

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 03/12/2025
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>49238</p> <p>Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, and record review the provider failed to ensure one of one sampled resident's (1) care plan had been updated to reflect his current needs regarding the fall intervention for his use of a wheelchair with an anti-rollback bracket (to prevent it from rolling backward) as indicated in the provider's SD DOH FRI following the residents fall on 1/17/25 when he sustained a head laceration that required evaluation and stitches at a hospital. Findings include:</p> <p>1. Review of the provider's SD DOH facility online report revealed:</p> <p>*On 1/17/25 Resident 1 had been sitting in his wheelchair in the common area near the nurses' station watching television.</p> <p>-The nurse heard a crash and resident 1 yelled.</p> <p>-The nurse noted resident 1 had tipped forward in his wheelchair and hit his head on the floor.</p> <p>-Resident 1 was assessed and had a laceration to his left eyebrow that needed repair and the resident was sent to the hospital.</p> <p>-Resident 1 was able to ambulate short distances with staff.</p> <p>-He used the wheelchair for locomotion and was able to propel himself in the wheelchair or staff would propel him for longer distances.</p> <p>-He was known to self-transfer and was forgetful.</p> <p>-He had diagnoses of dementia, diabetes, memory deficit, delirium, cerebral infarction and psychosis disorder with hallucinations.</p> <p>-The fall was investigated, and it appeared resident 1's wheelchair brakes were not locked when he attempted to self-transfer.</p> <p>-A maintenance ticket had been placed to add an anti-roll back bracket on his wheelchair to prevent his wheelchair from rolling backwards if he attempted to self-transfer.</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
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident 1's care plan be updated to include that intervention.</p> <p>2. Review of resident 1's care plan dated 1/2025 revealed:</p> <p>*His problems list indicated:</p> <p>-He was at high risk for falls related to confusion, deconditioning, gait and balance problems, incontinence, poor communication/comprehension, psychoactive drug use, unaware of safety needs and history of falls.</p> <p>-He had multiple falls since admission due to cognition and impulsiveness.</p> <p>-He had a fall on 1/17/25 and had sutures above his left eye.</p> <p>*His interventions and tasks indicated staff to ensure:</p> <p>-A bedside commode be placed by his bedside at night to ensure that his toileting needs were met.</p> <p>-He had on appropriate nonskid footwear when walking or mobilizing in his wheelchair.</p> <p>-He had his call light within reach and encourage him to use it for assistance as needed.</p> <p>-Followed facility fall protocol.</p> <p>-Followed medical doctors orders for treatment of laceration above his left eye.</p> <p>-Provided a safe environment with even floors free from spills and/or clutter, adequate, glare-free light at night.</p> <p>-Placed his bed in low position at night.</p> <p>-He had handrails on walls.</p> <p>-He had personal items within reach.</p> <p>-His bed was kept in lowest position while he was in bed.</p> <p>-His room was kept free of clutter.</p> <p>-Purposeful staff rounded to ensure his needs are met.</p> <p>-Toileting assistance was offered to him upon rising, before and after meals, and a night and as needed.</p> <p>-His wheelchair would be placed next to his bed and in a locked position.</p> <p>-Included his wheelchair had an antiroll back bracket intervention.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Interview and observation on 3/12/25 at 12:00 p.m. with director of nursing (DON) B regarding resident 1's wheelchair revealed:</p> <ul style="list-style-type: none"> *Resident one was sitting in the incorrect chair. *His wheelchair was found in another resident's room. *She stated someone must have used his wheelchair for a different resident and had not returned it to resident 1. *Resident 1 was assisted into his correct wheelchair. *DON B stated each nurse manager had a group of residents they were responsible for to update their care plans, but this intervention had been missed. *The provider did not have a specific care plan policy to review. <p>4. Review of the provider's Fall Management and Neurological check policy dated 1/2025 revealed:</p> <p>*Procedure:</p> <ul style="list-style-type: none"> -3. The Minimum Data Set (MDS), including Care Area Assessment (CAA) is utilized to further evaluate resident risk of falls and the development of the comprehensive care plan. -5. The licensed nurse (LN) updates care plans reflecting individualized intervention in an attempt to reduce or prevent falls. -7. The residents care plan is reviewed quarterly and after a fall to determine effectiveness of current intervention and considers the residents goals, choices and preferences.

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49238</p> <p>Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review and policy review, the provider failed to ensure one of one resident (1) had an antiroll back bracket on his wheelchair to prevent it from rolling backwards when he attempted to stand up and self-transfer after he fell on [DATE] sustaining a laceration to his head and going to the hospital for sutures to that area. Findings include:</p> <p>1. Review of the provider's SD DOH facility online report revealed:</p> <p>*On 1/17/25 Resident 1 had been sitting in his wheelchair in the common area near the nurses' station watching television.</p> <ul style="list-style-type: none"> -The nurse heard a crash and resident 1 yelled. -The nurse noted resident 1 had tipped forward in his wheelchair and hit his head on the floor. -Resident 1 was assessed and had a laceration to his left eyebrow that needed repair and the resident was sent to the hospital. -Resident 1 was able to ambulate short distances with staff. -He used the wheelchair for locomotion and was able to propel himself in the wheelchair or staff would propel him for longer distances. -He was known to self-transfer and was forgetful. -He had diagnoses of dementia, diabetes, memory deficit, delirium, cerebral infarction and psychosis disorder with hallucinations. -The fall was investigated, and it appeared resident 1's wheelchair brakes were not locked when he attempted to self-transfer. -A maintenance ticket had been placed to add an anti-roll back bracket on his wheelchair to prevent his wheelchair from rolling backwards if he attempted to self-transfer. -Resident 1's care plan be updated to include that intervention. <p>2. Interview on 3/11/25 at 10:44 a.m. with resident 1's family revealed:</p> <ul style="list-style-type: none"> *Resident 1 liked to sit near the nurse's station and watch television. *Resident 1 had a fall a few months ago and had hit his head, and went to the hospital for stitches to his head. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*They stated he would attempt to get up by himself.</p> <p>3. Observation on 3/12/25 at 11:37 a.m. of resident 1 revealed:</p> <p>*He was sitting in his wheelchair in the common area near the nurses' watching television.</p> <p>-That wheelchair did not have an anti-roll back bracket on it.</p> <p>4. Interview on 3/12/25 at 11:38 a.m. with certified nursing assistant (CNA) C regarding resident 1's wheelchair revealed the wheelchair resident 1 was sitting in was not his wheelchair and it did not have an anti-roll back bracket on it.</p> <p>5. Observation and interview on 3/12/25 at 11:45 a.m. with administrator A of resident 1's wheelchair revealed:</p> <p>*She confirmed that resident 1 was not in his wheelchair and the one he was in did not have the anti-rollback bracket.</p> <p>*She then left the area to look for resident 1's wheelchair.</p> <p>6. Review of resident 1's care plan dated 1/2025 revealed:</p> <p>*His problems list indicated:</p> <p>-He was at high risk for falls related to confusion, deconditioning, gait and balance problems, incontinence, poor communication/comprehension, psychoactive drug use, unaware of safety needs and history of falls.</p> <p>-He had multiple falls since admission due to cognition and impulsiveness.</p> <p>-He had a fall on 1/17/25 and had sutures above his left eye.</p> <p>*His interventions and tasks indicated staff to ensure:</p> <p>-A bedside commode be placed by his bedside at night to ensure that his toileting needs were met.</p> <p>-He had on appropriate nonskid footwear when walking or mobilizing in his wheelchair.</p> <p>-He had his call light within reach and encourage him to use it for assistance as needed.</p> <p>-Followed facility fall protocol.</p> <p>-Followed medical doctors orders for treatment of laceration above his left eye.</p> <p>-Provided a safe environment with even floors free from spills and/or clutter, adequate, glare-free light at night.</p> <p>-Placed his bed in low position at night.</p> <p>(continued on next page)</p>		

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