

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Palisade Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 920 4th St Garretson, SD 57030	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51370</p> <p>Based on South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI), interview, record review, and policy review, the provider failed to protect one of one (1) resident from neglect due to failure to provide physician-ordered care. Findings include:</p> <p>1. Review of the provider's SD DOH FRI report submitted on 10/28/24 at 7:27 p.m. revealed:</p> <p>*Resident 1 had a diagnosis of psoriasis (a skin disease that causes a rash and itchy, scaly patches).</p> <p>* On 10/27/24 a family member of resident 1 visited the facility and reported care concerns to another family member.</p> <p>-The room had a foul odor.</p> <p>-The resident's sock was very dirty and saturated.</p> <p>-Maggots were found on his feet.</p> <p>*The family member went to the nurse on duty on 10/27/24 with her concerns.</p> <p>-The nurse sent a certified nursing assistant (CNA) to help clean up the resident.</p> <p>*On 10/28/24 a different family member brought these concerns to administrator A and director of nursing (DON) B:</p> <p>*An assessment of resident 1's legs completed by DON B and the facility wound nurse indicated:</p> <p>-His socks were saturated with drainage from his legs.</p> <p>-He had reddened lower extremities with patches of dry skin from his knees to his toes.</p> <p>-His legs appeared edematous (swollen with fluid).</p> <p>-Nurses cleaned his legs with soap and warm water.</p> <p>(continued on next page)</p>

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Palisade Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 920 4th St Garretson, SD 57030	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-No evidence of maggots were present.</p> <p>*DON B asked resident 1 when he last had lotion applied to his legs per his physician's orders.</p> <p>-He reported that did it last night and put clean socks on.</p> <p>-He stated prior to that it had been a few days during the day.</p> <p>-He reported no treatment was done that day prior to when DON B and the wound care nurse assessed him.</p> <p>*His ordered leg treatment was documented in his electronic medical record (EMR) as completed every shift including that day by licensed practical nurse (LPN) C.</p> <p>*On 10/28/24 DON B interviewed LPN C regarding the care concerns reported by resident 1's spouse on 10/27/24.</p> <p>-When asked what resident 1's legs looked like on 10/27/24, LPN C stated I didn't look at them yesterday.</p> <p>-She sent a CNA to clean up his legs and feet after the family member came to her with concerns.</p> <p>-LPN C stated she again didn't do his treatment and stated that was on me.</p> <p>*DON B asked LPN C about the documentation that indicated his leg care had been completed on 10/27/24 and 10/28/24.</p> <p>-LPN C stated, I haven't done it yet.</p> <p>*DON B immediately placed LPN C on suspension while a further investigation was done related to suspected neglect.</p> <p>*LPN C was terminated on 10/28/24 due to false documentation of treatment completion.</p> <p>-DON B notified the Board of Nursing in the state where LPN C's license was issued.</p> <p>-The South Dakota Board of Nursing contacted DON B after being notified by that state's Board of Nursing.</p> <p>Review of resident 1's EMR revealed:</p> <p>*Resident 1 was admitted on [DATE].</p> <p>*There were current orders for bilateral lower extremity care including:</p> <p>-Aquaphor External Ointment (moisturizer) apply to dry skin topically every shift for dry skin related to Psoriasis Vulgaris.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Palisade Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 920 4th St Garretson, SD 57030	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-LPN C initialed that she completed that treatment on 10/25/24, 10/26/24, 10/27/24, and 10/28/24.</p> <p>Interview on 11/26/24 at 11:10 a.m. with DON B revealed:</p> <p>-Resident 1 was admitted on [DATE] with orders for skin care by applying Aquaphor ointment to his bilateral lower extremities.</p> <p>*His family member came to her on 10/28/24 with concerns of resident 1's care that were expressed to her by another family member who had visited resident 1 on 10/27/24.</p> <p>-She was provided with pictures taken on 10/27/24 of resident 1's foot that showed heavily saturated stained socks and clearly visible maggots near his toes.</p> <p>-DON B confirmed that the picture background was of resident 1's room at the facility when showing the pictures to this surveyor.</p> <p>*She would have expected nursing staff to follow doctor's order and to document appropriately.</p> <p>*She agreed that wound care not provided daily as ordered would be considered neglect if it could cause harm.</p> <p>*During the 10/28/24 investigation, LPN C admitted to DON B that she had been using vinegar to wash Resident 1's legs.</p> <p>-There was no order to use vinegar as a skin wash on resident 1's legs in his EMR.</p> <p>*There was a physician's order dated 11/14/24 to stop using vinegar for skin cleaning. Just use warm soapy water.</p> <p>-The order was in response to a contact by family member who was concerned that LPN C was washing resident 1's legs with vinegar.</p> <p>Interview on 11/26/24 at 1:45 p.m. with administrator A revealed:</p> <p>*She was approached on 10/28/24 by a family member of resident 1 with concerns about his care.</p> <p>-She was shown pictures of resident 1's feet with maggots visible.</p> <p>*She immediately brought in DON B who provided care to resident 1 and began the investigation.</p> <p>*Her expectations regarding wound care were for the nursing staff to follow the doctor's orders, if you're signing something off it had better be done.</p> <p>*She agreed that maggots in a wound would be considered harmful to some extent, definitely neglect.</p> <p>*She directed DON B to report LPN C to the Board of Nursing.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Palisade Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 920 4th St Garretson, SD 57030	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the provider's updated October 2022 Abuse, Neglect, and Misappropriation of Resident Property Prohibition Policy revealed:</p> <p>*Each resident has the right to be free from abuse, including verbal, mental, sexual, or physical abuse, corporal punishment, involuntary seclusion, mistreatment, neglect .</p> <p>*Definition of Deprivation of Goods or Services by Staff: The deprivation by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. In these cases, staff has the knowledge and ability to provide care and service, but choose not to do it, or acknowledge the request for assistance³ from a resident(s), which result in care deficits to a resident.</p> <p>*Definition of Neglect: Failure of the Center, its employees or service providers to provide goods and eservices to a resident that are necessary to avoid physical harm pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in physical harm, pain, mental anguish, or emotional distress.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Palisade Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 920 4th St Garretson, SD 57030	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>50015</p> <p>Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review and interview the provider failed to ensure the care plan reflected the current individualized care needs for one of one sampled resident (1) with physician-ordered skin treatments. Findings include:</p> <p>1. Review of resident 1's electronic medical record (EMR) revealed:</p> <p>*He had physician orders dated 10/31/24 for skin care to lower extremities (LE) every day shift.</p> <p>-LE were to be washed daily with warm soapy water.</p> <p>-Pat dry.</p> <p>-Apply Aquaphor external ointment.</p> <p>-Apply ABD pads to areas that are weeping.</p> <p>-Wrap with Kerlix.</p> <p>-Apply Ace wraps (compression wraps) from toes to knees.</p> <p>-Aquaphor external ointment was discontinued on 11/7/24.</p> <p>-Vaseline was started on 11/7/24.</p> <p>-An order dated 10/31/24 for Ace wraps to be removed every night shift.</p> <p>*His diagnoses included:</p> <p>-Psoriasis Vulgaris (skin cells build up and form scales and itch dry patches of skin).</p> <p>-Vascular Dementia (brain damage caused by multiple strokes).</p> <p>-Diabetes Mellitus type two with other specified complications.</p> <p>-Peripheral vascular disease (blood flow is reduced to extremities).</p> <p>-Chronic Kidney Disease.</p> <p>-Bipolar disorder (mood swings from depressive lows to manic highs).</p> <p>-Localized edema.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Palisade Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 920 4th St Garretson, SD 57030	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*He had a Brief Interview for Mental Status (BIMS) assessment score of 14 which indicated he was cognitively intact.</p> <p>*He had weekly skin observations completed on 10/16/24, 10/23/24, 11/4/24, 11/6/24,11/13/24 and 11/20/24. All noting no new area of concern.</p> <p>*Behavior charting documenting refusal of bathing care and leg treatment care.</p> <p>*Resident 1's current care plan revealed:</p> <p>*He had a focus area of activities of daily living (ADL) self-care performance deficit due to Dementia, Disease process: seizure activity initiated on 10/22/24.</p> <p>-He was Diabetic and had Psoriasis.</p> <p>*Interventions for his skin at risk were initiated on 10/22/24.</p> <p>-Barrier cream.</p> <p>-Lotion to dry skin.</p> <p>-Wheelchair cushion.</p> <p>-Pressure-reducing mattress to bed.</p> <p>-Resident requires skin inspection weekly.</p> <p>*His care plan did not indicate any other focus areas regarding skin condition/care.</p> <p>*Did not indicate dressing changes order by physician 10/31/24 to be completed every day shift.</p> <p>*His 11/5/24 comprehensive care conference meeting notes revealed:</p> <p>-He had a skin integrity issue.</p> <p>-He had skin care to LE's.</p> <p>-Wash with warm soapy water, pat dry, apply ABD's to areas that are weeping.</p> <p>-Wrap with Kerlix.</p> <p>-Apply ACE wraps from toe to knee. As needed.</p> <p>-Remove Ace wraps every night.</p> <p>2. Interview on 11/26/24 at 1:45 p.m. with administrator A revealed:</p> <p>*They did not have a care plan policy.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Palisade Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 920 4th St Garretson, SD 57030	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Director of nursing (DON) B or resident care manager (RCM)/licensed practical nurse (LPN) D would update care plans if there were changes regarding residents' skin issues or care needs.</p>