders. 3. Interview and observation on 8/17/21 at 2:44 p.m. with resident 31 revealed: *The resident was admitted to the facility on 7/21/21 for rehabilitation. *Her BIMS score of 15 indicating she was cognitively intact. *She had a PICC line placed in her right upper arm for intravenous (IV) antibiotics due to a recent surgery on her left foot. *Staff were busy and at times had not completed duties as they should. *She thought they could use more help. *Her IV antibiotics had been administered late at times.	F 658		

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F 658	Continued From page 35 Review of resident 31's August 2021 TAR revealed: *A missing entry for her PICC line dressing change on 8/13/21. *A missing entry on 8/20/21 for a nursing daily skilled evaluation. Interview on 8/23/21 at 5:15 p.m. with administrator A regarding documentation on the MAR/TAR record revealed: *She had been unaware nursing staff had been documenting inaccurately. *She agreed that nursing staff should follow physician orders and document the MAR/TAR accurately. Interview on 8/25/21 at 1:40 p.m. with LPN/Staff Development C regarding resident 31 revealed: *She had been familiar with the resident. *Knew she had a PICC line. *Confirmed the missing entry on her August TAR. *Stated the PICC line should have been changed as physician ordered and documented on the TAR that it had been completed. A review of the provider's LPN job description revealed: *"1. Takes and records residents' vital signs. 2. Dresses wounds, gives enemas, and douches. 3. Applies compresses, ice bags, K-packs, or other approved devices. 4. Observes residents and reports adverse reactions to medication or treatment to medical personnel in charge. 5. Administers specified medication, intravenously, orally, or by subcutaneous or intermuscular injection, and notes time and amount on resident charts (as allowed by state	F 658		

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F 658	Continued From page 36 law). 6. Assembles and uses such equipment as catheters, tracheotomy tubes, and oxygen supplies. 7. Collects samples, such as urine, blood, and sputum, from residents for testing and performs routine laboratory tests on samples. 8. Disinfects equipment and supplies using germicides. 9. Examines food trays for consistency or amount eaten during and after the meal. 10. Records and/or assesses food trays for prescribed diet and feeds resident as needed. 11. Bathes, dresses, and assists residents in walking and turning as needed." Surveyor: 26632 4. Review of resident 93's medical record revealed: *He had initially been admitted on 4/14/21. *He had been hospitalized multiple times. -Hospitalized: 4/26/21-5/7/21-for low hemoglobin, blood transfusion. -Hospitalized: 7/11/21-7/15/21-for chest pain. -Hospitalized: 7/22/21-7/27/21-for a wound infection. -Hospitalized: 8/1/21-8/16/21-as he had been unresponsive at the facility. *He had been last readmitted on 8/16/21. *His 8/16/21 physician re-admission orders revealed he was to have been weighed daily. *The last weight that had been recorded in his medical record was on 7/22/21. Review of resident 93's August 2021 TAR revealed: *Skilled charting was to have been completed daily at 10:00 p.m. -There was no documentation that was	F 658		

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F 658	Continued From page 37 completed on 8/19/21 and 8/20/21. *A dialysis transfer form was to have been completed and sent with him to each of his dialysis treatments: -No dialysis transfer form had been completed or sent on 8/17/21, 8/19/21, and 8/21/21. -The reason why they had been sent was 8/17/21 and 8/19/21 stated "No Coverage Required." -There was no documentation of why the form had not been completed and sent for 8/21/21. Interview on 8/24/21 at 2:00 p.m. with the interim director of nursing/divisional director of clinical operations B confirmed there had been no communication with the dialysis center. She was unable to find any dialysis transfer forms for resident 93. She agreed that information was important for the care of the resident. Surveyor: 42477 5. Observation and interview on 8/19/21 at 9:20 a.m. with resident 35 revealed: *Staff had been performing dressing changes for him. *Surveyor asked if she would be able to observe the dressing changes, he stated yes but they only happen at night. *He stated staff had been doing dressing changes on those areas for a while now. Review of resident 35's electronic medical record (EMR) revealed: *He had been admitted to the facility in March of 2020. *His diagnoses included: -Spinal cord injury. -Quadriplegia. -Pressure ulcer of contiguous site of back, buttock, and hip, stage two.	F 658		

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F 658	Continued From page 38 Review of his weekly skin audits completed by nursing staff revealed: *On 6/4/21 he was noted to have: -"Peri [perineum] area: Redness present in peri area and buttocks. Small skin lesion between buttocks. Blood present. Dressing applied." *On 6/11/21 he was noted to have: -"Peri area: Redness present in peri area and buttocks. Small skin lesion between buttocks. Blood present. Dressing applied." *On 6/18/21 he was noted to have: -"Peri area- Groin area: Redness noted. Buttocks. Skin Lesion. Redness noted. Zinc cream applied." *On 6/25/21 he was noted to have: -"Peri area- Groin area: Redness noted. Buttocks. Skin Lesion. Redness noted. Zinc cream applied." *On 7/2/21 he was noted to have: -"Peri area- Groin area: Redness noted *On 8/6/21 he was noted to have: -"Peri areas still open and bleeding, dressing and covered with xero foam and abdominal pad." -"resident had a bath today. Bleeding from scrotum. area cleansed, dried, xerofoam applied and covered with an abdominal (ABD) and depend. Registered nurse (RN) informed resident that the dressing to his flank also needs to be changed. Resident not happy with this and said no. RN educated him. He did allow RN to change dressing to right flank." *On 8/12/21 he was noted to have: -"No new skin issue, except wound on scrotum, resident refuse[d] to get dressing change[d] this shift." *On 8/20/21 he was noted to have: -"Peri area: No abnormalities noted. Extremely sensitive. Buttock area: 2 skin tears, blood present, redness noted."	F 658		

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F 658	Continued From page 39 Review of resident 35's nursing notes revealed: *Staff were to document any refusals for dressing changes or refusals to have sling removed. *Staff were also supposed to document if any education and interventions were provided because of the refusals. *He had a stage III pressure ulcer to his left hip on 7/23/21. Review of resident 35's physician communication revealed: *On 6/9/21,a nursing staff asked if they could discontinue his lift sling when he is up in his chair. *Nurse Practitioner replied: "This is what is causing chronic skin breakdown. There [sp] are to be removed for this reason." *An additional note pointing to the nurse practitioner's note stated: "Resident refuses and prefers not to remove thank you." *Resident 35 had an order to document all refusals of dressing changes, removal of the sling, repositioning, laying down in between meals. -This was to be completed every day and night shift. Observations made by surveyor 42477 of resident 35 throughout the survey revealed: *He had always had his sling underneath him. *There had not been any documented refusals from 8/17/21 through 8/23/21. Review of resident 35's TAR revealed: *Since April 2021 the weekly checks were marked with a checkmark. *Staff were supposed to note if there were any issues found.	F 658		

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F 658	Continued From page 40 Review of resident 35's August 2021 care plan revealed: *He had the following interventions in place: -"My skin will be observed at least weekly by the nurse." -"I want staff to monitor for any potential skin breakdown." -"Nursing to continue to educate me on the benefits of removing my sling when I am in bed and WC [wheelchair]. I have agreed to remove this as of 10/18 but upon readmission in January, I prefer to leave it in place." -"Encourage me to remove the sling from under me as I prefer to have it under me due to no hip and the discomfort [it] causes me when removing it therefore I often refuse to have it removed, staff will continue to encourage and educate on [the] reasoning for this." --This intervention had last been revised in September of 2019. Interview on 8/24/21 at 3:03 p.m. with LPN/staff development C revealed: *She had been responsible for skin assessments for residents with wound care concerns. *If she had found a pressure ulcer on a resident they complete a risk management note. *After a pressure ulcer has been concerned healed, she will follow-up again in two weeks. -Which is documented in the evaluations/assessments. *She stated the weekly skin checks are completed in the TAR with a "+" or a "-." -If there had been a "-" documented, there would have been a corresponding note in the progress notes. *If a resident had a wound that was not classified as a pressure ulcer then she did not complete evaluations on it.	F 658		

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F 658	Continued From page 41 *She was not aware that the skin checks were completed with a checkmark and not a plus or a minus. *Surveyor informed her that we were unable to find her evaluations for resident 35's wounds. -She stated that since they were not pressure injuries she did not complete an evaluation on them. *She had not been aware that their facility policy mentioned otherwise. *She agreed that the communication sent to the physician was to try to discontinue the order for removing the sling because he refuses. *She agreed refusals were not being routinely documented. Review of the provider's May 2019 Skin Integrity policy revealed: *For skin impairment identified with admission including, abrasion, bruise, burn, excoriation, pressure sore, rash, skin tear, surgical wound, etc. then the following would be done: -"Documents skin impairment that includes measurements of size, color, presence of odor, exudates, and presence of pain associated with the skin impairment in the Nurse's Notes and on the Weekly Wound Evaluation." -"Notifies the Physician and, if needed, obtains a Treatment Order and documents on the Treatment Administration Record (TAR) after an order is implemented." -"Notifies Responsible Party/Family Member of skin condition and treatment plan." -"Evaluates environment mobility equipment, functional and cognitive ability, medications, and labs to identify interventions to promote healing/resolution of skin impairment." -"Implements interventions and document on the resident's care plan Care Directive."	F 658		

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*"If skin impairment is noted after admission (in addition to the above steps), the LN [licensed nurse]: completes the following:
-"Initiates Alert Charting."
-"Completes (and documents) notifications to the physician and Resident representative."
-"Completes Braden Scale and evaluates current interventions as necessary."
-"Implements new interventions as needed. Documents on the resident's care plan and Care Directive."
-"Notifies Food and Nutrition Services Manager (FANS) and/or Registered Dietitian of new Pressure Sore, worsening would condition for nutritional needs evaluation."
-"Notifies Director of Nursing Services (DNS) of Skin Impairments that indicated a potential significant change in condition (Stage II or greater Pressure Ulcer, surgical wound dehiscence, hematoma, or bruise on an area of a body not usually vulnerable to trauma (e.g. [for example] head, breasts, inner thighs).
-"The DNS and/or designee complete a comprehensive review of the resident's medical record to evaluate if the Pressure Ulcer was avoidable or unavoidable. This evaluation is documented in the Nurse's Notes."

6. Observation and interview on 8/18/21 at 2:07 p.m. with LPN D administering resident 31's antibiotic revealed:
*She had been ordered to receive her antibiotic every 6 hours.
*LPN D stated he was administering it late due to a potential new admission and lunch schedules.

7. Observation and interview on 8/18/21 at 3:56 p.m. LPN D administering resident 26's enteral feeding revealed:

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F 658	Continued From page 43 *Resident 26's order was to: -"Enteral Feed Order two times a day for nutritional Diabetic Source AC @ [at] 65 mL/hr [milliliters per hour] for 20 hours out of 24 hours. On at 1400, off at 1000." -"225 ml free water flush via [by] g [gastrostomy] tube every 6 hours for hydration." *Resident 26 was receiving her enteral feeding late because he had been busy. *LPN D administered 50 ml of free water before to enteral feeding, not 225 ml. Review of resident 26's enteral feed and water administrations revealed: *From 6/19/21 through 8/19/21 she had received: -Her enteral feeding late 15 times. --The longest of those times was 2 hrs and 50 minutes late. *From 6/19/21 through 8/19/21 she had received: -Her water was late 25 times. --The longest of those times was 7 hours and 36 minutes late. On 8/24/21 at 12:00 p.m. surveyors requested policies regarding enteral feeding and medication error. Interim director of nursing/divisional director of clinical operations B stated that they did not have policies for those items.	F 658		
F 678 SS=H	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 advance directives. This REQUIREMENT is not met as evidenced	F 678	1. All full code residents have the potential to be affected. Unable to correct deficient practice for resident 30. See next page	9/23/21

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F 678	Continued From page 44 by: Surveyor: 42477 Based on observation, interview, record review, and policy review, the provider failed to ensure the following: *One of one resident (30) who was of full code status received interventions to prevent his death. *Residents who were cognitively impaired understood what their code status entailed. *Registered nurse (RN) E was aware of which residents were full code and where the crash cart was located. *Code status book was updated with the most current code statuses of residents. Findings include: 1. Observation and interview on 8/19/21 at 9:09 a.m. RN E revealed: *She was the nurse in charge of the 100 and 200 hallway, that day. *Surveyor asked which residents were full code status. -She said she knew of one for sure. *They kept the code status' in the nurses station in a book. *They had two crash carts, one on for the 100/200 hallways and one on the 300 hallway. *Surveyor asked RN E where the crash cart for the 100/200 hallways was kept: -It took her four minutes to find it. *The crash cart was located behind a locked door in a room where employees clock in. *The crash cart had a box on top of it that contained an employee clock in a kiosk. *The cart contained: -A suction machine and Yankhauer tubing. -Oxygen canister and tubing. Review of the code status book for the 100/200	F 678	Cont from previous page: 2. The ED and interdisciplinary team reviewed the code blue policy by 9/23/21. The ED or designee will educate all licensed nursing staff on the intitiation of a full code and the code blue policy by 9/23/21. All licensed staff not in attendance will be educated prior to their next working shift. Code status is identified on the report sheet and code status binder. 3. The ED or designee will conduct a code drill on different shifts with different scenarios weekly times six weeks and monthly times three months. This drill will include nurse D, F and N on random occasions. The ED or designee will bring the results of the drills to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	

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hallway revealed:
*There were 34 residents located on the 100/200 hallway.
-15 of those residents wished to be of full code status.

2. Review of resident 30's electronic medical record (EMR) revealed:
*He was transported to the hospital the morning of 8/21/21.
*He passed away after arriving at the hospital.
*Resident 30 was of full code status.
*Licensed practical nurse (LPN) N documented the following:
-"On 8/21/21 at 9:49 a.m. Headed to resident's room around 5:40am. [a.m.] Upon entering the room (this nurse) notices he is clenching his mouth. There was saliva/snot around his mouth and nose. (This nurse) wiped off the substance with a towel. While doing this he points to the door. Vitals obtained around 0540 [5:40 a.m.] on 8/21/21 Blood Sugar 336. B/P [blood pressure] 52/32 HR [heart rate] 55. Resp [respirations] 16. 911 dialed approximately 0545 [5:45 a.m.]. Ambulance dispatch 0545. Second nurse appeared around 0554 [5:54 a.m.] to assist. [hospital name] Eltc [telemedicine for emergency long-term care] dialed at 0606 [6:06 a.m.]. Administer [Administrator] dialed at 0618 [6:18 a.m.]. Resident taken by EMS [emergency medical system] approx. [approximately] 0640-0645 [6:40 to 6:45 a.m.] to [hospital name]."
*On 8/21/21 at 10:02 a.m. administrator A documented:
-"Call placed to [hospital name] and spoke with [staff member's name] and she stated that they were running tests and that he was intubated and trying to get his blood pressures stable. She stated they would know more after lunch. Call

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F 678	Continued From page 46 then placed to his ex-wife and [ex-wife's name] was given an update and she stated she called up there and they told her the same. She thanked writer for the update. Spoke with the EMS [initials of staff], and she stated that she did not have to use the AED [automated external defibrillator] or LUCAS [lund university cardiac assist system] during the ride and that she only bagged him at this time. However the North charge nurse stated that they did use the LUCAS and AED at the facility and the EMS went through 3 cycles where no shock advised each time. Female EMS stated that he had a really faint pulse and if he did not have a pulse then the [they] would not have transported him." *Administrator A documented another entry on 8/21/21 at 2:09 p.m. which stated: -"Received a call from [RN's name] at [hospital's name] and she stated that resident passed away. She stated that it happened so fast she could not put all the puzzle pieces together. This RN asked for a diagnosis and she stated cardiac arrest. She stated that the ex-wife was made aware." Review of the report received from the hospital about resident 30 revealed: *"...noted to be normal at 5 AM today but at 6 AM was noted to have agonal respirations and pulse. Then they lost the pulse and started cardiopulmonary resuscitation. 20 min [minutes] if CPR. EMS gave 3 mg [milligrams] of EPI [epinephrine] with return of pulse, but needed to resume CPR. Hypotensive [low blood pressure] during transport to hospital. Remained unresponsive the entire time. He arrested again in the [emergency department's name]. Did have a return of pulses..." *"Wife agreed to place resident 30 on comfort measures."	F 678		

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F 678	Continued From page 47 *Resident 30 was extubated [removal of tube] and passed away on 8/21/21 at 1:14 p.m. Review of the provider's death report revealed: *Resident's age was 10 years older than his actual age. *Resident 30's time of death was listed as 6:00 a.m. 0n 8/21/21. -Which was before EMS arrived and CPR had been started. Review of ELTC consultation report revealed: *Date of service was listed as 8/21/21 at 6:03 a.m. *"Nurse was calling because resident passed away and wanted release of body order. Educated that ecare cannot provide and would need to call [physician's name]/or physician on call for her." Interview on 8/25/21 at 10:06 a.m. with LPN F revealed, she: *Arrived at the facility for her scheduled shift on 8/21/21 around 6:02 a.m. *Observed LPN N was on the phone with ELTC trying to get an order to "release the body." *Went into resident 30's room and LPN D was in the room with two certified nursing assistants (CNAs]. *Stated LPN D was cleaning up the resident for transport to the funeral home. *Stated resident 30 did not have a pulse and his skin was still slightly warm. *Went back to the nurse's station to see what LPN N needed help with. *Observed the code status book was open on the desk. *Was asked by LPN N to call resident 30's wife and ask what funeral home she wanted resident	F 678		

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30 to be transported to.
*Had known resident 30 was a full code so she assumed that they had already administered CPR.
*Stated EMS showed up and asked what resident 30's code status was and began performing CPR in the nursing home.

Interview on 8/25/21 at 11:04 a.m. with LPN D revealed he:
*Arrived at the facility around 5:52 a.m.
*Had been flagged down by LPN N.
*Was informed by LPN N that resident 30 was not responding.
*Went to look at resident 30, he was not responsive.
*Stated LPN N went to call 911.
*Was trying to see if resident 30 had a pulse.
*Thought he had felt a slight pulse but stated he could have been feeling his pulse.
*Tried to look at his airway, and tried to remove the saliva.
*Stated LPN N came back to the room.
*Used a stethoscope to see if he could hear anything.
*Did not hear any air movement or breath sounds.
*Was not aware of resident 30's code status, he thought he was a do not resuscitate (DNR) status.

Interview on 8/25/21 at 11:46 a.m. with LPN N revealed she:
*Went into resident 30's room to give his scheduled 6:00 a.m. medications.
*Had noticed he had foaming around his mouth, his jaw was clenched, and his index finger was pointing towards the door.
*Used the towel to wipe off the saliva from his

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mouth, she noticed he was sweating.
*Left the room to get the vitals machine.
*Recalled his respirations were very low around 7 or 8, his blood pressure was low, and he had a low heart rate.
*Had left the room again to call 911.
*Stated 911 was inquiring over the phone what his code status was.
*Went back into resident 30's room and could not obtain vitals with the vitals machine.
-His heart rate and blood pressure were not registering.
*Thought that maybe she could feel a pulse.
*Did not notice him breathing or his chest rising.
*Had not placed any oxygen on resident 30.
*Had not retrieved the crash cart and used the suction machine.
*Stated she had not repositioned the resident or turned him on his side.
*Informed this surveyor that she did not see EMS do CPR in the building but acknowledges that they left around 6:45 a.m.
*Called ELTC to obtain an order to have his body released.

Review of the EMS report from an encounter with resident 30 on 8/21/21 revealed:
*They were dispatched to the nursing home for a report of a transfer.
*When they arrived at the nursing home they were informed that resident 30 had "gone on a journey."
*They questioned staff further who stated resident 30 had "died."
*Staff was questioned about his code status, they reported it was unknown.
*EMS found resident 30 laying on his back, without a pulse, foaming from his mouth, his skin was warm, and no lividity was noted.

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F 678	Continued From page 50 *Nursing home staff had come in the room to report that resident 30 was a full code. *Resident 30 was moved to the floor and CPR was administered by EMS personnel. *Mechanical CPR device (LUCAS) was applied, and the airway was suctioned. *EMS inserted an airway and began continuous compressions with ventilation. *Oxygen was administered at 15 liters per minute. *AED patches were applied, no shock was advised, CPR was continued. *Due to copious amounts of secretions from resident 30's mouth, suctioning had been continued through CPR. *Epinephrine was administered. *Resident 30 had a heart rhythm that became organized. *EMS staff were able to obtain a pulse at 82 beats per minute. *Resident 30 was transported to the hospital. *CPR was not administered during transport due to the return of heart rate and blood pressure. *Resident 30 was handed over to personnel at the hospital. Review of EMS time log of the event involving resident 30 revealed: *911 was called at 5:51 a.m. *Their unit was dispatched at 5:54 a.m. *Arrived at the nursing home at 6:09 a.m. *They were with resident 30 at 6:12 a.m. *They departed the nursing home at 7:06 a.m. *They arrived at the hospital at 7:32 a.m. Review of the provider's September 2017 CPR policy revealed: *CPR was not initiated in the following instances: -"Decapitation- Removal of the head." -"CPR would place rescuer in danger."	F 678		

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F 678	Continued From page 51 -"Dependent lividity- settling of blood." -"Transection-transverse cut/cut in half." -"Decomposition-state of rotting or decay." *CPR would be initiated for residents who: -"Have requested, through advanced directive or POLST/POST [physician orders for life sustaining treatment], to have CPR initiated when cardiac or respiratory arrest occurs." -"Have not formulated an advanced directive nor have a POLST in their medical record." -"Do not have a valid DNR order." Review of the provider's admission packet revealed: *"Advance Directives: Please notify the center of any changes to your Advance Directive by providing a current copy to the Center. Upon receipt, the center will abide by any instructions provided in your Advance Directive. If you have not provided an Advance Directive, the Center will take all actions possible during an emergency, including calling 911 and sending you to a hospital." Interview on 8/25/21 at 1:00 p.m. with divisional director of clinical operations B and administrator A regarding resident 30 revealed: *Surveyors had expressed their concern for the severity of the situation. *Surveyors had expressed concern that this situation could impact all other resident. *They did not provide any input or further information. Refer to F600 Finding 1 and 2.	F 678		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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F 689	Continued From page 52 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Staff that supervised one of one resident (8) who smoked and had a history of getting burned had used a finger safety device to prevent burns. *One of one electric stoves in the conference/activity room that residents had access to had been disabled to prevent burns. 1. Interview on 8/18/21 at 12:09 p.m. with resident 8 revealed: *He had smoked since his admission. *He wore a smoking apron when he smoked. *He tended to smoke cigarettes down to the butt. *He had gotten burned while smoking a cigarette at the end of May 2021. *The cigarette he was smoking had gotten stuck to his finger and burned his fingertips. *The facility had gotten a cigarette extender for him to use to prevent future burns. *He had only used the cigarette extender a few times. *Staff had not been offering the cigarette extender to him when going out to smoke and he did not ask for it. *He did not think he needed it to be safe while smoking.	F 689	1. All smoking residents have the potential to be affected. Resident #8 has discharged from the facility. 2. The ED or designee will educate all staff on the smoking policy and turning off the power to the electric stove in the north conference room when not in use and securing smoking devices such as lighters by 9/23/2021. All staff not in attendance will be educated prior to their next working shift. 3. The ED or designee will audit a random sample of 4 smoking residents and securing of smoking devices and unsecured areas for lighters weekly times four weeks and monthly times two months. The ED or designee will audit that the power is turned off to the stove in the conference room weekly times four weeks and monthly times two months. The ED or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	9/23/21

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F 689	Continued From page 53 Review of resident 8's electronic medical record revealed: *His brief interview for mental status (BIMS) score of 15 indicating he was cognitively intact. *He had been assessed as able to smoke safely on admission with staff supervision and without the need for a special device to hold the cigarette. *He had been burned by a cigarette on 5/25/21 when the lit cigarette had stuck to his finger. *A new smoking assessment had been completed on 5/28/21. *Staff had been educated on 6/1/21 about the smoking policy and that resident 8 was to use a cigarette extender when he smoked. *He had another smoking assessment completed on 7/8/21. *The results of the 5/28/21 and 7/8/21 smoking assessments had indicated the need for a special device to hold the cigarette to be used while he smoked. Interview on 8/19/21 at 7:51 a.m. with dietary manager S revealed: *She had taken the residents out to smoke at times. *The residents who smoked all wore smoking aprons. *Cigarette supplies were kept in the medication room. *The supplies for the residents were kept in containers labeled for each smoker. *Staff got the supplies and handed out the cigarettes to each resident and lit the cigarettes. *Staff kept the lighters in their possession. *She was aware that resident 8 had been burned by a cigarette in the past. *He was to use a cigarette extender for safety.	F 689		

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F 689	Continued From page 54 Interview on 8/19/21 at 11:32 a.m. with certified nursing assistant (CNA) G revealed: *Smokers gathered in the area between the 100 and 200 wings of the nursing home when it was time to smoke. *Staff get the smoking supplies which are kept locked inside a safe in the medication room. *Staff assisted the residents to get smoking aprons on. *The residents are given their cigarettes and staff uses a lighter to light them. *Lighters were kept by staff. *She had not offered the cigarette extender to him unless he asked for it. *Resident 8 had not normally asked for the cigarette extender. Observation on 8/19/21 at 2:04 p.m. with CNA G and resident 8 outdoor in the designated smoking area revealed: *He had been wearing a smoking apron. *He had been smoking a cigarette without the cigarette extender. Interview on 8/24/21 at 10:55 a.m. with CNA O revealed: *She was the staff that usually took the residents out to smoke during the evening shift. *She got the keys for the medication room from the nurse on duty and gets the smoking supplies. *She assists the residents to go outdoors and places a smoking apron on them. *She gives out the cigarette supplies to the residents. *She had never seen resident 8 use a cigarette holder or offered one to him. Review of education provided to staff on 6/1/21 for review of smoking safety revealed:	F 689		

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F 689	Continued From page 55 *CNA G had signed the signature sheet. *CNA O had not signed the signature sheet. Interview on 8/23/21 at 5:14 p.m. with administrator A revealed: *Residents that smoked were to be assessed on admission and quarterly. *All smokers were to wear a smoking apron. *Supplies were kept in the medication room and gathered by the staff taking out the residents. *Staff was to hand out the cigarettes and light them. *Resident 8 was to use the cigarette extender and staff should have offered it to him. *Staff had been educated on the smoking policy on 6/1/21 and should follow the policy. A review of the updated November 2018 facility resident smoking policy revealed: *Residents are supervised when utilizing any smoking device while on center grounds. *Smoking interventions were implemented based on the results of the smoking assessment. 2. Random observations throughout the survey from 8/17/21 through 8/19/21 and from 8/23/21 through 8/25/21 of the electric stove in the north conference/activity room had been in working condition on the following dates: *8/17/21 from 1:45 p.m. through 6:45 p.m. *8/18/21 from 7:30 a.m. through 6:00 p.m. *8/19/21 from 7:30 a.m. through 4:00 p.m. *8/23/21 from 1:15 p.m. through 7:15 p.m. *8/24/21 from 8:30 a.m. through 6:30 p.m. *8/25/21 from 8:00 a.m. through 2:00 p.m. *The right front burner had the control knob in place and heated when turned on. *The other control knobs for the burners had been removed and placed in the top drawer to the	F 689		

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F 689	Continued From page 56 right of the electric stove. *Residents had been observed to access that room several times throughout the survey to obtain items from the vending machines. Surveyor: 42477 Observation and interview on 8/18/21 at 9:00 a.m. with licensed practical nurse (LPN) F revealed: *There was a lighter in the side compartment of the treatment cart, unsecured. *LPN F stated lighters are supposed to be secured in the medication room. *There were also two lighters and a can of chewing tobacco laying on the nurses' station desk, unsecured.	F 689		
F 729 SS=D	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every	F 729	1. All residents have the potential to be affected. Staff member Q is no longer employed at the facility. 2. The Divisional Director of Clinical Operations completed education on the NA training program requirements on 9/15/21 to the ED, DNS and Staff Development Coordinator. 3. The ED or designee will audit all new NA's for proper education and training requirements weekly times four weeks and monthly times two months. The ED or designee will bring the results of these audits to the monthly QAPI for further review and recommendations to continue or discontinue the audits.	9/23/21

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F 729	Continued From page 57 State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one nurse aides (NA) Q had a competency evaluation and was in an approved training program before working independently with residents. Findings include: 1. Observation and interview on 8/24/21 at 4:30 p.m. with NA Q revealed he had: *Been working on the 300 hallway. *Been observed caring for and transferring residents without supervision. *Worked in the facility for a little over a week. *Not been in a nurse aide training program before. *Received orientation by different departments on his first day. *Training on the floor for three to four days. *Been on his own since then. *Received a temporary nurse aide license online. -Which meant he was able to work on his own.	F 729		

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F 729	Continued From page 58 Interview on 8/24/21 at 5:00 p.m. with licensed practical nurse (LPN) D revealed: *NA Q had been his aide on the 300 wing for that day. *NA Q had been working independently. Interview on 8/24/21 at 5:30 p.m. with LPN/staff development C revealed she: *Had been in charge of staff development. *Confirmed NA Q had been working independently. *Confirmed he had received a license online. Review of the temporary NA licenses website <educate.ahcancal.org/products/temporary-nurse-aide> revealed: *It had offered free courses. *"This course is free and was designed to meet the critical staff shortages occurring as a result of COVID-19." *"This 8-hour online training, in combination with the on-site training you will get at the facility where you are hired, will prepare you to work as a Temporary Nurse Aide, a temporary position intended to address the current state of emergency." *"Currently, the 8-hour training program is permitted under special waivers, exceptions, or flexibility for temporary nurse aide roles..." *"Additional training or other actions may be required in these states (please contact your state health care association or appropriate state agency for additional information about your state's requirements)..."	F 729		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		

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F 755	Continued From page 59 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, record review, interview, and policy review, the provider failed to ensure: *One of two facility medication (med) rooms remained locked from unauthorized access. *One of two facility med fridge that contained controlled substances remained locked.	F 755	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey. An accountability log is in working order for the E-kits. 2. The ED or designee will educate all nursing staff on the medication storage policy, medication destruction and no access to the medication room by unlicensed staff by 9/23/21. All staff not in attendance will be educated prior to their next working shift. 3.The ED or designee will audit medication storage as it specifically relates to accountability of E-kits, locking of controlled substances and medication rooms, destruction of medications and unauthorized access to medication rooms weekly times four weeks and monthly times two months. The ED or designee will take the results of the audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	9/23/21

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F 755	Continued From page 60 *One of two controlled medications stored in medication was monitored. *Unauthorized staff were not given keys to one of two facility med rooms. *A system was in place to monitor facility emergency kits (e-kits). *Prescription medications were disposed of properly and not thrown in an open trash can. *Disposition of three of three sampled residents' (13, 17, and 18) medications had been signed by a witness. *Medication was not left in one of one random resident's (21) room unsecured. Findings include: 1. Observation and interview on 8/18/21 at 9:35 a.m. with licensed practical nurse (LPN) F revealed: *The facility had two medication rooms, which were located in between the 100 and 200 hallway and one on the 300 hallway. *E-kits were kept in the 100/200 hallway med room. Observation and interview on 8/18/21 at 9:40 a.m. with LPN F in 100/200 med room revealed: *They had three e-kits in the room. *They also had three emergency intravenous (e-iv) kits. *When they took a medication out of the e-kit they were supposed to fill out a sheet. *The sheet included some of the following information: -What tag had been removed from the e-kit. -What new tag had been placed on the e-kit. -Who the staff member was. -What medication had been removed. *LPN F was unable to find the sheets for all of the e-kits in the med room.	F 755		

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F 755	Continued From page 61 -She stated the sheets do not always get filled out. *The refrigerator in the med room contained a lock but it was not locked. *The refrigerator contained: -Two bottles of lorazepam, a controlled substance. -Two expired Hepatitis B vaccine vials. -Six expired influenza vaccine vitals. *LPN F was unable to find an accountability record for one of the bottles of lorazepam. *LPN F stated they do not keep a record of the medications that they destruct. Observation and interview on 8/19/21 at 7:41 a.m. with certified medication aide M revealed: *She had just spilled a pill on the medication cart. *She had grabbed the pill with Kleenex and threw it in the trash can. Observation and interview on 8/18/21 at 12:08 p.m. with LPN D revealed: *He was the nurse for the 300 hallway. *The medication room door was unlocked. *He stated that you have to lock the door from the inside so sometimes it does not get locked. *They did not count the control kit that contained the lorazepam. Observation and interview on 8/19/21 at 9:18 a.m. with administrator A revealed: *She stated all prescription drugs should be placed in the drug buster for disposal. *Had been aware that staff forget to sign the form when they put a new tag on the e-kit. *Agreed that they needed a better system for tracking their e-kits. Surveyor: 26632	F 755		

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F 755	Continued From page 62	F 755		

2. Review of resident 13's medical record revealed medications had been destroyed on 3/16/21. Those medications included divalproex, paroxetine, and tamsulosin. LPN U had been the person who destroyed those medications. There was no witness to the destruction of those medications.

3. Review of resident 17's medical record revealed medications had been destroyed on 4/22/21. LPN U had been the person who destroyed the medication. There was no witness to the destruction of the medication. The medication destroyed was spironolactone.

4. Review of resident 18's medical record revealed medications had been destroyed on:
*3/16/21 LPN U had been the person who destroyed the medication. There was no witness to the destruction of the medication. The medication destroyed was warfarin.
*7/3/21 administrator A had been the person who destroyed the medication. There was no witness to the destruction of the medication. The medication destroyed was warfarin.

Interview on 8/25/21 at 1:30 p.m. with administrator A confirmed the above findings. When medications were destroyed two nurses or a nurse and the pharmacist were to have destroyed them.
Surveyor: 41088
5. Interview and observation on 8/24/21 at 9:51 a.m. with resident 21 in his room revealed:
*He had been lying in his bed watching television.
*On his bedside stand was a tube of hydrocortisone cream with a pharmacy label inside of a clear plastic bag.
*The plastic bag with the tube of hydrocortisone

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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 755	Continued From page 63 had been placed inside of a plastic cup that contained exercise putty. -Rehabilitation staff had given the exercise putty to use to strengthen his muscles. *There was another used plastic water cup on the inside of the exercise putty cup. *Beside the plastic bag of hydrocortisone cream inside of the same plastic cup was a rolled up used microwave popcorn bag. *Resident states the tube of hydrocortisone cream stayed in his room. *He stated he used the hydrocortisone cream two or three times a day on areas of itchy skin. Interview and observation on 8/24/21 at 3:20 p.m. with LPN D in resident 21's room revealed: *The above hydrocortisone cream tube in the same location and condition as the above observation. *LPN D confirmed that the tube should not have been left inside of his room but stored inside the medication cart. Interview on 8/19/21 at 10:55 a.m. with certified nursing assistant (CNA) O regarding usage of med room keys revealed: *She had usually been the staff that took the residents out to smoke. *Her routine was to ask the nurse on duty for the keys to the med room to get smoking supplies for the residents. *She did not like to bother the nurses to get the supplies because they had been busy with tasks. *She had returned the keys after she had gathered the smoking supplies to the nurse. Surveyor 42477 Review of the provider's November 2011 Medication Storage in the Facility policy revealed:	F 755		

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F 755	Continued From page 64 *"Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible to only licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications." *"B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access." *"H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal..." *"H. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining..." Review of the provider's September 2015 Long Term Care Pharmacy policy revealed: *"7. Drugs used from the kit shall be replaced by faxing an Emergency Kit Replacement Slip for the used item to the pharmacy immediately upon use." *"8. The facility will retain a complete record of all emergency kit forms used in facility for two years, which include the following: A. Control E-Kit Shift Count, b. Control E-Kit Check-In List, C. Monthly E-Kit Check List, d. Emergency Kit Replacement Slip, e. Emergency IV Kit Replacement Slip." *"The facility will store the control case in a double lock system; monitor and document the control case each shift, using the Control E-Kit Shift Count."	F 755		

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F 755	Continued From page 65 *"i. The facility will keep this document as a record for reference and to be compliant with the pharmacy's policy."	F 755		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Surveyor: 42477 Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure the facility was operated and administered in a manner that ensured the safety and overall well-being of all forty-four residents in the facility. Findings include: 1. Observations, interviews, record reviews, and policy reviews throughout the survey revealed administrator A and director of nursing/divisional director of clinical operations B had not ensured the safe management and overall well-being of all the residents who lived in the facility. Interview on 8/23/21 at 5:30 p.m. with administrator A revealed: *She was responsible for the overall management of the center. *She also performed other duties that included: -Ensured the required nursing staff was available. -Was in charge of the infection control program.	F 835	1. All residents have the potential to be affected. 2. The Divisional Director of Clinical Operations reviewed the ED job description with ED prior to 9/23/2021. An interim DNS is in place as of 9/20/2021. 3. The ED or designee will complete audits for F550, F576, F582, F584, F600, F658, F678, F689, F729, F755, F865, F880 and F886. The ED will take the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits. The DDCO will ensure these audits are completed weekly times four weeks and monthly times two months. There will be continue oversight and availability of the DDCO for the next quarter.	9/23/21

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F 835	Continued From page 66 -Was in charge of ensuring the COVID-19 policies and procedures had been followed. -Worked as a registered nurse when needed. Review of the provider's November 2019 Executive Director (ED) Job Description revealed: *"The Executive Director (ED) is directly accountable to the Divisional Vice President of Operations (DVP) to provide strong overall leadership and management of a long-term care center. Manages delivery of the highest level of health services and quality of care that is responsive to customers' needs. Directs efforts to facilitate the overall well-being of Center. Performs other duties as assigned." *"Leads the process to develop and implement programs to maintain quality of care to meet established goals." *"Responsible to maintain a safe, healthy, clean, and well-organized building that reflects a high standard of care and service." *"Hold Department Managers accountable for departmental quality performance." *"Confirm that employee in-service training is conducted as required." Refer to: F550, F576, F582, F584, F600, F658, F678, F689, F729, F755, F865, F880, and F886.	F 835		
F 837 SS=F	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and	F 837	See next page.	

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F 837	Continued From page 67 §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Surveyor: 42477 Based on observations, interviews, record reviews, job description reviews, and policy reviews, the governing body failed to ensure the facility was operated in a manner that ensured the safe management and overall well-being for all forty-four residents in the facility. Findings include: 1. During the survey from 8/17/21 through 8/19/21 and 8/23/21 through 8/25/21 the provider had not been operated in a manner to ensure the residents had received quality care. Administrator A had not been assisted with her duties to ensure she was able to effectively provide quidance to staff to be able to provide quality care. Refer to F550, F576, F582, F584, F600, F658, F678, F689, F729, F755, F865, F880, and F886.	F 837	1. Unable to correct deficient practices noted during survey. All residents have the potential to be affected. 2. Job descriptions were reviewed with DDCO and ED by 9/23/2021. The DDCO will continue bi-weekly visits times two months and re-evaluate at that time for continued frequency of visits. 3. The ED or designee will complete audits regarding F550, F576, F582, F584, F600, F658, F678, F689, F729, F755, F865, F880 and F886. The ED or designee will take the results of these audits to the monthly QAPI committee for review and recommendation to continue or discontinue the audits. The governing board will be in attendance at the meeting to review these audits until substantial compliance is met.	9/23/21
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State	F 865	See next page.	

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F 865	Continued From page 68 Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. 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: 26632 Based on interview and record review, the provider failed to ensure performance improvement projects (PIP) had been thoroughly examined and resolved with an effective quality assurance performance improvement (QAPI) process. Findings include: 1. Interview and QAPI record review on 8/25/21 at 8:51 a.m. with licensed practical nurse/staff development C revealed: *The QAPI committee met monthly. *The QAPI committee members also included: -Administrator A. -The interim director of nursing. -The department managers. -The medical director. -The nurse managers. *The QAPI meeting consisted of reviewing: -The current Centers for Medicare and Medicaid Services (CMS) quality measures. -Employee retention and turnover. -COVID-19 screening and policy updates.	F 865	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey. 2. The ED and DNS reviewed all current PIPS in place for relevance. PIPS will be discontinued and started on new areas identified by 9/23/21. 3. PIPS will be reviewed monthly and as needed for progress through the monthly QAPI committee by the QAPI team.	9/23/21

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F 865	Continued From page 69 -Grievances. -Pharmacist reviews of psychotropic medication use. -Audits from previous surveys. -Resident council minutes. *Active PIPs included: -Falls. -Bathing and dignity. -Infection control and immunizations. -Pressure ulcers. -Rehospitalizations. -Medication errors. *There were QAPI summary notes from the July 2021 meeting that included: -"Falls-Continuous, working as a facility to reduces falls." -"Baths/Dignity-Continue to ensure we stay on track, charting and care planning residents preference." -"Infection control/immunizations-Continuous, working as a facility to reduces falls." This was the same as the falls PIP. -"Pressure Ulcer-Continuous." *A mock survey had been conducted in March 2021. That included: -"Mock Survey Audits: med [medication] cart audits/med cart lock, hand hygiene, housekeeping, lint removal, catheters, coumadin, dialysis, risk management, tube feeding orders, DC [discharge] acknowledgement form signed, pain, and grievance." *She agreed no goals had been set for those PIPs. *The information had been collected but had not been acted on with any plan. Review of the provider's 9/18/20 QAPI Plan revealed: *"Quality improvement is tied to our ability to	F 865		

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F 865	Continued From page 70 identify and correct quality deficiencies any time they occur throughout the facility as well as opportunities for improvement. QAPI addresses areas in need of systemic of process improvements. We are committed to creating solutions that are preventative in nature; improve safety while emphasizing resident autonomy and choice. We are committed to integrating our solutions across departments and services." *"The Governing Body is responsible for the development and implementation of the QAPI program. The Executive Director is responsible and accountable to the corporation to ensure QAPI is effectively implemented and integrated throughout the center. They are accountable to the governing body for requested documentation to be complete and submitted timely. The Executive Director reports QAA/QAPI Activities to the Divisional Vice President/Governing Body who review, offer feedback and provide support and resources to the center's QAPI Plan, no less than quarterly. " *"The QA&A Committee reports to the executive leadership and Governing Body and is responsible for: 1) Meeting, scheduled monthly and conducted at a minimum, on a quarterly basis; 2) Coordinating and evaluating QAPI activities 3) Developing and implementing appropriate plans of action to correct identified quality deficiencies 4) Regularly reviewing and analyzing data collected under the QAPI program and data resulting from drug regimen review and acting of available date to make improvements. 5) Determining areas for PIPs and Plan-Do-Study-Act (PDSA) rapid cycle improvement projects 6) Analyzing the QAPI program performance to	F 865		

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F 865	Continued From page 71 identify and follow up on areas of concern and/or opportunities for improvement."	F 865		
F 880 SS=E	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, 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;	F 880	1. Time cannot be turned back to a time prior to the identification of lack of: *appropriate hand hygiene and glove use and procedural technique during provision of resident cares. *appropriate hand hygiene and glove use and procedural technique when conducing a blood glucose check and hanging an IV antibiotic. *appropriate maintenance and sanitation of multi-resident care areas. *appropriate wearing of face masks. The administrator and DON in consultation with the medical director and infection control nurse and whomever else identified will review, revise, create as necessary policies, procedures or competencies about: *Appropriate hand hygiene and glove use and procedural technique during provision of resident cares. See next page	9/23/21

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F 880	Continued From page 72 (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 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: 41088 Based on observation, interview and policy review, the facility failed to ensure staff had used proper infection control measures for: *Certified nursing aide (CNA) J who had not used proper hand hygiene and glove usage when she had assisted resident 31 with personal cares.	F 880	*Appropriate hand hygiene and glove use and procedural technique when conducting a blood glucose check and hanging an IV antibiotic. *Appropriate maintenance and sanitation of multi=resident care areas. *Appropriate wearing of face masks. *Necessary infection control and prevention plan that includes effective compliance. All staff who provided above care and services to residents will be educated/re-educated by ED or designee by 9/23/2021. All staff were educated by 8/23/21. Those not in attendance will be educated prior to their next working shift. 2. ALL residents have the potential to be affected if staff do not adhere to: *Appropriate hand hygiene and glove use as well as procedure technique when providing cares. *Appropriate maintenance and sanitization of multi-resident and individual resident care areas. *Appropriate wearing of face masks	

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F 880	Continued From page 73 *Licensed practical nurse (LPN) D who had not used proper hand hygiene and glove usage while providing care for residents (31, 32, and 143). *Laundry/housekeeper manager R who had not properly disinfected the toilet, or used gloves appropriately while cleaning resident room 101. *Disinfection of a lift by CNA I, registered nurse (RN) E and CNA/certified medication aide (CMA) M. *Checking blood glucose readings by CNA/CMA M and LPN D. *RN E and LPN D wore clean masks that covered their noses while interacting with residents. 1. Observation on 8/19/21 at 9:07 a.m. with CNA J completing personal care with resident 31 revealed: *She had a peripherally inserted central catheter (PICC) line placed in her right arm. *She had been lying in her bed. *CNA J entered the room to assist her with getting dressed. *CNA J had not washed her hands or performed hand hygiene before putting gloves on. *She closed the door to the room with her gloved hands. *With the same gloved hands opened the door to the closet and selected a blouse the resident requested. *She closed the closet door. *She walked to the resident's right side. *Using the same gloved hands she assisted the resident to take off her hospital gown and put on the blouse. *Exited the room and took the soiled hospital gown to the soiled linen receptacle. *Removed her gloves and discarded them. *She had not performed hand hygiene. *Walked to the cart with breakfast trays down the	F 880	ALL staff completing the care and/ or assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by ED or designee by 9/23/21. 3. Root cause analysis conducted answered the 5 Whys: Root cause of blood glucose: Routine training was delayed during pandemic and shouldn't have been. Root cause of IV hanging: No training on IV policy or competency completed after hire. Root cause of mask wearing: No repeat training of mask wearing per policy and supervisor not holding staff accountable for proper mask wearing. Root cause of cleaning: Lack of hands on training due to restricted visiting during the pandemic. Administrator, DON, infection control nurse, medical director and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency. See next page.	

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F 880	Continued From page 74 hallway and grabbed a breakfast tray, brought it into her room and placed it onto her bedside stand. *She exited the room and had not been observed to wash hands or perform hand hygiene. Interview on 8/19/21 at 12:00 p.m. with CNA J regarding her care of resident 31 revealed: *She was a traveling CNA and had just started at the facility that morning. *She said she had not gotten much training prior to starting her shift. *She had been the only CNA scheduled to work in the 300 hallway that shift. *She agreed that she had missed opportunities for hand hygiene and glove use while assisting resident 31. Interview on 8/23/21 at 5:33 p.m. with administrator A revealed: *Confirmed CNA J had been a traveling CNA and started on 8/19/21. *Her personnel file had included information that she had been educated and trained in proper hand hygiene and glove use. *She agreed CNA J should have followed proper procedures for glove use and hand hygiene. Review of the provider's updated March 2018 Handwashing/Hand Hygiene Policy revealed: *Use an alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap and water for the following situations: -Before and after direct contact with residents. -After contact with objects in the immediate vicinity of the resident. -After removing gloves. -Before and after assisting a resident with meals. *The use of gloves does not replace hand	F 880	DDCO contacted the South Dakota Quality Improvement Organization (QIN) on 9/16/21. Webinar held on 9/17/21. Discussed root cause analysis and reviewed several tools to assist with staff training. **Monitoring:** 1. Administrator, DON, infection control nurse, and whomever else determined necessary will conduct auditing and monitoring for areas identified above. Observations of staff performing task(s) do need to be documented. Verbally talking through a process is a way of teaching but also need actual observed performance for demonstrated competency. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum 3-5 times weekly for 4 weeks, administrator, DON, and/or infection prevention nurse making observations across all shifts to ensure staff compliance with: *Necessary infection control and prevention plan that includes compliance in the above identified areas. *Any other areas identified thru the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months.	

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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 880	Continued From page 75 washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 2. Observation and interview on 8/19/21 at 10:52 a.m. with laundry/housekeeping manager R cleaning resident room 101 revealed: *She had not used the agency cleaning checklists to keep track of what she had completed. *She stated she had been responsible for training the laundry and housekeeping staff and would expect them to use the checklists. *She had not been tracking the checklists as she had been the only housekeeper on staff. *While cleaning the restroom of room 101 she had sprayed the peroxide cleaner on the toilet and stated it had a three-minute wait time. *She proceeded to clean other areas of the restroom and then continued wiping down the toilet. *She had not waited three minutes before wiping down the surface of the toilet. *She had not made it a practice to use a timer and had just estimated the time. *Once she had completed that task she had not changed her gloves. *Using the same gloved hands she grabbed the mop and placed and clean mop head on it. *She had not swept the floor before mopping it, stating it had been easier for her to gather the dirt as she mopped. *Once the floor had been mopped she gathered the dirt inside of the mop-head, discarded the dirt, then placed the mop-head into a plastic bag. *She agreed that her gloves should have been changed after cleaning the toilet and before using the mop. *She agreed that she should use a timer for the	F 880		

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 _____	08/25/2021

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 880	Continued From page 76 three-minute wait time. *She agreed she had not followed the company policy for cleaning rooms as listed on the checklist. *She admits that she had been "slacking" lately and had not cleaned the facility to the best of her ability. Further interview on 8/19/21 at 2:04 p.m. with laundry/housekeeping manager R revealed: *She had been working long days. *Her priority was to make sure the resident rooms were cleaned. *She stated she was normally able to get all of the resident rooms cleaned each day. *If she had not completed all the rooms, she would start on those the next day. *She had not always had time to clean the other areas of the facilities such as the shower/tub rooms or utility rooms. *Confirmation she had not used the cleaning checklists as was the policy of her agency. *She agreed she had not been able to keep up with all of the cleaning tasks. *Stated she was the only one doing housekeeping and hoped they could get someone hired soon. Review of the 9/5/2017 daily patient room cleaning checklist revealed: *A. Announce yourself at the door. *B. Do quick straighten up. *C. Follow 5-step room cleaning method: -1. Empty trash. -2. Horizontal dusting. -3. Spot clean with a cloth and disinfectant all vertical surfaces. -4. Dust mop the floor. -5. Damp mop	F 880		

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F 880	Continued From page 77 *When disinfecting, please be sure to use an EPA-approved solution and to allow for the recommended solution dwell time. Review of the high touch services log for August 2021 revealed: *It was to be completed three times daily, in the morning, noon and afternoons. *There had been blank entries for: -8/6/21 on the a.m. and afternoon times. -8/10/21 on the noon and afternoon times. -8/11/21 on the noon time. -8/12 on the afternoon time. -8/17 all times. -8/18 all times. -8/21 all times. -8/22 all times. -8/23 afternoon time. Review of the laundry/housekeeping manager job description revealed: *Interviews, hires and orients housekeeping, floor care and laundry staff. *Communicates between various shifts to ensure completion of tasks. *Maintains proper staffing levels and schedules all environmental services staff. *Supervises, coordinates and evaluates work of all environmental services employees. *Trains workers in housekeeping, floor care and laundry methods and procedures and proper operation of equipment. *Daily inspection (quality control inspections) and follows through on all assignments, directives and projects to ensure task completion. Review of housekeeping services assessment reports submitted by administrator A for the cleaning contract company revealed:	F 880		

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F 880	Continued From page 78 *She had assessed housekeeping services the following dates and rankings on a scale of 1-70 points: *3/15/21 had given 58/70 points which were ranked as average to good services. *4/30/21 had given 61/70 points which were ranked as good to excellent services. *No report of May 2021. *6/29/21 had given 60/70 points which were ranked as good to excellent services. *7/29/21 had given 57/70 points which were ranked as average to good services. Interview with administrator A on 8/23/19 at 5:33 p.m. revealed: *She stated she had not done environmental audits of the building. *She expected her unit managers to do walk throughs and check for any problems in the resident rooms. *All staff should be helping out to keep the areas clean and safe. Surveyor: 42477 Observation on 8/18/21 at 7:40 a.m. with LPN D revealed he had: *Been in a resident 143's room. *Been in the process of cleaning what appeared to be feces off of the floor. *Came out of the room with the same soiled gloves he had used to clean up the feces. *Touched the medication cart with those same soiled gloves. *Then removed the soiled gloves and put them in on top of the medication cart. *Reached inside the medication cart drawer and grabbed a clean pair of gloves. *Not performed hand hygiene. *Not sanitized the top of the medication cart.	F 880		

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F 880	Continued From page 79 Observation on 8/18/21 at 11:56 a.m. with LPN D revealed he had: *Been getting ready to check a resident 32's blood glucose. *Brought his items into the resident's room. *Laid a down a piece of hamburger patty wax paper on top of a stack of the resident's papers. -The patty paper was approximately 5 inches by 5 inches. *The patty paper was not big enough to contain the glucometer, gloves, and alcohol pad. *Checked the resident's blood glucose and with the soiled gloves he brought the soiled glucometer back to the medication cart. *Laid the soiled glucometer on top of the medication cart. *Grabbed a bleach wipe and wrapped it around the glucometer, still wearing the soiled gloves. *Not wiped the glucometer off or cleaned it for the recommended three minutes. Further observation on 8/18/21 at 2:07 p.m. with LPN D revealed he: *Was going to administer IV antibiotics to resident 31. -She was to receive antibiotics for an infection every six hours. *Had put on gloves and went into the resident's room and he: -Put patty paper on top of the bedside table, on top of the resident's items. -Had taken down the old empty antibiotic bag, placed it in his pocket. -Had taken the previously used IV tubing and laid it on the resident's bed, on top of her blanket. -Reached in his pocket with the same gloves and grabbed a pen. -Used the pen to poke through the perforated tab	F 880		

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F 880	Continued From page 80 to hang the IV bag. -Had used those same gloves to connect the iv tubing to the iv antibiotics and start the infusion. Observation and interview on 8/19/21 at 7:41 a.m. with CMA M revealed: *Entered resident 2's room. *Placed a piece of patty paper on the resident's bedside table. *Placed the glucometer, alcohol pad, cotton ball on top of the patty paper. *The resident's tv remote control was also located on the paper. *Washed her hands for approximately 5 seconds. *Had put on gloves and checked the resident's blood glucose reading. *Wearing her soiled gloves she had walked back out to the medication cart: -Put the soiled glucometer down on the cart. -Grabbed a wipe. *She had wrapped the glucometer with a bleach wipe but did not clean the glucometer. Observation on 8/23/21 at 2:25 p.m. with CMA M, RN E, and CNA I revealed: *They had just used a lift to transfer a resident. *They did not disinfect the lift after using it. Refer to F584-B. Findings 1-4.	F 880		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement	F 886	See next page.	

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F 886	Continued From page 81 and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms	F 886	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey. 2. All staff will be educated by ED or designee on testing protocols based on county positivity rate from CMS staff will be tested by staff competent to test and on call in procedures regarding symptoms of Covid 19 by 9/23/2021. All staff not in attendance will be educated prior to their next working shift. 3. The ED or designee will audit testing performed in the center and staff knowledge of call in of symptoms on a random sample of 4 staff weekly times four weeks and monthly times two months. The ED or designee will take the results of these audits to the monthly QAPI committee for urther review and recommendation to continue or discontinue the audits.	9/23/21

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F 886	Continued From page 82 consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, record review, and policy review, the provider failed to follow testing procedures for staff who worked in their building. Findings include: 1. Observation on 8/18/21 at 9:00 a.m. of the facility's side entrance revealed; *They had a cart set up with COVID-19 testing information. *There had been a sign that stated that staff were responsible for ensuring they tested two times per week. *Staff were testing themselves. Review of the provider's employee testing documentation revealed: *There were inconsistencies noted such as: -Not all staff were tested two times per week as required. -New employees had not been added to the testing log.	F 886		

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F 886	Continued From page 83 -Some staff were testing themselves one day apart, for the testing two times per week. Observation on 8/18/21 from 10:00 a.m. through 2:00 p.m. revealed a staff member had performed a COVID-19 test and had left it on the testing cart. It had not been read within the correct time frame. Interview on 8/23/21 05:34 PM with administrator A revealed she agreed: *The COVID-19 tests needed to be read within a certain amount of time. *That housekeeping staff who are symptomatic are required to be tested. *New staff and agency staff need to be tested prior to working. Review of the provider's October 2020 Interim Guidelines for Collecting, Handling, and testing Clinical Specimens from Residents for Coronavirus Disease 2019 (COVID-19) revealed: *Health care personnel who were collecting specimens were to be wearing proper personal protective equipment (PPE), which included respirators, gloves, and gloves. *"Proper collection of specimens is the most important step in the laboratory diagnosis of infectious diseases. The following specimen collection guidelines follow standard recommended procedures." Review of the provider's September 2020 COVID-19 Abbott BinaxNOW POC Device Policy and Procedure revealed: *Staff were supposed to review information and take a competency for administering tests. *Results were to be read 15 minutes after closing the card.	F 886		

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F 886	Continued From page 84 -Results were to be recorded after 15 minutes had passed. Surveyor: 41088 Observation and interview on 8/19/21 at 9:31 a.m. with laundry/housekeeping manager R and district manager T while in the laundry room revealed: *District manager T had been in the process of giving a tour regarding laundry and housekeeping services. *Laundry/housekeeping manager R entered the laundry room. *She had been wearing a N-95 mask and faceshield. *She announced to district manager T that she had been ill with symptoms of diarrhea and vomiting. *She had used the COVID-19 kiosk to sign into the building and it had directed her to contact the administrator after she had entered her symptoms. *District manager T asked her to go home and avoid walking through the hallway. *She left the building. *Laundry/housekeeping manager R had been trained to call in to the facility if she had any COVID-19 symptoms. Interview on 8/23/21 at 5:43 p.m. with administrator A regarding Laundry/housekeeping manager R revealed: *Staff are not supposed to come into the building if they are not feeling well. *She had received training on what to do if she had symptoms. *She should have called and stayed home. *She had been tested for COVID-19 before she came back to work and tested negative.	F 886		

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F 886	Continued From page 85 *She thought laundry/housekeeping manager R could have been avoiding the survey team. Interview on 8/24/21 at 2:04 p.m. with laundry/housekeeping manager R revealed: *She had gone home on 8/19/21 after she spoke with district manager T in the laundry room. *She thought it was something she ate that caused her symptoms. *She had come to the facility and been tested twice for COVID-19 by her district manager prior to working. *She had been tested while she remained in her car. *Both tests had been negative. *She agreed she should have stayed home and called in rather than coming into the building.	F 886		

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

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E 000	Initial Comments Surveyor: 26632 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 8/17/21 through 8/19/21 and from 8/23/21 through 8/25/21. Palisade Healthcare Center was found in compliance.	E 000		

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

Lourdes Parker | Administrator | 9/19/2021

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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	435115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/18/2021**

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/18/21. Palisade Healthcare Center 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 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K222, K300, K321, K355, K362 and K363 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the	K 222	1.All residents have the potential to be affected. Dining Room and East exit door has been resolved on 8/19/2021. S.E. exit door has been resolved on 8/21/2021. 2.The Executive Director or designee will educate all staff to bring any issues to the attention of the Maintenance Department by 9/23/2021. All staff not in attendance will be educated prior to their next working shift. 3.Audits to be conducted weekly times four then monthly times two to ensure doors are functioning. All audits will be brought to monthly QAPI committee for review and recommendations to continue or discontinue audits.	9/23/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lourdes Parker	Executive Director	9/20/21

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PALISADE HEALTHCARE CENTER	**920 4TH ST** **GARRETSON, SD 57030**

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K 222	Continued From page 1 Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 222		

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 _____	**08/18/2021**

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

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K 222	Continued From page 2 Surveyor: 27198 Based on observation, testing, and interview, the provider failed to provide operable egress doors as required at two randomly observed exit door locations (dining room and southeast wing). Findings include: 1. Observation beginning at 12:00 p.m. on 8/18/21 revealed the east facing dining room exit door was unable to be easily opened. Testing of the door revealed it would not open without applying greater than fifty pounds of force in the direction of the path of egress. Interview at the time of the observation with the maintenance director confirmed those conditions. He stated he was unaware that door was not able to be opened. 2. Observation beginning at 1:35 p.m. on 8/18/21 revealed the southeast wing exit door was unable to be easily opened. Testing of the door revealed it would not open without applying greater than fifty pounds of force in the direction of the path of egress. Interview with the maintenance director at the time of the observations confirmed those conditions. He stated he was unaware that door was not able to be opened. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiencies affected 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3),	K 222		

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	435115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/18/2021**

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K 222	Continued From page 3 7.2.1.6.2(3)(a)	K 222		
K 300 SS=D	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to maintain the fire-resistive rating for one of one randomly observed ninety-minute rated fire doors (outside of administrator's office). Findings include: 1. Observation and testing at 2:48 p.m. on 8/18/21 revealed the east leaf of the ninety-minute, cross-corridor doors in the corridor, outside of administrator's office was not latching. That door leaf must latch to maintain the ninety-minute fire-rating of the cross-corridor doors. Interview with the maintenance director at the time of the observation confirmed that finding. He stated he was unaware that condition existed. He further stated this door had previously latched	K 300	1.All residents have the potential to be affected. Fire doors outside of the Administrator's office were corrected on 9/16/2021. 2.The Executive Director or designee will educate all staff about the fire doors needing to latch by 9/23/2021. All staff not in attendance will be educated prior to their next working shift. 3.Audits to be conducted weekly times four then monthly times two to ensure doors are latching properly. Audits will be brought to monthly QAPI for review and recommedations to continue or discontinue audts.	9/23/2021

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K 300	Continued From page 4 when he tested it as part of his monthly maintenance in the previous month. The deficiency could affect 100% of the occupants of the smoke compartments on either side of the cross-corridor doors.	K 300		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 321	1.All residents have the potential to be affected. The maintenace office door, linen storage room and the boiler room door were all corrected 8/26/2021. 2.The Executive Director or designee will educate all staff on Hazardous areas and Enclosure by 9/23/2021. All staff not in attendance will be educated prior to their next working shift. 3.Audits to be conducted weekly times four then monthly times two. Audits will be brought to monthly QAPI committee for review and recommendations to continue or discontinue audits.	9/23/2021

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K 321	Continued From page 5 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to maintain three separate hazardous areas (maintenance storage room, linen storage room, and boiler room) as required. Findings include: 1. Observation and testing at 10:04 a.m. on 8/18/21 revealed the maintenance storage room was over 100 square feet and contained combustible items. The door from that room to the corridor was equipped with a closer but would not latch into the frame under the power of the closer. That room is considered a hazardous area and that door is required to automatically latch into the door frame. 2. Observation and testing at 10:52 a.m. on 8/18/21 revealed the linen storage room was over 100 square feet and contained combustible items. The door from that room to the corridor was equipped with a closer but would not latch into the frame under the power of the closer. That room is considered a hazardous area and that door is required to automatically latch into the door frame. 3. Observation and testing at 1:15 p.m. on 8/18/21 revealed the door from the boiler room was not equipped with a closer and would not automatically latch into the door frame. That room is considered a hazardous area and that door is required to automatically latch into the door frame. Interview with the maintenance director at the time of the observations confirmed those findings.	K 321		

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	435115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/18/2021**

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K 321	Continued From page 6 Failure to provide separation from hazardous areas as required increases the risk of death or injury due to fire. The deficiencies affected 100% of the building occupants.	K 321		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider failed to properly mount four randomly observed fire extinguishers (laundry room, outside the clock room, boiler room, and north conference room). Findings include: 1. Observation at 10:52 a.m. on 8/18/21 revealed the extinguisher on the wall in the laundry room was mounted with the top seventy inches from the ground. That height was ten inches above the maximum five feet allowed by the standard for portable fire extinguishers. The deficiency has the potential to affect the entire smoke compartment. 2. Observation at 12:18 p.m. on 8/18/21 revealed the extinguisher on the corridor wall outside the clock room was mounted with the top sixty-eight	K 355	1.All residents have the potential to be affected. All portable fire extinguishers have been corrected on 8/26/2021. Laundry room, outside the time clock room, boiler room and the North conference room were repositioned below 60". 2.The Executive Director or designee will educate all staff on the Portable Fire Extinguishers and the appopriate height by 9/23/2021. All staff not in attendance will be educated prior to their next working shift. 3. Audits will be conducted weekly times four then monthly times two. Audits will be brought to monthly QAPI committee for review and recommendations to continue or discontinue audits.	9/23/2021

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K 355	Continued From page 7 inches from the ground. That height was eight inches above the maximum five feet allowed by the standard for portable fire extinguishers. The deficiency has the potential to affect the entire smoke compartment. 3. Observation at 1:52 p.m. on 8/18/21 revealed the extinguisher on the wall of the boiler room was mounted with the top sixty-seven inches from the ground. That height was seven inches above the maximum five feet allowed by the standard for portable fire extinguishers. The deficiency has the potential to affect the entire smoke compartment. 4. Observation at 2:48 p.m. on 8/18/21 revealed the extinguisher on the wall of the north conference room was mounted with the top sixty-four inches from the ground. That height was four inches above the maximum five feet allowed by the standard for portable fire extinguishers. The deficiency has the potential to affect the entire smoke compartment. Interview with the maintenance director at the time of the observations confirmed those findings. He stated he was unaware of the maximum height requirement for fire extinguishers.	K 355		
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls	K 362		

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K 362	Continued From page 8 constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider failed to maintain a corridor separation from staff use areas at one randomly observed room (administration office). Findings include: 1. Observation beginning at 10:44 a.m. on 8/18/21 revealed the administration office had a portable air conditioner installed with its exhaust vented through the wall. That vent compromised the smoke tight rating of the wall and made that room open to the corridor. That room was not equipped with a smoke detector on the fire alarm system. Rooms open to the corridor require smoke detection tied into the buildings fire alarm system. Interview with the maintenance director the time of the observations confirmed that finding. He	K 362	1.All residents have the potential to be affected. Administrator's office has a portable AC unit with the exhaust vented through the wall. The AC unit will be removed and the wall repaired by 9/23/2021. 2. The Executive Director or designee will educate all staff on Construction of walls by 9/23/2021. All staff not in attendance will be educated prior to their next working shift. 3.Audits to be conducted weekly times four weeks then monthly times two. Audits will be brought to monthly QAPI committee for review and recommendations to continue or discontinue audits.	9/23/2021

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K 362	Continued From page 9 stated that condition had existed the entire time he had been employed there. The deficiency has the potential to affect the entire smoke compartment.	K 362		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or	K 363	1.All residents have the potential to be affected. The S.Kitchen door and N.conference room were corrected as of 8/28/202. 2.The Executive Director or designee will educate all staff on the Corridor Doors and latching properly by 9/23/2021. All staff not in attendance will be educated prior to their next working shift. 3.Audits wll be conducted weekly times four then monthly times two. Audits will be brought to monthly QAPI committee for review and recommendations to continue or discontinue audits.	9/23/2021

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K 363	Continued From page 10 frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to ensure two randomly observed corridor doors (kitchen service entrance and north conference room) were equipped with functioning positive latching hardware. Findings include: 1. Observation and testing at 11:16 a.m. on 8/18/21 revealed the corridor door from the kitchen to the service corridor revealed the door was equipped with a closer but it was not automatically latching into the door frame. That door hit its frame upon closing and kept it form latching. 2. Observation and testing at 2:50 p.m. on 8/18/21 revealed the corridor door from the kitchen to the service corridor revealed the door was equipped with a closer but it was not automatically latching into the door frame. That door hit its frame at the top corner upon closing and kept it form latching. Doors provided with closers are required to latch into their frames automatically. Interview with the maintenance director at the time of the observations confirmed those findings. He stated he was unaware of those conditions.	K 363		

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K 363	Continued From page 11 Those deficiencies could affect 100% of the occupants of their smoke compartments.	K 363		

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	10623	A. BUILDING: _____ B. WING _____	08/25/2021

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S 000	Compliance/Noncompliance Statement Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/17/21 through 8/19/21 and 8/23/21 through 8/25/21. Palisade Healthcare Center was found not in compliance with the following requirements: S236, S301, S355, S443 and S447.	S 000	AI	
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 236	1. All resident and staff have the potential to be affected. All staff, in 2021, not in compliance will have one TB skin test completed and for staff with no records in 2021, Staff Development nurse will start the 2-step skin tests prior to 9/23/2021. 2.The Executive Director or designee will educate the Staff Development nurse onTuberculin screening and skin test policy when the facility is not in compliance, and the corrective actions taken, by 9/23/2021. 3. Staff Development nurse or designee will complete audits on ensuring TB screening and testing is maintained on all new hires per protocol. Will conducted weekly times four and monthly times two months by the Staff Development nurse or designee. The Staff Development nurse will take audits to monthly QAPI committeefor further review and recommendation to continue or discontinue the audits.	9/23/21

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

TITLE: Executive Director

(X6) DATE: 9/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 236	Continued From page 1 This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 26632 Based on interview and record review, the provider failed to ensure eight of eight randomly sampled employees (D, E, F, G, H, P, W, and X) had a two-step tuberculin (TB) skin test completed within fourteen days of hire. Findings include: 1. Review of the following personnel health records revealed: *The following staff had no record of a TB skin test: -Licensed practical nurse (LPN) D had been hired on 6/21/21. There was no record of any TB skin tests. -LPN F had been hired on 3/23/21. There was no record of any TB skin tests. -RN P had been hired on 5/3/21. There was no record of any TB skin tests. -Dietary aide W had been hired on 6/2/21. There was no record of any TB skin tests. *The following staff had their second TB skin test outside the required time frame: -Social service designee H had been hired on 1/13/21. Her second TB skin test had not been completed until 3/29/21. That was over two months after her date of hire. -RN X had been hired on 1/7/21. Her second TB skin test had not been completed until 2/10/21. That was more than one month after her date of hire. -Registered nurse (RN) E had been hired on 3/22/21. Her second TB skin test was on 4/7/21 sixteen days after her date of hire. *Certified nursing assistant G had been hired on 5/28/21. Her two-step TB skin tests had not been started until 6/17/21. Eighteen days after her date	S 236		

South Dakota Department of Health

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	10623	A. BUILDING: _____ B. WING _____	08/25/2021

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 236	Continued From page 2 of hire. Interview on 8/24/21 at 3:30 p.m. with interim director of nursing/divisional director of clinical operations B confirmed the above employees had not received their two-step TB skin tests within the required time frame. She stated there was no policy regarding TB skin tests.	S 236		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 26632 Based on interview and record review, the provider failed to ensure all of the required dietary training's (food safety, hand washing, food handling/prep, food-borne illness, serving and distribution, leftovers, time/temp controls, nutrition/hydration, and sanitation) were completed by all dietary staff. Findings include: 1. Review of the provider's last dietary training revealed the last training had been conducted in March 2020. They were individual inservices and had not covered all the required topics. Interview on 8/24/21 at 3:00 p.m. with dietary manager S and administrator A confirmed the	S 301	1. All residents have the potential to be affected. Ongoing annual dietary inservices will be conducted with all dietary staff via Relias and in-services held by Registered Dietician or designee. All new hires will have the required Dietary training provided by the Dietary manager or designee. 2. Executive Director or designee will educate all staff on ensuring the ongoing inservice training for all dietary and food-handling employees is completed accordingly. Education will be provided by 9/23/2021. All staff not in attendancewill be educated prior to their next scheduled working shift. 3.Audits will be conducted to ensure dietary training are being conducted weekly times 4 weeks and then monthly times 2 months by the Dietary manager or designee. Dietary manger will take to QAPI committee for further review andrecommendations to continue or discontinue the audits.	9/23/21

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S 301	Continued From page 3 dietary training had not been completed in the last twelve months that covered all the required topics. Administrator A stated the training could be on Relias, their online training platform. Those records had been requested and were never received. There was no policy on the mandatory dietary training.	S 301		
S 355	44:73:10:04 Provision of Social Services A facility shall provide or make arrangements to provide social services for each resident as needed. A staff social worker or social service designee shall be designated as responsible to facilitate the provision of social services. If the staff member is not a social worker, the facility shall have a written agreement with a social worker for consultation and assistance to be provided on a regularly scheduled basis but at least quarterly. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 26632 Based on interview and record review, the provider failed to have a social worker provide quarterly consultations during the COVID-19 pandemic. Findings include: 1. Interview on 8/24/21 at 10:00 a.m. with social services designee (SSD) H revealed: *She had been the SSD since January 2021. *There had been no SW consultation until 7/29/21. *She was not aware this was to have occurred every quarter. Interview on 8/25/21 at 10:30 a.m. with administrator A revealed social worker V had not	S 355 S 355	1. All residents have the potential to be affected. Social Services Designee has quarterly visits with Social Service Consultant and will receive the reports from these visits. The Executive Director will review these reports. 2.The Executive Director or designee will educate all staff on ensuring the Social Service Consultant visits are done Quarterly. 3. The ED will review quarterly reports and review the results at monthly QAPI committee.	9/23/21

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S 355	Continued From page 4 been to the facility since the COVID-19 pandemic. There had been no remote consultations during that time. Review of the 7/29/21 social work consultation onsite visit documentation revealed social worker W had received a call from administrator A to resume contracted visits with SSD H.	S 355		
S 443	44:73:12:34 Vacuum Breakers An antisiphon device or backflow preventer shall be installed on any hose bib and on any fixture to which hoses or tubing can be attached such as janitor sink, bedpan flushing attachment, and handheld shower. An antisiphon device or backflow preventer shall be installed on all plumbing and equipment where any possibility exists for contamination of the potable water supply. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider failed to install a vacuum breaker on a hand-held shower hose in one randomly observed shower rooms (north wing locations). Findings include: 1. Observation on 8/18/21 beginning at 2:54 p.m. revealed the hand-held hose in the following location was directly attached to the main water supply line and were not equipped with a vacuum breaker: *The shower in the north wing shower room. Interview with the maintenance director at the time of the observation confirmed there was not a vacuum breaker on that shower hose.	S 443	1. All residents have the potential to be affected. The North and South hand held showers had vacuum breakers installed on 8/25/2021. 2. The Executive Director or designee will educate all staff on the vacuum breakers by 9/23/2021. Maintenance personnal was educated on the importance of the vacuum breakers by the Life Safety surveyor. All staff not in attendance will be educated prior to their next working scheduled shift. 3.Maintenance designee or designee will conduct audits weekly times four then monthly times two to ensure the vacuum breakers are in working conditions. Maintenance designee or designee will bring the audits to monthly QAPI committee for review and recommendations to continue or discontinue the audits.	9/23/21

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S 447	44:73:12:38 Lighting Any space occupied by people, machinery, or equipment within buildings, the approaches to the buildings, and parking lots shall have artificial lighting approved by the department. Each resident bedroom shall have general lighting of at least ten footcandles (0.929 lumens per square meter) and night lighting. If task illumination is required, a light with an intensity of at least 30 footcandles (2.79 lumens per square meter) at the work surface shall be provided for each resident. At least one luminaire for night lighting shall be switched at the entrance to each resident room. Any resident's reading light and other fixed light not switched at the door shall have a switch control convenient for use at the luminaire. Each switch for control of lighting in a resident area shall be of the quiet operating type. Illumination of at least 100 footcandles (9.29 lumens per square meter) shall be provided at the medication set-up area. Illumination of at least 50 footcandles (4.65 lumens per square meter) shall be provided at the activity room work tables. Illumination of at least 30 footcandles (2.79 lumens per square meter) shall be provided in each dining area, physical and restorative therapy area, and at any bathing facility. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider failed to furnish 100 foot-candles of illumination for one randomly observed medication room Findings include: 1. Observation beginning at 10:39 a.m. on 8/18/21 revealed the medication set up area in the medication room did not have the minimum 100 foot-candles of lighting required. That room	S 447	1.All residents can be potentially affected. The lighting in the medication room will be corrected by 9/23/2021 as an electrician needs to fix. 2.Executive Director or designee will conduct education by 9/23/2021 on the lighting in the medication and any lighting issues will be reported to maintenance personnel. All staff not in attendance will be educated by their next working shift. 3.Maintenance designee or designee will conduct audits to ensure the lighting is at least 100 footcandles in the medication set up area, weekly times four weeks then monthly times two. Maintenance designee or designee will take to monthly QAPI committee for review and recommendation to continue or discontinue the audits.	9/23/21

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S 447	Continued From page 6 had lighting fixtures that were not completely operational. Interview with the maintenance director at the time of the observation confirmed there were light fixtures not working in the medication room.	S 447		