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	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palisade Healthcare Center	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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) complaint intake report review, record review, interview, and policy review, the provider failed to ensure staff provided quality care related to skin injury prevention and skin management processes including completing skin evaluations, accurate communication, accurate documentation, and implementing interventions and treatment orders for one of one sampled resident (1) who developed skin injuries to his left lower leg, left foot, and right lower leg and was hospitalized related to those wounds. Those failures put all residents at potential risk for serious injury or harm. Immediate Jeopardy (IJ) at F684 began on 11/18/25 when the provider failed to evaluate resident 1's left lower leg, left foot, and right lower leg wounds and implement appropriate follow-up procedures. *Administrator A was notified of the IJ on 11/18/25 at 4:03 p.m., and a removal plan was requested.*The IJ was removed on 11/19/25 at 1:00 p.m. as confirmed by onsite verification by the survey team. *After the IJ removal, the severity of non-compliance remained at a E.*Current census was 46. Findings include: 1. Review of the 11/12/25 SD DOH complaint intake report regarding resident 1 revealed:*Resident 1 went to his scheduled wound clinic appointment for treatment of his pressure ulcer (skin and/or underlying tissue injury caused by prolonged pressure) on his coccyx (tailbone), where it was determined that he needed to be transferred to the emergency room for further evaluation because of the condition of his left foot and left and right lower leg wounds. *The nursing home where resident 1 resided was aware and concerned of the left foot and both leg wounds and planned to move up his wound care treatment appointment to be seen earlier, but that did not occur. *The vascular physician indicated that resident 1's left foot and both leg wounds should have been treated sooner.*Resident 1 was admitted to the hospital on [DATE] with wounds to his left lower leg, left foot, and right lower leg. 2. Review of resident 1's electronic medical record (EMR) revealed: *He admitted to the nursing home on 8/29/25 with a pressure ulcer on his coccyx. That pressure ulcer was categorized as unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed) by licensed practical nurse (LPN) D on 9/2/25. *His 8/29/25 Brief Interview for Mental Status (BIMS) assessment score was 7 which indicated his cognition was severely impaired. *His diagnosis included chronic diastolic (congestive) heart failure, peripheral vascular disease (arteries narrow, restricting blood flow to the limbs), unspecified protein calorie malnutrition, and Brown-Sequard syndrome (damage to one half of the spinal cord that causes weakness and paralysis). Resident 1's current care plan (personalized plan that addresses a resident's care needs, goals, and interventions) revealed: *He was dependent on staff members to reposition him.*He required the use of a full body lift (a mechanical lift and sling used to lift a person's full body) for transferring. *He had actual impaired skin integrity related to his pressure injury to his coccyx and wounds (revised on 10/30/25) on his left heel, left inner ankle, left medial foot, and bilateral shins.Interventions last updated on 9/30/25 in that impaired skin integrity care plan area included:* Administer treatments as ordered and monitor for effectiveness.* Air mattress to bed.* [Name redacted] wound clinic as scheduled or as needed.* Inspect skin while providing care, notify nurse of any new skin conditions.* Pressure reducing cushion to wheelchair.* Use draw sheet to pull resident up in bed with two staff to prevent shearing.* Wound vac [a device that uses negative pressure to remove excess fluid and debris from a wound to promote wound healing]. Make sure this keeps a charge and is running at 125 mmHg. Review of resident 1's physician's orders included: *On 8/29/25, Heel boots on while in bed. Reposition frequently with wedge. Every day and night shift.*On 9/3/25, Weekly Skin Audit every day shift every Wed [Wednesday] Nurse initials = Head to Toe Skin Evaluation completed. If new skin impairment is found, document in Progress Notes, notify Medical Provider, and initiate Weekly Skin Evaluation. *On 9/26/25, Wound vac dressing changes every MWF [Monday, Wednesday, and Friday] to coccyx.*On 10/28/25, Wound treatment to left foot. Apply foam dressing to left heel, left lateral foot and inner ankle. Change every 3 days and prn [as needed] if loose/soiled.*On 10/30/25, Wound care to bilateral shins: Cleanse with Vashe [skin cleanser], cover with dry dressing, change every day. Do until healed.Review of resident 1's treatment administration record (TAR) indicated:*His weekly skin audit was completed every Wednesday from 9/1/25 through 11/4/25. *LPN F completed resident 1's left foot treatment on 10/28/25 and his bilateral shin treatment on 11/1/25, 11/2/25, and 11/3/25. *LPN D completed resident 1's left foot and bilateral shin treatment on 10/31/25. *Registered nurse (RN) L completed resident 1's left foot and bilateral shin treatment on 11/3/25. Resident 1's nursing progress notes indicated:*A late entry note