

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 08/07/2025
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, interview, and policy review, the provider failed to report an allegation of suspected neglect for one of one sampled resident (56). This citation is considered past non-compliance based on the corrective actions the provider implemented immediately following the incident. Findings include:1. Review of the provider's 4/10/25 SD DOH FRI revealed:*On 4/3/25 certified nursing assistant (CNA)/certified medication aide (CMA)/activities director J reported via a grievance form that resident 56's incontinence product had not been changed on the night shift.*Resident 56 was noted to be very incontinent of urine.*Resident 56's diagnoses included: -Dementia (a group of symptoms affecting memory, thinking, and social abilities).-Congestive heart failure (heart does not pump blood as well as it should).-Chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe).-Agitation (feeling of restlessness or nervous excitement).*Resident 56 was receiving end-of-life hospice care services.*On 4/9/25 a skin review was completed for resident 56, with no new identified areas of concern noted.*Resident 56's care plan was reviewed and updated.*Resident 56's family and primary care provider was notified of incident.*Staff education was started.*CNA X was suspended pending investigation. 2. Interview on 8/6/25 at 8:26 a.m. with CNA/CMA/activity director J regarding the reported 4/3/25 incident revealed:*She started her shift at 6:00 a.m. on 4/3/25.*Resident 56 was in her recliner in the same clothes she had worn the day before.*Resident 56 was wet with urine from her waist down.*She was told by CNA X that resident 56 had behavioral episodes during the night shift and had refused to get changed.*When she provided resident 56's incontinence care, she did not observe any skin areas that were open.*She had filled out a grievance form later that day on 4/3/25 and turned it in. Interview on 8/6/25 at 4:12 p.m. with licensed practical nurse (LPN)/resident care manager (RCM) I revealed:*CNA/CMA/activities director J had given her a grievance form regarding resident 56 on 4/3/25.*She reviewed CNA documentation and behavior documentation for resident 56.*She had notified director of nursing (DON) B and was unsure if it was neglect due to resident 56's behaviors of refusing toileting when she asked CNA X.*Resident 56's skin evaluation had been completed on 4/9/25 and there were no new areas of concern noted.*She had given the grievance form to either DNS B or administrator A after completing her investigation on 4/4/25. Interview on 8/7/25 at 9:48 a.m. with DON B revealed:*She was notified of the grievance form on 4/7/25 by LPN/RCM I.*Based on the information shared with her she did not consider the 4/3/25 incident to have been a neglect issue.*She was unsure when administrator A was made aware of the 4/3/25 incident.*She was aware that allegations or incidents of neglect or abuse of a resident DOH needs to be notified within two hours. Interview on 8/7/25 at 10:01 a.m. with administrator A revealed:*She was notified of resident 56's incident on 4/10/25 at approximately 10:00 a.m.*CNA X had worked shifts on 4/3/25, 4/5/25, 4/6/25 and 4/8/25.*She identified the incident on 4/3/25 as a neglect issue and reported it to DOH on 4/10/25.*She had been out to a conference when the incident happened, no one notified her until 4/10/25.*CNA X was suspended on 4/10/25 and an investigation was initiated.*CNA X's employment was terminated on 4/11/25 after being interviewed and admitting to not changing resident 56's incontinence products. Review of the provider's updated September 2017 Grievance procedure Policy revealed:*8. If the grievance involves abuse, neglect, exploitation, or misappropriation of resident property, the ED [Administrator] is notified immediately, and an investigation begins. Review of the provider's published September 2017 Abuse Reporting and Response Policy revealed:*Policy statement: The center immediately reports all suspected and /or allegations of abuse, neglect, and exploitation of residents, misappropriation of resident property, mistreatment, and injuries of unknown source in accordance with state and federal law.*4. The Executive Director or designee reports alleged violations to the state survey agency and other officials in accordance with state law (such as Adult Protective Services and local law enforcement) as follows:a. Immediately but no later than 2 hours-All allegations of abuse, neglect.b. Immediately but not later than 24 hours- All allegations, if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The provider's implemented systemic changes to ensure the deficient practice does not reoccur was confirmed after record review revealed the facility had followed their quality assurance process, education was provided to all direct care staff regarding reporting abuse and neglect, what to do when residents reject cares and how to deal with refusals such as incontinence cares and toileting, what is a reportable incident and who needs to be contacted and within what time frame they need to be contacted. Continued monitoring on all residents through clinical alert monitoring was being</p>		