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
	435041	A. BUILDING _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEALTH AND REHAB	1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/25/22 through 10/27/22. Aberdeen Health and Rehab was found not in compliance with the following requirements: F554, F565, F609, F676, F686, F761, F809, F812, F867, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/25/22 through 10/27/22. Areas surveyed included quality of care, resident rights, and infection control. Aberdeen Health and Rehab was found not in compliance with the following requirements: F565, F609, and F867.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (15) had a physician's order and was assessed to self-administer medications. Findings include: 1. Observation and Interview on 10/27/22 at 8:1 5 a.m. with certified medication aide (CMA) D as she administered medications in the dining room revealed: *She placed a medication cup on the table in front of resident 15 as well as a plastic cup with liquid	F 554	Aberdeen Health & Rehab denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kirstie Hoon, LNHA
TITLE: Executive Director
(X6) DATE: 11/23/2022

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F 554	Continued From page 1 in it. *CMA D confirmed the contents of the medication cup and the liquid in the plastic cup was MiraLAX. *She shared resident 15 would not take her medications until after she ate. The resident had not had breakfast at this time. *CMA D was not aware if resident 15 was allowed to take her medications unsupervised. Review of resident 15's electronic medical record revealed there was no: *Physician order the resident could self-administer medications. *Self-administration assessment documented by the licensed nurse. *Self-administration was not documented on her care plan. Interview on 10/27/22 at 1:30 p.m. with clinical coordinator C regarding resident 15 revealed: *CMA D should not have left any medications on the table for resident 15. *There were no assessments for those who had requested self-administration of medication, no physician orders to acknowledge, and no inclusion on the care plan. This included resident 15. Review of the provider's revised 2018 Medication Self Administration Safety Screen and/or Self-Administration policy revealed; *The medication self-administration safety screen would have been completed prior to the resident initiating self-administration of medications. *An ongoing evaluation should have occurred at a minimum of quarterly. *The interdisciplinary team would review the self-administration safety screen to determine the appropriateness of self-administration of	F 554	F554 1. In continuing compliance with F 554, Resident Self-Admin Meds-Clinically Approp, Aberdeen Health & Rehab corrected the deficiency by reviewing all resident MARs/TARs to ensure that all medications/treatments that are self-administered have appropriate assessment completed and physician order obtained. 2. To correct the deficiency and to ensure the problem does not recur all Nurses and Certified Medication Technicians were educated on 10/28/2022 on ensuring to observe all residents taking their medications or to ensure that a self-administration of medication assessment is completed, and a physician order is obtained to have a resident self-administer medications and that order is added to MAR and care plan by the Director of Nursing Services. MDSC was educated by Regional Clinical Nurse Specialist on ensuring all residents who self-administer medications have assessments completed prior to initiating self-administration of medications, quarterly and with any significant change in condition; order is obtained from physician for resident to self-administer medications and is added to MAR/TAR and care plan on 10/28/2022. The DNS and/or designee will audit medication pass 2x/week for 4 weeks, weekly for 2 months, and then randomly to ensure continued compliance. The DNS and/or designee will audit 3 resident self-administration of medication assessments, orders, and care plans weekly for 4 weeks, 1 for 8 weeks, and then randomly to ensure continued compliance. 3. As part of Aberdeen Health & Rehabs ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process. 4. The DNS is responsible for this area of compliance.	10/28/2022

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F 554	Continued From page 2 medications. *A physician order would have been obtained to indicate which medications the resident may self-administrator with or with-out supervision.	F 554		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident	F 565	F (565) 1. In continuing compliance with F 565, Resident/Family Group and Response, Aberdeen Health & Rehab corrected the deficiency by providing documented follow-up to resident 36 and resident 49 on the request for fried eggs twice per week by Community Life Coordinator on 10/28/2022. 2. To correct the deficiency and to ensure the problem does not recur 1:1 education was provided to Community Life Coordinator on 10/28/2022 by the Executive Director on the process for documenting concerns/grievances during resident council meetings. The ED and/or designee will audit concerns/grievances with resident council meetings monthly x 3 months and then randomly to ensure resident concerns/grievances/follow-up are being documented. 3. As part of Aberdeen Health & Rehabs ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process. 4. The ED is responsible for this area of compliance.	10/28/2022

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F 565	Continued From page 3 representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to follow their policy for documenting and responding to resident and/or family grievances, suggestions, or opportunities for improvement in care and services for any resident. Findings include: 1. Interview on 10/26/22 at 3:00 p.m. with resident council president/resident 36 and resident 49 revealed: *The resident council met monthly with community life manager (CLM) K as the designated staff person who provided assistance to their resident group. *They identified the resident council's recurrent concern with eggs served at breakfast. -Scrambled eggs were served routinely and fried eggs were served once a week. --They would have preferred fried eggs served at least twice a week. *When asked if the provider acted promptly to grievances or suggestions from the resident council, resident 36 voiced he was not aware of any responses they had received from the provider. *When asked if the resident council received responses from the provider's grievance official, resident 36 stated, "I haven't heard them," and added "nothing gets done." -Resident 49 shared when a resident or family member voiced concern, it should be checked into.	F 565		

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F 565	Continued From page 4 Interview on 10/26/22 at 4:30 p.m. with CLM K revealed: *She had worked at the facility for 38 years with the last 33 years as the activity director. *She responded to the concerns and recommendations of the resident council, assisting by addressing their concerns verbally with the appropriate department director and administrator, the provider's grievance official. -Monday through Friday at the daily interdisciplinary team (IDT) meeting and at the quarterly quality assurance performance improvement meetings she verbally shared resident council concerns. --She did not complete the provider's grievance form. --She could not provide documentation of the provider's responses, actions, and rationale taken about the concerns from previous months. --She confirmed administrator A was the designated grievance official. Interview on 10/27/22 at 8:57 a.m. with administrator A confirmed and revealed: *She was the grievance official. *The concern about having fried eggs at breakfast more often had been brought up at the daily IDT meetings. *There was no documentation available about how the concerns brought from resident council meetings were acted upon or resolved. Review of resident council minutes from August 2022 through October 2022 revealed: *The provider used the undated form "SNF [Skilled Nursing Facility] Resident Council Meeting Agenda and Minutes" to record those in attendance and what was discussed. -First name and initial of last name were used to	F 565		

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F 565	Continued From page 5 identify the attendees. *Minutes were handwritten by CLM K. *Attendance varied between eight and 11 for the three months. *Desire for "more fried eggs" was discussed at each of the meetings. Review of the provider's December 2017 "Grievance/ Feedback Form Guideline and Action Plan" policy revealed: *"Purpose: To ensure that staff, residents/tenants and family members have a mechanism to communicate comments, suggestions and opportunities for improvement." *"Comments/suggestions may be made orally, in which a staff member would complete the form, in writing or anonymously." *"Completed forms shall be routed to the charge nurse or nursing supervisor who shall forward to the Executive Director immediately. Completed forms may also be delivered directly to the Executive Director." *"The Executive Director reviews the request...document[s] receipt of the Feedback Form and forward to the department determined most appropriate for follow-up." *"The Department Head or his/her designee will investigate the grievance/comment/suggestion and record the findings of the investigation as well as the action plan for the resolution on the appropriate area on the attached Feedback Form Action Plan." *"The Investigation and subsequent action planning must be completed and the Feedback Form returned to the Executive Director within three (3) working days of receiving the concern." *"The Grievance Official is responsible for contacting the person who initiated the Feedback Form and providing them with feedback on the	F 565		

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F 565	Continued From page 6 resolution of the concern within three (3) working days of receiving the concern."	F 565		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure bruises of unknown origin were promptly reported	F 609	F (609) 1. In continuing compliance with F 609, Reporting of Alleged Violations, Aberdeen Health & Rehab corrected the deficiency by providing 1:1 education to CNA E & CNA F on timely reporting of unknown injury for resident 124 and all like residents and the vulnerable adult policy on 10/26/2022 by the Regional Clinical Nurse Specialist. 2. To correct the deficiency and to ensure the problem does not recur education was provided to all staff on 10/28/2022 by the Director of Nursing Services on timely reporting of injury of unknown origin and the vulnerable adult policy. DNS and/or designee will audit 24-hour report and risk management 3x/week for 4 weeks, weekly x 2 months, and randomly to ensure continued compliance. 3. As part of Aberdeen Health & Rehabs ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process. 4. The DNS is responsible for this area of compliance.	10/28/2022

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F 609	Continued From page 7 for one of one sampled resident (124). Findings include: 1. Observation and interview on 10/25/22 at 12:43 p.m. with certified nursing assistants (CNA) E and F while assisting resident 124 with personal care revealed: *A purple bruise to her lower left abdomen. *Purple bruising behind her right knee, upper outer right thigh and her right calf. *Neither had observed the bruises before. *Neither were aware where she could have acquired the bruises. *They both stated maybe when she had gotten the bruises from her fall prior to having been admitted to the nursing home. Interview on 10/26/22 at 8:30 a.m. with registered nurse (RN) G regarding resident 124's bruises revealed she had not been informed the resident had bruises. *She had not worked the week prior. *CNAs E and F had not reported the bruising on resident 124 to her on 10/25/22. *If they had reported it to her she would have started an investigation and informed director of nursing (DON) A. Review of resident 124's 10/14/22 admission assessment revealed the above bruises had not been identified having been present on admission. Interview on 10/26/22 at 1:30 p.m. with DON A and clinical consultant C revealed: *Resident 124's bruising had been reported to them by RN G after this surveyor had asked RN G about the bruises. *CNAs E and F had not reported the bruises to	F 609		

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F 609	Continued From page 8 RN G or DON A. *They agreed the policy had not been followed when CNAs E and F had not reported the bruising. *They started an investigation and determined it was bruising of an unknown origin. *DON B was responsible for the investigation and reporting of any incidents. Review of the provider's 10/19/22 Vulnerable Adult policy revealed: *"Each and every employee providing services to residents are considered mandated reporters." *"Mandated reporters employed by Accura HealthCare shall report injuries of unknown source sustained by a vulnerable adult that is not reasonably explained immediately (as soon as possible) after the discovery of the incident." *"An injury should be classified as an "injury of unknown source" when both of the following conditions are met: -The source of the injury was not observed by any person or the source of the injury could not be explained by the resident: and -The injury is suspicious because of the extent of the injury or the location of the injury (e.g. [for example] the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time." *"During the shift that the alleged abuse/neglect or unexplained injury is first observed, a mandated reporter will immediately make an initial report to their Supervisor, after securing the resident's safety. Following the review of the situation, the Supervisor will immediately report to the Administrator and the Director of Nursing."	F 609		
F 676	Activities Daily Living (ADLs)/Mntn Abilities	F 676		

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F 676 SS=D	Continued From page 9 CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.	F 676	F 676 1. In continuing compliance with F 676, Activities of Daily Living/Mntn Abilities, Aberdeen Health & Rehab corrected the deficiency by installing one grab bar on the Arbor Avenue bariatric shower on 10/28/2022 by the Director of Environmental Services. The other 3 grab bars were ordered on 10/28/2022 by the Executive Director and were installed on 11/9/2022 to ensure resident 21 and all like residents have assistive devices to maintain independence. 2. To correct the deficiency and to ensure the problem does not recur education was provided to all staff on 10/28/2022 by the Executive Director on bringing forth ideas or resident requests for maintaining independence. ED and/or designee will audit shower rooms weekly for 4 weeks and monthly for 2 months, and randomly to ensure assistive devices are in place to promote resident independence. 3. As part of Aberdeen Health & Rehabs ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process. 4. The ED is responsible for this area of compliance.	10/28/2022

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F 676	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure assistive devices were available for one of one resident (21) while showering to maintain his independence. Findings include: 1. Observation and interview on 10/25/22 at 3:52 p.m. with resident 21 regarding his bathing revealed: *He was in his room lying in bed. *His hair appeared to be oily and not clean. *He preferred a shower and that was scheduled for Thursdays. *He had transferred to Arbor Avenue hall about a month ago. *The shower room he used on current hall did not have grab bars to hold onto while he showered. *The other hall he had lived on had grab bars in the shower room. *He needed the grab bars since he had a stroke and his right side had been affected. *He did not feel safe showering without grab bars. *He stated he had not had a shower for two weeks. Review of resident 21's medical record revealed: *He had diagnosis of: -cerebral infarction, unspecified -atherosclerotic heart disease -coronary artery without angina pectoris *His last documented shower was on 10/13/22. *He had been scheduled for a shower on 10/20/22 but it was documented as refused. Interview on 10/27/22 at 8:56 a.m. with registered nurse I revealed she: *Was not aware there were no grab bars in the	F 676		

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F 676	Continued From page 11 shower room. *Would update his care plan to indicate he needed grab bars while he showered. *Would offer to let resident 21 use the shower in the rehabilitation unit until the grab bars were installed. Interview and observation of the bathing room on 10/27/22 at 9:33 a.m. with maintenance manager L revealed: *That area had recently been converted back to a shower area from being storage. *He confirmed there were not grab bars in the shower room on Arbor Avenue. A bathing policy was requested from administrator A on 10/27/22 but was not provided before the survey team exited the building.	F 676		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 686	F 686 1. In continuing compliance with F686, Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii). Aberdeen Health and Rehab corrected the deficiency by placing an air mattress on resident 124's bed, placing heel lift boots bilaterally at all times, a 2nd wheelchair cushion added, head to toe assessment completed on all residents, comprehensive skin and positioning assessment completed on all residents.	11/2/2022

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	435041	A. BUILDING _____ B. WING _____	C 10/27/2022

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F 686	Continued From page 12 and policy review, the provider failed to ensure one of two sampled residents (124) received preventative skin care to prevent acquiring two pressure injuries. Findings include: 1. Observation on 10/25/22 at 12:43 p.m. of resident 124 before and after certified nursing assistants (CNA) E and F had provided personal care revealed: *She required total assistance with a full body lift to transfer from her wheelchair to her bed. *She required total assistance to be repositioned from side-to-side. *Had an incontinent bowel movement (BM) and required her brief to be changed. *The BM was up to her waist in the back and the edges were dried. *No protective ointment was applied after she had been cleansed. *She was positioned on her back and her heels were not elevated. *There were no extra pillows or heel protectors in the room. *She did not have a special cushion in her wheelchair. *Did not have a special mattress on her bed. Review of resident 124's 10/14/22 at 4:45 p.m. admission nursing assessment included: *She was incontinent of bowel and bladder and was to have had a barrier cream or protective ointment applied after each incontinent episode. *Her skin was to have been observed with personal cares and any concerns were to have been reported to the nurse. *She had bruising to her right inner elbow, left elbow, the right side of her back, and a stage two pressure injury to her right third toe.	F 686	2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 11/2/2022 on accurate skin assessments on admission, implementing appropriate and necessary interventions to prevent injury, ensuring interventions are added to care plan and/or TAR, repositioning per individual need per identified risk, and ensuring timely assessments completed per facility protocol by Director of Nursing Services. The DNS and/or designee will audit all new admits for preventative skin interventions 3x/week for 4 weeks, weekly for 2 months, and randomly to maintain continued compliance. The DNS and/or designee will audit comprehensive skin and positioning assessments 3x/week for 4 weeks, weekly for 2 months, and randomly to maintain continued compliance. The DNS and/or designee will audit 3 resident care plans for skin interventions per week for 4 weeks, 2 per week for 8 weeks, and then randomly to ensure continued compliance. 3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process. 4. The DNS is responsible for this area of compliance.	

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F 686	Continued From page 13 Review of resident 124's 10/18/22 at 11:01 a.m. comprehensive skin and positioning evaluation included: *A Braden (skin risk assessment) score of 14 which indicated she was at moderate risk for skin breakdown. *A nursing summary statement "[Resident name] does have pressure area to her toe, does have potential for altered skin integrity r/t [related to] her weakness and use of w/c [wheelchair] and general shearing/friction r/t her scooting in w/c and bed and general repositioning, pressure reducing mattress on bed and pressure reducing cushion in w/c, skin inspected weekly." Review of resident 124's skin ulcer assessments revealed: *On 10/26/22 at 4:16 p.m. a nursing progress note "Right heel has fluid filled blister 4.0 x 2.0 cm [physician] updated." *On 10/26/22 at 8:22 p.m. an acquired unstageable pressure injury to her sacrum. It measured 1.5 centimeters (cm) by 1 cm by 0.5 cm. *On 10/26/22 at 8:30 p.m. a stage 2 pressure injury to the bottom of her left third toe. It measured 0.6 cm by 0.5 cm. This had been noted in her admission assessment and a skin ulcer assessment had not been completed until this date. *On 10/26/22 at 8:32 p.m. a stage 2 pressure injury to the top of her second toe on her left foot. It measured 0.7 cm by 0.8 cm. There was no documentation of this area in her admission assessment. Review of a 10/26/22 at 8:22 p.m. nursing progress note regarding resident 124's sacral pressure injury revealed: "Documentation is of a	F 686		

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F 686	Continued From page 14 new area that is a pressure wound. Wound base has slough [dead skin tissue] present. A scant amount of drainage noted. No odor is present. Drainage is serosanguinous [thin and watery with a light red or pink hue]. Wound edges are intact. Wound edges are pink. MD [medical doctor] notified of new area on Wound is new." Review of resident 124's baseline care plan revealed it had been initiated on 10/14/22. Areas related to skin integrity had been added on 10/26/22 and included: heel protectors/elevate heels, and wound locations. Written on the bottom border of the document was "-Repo [reposition] as needed." Interview on 10/27/22 at 11:30 a.m. with clinical coordinator C regarding resident 124's newly acquired pressure injuries to her right heel and sacrum revealed no other inventions were put in place based on a residents risk at admission or during their stay. The interventions were put in place if they developed any areas of concern. Interview on 10/27/22 at 2:30 p.m. with administrator A revealed they had started a skin process improvement plan for pressure areas. They were monitoring to ensure skin audits were forwarded to the wound nurse so they could be monitored and followed up on timely. The bath aides were responsible for the completion of a skin audit for each resident with each bath/shower they received. Those audits were then to have been reviewed by the charge nurse for any interventions needed. The completed bath audits were scanned and attached in the residents electronic medical record (EMR). No bath audits were found for resident 124 in her EMR.	F 686		

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F 686	Continued From page 15 Bath audits for resident 124 had been requested on 10/27/22 at 11:30 a.m. from clinical coordinator C. They had not been received by the end of the survey on 10/17/22 at 5:30 p.m. Review of the provider's updated 10/14/22 Skin Management Protocol revealed: *Notify DON (director of nursing) and wound nurse of the new skin alteration or skin ulcer. *Procedures for stage 2, 3, 4, or unstageable pressure injuries had no interventions other than treatment types.	F 686		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761	F 761 1. In continuing compliance with F 762, Label/Store Drugs Biologicals, Aberdeen Health & Rehab corrected the deficiency on 10/28/2022 by destroying all outdated/non-labeled medications, putting content list on outside of IV E-kit and storing on shelf in medication room, resident 2's home medications were provided to resident 2's brother to secure until resident 2's discharge, Arbor Avenue Medication Room fridge was defrosted and cleaned.	10/28/2022

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F 761	Continued From page 16 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to maintain one of two medication rooms (Arbor Avenue) to follow professional standards for the storage of medications, monitoring of outdated medications, and ensuring medications brought in by a resident were documented and kept secure. Findings include: 1a. Observation, interview, and record review, on 10/27/22 from 2:00 p.m. through 2:15 p.m. of the Arbor Avenue medication room with assistant director of nursing (ADON) H revealed: *Three bottles of medications with labels indicated they were for resident 2. They were in a plastic container on the medication room counter. One of those bottles contained an unknown number of acetaminophen with codeine #3 tablets. The bottle appeared to be nearly full. *ADON H was not aware those medications were in the medication room. *When asked about what the procedure would be for when a resident brought in medications both ADON H stated the practice of residents bringing in medications was discouraged. *He was not aware of any policy that should have been followed for medication brought in from home. *He agreed the acetaminophen with codeine #3 should have been kept secured. b. Observation of a red plastic partially open tote on the floor of the medication room revealed: *The top of the tote had a list of emergency	F 761	2. To correct the deficiency and to ensure the problem does not recur education was provided to all nurses on 10/28/2022 by the Director of Nursing Services on the process of residents bringing home medications into the facility, cleaning schedules for medication rooms, medication carts, treatment carts, ensuring all outdated medications are destroyed per policy, all medications are dated when opened, and nothing is stored on the floor of the medication rooms. DNS and/or designee will audit medication rooms, medication room fridges/freezers, medication carts, and treatment carts for cleanliness, expired medications, non-dated medications and resident home medications weekly for 3 months and then randomly to ensure continued compliance. 3. As part of Aberdeen Health & Rehabs ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process. 4. The DNS is responsible for this area of compliance.	

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F 761	Continued From page 17 medications. *ADON H stated those medications were stored in a different cart at the nurse's station. *The tote contained intravenous access supplies and fluids. *The list of the acutal contents and red zip ties with numbers were inside the tote. *He agreed the contents of the tote should have been located on the outside of the tote. *He agreed the tote should not have been stored on the floor. c. Observation of the medication refrigerator revealed: *It contained medications in plastic bags and in a plastic container that included: -Seven pre-filled syringes in a plastic bag. There was approximately an ounce of water that had collected in the bottom of the bag. -Nine dulcolax suppositories with an expiration date of January 2022 in the bottom of the plastic container. -An influenza vaccine vial with an expiration date of June 2022. The label also stated the vaccine was the 2021-2022 formula. *Two tuberculin vials that had been accessed and there was no open date or expiration date. *A box was frozen to the back of the refrigerator. It was unable to tell what the medication was as the front part of the box had been destroyed by water. *ADON H was not aware the medication refrigerator had not been maintained. *He thought it should have been cleaned on a weekly basis. d. Review of a medication unit review checklist with ADON H revealed: *A handwritten note "To be done on Days."	F 761		

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F 761	Continued From page 18 *Had been prepared by the consulting pharmacy. *Included the following areas to have been reviewed: -Medication room. -Labeling of medications. -Emergency kit and records. -Ordering and receiving of medications. -Quality assurance records for blood glucose machine. -Medication cart review. *ADON H was not sure who completed those checklists. He stated at 3:00 p.m. he would provide copies of previous completed checklists. Those checklists had not been provided by exit. e. Interview on 10/27/22 at 4:00 p.m. with director of nursing B revealed she was not aware of the medication room condition. Her expectation was for the medication rooms and refrigerators to have been kept in a clean and in an orderly manner and checked for outdated medications on a regular basis. f. Review of the provider's 10/19/22 Medication Rooms policy revealed: *Refrigerators should have been cleaned weekly and the freezers defrosted monthly. -Check for discontinued and outdated medications. *Locked medication room should have been: -Cleaned every night. -Every week, organize and replace used items. -Check for outdated supplies/medications. *Cupboards in the medication room should have been checked and reorganized once a week as needed.	F 761		
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3)	F 809		

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F 809	Continued From page 19 §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the provider failed to ensure a substantial bedtime snack was offered to all 68 residents when mealtimes were more than 14 hours apart. Findings include: 1. Interview on 10/25/22 at 7:56 a.m. with cook N and cook O regarding mealtimes and snacks revealed: *Breakfast was at 8:00 a.m., lunch was at 12:00 p.m., and supper was at 5:00 p.m. *They kept the unit fridges stocked with snack items so the facility staff could offer snacks to the residents. Interview on 10/25/22 at 12:20 p.m. with dietary	F 809	F 809 1. In continuing compliance with F 809, Frequency of Meals/Snacks at Bedtime, Aberdeen Health & Rehab corrected the deficiency by offering a substantial snack at HS to resident 36, 49, and all like residents on 11/18/2022. 2. To correct the deficiency and to ensure the problem does not recur education was provided to all nursing staff on 11/18/2022 by the Director of Nursing Services on HS snack process. DNS and/or designee will audit HS snack pass 3x/week for 4 weeks, weekly for 2 months, and then randomly to ensure continued compliance 3. As part of Aberdeen Health & Rehabs ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process. 4. The DNS is responsible for this area of compliance.	11/18/2022

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F 809	Continued From page 20 manager (DM) M regarding snacks revealed: *They did not have a scheduled time for residents to have snacks. *If a resident was prescribed a supplement, they would place the supplement on their meal tray. *She and her staff kept the unit refrigerators stocked with snack items like sandwiches, ice cream, yogurt, and string cheese. -The sandwiches were meat salad or egg salad, so residents who required ground food could eat them. *She was unsure if the evening staff offered a substantial bedtime snack to all residents or not. *The dietary department closed at 7:00 p.m., so she and her staff were unable to be at the facility to ensure a bedtime snack had been served. Interview on 10/26/22 at 3:00 p.m. with residents 36 and 49 during a resident council meeting revealed: *When asked, "Do you receive snacks at bedtime?" -Resident 49 said they did not get a bedtime snack. -Resident 36 responded to resident 49, "You have to go to the nurse's desk and ask for one, I don't get a bedtime snack because I don't ask for one." An interview on 10/27/22 at 11:29 a.m. with administrator A revealed she was unaware that supper and breakfast were more than 14 hours apart but would bring the topic of mealtimes up at the next resident council meeting to get resident input. Interview on 10/27/22 at 12:46 p.m. with director of nursing (DON) B revealed: *She had only been the DON for one week at the time of the survey.	F 809		

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F 809	Continued From page 21 *She was not aware if the evening staff offered a substantial bedtime snack or not. *If the mealtimes were to remain the same, she would ensure the evening staff offered a substantial bedtime snack to all residents. A meal and snack time policy was requested on 10/27/22 at 10:44 a.m. from DM M, however she revealed they did not have a specific policy on mealtimes or snack times.	F 809		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to maintain the cleanliness of one of one kitchen according to current standards of practice. Findings include:	F 812	F 812 1. In continuing compliance with F 812, Food Procurement, Store/Prepare/Serve-Sanitary, Aberdeen Health & Rehab corrected the deficiency on 10/28/2022 by cleaning the grease trap, oven backsplash, ice machine, and floors by flattop grill/ovens 2. To correct the deficiency and to ensure the problem does not recur education was provided to all dietary staff on 11/16/2022 by the Dietary Manager on cleaning schedules for grease trap, oven backsplash, ice machine, and floor by flattop grill/ovens. The ED and/or designee will audit cleaning of grease trap, oven backsplash, ice machine, and floors 3x/week for 4 weeks and weekly for 2 months and then randomly to ensure continued compliance.	11/16/2022

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F 812	Continued From page 22 1. Observation on 10/25/22 at 7:56 a.m. in the kitchen revealed: *The gas stovetop range and flattop grill were connected. *Ovens were to the right of the gas stovetop range and the flattop grill. *The backsplash on the gas stovetop was caked with an unknown burnt black substance. *There was a half-inch layer of thick grease surrounding the perimeter of the grease trap drawer opening on the flattop grill. *The grease trap drawer was full of grease and it could not be opened. *The floor beneath the flattop grill and the ovens was splattered with a stuck-on, black, greasy substance. 2. Observation on 10/27/22 at 10:28 a.m. in the main dining room revealed: *The ice dispenser was covered in white mineral deposits. *The metal drip tray rack had exposed metal pieces that were rusted. *The plastic drip tray had unknown black splotches and more white mineral deposits. Interview on 10/27/22 at 10:44 a.m. with dietary manager M about the cleanliness of the kitchen revealed: *They had not cleaned the ice machine in a while because they could not remove the plastic drip tray from the machine. *An effort had been made to clean the backsplash on the gas stovetop, but they were unable to get it completely clean. *New ventilation hoods were recently installed, and they had to move the ovens, flattop grill, and gas stovetop range out of the way, which	F 812		

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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 812	Continued From page 23 revealed the dirty floor. -Her staff had tried to clean the floors but there were a few stuck-on spots left to clean. *Their current cleaning checklist did not include cleaning the grease trap drawer or the ice machine. *She could not remember the last time the grease trap drawer was cleaned. *The grease trap drawer was in an unacceptable state and needed to be cleaned. Review of the provider's "Weekly Cleaning Schedule Sample Form" included the following items to be cleaned weekly: *Dessert carts. *Shelves. *Garbage cans. *Lazy Susans. *Hand sinks. *Wall/ceiling. *Mixers. *Dish machine. *Microwave. Review of the provider's "Monthly Cleaning Schedule Sample Form" included the following items to be cleaned monthly: *Steam tables. *Steamer. *Cooler. *Freezer. *Ovens. *Stovetop. *Shelves. *Drawers. *Dish machine. *Garbage cans. *Mixers. *Walls/ceiling.	F 812		

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	435041	A. BUILDING _____ B. WING _____	C 10/27/2022

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ABERDEEN HEALTH AND REHAB	1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401

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F 812	Continued From page 24 *Lazy Susans. Review of the provider's 2013 "Cleaning and Sanitation of Dining and Food Service Areas" policy revealed: *The policy statement indicated, "The food service staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule." *The procedure section indicated: -"1. The food service manager will record all cleaning and sanitation tasks needed for the department." -"2. Tasks shall be designated to be the responsibility of specific positions in the department ..." -"3. All staff will be trained on the frequency of cleaning necessary." -"4. The method and guidelines to be used and agents used for cleaning shall be developed for each task or piece of equipment to be cleaned ..." -"5. A cleaning schedule will be posted for all cleaning tasks, and staff will initial the tasks as completed ..." -"6. Staff will be held accountable for cleaning assignments."	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by:	F 867	F 867 1. In continuing compliance with F867, QAPI/QAA Improvement Activities, Aberdeen Health and Rehab corrected the deficiency by adding appropriate action plans and interventions to both the call light and skin performance improvement plans on 11/16/2022.	11/16/2022

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F 867	Continued From page 25 Based on interview, call light record review, quality assurance performance improvement plan (QAPI), and QAPI meeting minutes, the provider failed to ensure the QAPI plan had been followed for performance improvement projects (PIP) including call light response and pressure injury prevention. Findings include: 1. Interview on 10/27/22 at 2:30 p.m. with administrator A revealed: *A QAPI meeting was held monthly with all the department managers. *A quarterly QAPI meeting also included the medical director and consultant pharmacist. *The department managers presented information for the monthly QAPI meetings. *The quarterly QAPI meetings were an overview of the previous quarter and administrator A presented the information. *A PIP for skin assessments to ensure the skin audits were completed, areas of concern were reported to the wound nurse to monitor, followed-up on timely, and watch for healing. *Started call light PIP the beginning of October 2022, after the monthly September 2022 QAPI meeting. *Part of the call light PIP included walkie talkies so staff can communicate each other. *Staff from the leadership team will pull random call light documentation and forward that information to director of nursing B. *Administrator A had been on leave in September and the first part of October. An interim administrator had implemented the call light PIP that had been discussed at the September QA meeting. *There had been call light concerns reported in August. *Nursing staff had pagers that would alert them to	F 867	2. To correct the deficiency and to ensure the problem does not recur all leadership staff were educated on 11/15/2022 by Regional Clinical Nurse Specialist on the importance of ensuring performance improvement plans have appropriate action plans/interventions and are being audited to ensure compliance. The ED and/or designee will audit all QAPI/QAA PIPs to ensure action plans/interventions are implemented, audits are occurring, and PIP meetings are being held weekly with documentation of progress weekly for 3 months and then randomly to ensure continued compliance. 3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process. 4. The ED is responsible for this area of compliance.	

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F 867	Continued From page 26 answer a call light. *Assistant director of nursing (DON) H and administrator A had pagers that went off ten minutes after the residents call light went off to elevate it to another level of staff. *Dietary and activity staff would answer call lights if needed. *Walkie talkies had been ordered to enhance communication for staff. *The leadership team had pulled random call light times and had given that information to clinical coordinator C to review. *The provider had been monitoring call lights once or twice a month. *There was no documentation of those call light audits. 2. Review of the provider's 10/18/22 QAPI minutes for July, August, and September 2022 revealed areas discussed included: *Nursing/clinical: Skin issues of vascular, surgical, abrasion, moisture related skin breakdown, cellulitis, pressure injuries, blisters, skin tears, excoriations, bruises, and skin lesions were reported. There was no action plan implemented to ensure skin audits had been conducted and reported to the wound nurse. *There was no action plan implemented to ensure call lights had been answered in a timely basis. Review of call light records revealed: *Between 9/28/22 and 10/25/22 resident 19 had 28 instances where her call light was on for more than 20 minutes. *Between 9/2922 and 10/25/22 resident 40 had 33 instances where his call light was on for more than 20 minutes *Between 10/4/22 and 10/25/22 resident 7 had 3 instances where her call light was on for more	F 867		

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F 867	Continued From page 27 than 20 minutes *Between 9/28/22 and 10/25/22 resident 62 had 17 instances where her call light was on for more than 20 minutes *Between 9/27/22 and 10/25/22 resident 53 had 32 instances where her call light was on for more than 20 minutes Review of the provider's updated 10/19/22 Quality Assurance and Performance Improvement Plan revealed: *The purpose of the plan was to ensure the provider develop a plan for conducting QAPI activities, identifying and correcting quality deficiencies, and identifying opportunities for improvement. *QAPI focused on systems and processes. The emphasis was on identifying system gaps. *The provider makes decisions based on data, which included the input and experience of caregivers, residents, families, healthcare practitioners, and other care partners. *Identify root causes of concerns that produce unacceptable quality through QAPI monitoring and evaluation activities. *The QAPI committee has the responsibility for planning, designing, implementing, coordinating resident care and services, and selecting QAPI activities to meet and exceed the needs of the residents. *The performance improvement projects (PIP) process included: -Identification of a performance improvement opportunity through the QAPI committee. -PIP charters will be identified and documented through the QAPI committee by initiating a PIP documentation form. -The PIP team would brainstorm possible solutions and start a root cause analysis.	F 867		

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F 867	Continued From page 28 -The PIP team would measure the progress of the solution. -PIP team members would report back to the QAPI committee and provide documentation. *The QAPI committee monitors the process according to pre-determined time frames observing if the changes to the process have not resulted in the goal of the PIP, further changes are made, and monitoring of the process takes place again. *Once the PIP goals have been met, the PIP will be placed on a permanent tracking log for ongoing measurement.	F 867		
F 880 SS=D	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;	F 880	Directed Plan of Correction Aberdeen Health and Rehab F880 Corrective Action: 1. For the identification of lack of: *Appropriate procedural technique while providing personal cares in use of hand hygiene and glove use as well as cleaning and sanitizing multi-resident use equipment. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 10/28/2022 by Director of Nursing Services.	10/28/2022

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F 880	Continued From page 29 §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; (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.	F 880	2. Identification of Others: ALL residents and staff have the potential to be affected by lack of: *Appropriate procedural technique while providing personal cares in use of hand hygiene and glove use as well as cleaning and sanitizing multi-resident use equipment. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks was provided by 10/28/2022 by Director of Nursing Services. System Changes: 3. Root cause analysis conducted answered the 5 Whys: 1. Staff were nervous. -State surveyors were watching. Solution: Audits/Competencies will be performed routinely so staff are comfortable with procedure. 2. Staff were in a hurry. -Other call lights were going off. -Staff were trying to be efficient. -Staff were trying to provide care to more people. Solution: Audits will be routinely performed. 3. Staff were not prepared. -Staff did not bring an extra pair of gloves to the bedside. -Staff did not have hand sanitizer on their person or within reach to quickly perform hand hygiene between glove change.	

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F 880	Continued From page 30 §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: Based on observation, interview, and policy review, the provider failed to ensure two of two certified nursing assistants (E and F) had provided personal care to one of one (124) observed resident had been provided in a sanitary manner. Findings include: 1. Observation on 10/25/22 at 12:43 p.m. while providing personal cares to resident 124 revealed: *CNA E: -Assisted to provide incontinence care. -Used gloves that had been contaminated with bowel movement and touched surfaces including the sink faucet handles, drawer handles, full body lift, personal wipe package, and the bed controller. -Reached into her pocket with soiled gloves on to check her beeper. -Did not perform hand hygiene before or after glove changes. -With no gloves on she took the trash bags, laundry bags, and the full body lift out of the room. -She left the lift in the hallway and opened the door to the bathing room. -Disposed of the trash and laundry bags. -Did not perform any hand hygiene. -Moved full body lift into the oxygen storage room. -Brought the lift out immediately as it was needed to transfer another resident. -The lift had not been sanitized after it had been used for resident 124. *CNA F:	F 880	-Facility did not provide small personal bottles of hand sanitizer for staff to keep on their person. Solution: Audits will be routinely performed and personal bottles of hand sanitizer will be ordered by the facility. Administrator, DON, 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 and documentation. Director of Nursing Services contacted the South Dakota Quality Improvement Organization (QIN) on 11/15/2022 and discussed root cause analysis and implementing mitigation tactics to ensure a relapse does not occur which included education, communication, and auditing. Provided with many tools/resources to ensure success including a video clip on transmission-based precautions Monitoring: 4. Administrator, DON, and/or designee will conduct auditing and monitoring of above identified items 2-3 times weekly over all shifts. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area.	

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F 880	Continued From page 31 -Put on gloves when she entered the room. She had not performed any hand hygiene. -Assisted CNA E to transfer resident 124 with the full body lift from her wheelchair to her bed. -Assisted to remove her brief and cleanse her. Resident 124 had a large amount of bowel movement (BM) and required extensive cleansing. -Had gone to the sink to moisten the wipes more several times. She touched the faucet handles with her soiled gloves each time. -Touched those faucet handles with the new gloves and contaminated them. -Did not perform any hand hygiene between glove changes. -Used gloves that had been soiled with bowel movement and touched surfaces including the sink faucet handles, drawer handles, full body lift, personal wipe package, and the bed controller. Interview on 10/26/22 at 2:45 p.m. with assistant director of nursing (ADON) H regarding the above observations revealed: *There were many missed opportunities for hand hygiene and glove changes. *The lift was to have been sanitized between resident use. *Competencies had been completed with all the CNAs on hand hygiene, glove use, and sanitation of the lifts. Interview on 10/27/22 at 1:45 p.m. with director of nursing B and clinical coordinator C revealed: *ADON H had informed them of the observation of the personal care CNA E and F had provided to resident 124. *They had completed competencies with CNAs E and F this morning and they had done fine. *They told her they had been nervous during the	F 880	*Any other areas identified through 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. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 32 observation. Review of the provider's updated 10/19/22 Hand Hygiene policy revealed: *Hand hygiene may occur multiple times during a single care episode. *Alcohol based hand sanitizer could be used in the following situations including: -Immediately before touching a resident. -Immediately before putting on gloves and after glove removal. -After touching a resident or the residents immediate environment. -After contact with blood, body fluids, or contaminated surfaces. *Hand washing with soap and water was to have been used in the following situations including: -When hands were visibly soiled. -After known or suspected exposure to communicable infectious disease. -Before moving from a soiled body site to a clean body site on the same resident.	F 880		

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

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E 000	Initial Comments 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 10/25/22 through 10/27/22. Aberdeen Health and Rehab was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kirstie Hoon, LNHA

TITLE: Executive Director

(X6) DATE: 11/18/2022

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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	435041	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/25/2022**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/25/22. Aberdeen Health And Rehab was found not in compliance with 42 CFR 483.90 (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 K211, K223, K372, and K781 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	K 211 PLAN OF CORRECTION Aberdeen Health and Rehab denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain egress paths free of hazards for two of ten exits (north and east exits from the employee break/kitchen/boiler area). Findings include: 1. Observation on 10/25/22 at 11:15 a.m. revealed the paths of egress for the employee area to the north and east exits were also being used as an equipment charging area for janitorial services before reaching the exit discharge	K 211	1. In continuing compliance with K 211, Means of Egress-General, Aberdeen Health and Rehab has corrected the deficiency by removing the housekeeping equipment on 10/25/22 at the north and east exits. 2. To correct the deficiency and to ensure the problem does not recur, the manager of HCSG (contracted services) was educated on 11/15/22 and a designated place for storage is available. The ED and/or designee will audit all entrance areas 3x/week for 4 weeks, weekly for 2 weeks and then randomly to ensure continued compliance.	11/15/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Kirstie Hoon, LNHA

TITLE
Executive Director

(X6) DATE
11/18/2022

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K 211	Continued From page 1 location. An exit enclosure may not be used for any purpose that had the potential to block use as an exit. Interview with director of maintenance at the time of the observation confirmed that condition. He stated a contract agency oversaw janitorial services. The deficiency had the potential to affect 100% of the smoke compartment's occupants.	K 211	3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process. 4. The ED is responsible for this area of compliance.	
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain one of seven hazardous areas (soiled laundry room) as required. Findings include: 1. Observation on 10/25/22 at 10:00 a.m. revealed the soiled laundry room was 100 square	K 223	K 223 PLAN OF CORRECTION Aberdeen Health and Rehab denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with K 223, Doors with Self-Closing Devices, Aberdeen Health and Rehab has corrected the deficiency by removing the door stop to the laundry room and moving the laundry cart that was obstructing the other door to properly close on 10/25/22. 2. To correct the deficiency and to ensure the problem does not recur, the manager of HCSG (contracted services) was educated on 11/15/22 and a designated place for storage is available. The ED and/or designee will audit all entrance areas 3x/week for 4 weeks, weekly for 2 weeks and then randomly to ensure continued compliance.	10/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEALTH AND REHAB	**1700 NORTH HIGHWAY 281** **ABERDEEN, SD 57401**

(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
K 223	Continued From page 2 feet and contained combustible items. The corridor door and the door into the laundry were equipped with a closers, however, neither were able to close and latch. Interview with the maintenance director at the time of the observation confirmed that finding. The deficiency had the potential to affect 100% of the occupants of that smoke compartment.	K 223	3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process. 4. The ED is responsible for this area of compliance.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain a corridor separation from the south nurses' station in two of six smoke compartments. Findings include: 1. Observation on 10/25/22 at 11:30 a.m. revealed the cross corridor doors at the south nurses' station had two penetrations in the wall above the doors and extending to the roof deck.	K 372	K 372 PLAN OF CORRECTION Aberdeen Health and Rehab denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with K 372, Subdivision of Building Spaces – Smoke Barrier, Aberdeen Health and Rehab corrected the deficiency filling the open spaces with red fire caulk on 11/15/22. 2. To correct the deficiency and to ensure the problem does not recur, Maintenance Director was educated on 11/15/22 to ensure all open areas are reviewed for smoke barrier issues after contractor is in the building completing work. The ED and/or designee will audit all construction events weekly x4 weeks and then randomly to ensure continued compliance.	11/15/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEALTH AND REHAB	**1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401**

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K 372	Continued From page 3 Both penetrations were above the west side of the corridor, one being 2.5 inches in diameter, the second approximately one inch in diameter. Interview with the director of maintenance at the time of the observations confirmed these findings. The deficiency affected two smoke compartment locations that are required to maintain corridor separation.	K 372	3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process. 4. The ED is responsible for this area of compliance.	
K 781 SS=E	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to prohibit space heaters from two resident rooms (rooms 114 and 119) as required. Findings include: 1. Observation on 10/25/22 at 12:10 p.m. revealed patient room 114 had a portable space heater. The space heater had a 110V plug-in to power the unit. 2. Observation on 10/25/22 at 12:20 p.m. revealed patient room 119 had a portable space heater. The space heater had a 110V plug-in to power the unit. Interview with the maintenance supervisor at the	K 781	K 781 PLAN OF CORRECTION Aberdeen Health and Rehab denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with K 781, Portable Space Heaters, Aberdeen Health and Rehab corrected the deficiency by removing the space heaters from rooms 114 and 119 on 10/25/22. 2. To correct the deficiency and to ensure the problem does not recur, leadership staff were educated on 10/28/22 to ensure all residents and families are informed on non-usage of space heaters by the ED. The ED and/or designee will audit resident rooms weekly for 4 weeks, 1 time per month for 2 months and randomly to ensure continued compliance.	10/25/2022

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

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	435041	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEALTH AND REHAB	**1700 NORTH HIGHWAY 281** **ABERDEEN, SD 57401**

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K 781	Continued From page 4 time of the observation and testing confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the smoke compartments.	K 781	3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process. 4. The ED is responsible for this area of compliance.	

South Dakota Department of Health

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	10587	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEALTH AND REHAB	1700 N HWY 281 ABERDEEN, SD 57401

(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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/25/22 through 10/27/22. Aberdeen Health and Rehab was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kirstie Hoon, LNHA

TITLE: Executive Director

(X6) DATE: 11/18/2022