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 02/06/2025

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 2/4/25 through 2/6/25. Aberdeen Health and Rehab was found not in compliance with the following requirements: F584, F600, F686, F688, F695, and F812. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/4/25 through 2/6/25. Areas surveyed were quality of care and treatment/neglect related to lack of skin assessments and monitoring for weight loss. Aberdeen Health and Rehab was found not in compliance with the following requirement: F600.	F 000	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.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584	1. In continuing compliance with F584 Safe/ Clean/Comfortable/Homelike Environment, Aberdeen Health & Rehab corrected the deficiency ensuring a homelike environment is maintained for all residents. Aberdeen Health and Rehab corrected the following to ensure a clean and safe environment: - C wing carpets were cleaned. All other like areas were inspected and cleaned as needed. - Resident 55/2, 53/44, 21/61, 15/14 dresser tops, end tables and chairs were cleaned/cleared off giving room for residents to place items - Toilet and toilet riser in resident 24/33 room was cleaned. All other resident toilets/ risers were inspected and cleaned as needed. -toilet paper dowel in resident 24/33 room was replaced. -reviewed peeling wallpaper border resident 24/33 room with maintenance – estimated repair to be done by 3/15/24.	03/06/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kirstie Hoon, LNHA	Executive Director	03/01/25

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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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, resident council meeting, and policy review, the provider failed to ensure a clean and homelike environment had been maintained for 25 of 25 residents (2, 6, 8, 11, 12,14, 15, 16, 19, 21, 23, 24, 26, 33, 36, 38, 41, 44, 45,52, 53, 55, 59, 60, 61) of the C wings. Findings include: 1. Observation on 2/4/25 of the two C wing hallways of revealed a buildup of gray dust and debris along the edges where the carpet met the wall. Observation on 2/4/25 at 8:30 a.m. of the room shared by resident 55 and resident 2 revealed: *A large quantity of items on the dresser tops and	F 584	-build up of crumbs/dirt along edges of flooring in resident 24/33, 53/54, 21/61, 23, 60 rooms were cleaned. All like resident rooms were reviewed and cleaned as needed. -flooring for room 178, resident 6 has been ordered and estimated installation will be completed by 3/31/25. All like rooms were reviewed for flooring repair and scheduled estimated installation dates. -all resident bed linens were inspected and bedding changed as needed for all residents in the building. -resident 23 overbed light was repaired by maintenance. -window in resident 60 room was cleared of debris and plastic and dried duct tape was removed. -all resident rooms were checked for handtowels and washcloths. -all resident rooms were checked for stocking of can liners, garbage was removed and liners placed back in garbage cans. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated by the Director of Nursing 2/16/25 on ensuring that they maintain a safe/ clean/comfortable/homelike environment for the residents. All housekeeping and l aundry staff were educated by HealthCare Services Group Department Manager 03/06/25 on ensuring laundry is returned to correct resident room and thorough cleaning occurs in the facility. Director of Nursing and/or designee will audit resident bedding changes 3 times per week for 4 weeks, 2 times per week for 4 week, weekly for 4 weeks and then randomly to ensure continued compliance. ED and/or designee will audit facility for clean and homelike environment weekly for 12 weeks and then randomly to ensure continued compliance.	

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F 584	Continued From page 2 end tables, leaving no room for either resident to set additional things down. -The residents were out of the room and both beds were unmade. *At 9:55 a.m. the bathroom shared by resident 24 and resident 33 had: -A toilet riser on the toilet with yellow spots. -The exposed toilet rim had yellow spots. -No toilet paper dowel in the holder leaving the toilet paper sitting on the grab bar. -A wallpaper border above the tile that was peeling off along the entire top edge. -A buildup of crumbs and dirt along the edges of the floor. *At 9:58 a.m. the room shared by resident 53 and resident 44 had: -Large amounts of clutter with the dresser tops piled full of items. -The edges of the floor contained crumbs and dirt. -Resident 44 was not in the room and the bed was unmade. *At 10:00 a.m. of the room shared by resident 41 and resident 38 revealed: -Both residents were dressed and sitting in their room. -Both beds were unmade. *At 10:01 a.m. the room shared by resident 21 and resident 61 had: -An upholstered chair that was full of blankets and stuffed animals stacked on the seat and above the back chair. *At 10:01 a.m. the bathroom shared by resident 21 and resident 61 had: -An unpleasant odor. -A buildup of crumbs and dirt along edges of floor. * At 10:44 a.m. the room shared by resident 12 and resident 59 revealed:	F 584	3. As part of Aberdeen Health & Rehabs ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	

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F 584	Continued From page 3 -Resident 12 dressed in day clothes and asleep on his bare mattress that had been stripped of bedding. -Room 178 on 2/4/25 at 4:39 p.m. revealed a three inch by six inch piece of linoleum flooring was missing from the center of the room in front of the recliner with three other gouges and numerous cracks in the flooring. 2. Interview on 2/5/25 at 8:40 a.m. in resident 6's room revealed: *He had lived at the facility for one year. *He stated the missing piece of linoleum, the gouges, and the cracks in the flooring was from the use of the mechanical lift. *He stated an unidentified staff person had said the provider was going to repair the flooring but the flooring had been in disrepair since March 2024. Observation and interview at 2:30 p.m. observation and interview with resident 15 in the room she shared with resident 14 revealed: -The double room was cluttered with items on end tables and bathroom vanity. -The chair for resident 14 had clothing in it. -The chair for resident 15 was completely filled with a stack of clothing on hangers. *She was seated in her recliner with her oxygen cannula in place. She had been recently hospitalized for pneumonia and cellulitis and used the oxygen at night when sleeping and sometimes when napping if she feels short of breath. -She was not aware of the provider's process for the care of the oxygen and nebulizer equipment and supplies. -She had not seen staff clean or change the tubing.	F 584		

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F 584	Continued From page 4	F 584		

*Her clothing was frequently lost when it was in the laundry. When items had not been returned, she would tell someone with the Activities Department and they would look for it.
-She did not always get the lost item back.
-The facility had not replaced lost laundry items.
-She felt the housekeeping service wasn't very good and it should happen more often.

Observation and interview on 2/4/25 at 3:19 p.m. of resident 23 in his room revealed:
*The resident's bed had not been made and there were several brown smears approximately two inches by four inches visible on the lower front edge of the bottom sheet.
*The resident indicated he had turned on his call light to request the bed to be made prior to the surveyor's entrance to the room.
-He stated the bed will frequently remain unmade throughout the day and he will turn on his light and ask for it to be done.
-The sheets were not always changed on his bath day or when they were dirty.
*At 3:29 p.m. certified nursing assistant (CNA) I answered the call light and made the bed without changing the sheets.
*There was food crumbs, dirt, and candy pieces along the edges of the wall on the floor.
*The overbed light went on and off several times during the interview. The resident stated the light had been like that for several months and the CNAs were aware of it.

Observation and interview with resident 60 on 2/5/25 at 10:30 a.m. in his room revealed:
*Resident 60 was the sole occupant of the room.
*One section of the three-part window had a stiff opaque torn plastic hanging loose over it with dried duct tape around the edges.

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F 584	Continued From page 5 -The visible portion of the window screen below the plastic was filled with unidentifiable seeds, grass, and leaves. -He mentioned the plastic had been there since he arrived in March of 2024. -He did not know the purpose of the plastic covering but expressed that it looked "trashy." *The floor appeared clean in the center but there were crumbs and dirt along the edges. *He was unhappy with the housekeeping of his room. -He had been told upon admission that there would be daily housekeeping. -Housekeeping did not happen daily and it was poorly done because they just mopped without sweeping or moving things. *Hand towels and washcloths were replaced infrequently or not at all. -His relative did his laundry and had offered to purchase him his own towels and washcloths due to not having them. *Bed linens were changed only if he requested them to be changed and they were not changed regularly or on his bath days. *The noise level from the closets and drawers in the next room was at a level that the surveyor and resident had to pause their conversation while they were being opened and closed. -The resident expressed irritation of the noise happening multiple times per day. 3. Interview on 2/4/25 at 4:29 p.m. with CNA I revealed: *If a resident's sheets were soiled, she would change them when she made the bed. -She had not seen that resident 23's sheets were soiled when answering his call light and making the bed at 3:29 p.m. that day. *The daily bed-making was to be completed by	F 584		

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F 584	Continued From page 6	F 584		

CNAs when getting residents up for the day, but that there were days like today where they were short of staff and a lot of beds did not get made.
*Residents were supposed to get clean sheets on their bath day but they don't always get that done when they are short of staff.

Interview on 2/4/25 at 4:00 p.m. with Activities Director J revealed:
*Residents were to bring new clothing items to the Activities department for labeling.
*Activities staff looked for items that were reported as missing.
*Missing items were often found in the wrong resident's room.
*They did not replace resident's missing laundry.
*She thought the missing laundry issue was improving.

Interview on 2/5/24 at 9:00 a.m. with assistant director of nursing (ADON) and licensed practical nurse (LPN) C revealed:
*CNAs were responsible for making the residents' beds and changing sheets if they were soiled and on the resident's bath day.
*They confirmed it had been a problem getting it done.

4. Resident council was conducted on 2/5/24 from 3:00 p.m. to 4:00 p.m. with 14 residents and revealed:
*Resident 21 reported she her own washcloths and towels that were purchased and laundered by a relative since the ones provided by the facility were only enough for her roommate.
*Resident 21 reported that garbage was not removed from her room regularly.
*Resident 36 reported that he and his wife shared a room and they frequently did not have clean

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F 584	Continued From page 7	F 584		

towels, they were always short of washcloths, and that they had to ask for their bedding to be changed.
*Resident 36 indicated that the garbage was frequently overflowing.
-If the garbage was removed by staff, the liner was often not replaced.
*Resident 52 reported that she retrieved clean sheets from the linen closet herself and changed her own bedding as the sheets do not get changed.
-She made her own bed in the mornings.
*Her garbage did not get removed from her room regularly.
*Resident 19 reported that their beds did not get made without asking staff and clean sheets were not provided regularly.
*Resident 26 indicated that she had to ask staff to have her bed made and did not have clean hand towels or washcloths regularly.
*Resident 15 stated they were always short of washcloths for their rooms.
*Resident 6 reported that laundry frequently gets lost and it is not consistently found.
*Residents 15, 52, 45, 26, 36, and 19 reported that laundry was frequently returned to the wrong resident's room and they had laundry that had been lost.
*Review of the 11/26/24 resident council minutes revealed:
*Old business included garbage cans/bags still needed improvement.
*Hand towels and washcloths in rooms still needed improvement.
*Residents were not satisfied with cleaning services, particularly sweeping.
*A feedback form to Administrator A had been completed by Activities Director J regarding residents' grievance that housekeeping was not

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F 584	Continued From page 8 cleaning thoroughly enough and not sweeping before mopping. *A feedback action plan form marked resolved described a walk-through with housekeeping manager who stated they were to sweep before mopping and she would review with staff and add to the training. Review of the 12/23/24 resident council minutes revealed: *Old business included housekeeping not sweeping before mopping, marked resolved. *Old business included towels and washcloths not being passed, marked not resolved, action needed. *A feedback form to Administrator A stating resident complaint that towels and washcloths were not being passed "stated by multiple residents." *A feedback action plan form noted resolved, stating that staff working on nights were filling in and not typically on night shift. *DON B, Minimum Data Set (MDS) assessment coordinator M, and the unit managers were given reeducation from 12/24/24 through 12/27/24 so all staff are aware, per DON B. Review of the 1/22/25 resident council minutes revealed old business included towels and washcloths not being passed, the staff had been educated, and it was marked resolved. Review of the provider's undated Routine Cares of a Certified Nursing Assistant: 6 a.m.-2 p.m. shift instructions revealed that upon resident rising the: *CNA was to make bed. -Complete bed change if the resident was to have a shower.	F 584		

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F 584	Continued From page 9 *Make sure the resident's room was neat and tidy. *Take out the resident's trash and dirty linen/clothing.	F 584		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint intake review, record review, interview, and policy review, the provider failed to protect the resident's right to be free from neglect related to assessing and providing skin care to prevent skin necrosis (death of cells or tissue through disease or injury) of both the residents feet and implementing monitoring to potentially prevent a significant weight loss for one of one sampled discharged resident (51) who required hospitalization related to those conditions. Findings include: 1. Review of the 1/9/25 SD DOH complaint intake	F 600	1. In continuing compliance with F600, Free From Abuse and Neglect, Aberdeen Health & Rehab corrected the deficiency by completing a body audit assessment on all residents by 2/14/25, reviewing all current resident care plans to ensure all identified needs are care planned as of 2/26/25 and reviewing all resident weights to ensure accuracy and are being weighed per physician order and/or facility policy by 2/23/25. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on the following: Accura Weight and Height Management policy – including those residents in isolation; ensuring resident identified needs are followed per resident's plan of care; body audit assessment process; their roles and responsibilities related to resident conditions, identified needs, and weight management. The Director of Nursing Services and/or designee will audit weekly body audits for completion and accuracy 5x/week for 4 weeks, 2x/week for 4 weeks, weekly for 4 weeks, and then randomly to ensure continued compliance. The Director of Nursing Services and/or designee will audit resident weights weekly for 12 weeks and then randomly to ensure continued compliance. The Director of Nursing Services and/or designee will audit 3 care plans weekly for 12 weeks and then randomly to ensure continued compliance. 3. As part of Aberdeen Health & Rehabs' ongoing commitment to quality assurance, the Director of Nursing Services and/or designee will report identified concerns through the community's QA Process.	02/23/25

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F 600	Continued From page 10 revealed: *The complainant had a concern regarding the quality of care and treatment for resident 51. *The reported the resident was admitted to the hospital on 1/7/25. *The resident's left foot great toe, three other toes, and 3 last toes and part of his foot was necrotic. *The resident's right foot necrosis was between his great toe and the next toe. *The resident had been previously hospitalized in October 2024 and had no skin issues at that time. *The first time the facility had reached out to the doctor about the necrosis on his feet was on 1/1/25.. *The resident had dementia (impaired memory and cognition) and thought his foot was broken. *The resident's wife lived at a different facility and his durable power of attorney (DPOA) was his daughter who did not live close by. 2. Review of the 1/16/25 SD DOH complaint intake revealed: *The complainant wanted to remain anonymous. *They reported the resident was admitted to the facility late fall 2024. *The complainant reported the resident's family had not been invited to his care plan meetings to review his current status and allow them to be a part of any changes in his plan of care. *His family had been notified of a fall and skin tear but had not been notified about his toes until 1/1/25. *The resident's family had been informed by the unit manager, licensed practical nurse (LPN) C regarding the necrosis of his toes. *They reported the family had been informed the resident's toes had started to turn black related to his diabetes diagnosis.	F 600		

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F 600	Continued From page 11 *They felt the resident should have been sent to the emergency room (ER) but it was decided he would be seen by a podiatrist (foot doctor) instead. *On 1/7/25 the hospital podiatry department informed the family the resident had gangrene (dead tissue caused by an infection or lack of blood flow) in both of his feet related to an untreated infection. *The family had been told his condition "Was brewing for months: and could not have been a recent onset." *The complainant reported the hospital staff informed the family that when they took off the resident socks, they had been afraid his toes would peel off with the socks due to the advanced state of the gangrene. *They were aware the resident had been hospitalized in December of 2024 due to Coronavirus disease (COVID -19) and had returned to the facility on 12/23/24. *The hospital's podiatry department also informed the family the resident was malnourished (had a nutritional deficiency). *He had lost 23 pounds (lbs.) from 10/23/24 through 1/7/25. *The facility had not informed the resident's family of his extreme weight loss and when discussed with the facility they were informed he had been refusing his medications also. *The complainant reported the family felt like no one was paying attention to the resident and they had been concerned he was being neglected. *The hospital informed the family the only options for him was a double amputation of his legs or Hospice Care (end-of-life care). *The family made the difficult decision for the resident to start Hospice Care and admitted him to a different long term care facility (LTC) for	F 600		

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F 600	Continued From page 12 Hospice Care. 3. Review of resident 51's electronic medical record (EMR) revealed: *He was admitted on 10/29/24. *His diagnoses included: -Chronic Obstructive Pulmonary Disease (a disease that makes it hard to breathe). -Type 2 Diabetes Mellitus without complications. -Type 2 Diabetes Mellitus with Diabetic Neuropathy (decreased sensation in the feet, legs, hands, and arms). -Chronic Kidney Disease Stage 3 (moderate damage to the kidneys, where they are not filtering waste effectively). -Dependence on Renal Dialysis (medical treatment that removes waste products and excess fluid) 3 times per week. -Dementia. -He had been affected by COVID-19 from 12/16/24-1/1/25. *His Brief Interview for Mental Status (BIMS) score was 11 which indicated he had moderate cognitive impairment. *On admit on 10/29/24 he had a skin tear on his left 2nd toe which measured 0.3 centimeters (cm) x 0.3 cm, and it had healed on 11/19/24. *There was a note in his Dialysis report dated 12/20/24 which indicated: -"Dialysis education additional information:" "Nursing Home staff: Please check bilateral feet as they are red." *There was no documentation, progress note, or a "Non-Ulcer Skin Assessment" form in his EMR to indicate his feet were checked for that redness. *He had an order dated 11/12/24 for daily weights to be checked. -Upon admission on 10/29/24 he had weighed 158.6 lbs. and by 1/7/25 he had weighed 128.2	F 600		

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F 600	Continued From page 13 lbs. -He had lost 30.4 lbs. within 69 days. *There was no documentation that indicated the weight loss was reported to his doctor or his family to ensure further guidance was provided. 4. Interview on 2/5/25 at 9:20 a.m. with director of nursing (DON) B regarding skin assessments for residents who were in isolation related to COVID-19- revealed: *She would have designated a tub room for residents on isolation to use, the resident could have worn a mask in the hallway when staff transported them to the tub room, or they resident could have received a bed bath in their room. *CNAs would do skin checks on residents when they bathed or showered them. *If a CNA noted a skin concern for a resident, they would have been reported that to the nurse or unit manager *The nurse, unit manager, or wound nurse would have completed the "Non-Ulcer Skin Assessment" form in the residents' EMR and added the resident and skin concern to their weekly wound rounds for follow up. 5. Interview on 2/6/25 at 11:50 a.m. with wound nurse N regarding resident 51's necrotic skin revealed: *She had been wound nurse since employed at the facility. *She had not received any special training related to wounds. -no special training *She completed the resident's "Non-ulcer Skin Assessment" on 10/29/24 for weekly wound rounds and had notified the family that the area of concern had been healed by 11/19/24. *The resident had COVID-19 from 12/16/24 through 1/1/25 and had remained isolated to his	F 600		

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F 600	Continued From page 14 room, and had not received a shower during that time. -He had a shower after the COVID-19 had been resolved on 1/1/25. -The skin concerns on his feet had been discovered at that time. *The CNA identified the concerns during the resident's shower and had let the nurse know about the new skin issue. *She knew the nurse working that day had called for an appointment to get his foot looked at and he had gone later that week to a podiatry appointment. *She did not do regular diabetic skin checks and was not sure if that had been completed by the nurses. *She expected the CNA's and nurses to let her know when they identified a new skin concern for her to follow up on it. 6. Interview on 2/6/25 at 12:57 p.m. with certified medication aid (CMA)/CNA O revealed: *She had been doing residents' baths for 12 years at the facility. *She stated if she found a skin tear, an open area, an abrasion, a bruise or anything she had not seen before on a resident during their bath she would let the nurse know about it. If it was new to her, she would have reported it even if nurse had seen it. -The nurse would have come in to assess that resident's area, get measurements, and fill out their documentation for wounds if one had not been started. -The nurse would take that information to the wound nurse so she could add it to their list and follow up on their weekly rounds. *She did not know anything about resident 51's feet or skin concerns.	F 600		

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F 600	Continued From page 15 *If there was COVID-19 in the building she would have given those not on precautions baths first. -She would take residents on isolation one by one to the bathing room at the far end of the hall that was for those on isolation. 7. Interview on 2/6/25 at 12:04 p.m. with assistant director of nursing (ADON) C revealed: *She had been notified by the nurse on Wednesday 1/1/25 about resident 51's feet by text message. *She read the text that had asked her, "Were you aware of pinky toe and next two toes are black?" *They had set up an appointment for the resident right away because his toes on both his feet were blackened. *On 1/1/25 they received an antibiotic order from the doctor, and he was given his first dose that day. *The resident was scheduled to see podiatry on 1/7/25 at 3:00 p.m. *He went to his podiatry appointment and was admitted to the hospital from there. She stated, "I am assuming because of the feet." *She completed weekly wound rounds on her area of the building with wound nurse N every Wednesday. *On 12/31/24 she had done wound rounds with the wound nurse and resident 51 was not on their list to monitor at that time. *She would not have expected the resident to be on the list that day because he did not have an identified skin issue at that time. *She stated they would have measured a new wound, documented in the resident's EMR and notified the resident's doctor, family, administrator, and DON of the skin concern. *The next step in the process or follow up would depend on what the doctor ordered.	F 600		

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F 600	Continued From page 16 *Nurses did not complete or perform regular diabetic skin or foot checks. -The bath aid would let her know if they saw anything. -She would check their feet when she cut their nails if the resident was Diabetic. -Nurses do not complete skin assessments for residents until there is an issue. *Resident 51: -Did not return to the facility. -Tested positive on 12/16/24 for COVID-19 and after he moved over from the rehab unit, she stated he didn't feel good. *She had not received a report from the rehab unit manager prior to his admit to long term care on 12/5/24 but she had done a chart review and had not seen skin issues to monitor for him. *He had been refusing most cares and would not eat much of anything while he was sick with COVID 19. *She was not sure if he had gotten a bath during his COVID-19 isolation, "He had been refusing cares and did not want to do much." *She stated his necrotic toes had come on kind of quick and then he was hospitalized on 1/7/25 and did not return to the facility. 8. Interview on 2/6/25 at 2:25 p.m. with RN E regarding resident 51 revealed: *She had been called to the tub room by the CNA on 1/1/25 to look at his skin. *She recalled his left foot had redness and dark spots on it. *She called the doctor and received orders to start him on an antibiotic and to make him a podiatry appointment instead of going to the emergency room. *She had contacted the resident's family to inform them of this skin concern.	F 600		

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F 600	Continued From page 17 *He had been started on an antibiotic for his foot infection. *She did not do skin assessments and had not assessed his skin when he moved over from the rehab unit on 12/5/24. *Bath CNAs checked residents' skin when they gave them a bath and would have let her know if they discovered a skin concern to be checked. *Residents cannot come out of their room for showers when they were on COVID-19 isolation, but they could have gotten a bed bath. *She thought 1/1/25 was the first shower resident 51 had since he had COVID-19 starting on 12/16/24. *Daily weights had not been done while resident 51 was on COVID-19 isolation. *She thought Covid isolation was for 7-10 days. *The resident did not have any treatments for his feet prior to the blackened toes being identified on 1/1/25. *There was no documentation in his EMR for wound care had been provided to his feet between 1/1/25 and when he had gone to the podiatry appointment on 1/7/25. 9. Interview on 2/6/25 at 3:49 p.m. with DON B revealed: *CNA's gave residents their showers and would have performed a head-to-toe skin check and would notify the nurse if skin issues were discovered. *Residents with wounds were added to the weekly wound rounds with the nurse to monitor. *Nurses did not complete or perform regular diabetic foot checks but did check (or trim) their nails weekly or every other week and checked their feet at that time. *The last COVID-19 outbreak had been from 12/16/24 through 1/7/25 and there had been	F 600		

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F 600	Continued From page 18	F 600		

confusion about resident's bed baths.
*Residents could have had showers if they wore a mask in the hallway or they could choose a bed bath if they refused to wear a mask.
*Resident 51 admitted in October 2024 with a skin tear on his left foot that had healed November 2024.
-All he wanted to do was to lay in bed and not receive cares while he had COVID-19.
-He refused care and would not go to dialysis while he was sick with COVID-19
*He could have come out of isolation and his room if he had worn a mask for certain activities.

10. Interview on 2/6/25 at 3:49 p.m. with nurse consultant P revealed, he had poor vascular circulation and was frail and fragile when he admitted here.

11. Review of resident 51's care plan dated 10/29/24 revealed:
*He had a diagnosis of Diabetes Mellitus and nursing would check his body for breaks in skin and treat promptly as ordered by medical practitioner.
*He had potential for impairment to his skin integrity and nursing would observe skin during cares and report changes to the nurse.
-Weekly skin inspections and as needed.
*Discharge plan was undetermined but resident 51 wished to return home after rehab, staff to assist the resident and family in decision making process based on home situation and resident's needs.
*He had the potential for nutritional problems related to type 2 diabetes, kidney dialysis.
-His weight would remain stable during the review date with targeted date 1/17/25.
-Registered Dietician would evaluate and make

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F 600	Continued From page 19 diet change recommendations as needed. Provide/serve modified renal diet 1500 milliliter (ml.) fluid restriction as ordered. *He was independent with eating after setting up and preferred meals in his room. A house supplement was ordered. *There was no focus area that indicated he had been refusing to eat and what further interventions had been put in place to promote nutritional health. *There was no focus area that indicated they were aware of his significant weight loss and the interventions put in place to support nutritional health. 12. Review of the provider's January 2024 "Person-Centered Care Plan" policy revealed: *"Guideline, Person centered care planning is an on-going process which actively encourages the resident and/or the resident's representative to be an active participant in the care planning process and addresses the development and implementation of individualized person care ..." -"2. The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:" -"(ii) A summary of the resident's medications and dietary instructions." -"(iv) Any updated information based on the details of the comprehensive care plan, as necessary." 13. Review of the provider's 10/19/22 "Vulnerable Adults" policy revealed: *"Purpose; Accura Health Care supports "Zero Tolerance" for resident abuse, neglect, mistreatment, and/or misappropriation of resident property."	F 600		

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F 600	Continued From page 20 -"Identifying Maltreatment: g) Neglect 1) Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." 14. Review of the provider's 1/20/23 "Weekly Skin Assessment and Documentation Process" revealed: *"Skin ulcers and Non-Ulcers will be assessed and documented weekly by the facility wound nurse." -"Assessment and Documentation Process, b) Identifying a Skin Ulcer or Non-Ulcer Assessment; 1) the nurse who initially identifies the Skin Ulcer or Non-Ulcer ulcer will complete the appropriate Skin Assessment (Non-Ulcer or Ulcer Assessment)." 15. Review of the provider's 11/13/24 "Process for Resident Activity Restrictions During an Outbreak" revealed: *"a) During an infectious disease outbreak, we may limit resident group activities to prevent the spread of communicable disease within the facility. When a significant number of resident's are exhibiting signs and symptoms of potentially infectious illness, the supervisor will restrict resident activity, after discussion with the IPN [infection prevention nurse] and/or the on-call representative of administration. If the supervisor is unable to reach either of the above, she or he will make a decision about restrictions based on information available." *"1. Restrictions may include:" -"i) Restriction of residents to their units." -"ii) Restriction of residents to their rooms." *"b) All other restrictions deemed appropriate by	F 600		

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F 600	Continued From page 21 the supervisor or the IPN [infection prevention nurse]." *Bathing and skin checks were not listed as resident restricted activities.	F 600		
F 686 SS=D	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, record review, interview, and policy review the provider failed to implement prescribed, and care-planned preventative pressure injury interventions for one of one (50) sampled resident with a history of skin breakdown on his feet. Findings include: 1. Observation on 2/4/25 at 2:28 p.m. revealed resident 50 was lying in his bed in his room. He had a floor mat on the floor next to the bed and had no heel-lift boots on his feet while he was taking his nap. Observation on 2/4/25 at 4:02 p.m. of resident 50 revealed he was lying on the right side of his bed,	F 686	1. In continuing compliance with F686, Treatment/Svcs to Prevent/Heal Pressure Ulcer, Aberdeen Health & Rehab corrected the deficiency by reviewing R50 and all like resident to ensure heel boots were available and in use per their plan of care. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated by the Director of Nursing on 2/16/2025 on ensuring that residents that have heel boots are applied per their plan of care. Director of Nursing and/or designee will audit all residents with heel boots to ensure accurate application per plan of care 3x/week for 4 weeks, 2x/week for 4 weeks, weekly for 4 weeks and then randomly to ensure continue compliance. 3. As part of Aberdeen Health & Rehabs' ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	02/16/25

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F 686	Continued From page 22 had a body pillow behind him, and had no heel lift boots on his feet. Observation on 2/5/25 at 2:07 p.m. of resident 50 revealed he was lying in his bed on his left side with no heel lift boots on his feet. 2. Review of resident 50's electronic medical record (EMR) revealed: *A care plan intervention of float/offload heels with heel lift boots when resident was in bed was initiated on 11/7/23. *A doctor's order for heel protection boots to be worn while the resident was in bed was dated 1/24/24. *Treatment administration record (TAR) documentation had been signed off by the nurse that the resident's heel lift boots were on for 2/4/25 and 2/5/25. 3. Interview on 2/5/25 at 10:07 a.m. with certified nursing assistant (CNA) D regarding resident 50 revealed: *The resident did not have heel-lift boots on that morning before she got him up from his bed. She did not think he was supposed to wear them. Interview on 2/5/25 at 10:09 a.m. with registered nurse (RN) E regarding resident 50 revealed: *CNAs and nurses would heel lift boots for residents if those were ordered or care planned for them. *It was the nurse's responsibility to verify that heel boots were in place for a resident according to the orders before signing them off on the TAR. Interview on 2/5/25 at 3:38 p.m. with the assistant director of nursing (ADON)/ licensed practical nurse (LPN) C revealed:	F 686		

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F 686	Continued From page 23 *Resident 50 had an open area on the outer bony aspect of his R) ankle bone on 1/24/24. *They implemented the heel lift boots as a preventative measure for resident 50 at that time to prevent further skin breakdown. *She agreed whenever resident 50 was in his bed he should have had the heel lift boots in place per his care plan and the doctor's order. *She could not find heel lift boots in resident 50's room when she looked on 2/5/25 following interview. Interview on 2/6/25 10:27 a.m. with director of nursing (DON) B revealed: *It would be her expectation for the doctor's order for heel lift boots to be followed. *She expected resident's care plans to be followed for any interventions listed. *Resident 50 should have been wearing his heel-lift boots whenever in bed for prevention of skin breakdown. *The CNAs had pocket care plans and those were updated with that information also. 4. Review of the provider's updated 1/20/23 Weekly skin assessment and documentation process policy revealed: *"The treatment orders for all Skin Ulcer or Non-Ulcer will be implemented per the Accura's Skin Management Protocol." *"The Nurse leader will fax the appropriate wound treatment order per Accura Skin/Wound Protocol for approval by the physician." *"The Care plan will be updated and reviewed to ensure that the skin/wound alteration and appropriate interventions have been identified on the Care plan."	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility	F 688		

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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 688	Continued From page 24 CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to effectively implement, monitor, and document a walk to meals restorative program for one of one sampled resident (54) to help maintain her mobility. Findings include: 1. Observation on 2/4/25 at 10:22 a.m. of resident 54 revealed: *She used her feet to propel her wheelchair independently to move up and down the hallway on Arbor Lane. *She did not respond to questions asked by this surveyor. 2. Observation and interview on 2/5/25 at 3:40 p.m. of resident 54 with registered nurse (RN) E	F 688	1. In continuing compliance with F 688, I ncrease/Prevent Decrease in ROM/Mobility, Aberdeen Health & Rehab corrected the deficiency by ensuring restorative programs were implemented for R54 and all like residents. 2. To correct the deficiency and to ensure the problem does not recur the Director of Nursing Services and MDSC were educated on the Accura Restorative Program process by Accura's Regional Clinical Quality Specialist on 02/07/2025. All nursing staff were educated on t heir roles and responsibilities of ensuring resident restorative programs are provided and documented by the Director of Nursing Services on 02/16/2025. The Director of Nursing Services and/or designee will audit all resident restorative programs monthly for 3 months and then randomly to ensure continued compliance. 3. As part of Aberdeen Health & Rehabs' ongoing commitment to quality assurance, the Director of Nursing Services and/or designee will report identified concerns through the community's QA Process.	02/16/25

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F 688	Continued From page 25 revealed: *The resident had wheeled herself via her wheelchair to Country Lane hallway from her living area on Arbor Lane on the rehab unit. *RN E stated resident 54 wheeled herself everywhere in the building in her wheelchair. 3. Record review of resident 54's electronic medical record (EMR) revealed: *She had a Brief Interview for Mental Status (BIMS) score of 8 which indicated she had moderate cognition impairment. *She had limited physical mobility and used of a four wheeled walker and wheelchair due to her risk of falls. *Her last fall was on 7/13/24. *He comprehensive care plan indicated she was to participate in the restorative therapy program of "walking-ambulate to meals" every day. -That intervention was initiated on 3/1/24 by Minimum Data Set (MDS) coordinator M. 4. Interview on 2/5/25 at 2:30 p.m. with certified nursing assistant (CNA) Q revealed resident 54 had not walked to meals for a long time. She indicated, it had been months and months ago. 5. Interview on 2/5/25 at 2:45 p.m. with certified occupational therapist assistant (COTA) K regarding resident 54 revealed: *She had worked with resident 54 and had discharged her from occupational therapy to continue on a restorative therapy on 10/30/24. *When a resident was discharged from occupational therapy to a restorative therapy program she would have told the nurse that day. *MDS coordinator M would know who would update residents" care plans. *She was not sure why resident 54 had not been	F 688		

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F 688	Continued From page 26 walking to meals according to her restorative program. 6. Interview on 2/5/25 at 2:49 p.m. with assistant director of nursing (ADON), RN L regarding resident 54 revealed: *She was the unit manager of the rehab unit that resident 54 resided on. *She was not sure about resident 54's "walking-ambulate to meals" restorative program. -She stated, that would be something to ask MDS coordinator M about, but to her knowledge the resident had not participated in that restorative program. 7. Interview on 2/5/25 at 2:58 p.m. with MDS coordinator M regarding resident 54's restorative program revealed. *The residents "walking-ambulate to meals" restorative program had been missed. *She stated the resident could walk by herself in her room a little bit. *She indicated she would like therapy to work with the resident again before starting the resident's restorative program to evaluate her current mobility and needs. *She stated a resident's care plan could be updated by anyone, but typically staff brought her information to update the care plans. 8. Review of the provider's 10/26/21 "Restorative Program Process" revealed: *"Purpose: To ensure our resident (s) achieve and maintain their highest level of function." *"Process: " -"a) Upon admission, quarterly, and with significant change the resident's level of function will be assessed by the licensed nurse or in collaboration with therapy."	F 688		

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F 688	Continued From page 27 -"b) Based on the results of the assessment the licensed nurse will develop a care plan showing the resident's individual problems, determine approaches/interventions and set goals." -"c) The licensed nurse will develop a restorative nursing program with individualized interventions and goals which may include recommendations for strategy and adaptive equipment from therapy. " -"d) The licensed nurse will educate all direct are staff assigned to the resident(s) on their restorative nursing program." -"e) The licensed nurse will monitor the daily restorative nursing program documentation in POC and follow-up with staff as needed." -"h) The licensed nurse will update the care plan and the restorative nursing program to reflect the resident (s) specific goals and interventions as needed." -"i) The licensed nurse will make referrals to therapy as needed." -"j) The licensed nurse will develop a discharge plan for the resident (s) who no longer need a restorative nursing program." 9. Review of the provider's "Person-Centered Care Plan" policy dated 1/2024 revealed: *"Person centered care planning is an on-going process which actively encourages the resident and/or the resident's representative to be an active participant in the care planning process and addresses the development and implementation of individualized person care ..." -"2. Contain measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessments. The comprehensive care plan must describe the following: (i) the services that are to be furnished	F 688		

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F 688	Continued From page 28 to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being." -"4. The overall person-centered care plan should be oriented towards: (i) Preventing avoidable declines, (ii) managing risk factors, (iii) Preserving and building on the resident's strength's."	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure respiratory needs of one of one sampled resident (15) had been met for changing of oxygen tubing and nebulizer tubing weekly according to the provider's policy. Findings include: 1. Observation and interview with resident 15 on 2/4/25 at 11:00 a.m. in her room revealed: *An oxygen concentrator was near her recliner. *The oxygen tubing and nasal cannula (nosepiece) was draped on top of the concentrator. *There was no visible dating or tag on the oxygen tubing. *The resident indicated she had been using the	F 695	1. In continuing compliance with F695, Respiratory/Tracheostomy Care and Suctioning, Aberdeen Health & Rehab corrected the deficiency by ensuring oxygen tubing was changed and dated for R15 and all like residents. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated by the Director of Nursing on 2/16/2025 on ensuring that residents on oxygen/nebulizer therapy have their tubing changed and dated weekly. Director of Nursing and/or designee will audit all residents on oxygen/nebulizer tubing changes to ensure they are completed weekly x12 weeks and then randomly to ensure continue compliance. 3. As part of Aberdeen Health & Rehabs' ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	02/16/25

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F 695	Continued From page 29 oxygen since her January 2025 hospitalization. *She used it when she was short of breath and when sleeping. *She was concerned that no one had changed the oxygen tubing yet. *She did three or more nebulizer treatments per day. *She did not think her nebulizer tubing or mask supplies had been changed. Observation of resident 15 on 2/5/25 at 4:00 p.m. revealed the resident was asleep in her recliner with the oxygen cannula under her nose and the oxygen concentrator running. 2. Review of Resident 15's (EMR) revealed: *Resident had a Brief Interview for Mental Status assessment score of 15, indicating that her cognition was intact. *She had diagnoses of Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, and Chronic Respiratory Disease *A physician's order for use of oxygen was not located. *Her physician had been notified by fax on 1/17/25 that she was using oxygen. *The response from the physician did not acknowledge the oxygen use or provide a flow rate for the oxygen. *Use of oxygen or a flow rate of use was not listed on her Interagency Transfer Orders (discharge orders) from her hospital stay from 1/21/25 through 1/24/25. *Her care plan had been updated on 1/24/25 to include "requires oxygen therapy." *There was no task noted in the Medical Administration Record (MAR) or Task Administration Record (TAR) addressing the changing of oxygen concentrator tubing.	F 695		

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F 695	Continued From page 30 *The TAR indicated that her nebulizer tubing had been changed weekly. 3. Interview with assistant director of nursing (ADON) and licensed practical nurse (LPN) C revealed: *Residents would have an order for oxygen use. *She had told the nursing staff that they needed to get an as needed order for resident 15's oxygen. *She did not realize that fax to the resident's physician on 1/17/25 had not acknowledged or ordered oxygen usage for her. *The physician's order would be how the staff knew the correct oxygen setting for rate of flow. *Resident 15 had been given oxygen based on her shortness of breath prior to being hospitalized in January 2025. *The oxygen tubing and nasal cannula was to be dated, initialed, and changed weekly by the night shift nurse and documented in the resident's TAR. *Her expectation was for that to be done. *Tubing would be changed by the night nurse. *She would not be able to verify the change of the tubing or cannula without TAR documentation or tape with initials on tubing and cannula. Interview with registered nurse (RN) G on 2/5/25 at 2:01 p.m. revealed: *All oxygen and nebulizer tubing was to be changed one time per week or more often if it had buildup or had been kinked. *Would be changed on night shift and would have a tape tag near the machine with date changed and initials of who changed it. Interview with Director of Nursing (DON) B on 2/6/24 at 3:00 p.m. revealed:	F 695		

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F 695	Continued From page 31 *She was unable to locate an order for resident 15 to receive oxygen in the EMR (electronic medical record). *She provided a Nursing Home Standing Order Protocol signed by the medical director on 2/29/24 that indicated to use oxygen at 4 L (liters) per nasal cannula as needed for oxygen saturation levels below 92%. *Notify physician any time 02 has been started on a resident. Review of the provider's updated 11/13/24 Respiratory Cleaning Procedure policy revealed: *Oxygen tubing and the nasal cannula/mask should have been changed weekly. *Nebulizer mouthpieces, tubing, and the medication receptacle should have been changed weekly. Review of provider's 2/29/24 Nursing Home Standing Orders Policy revealed: *Standing order for use of oxygen at 4 L (liters) per nasal cannula as need for oxygen saturation levels below 92%. *Notify the physician any time oxygen has been started on a resident.	F 695		
F 812 SS=F	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.	F 812	1. In continuing compliance with F0812, Food Procurement, Store/Prepare/Serve-Sanitary, Aberdeen Health & Rehab corrected the deficiency by ordering and receiving test strips beginning testing on 02/11/25. 2. To correct the deficiency and to ensure the problem does not recur Dietary Staff were educated by Dietary Manager on 2/21/25 on dish machine chemical testing/temperature and recording process. Dietary Manager and/or designee will audit sanitizer testing 3x/week for 4 weeks, 2x/week for 4 weeks and 1x/week for 4 weeks and then randomly to ensure continue compliance.	02/21/25

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F 812	Continued From page 32 (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, record review, and policy review, the provider failed to ensure the dishwasher temperatures and chemical sanitizer concentration were monitored and recorded for one of one mechanical dishwasher used for the cleaning and sanitization of dishes and items used to prepare and serve residents' food. Finding include: 1. Observation on 2/4/25 at 8:11 a.m. during the initial tour of the provider's main kitchen revealed a mechanical dishwasher was used to clean and sanitize dishes. 2. Interview and observation on 2/5/25 at 4:34 p.m. with dining services manager (DSM) F in the kitchen revealed: *She had worked at the facility for 14 years and was a certified dietary manager. *The new low temperature mechanical dishwasher used chemical sanitization and had been in use since 11/25/24. *The dishwasher was connected by a service line to a five gallon bucket of Low Temp Machine Sanitizer which listed sodium hypochlorite, commonly known as bleach.	F 812	3. As part of Aberdeen Health & Rehabs ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	

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F 812	Continued From page 33 *No logs or documentation was observed in the dish machine area ensuring the temperature and sanitizing solution were at the appropriate levels for the dishwasher. *DSM F used a test strip to test the chemical sanitizing solution in the mechanical dishwasher and it indicated it was at 200 parts per million (ppm) which was above the required 50 ppm. Interview and record review on 2/6/25 at 8:30 a.m. with DSM F revealed: *The previous mechanical dishwasher had used heat sanitization with high temperatures. *The Dishwasher Temperatures logs that were used for the old dishwasher from November 2023 through November 2024 were reviewed that indicated: -Temperatures were logged at each meal: Breakfast, Lunch, and Supper. -The wash cycle temperatures recorded were at the required minimum temperature of 150 degrees Fahrenheit (F) or higher. -The final rinse temperatures recorded were at the required minimum temperature of 180 degrees F or higher. -The last temperatures were recorded on 11/20/24 at the Supper mealtime with a handwritten note on the form "Switched to chemical sanitizer". *DSM F stated they had used paper products from 11/21/24 through the morning of 11/25/24 when the chemical sanitizer was hooked up to the new dishwasher and the chemical sanitizer level was tested to ensure it was sanitizing appropriately, but no documentation was left regarding that visit. *When asked why the logs did not continue with the new low temperature mechanical dishwasher, DSM F stated the new mechanical dishwasher	F 812		

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F 812	Continued From page 34 did not use heat sanitization that required monitoring of the high temperatures to ensure sanitization. *The dietary staff were not currently using a form to document the new mechanical dishwasher's wash temperature and sanitization level. *She agreed that if they were not regularly checking the mechanical dishwasher's wash temperature and sanitization levels there could have been a risk it was not sanitizing the dishes properly. On 2/6/25 at 8:45 a.m. record review and interview with DSM F regarding the October 2022 Centers for Medicare and Medicaid Services (CMS) Long Term Care (LTC) Survey Pathway's Form CMS-20055 Kitchen/Food Service Observation which included the following recommendations according to the U.S. Department of Health and Human Services, Public Health Services, Food and Drug Administration Food Code: *"Low Temperature Dishwasher (chemical sanitization): -Wash - [temperature of] 120 degrees F; and -Final Rinse - 50 ppm (parts per million) hypochlorite (chlorine) on dish surface in final rinse. -The chemical solution must be maintained at the correct concentration, based on periodic testing, at least once per shift, and for the effective contact time according to manufacturer's guidelines." *After review of the recommendations, DSM F agreed that she should have been using a form to document the mechanical dishwasher's wash temperature and chemical sanitization level. Observation on 2/6/25 at 9:02 a.m. of the low	F 812		

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F 812	Continued From page 35 temperature (chemical sanitization) dishwasher with DSM F revealed the wash cycle reached 145 degrees F and the chemical test strip indicated a sanitization level of 200 ppm which were in the acceptable ranges. Interview on 2/6/25 at 12:18 p.m. with administrator A regarding the kitchen's mechanical dishwasher revealed she: *Provided the mechanical dishwasher's manufacturer's manual and confirmed the new low temperature mechanical dishwasher that used chemical sanitization was put into service on 11/25/24. *Agreed the 2013 Dish Machine Temperature Log policy was their current policy and that its procedure should have been followed which included: -"...a log to be posted near the dish machine." -"...train dishwashing staff to monitor [the] dish machine..." *Agreed the dietary staff should have been logging the temperature and sanitizer levels at each meal according to their policy. Review of the provider's 2013 Dish Machine Temperature Log policy revealed: *"Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes." -"The food service manager will provide the dishwashing staff with a log to be posted near the dish machine." -"The food service manager will train dishwashing staff to monitor dish machine temperatures throughout the dishwashing process." -"Staff will be trained to record dish machine temperatures for the wash and rinse cycles at each meal."	F 812		

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F 812	Continued From page 36 Review of the 10/7/13 mechanical dishwasher's manufacturer's manual provided by administrator A on 2/6/25 at 12:18 p.m. revealed: *Chemical Sanitizing: -Final rinse minimum temperature: 120 degrees Fahrenheit. -Sanitizer required: 50 ppm available chlorine. *"Questions to Evaluate Operation of Conveyor Machines". -"When the machine fills with water, what is the incoming water temperature? It should be 120 [degrees] F for Chemical Sanitizing." -"Is the final rinse water at the correct temperature? 120 [degrees] F min. [minimum] for Chemical."	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
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 on 2/6/25. Aberdeen Health and Rehab was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at E004 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:	E 004	1. In continuing compliance with E0004, Develop EP Plan, Review and Update Annually, Aberdeen Health & Rehab corrected the deficiency by updating the EP plan as of 3/06/2025 with updated agreements. 2. To correct the deficiency and to ensure the problem does not recur Executive Director was educated on 2/24/25 by the Chief Operating Officer on ensuring EP Plan and agreements are reviewed/updated annually. Executive Director and/or designee will audit EP plan and agreements annually. 3. As part of Aberdeen Health & Rehabs ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	03/06/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kirstie Hoon, LNHA	Executive Director	03/01/2025

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.

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 _____	02/06/2025

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
E 004	Continued From page 1 * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to update the emergency preparedness plan agreements (emergency, evacuation transfer) annually. Findings include: Record review on 2/6/25 at 10:45 a.m. revealed no documentation that the provider's current emergency preparedness plan memorandums of understanding/agreements were updated annually. For example, the emergency food, supplements, and beverages agreement copy originally signed 12/21/17 and evacuation site agreement signed 11/14/17 had no documentation that they had been updated	E 004		

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	435041	A. BUILDING _____ B. WING _____	02/06/2025

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

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E 004	Continued From page 2 annually since those dates. Interview with the administrator on 2/6/25 at 11:30 a.m. confirmed those findings.	E 004		

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 _____	**02/06/2025**

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 000	INITIAL COMMENTS A recertification survey was conducted on 2/6/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Aberdeen Health and Rehab was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K324, K347, K522, and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324	1. In continuing compliance with K0324, Cooking Facilities, Aberdeen Health & Rehab corrected the deficiency by contacting the contractor that cleans the kitchen hood/ducts on 2/7/2025. Cleaning has been scheduled on a bi-yearly timeframe in March and September yearly. 2. To correct the deficiency and to ensure the problem does not recur Maintenance Supervisor was educated by Executive Director on 2/20/25 to ensure kitchen hood/ducting is cleaned every six months. Executive Director and/or designee will audit kitchen hood/duct cleaning every 6 months and then randomly to ensure continued compliance. 3. As part of Aberdeen Health & Rehabs ongoing commitment to quality assurance, A comprehensive life-safety audit is conducted annually by Accura Resource Center. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	02/20/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kirstie Hoon, LNHA	Executive Director	03/01/25

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.

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 _____	**02/06/2025**

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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 324	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the provider failed to conduct the required every six-months inspection of the exhaust ductwork system for the range hood. The records regarding the kitchen exhaust duct system indicated an inspection had been done in July 2023 and August 2024. Findings include: 1. Document review on 2/6/25 at 9:15 a.m. of the kitchen range hood cleaning inspections revealed duct cleaning documentation for August 2024 and July 2023. Kitchen range hood duct inspections must be performed not less than six months apart. There was no further documentation indicating other inspections had taken place. Interview with the administrator at 11:45 a.m. on 2/6/25 confirmed that finding. She stated the cleaning inspections had been scheduled annually only. This deficiency affected one of numerous kitchen hood system requirements.	K 324		
K 347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by:	K 347	1. In continuing compliance with K0347, Smoke Detection, Aberdeen Health & Rehab corrected the deficiency by purchasing and installing a smoke detector in the Arbor's nurses station on 2/13/25. 2. To correct the deficiency and to ensure the problem does not recur Maintenance Supervisor was educated by Executive Director on 2/20/25 to ensure proper corridor smoke separation or monitoring throughout the facility. The Executive Director and/or designee will audit corridor smoke separation/monitoring quarterly and then randomly to ensure continue compliance.	02/20/25

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K 347	Continued From page 2 Based on observation and interview, the provider failed to maintain corridor smoke separation or monitoring of that area for one randomly observed area (Arbor wing nurse station) as required. Findings include: 1. Observation on 2/6/25 at 10:30 a.m. revealed the Arbor wing nurse station had a 30 inch by 42 inch opening from the nurse station into the corridor. The opening had a 15 inch header which would contain smoke in the room. The nurses' station room did not have a smoke detector in that room tied into the fire alarm system. Interview with the administrator 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 347	3. As part of Aberdeen Health & Rehabs ongoing commitment to quality assurance a comprehensive life-safety audit is conducted annually by Accura Resource Center. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	
K 522 SS=D	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain combustion (fresh) air	K 522	1. In continuing compliance with K0522, HVAC – Any Heating Device, Aberdeen Health & Rehab corrected the deficiency by requesting and receiving a quote on 2/21/25 from a contractor to make smoke dampers functional again. Work is projected to be completed by 3/21/25. 2. To correct the deficiency and to ensure the problem does not recur Maintenance Supervisor was educated by the Executive Director on 02/20/25 to ensure dampers are in working order. The Executive Director and/or designee will audit all smoke dampers in the laundry room weekly for 1 month, monthly for 2 months and t hen randomly to ensure continue compliance. 3. As part of Aberdeen Health & Rehabs ongoing commitment to quality assurance a comprehensive life-safety audit is conducted annually by Accura Resource Center. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	02/21/25

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K 522	Continued From page 3 in one randomly observed area (laundry). Findings include: 1. Observation of the three commercial natural gas-fired dryers in the laundry room on 2/6/25 at 10:15 a.m. revealed the following: There was a dedicated combustion (fresh) air ductwork provided for the operation of the natural gas-fired commercial clothes dryers with a motorized damper actuator at the discharge end of the ductwork. Testing of the actuator by running each dryer revealed the actuator did not move. A damper operator for the required combustion fresh air supply must automatically open upon operation of any of the gas-fired dryers. The gas-fired dryers were taking combustion air from the room itself as a result. Interview with the administrator at the time of the observation confirmed that finding. The deficiency affected one of several requirements for fuel-fired devices.	K 522		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7	K 712	1. In continuing compliance with K0712, Fire Drills, Aberdeen Health & Rehab corrected the deficiency by educating the Maintenance Supervisor on monthly fire drill requirements. This education was completed on 02/20/25 by the Executive Director. An additional fire drill was completed on the day shift on 03/06/25, evening shift on 03/05/25 and NOC shift on 03/04/25. 2. To correct the deficiency and to ensure the problem does not reoccur, the Executive Director and/or designee will audit all fire drill documentation monthly for 3 months and then randomly to ensure continue compliance. 3. As part of Aberdeen Health & Rehabs' a comprehensive life-safety audit is conducted annually by Accura Resource Center. The cited findings will be inspected during this review. A written report will be sent to Administration after the review.	03/06/25

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K 712	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills, alarm signal verification, varying of drill times). Findings include: 1. Record review on 2/6/25 at 8:30 a.m. revealed there was no documentation of first shift (6 a.m. to 2 p.m.) fire drills for quarter four (October, November, December) or quarter two (April, May, June) of 2024. There was no documentation of third shift (10 p.m. to 6 a.m.) fire drills for quarter three (July, August, September) of 2024. There was no documentation of second shift (2 p.m. to 10 p.m.) fire drills for quarter four (October, November, December) 2023. 2. The minimum number of fire drills must be not less than one drill per shift per quarter (for a minimum of 12 fire drills). There were three silent drills (which were allowed for sleeping hours between 9 p.m. and 6 a.m.) in calendar year 2024 in January, April, and December. There was no documentation that the fire alarm was tested and reception of the alarm transmission verified by the monitoring agency for the silent drill months. That left seven alarmed fire drills for calendar year 2024 (February, March, May, July, August, September, and November). 3. The times of the fire drills were not varied as required. First shift drill times were 1053 (military time) on 9/30/24 and 1104 on 10/23/24; and 1400 on 2/29/24 and 1400 on 7/23/24. Second shift drill times were 1501 on 3/29/24, 1545 on 5/13/24, 1900 on 8/28/24 (ok), and 1502 on 11/27/24.	K 712		

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K 712	Continued From page 5 Third shift drills were held at 0600 on 11/28/23, 0530 on 12/28/23, 0545 on 1/8/24, 0600 on 4/9/24, 0500 on 12/19/24, and 0520 on 1/24/25. Interview with the administrator at the time of the record review confirmed those findings. She was unaware of the minimum number of fire drills per the required frequency had not been met for each shift since the last life safety code inspection on October 18, 2023. The deficiency had the potential to affect 100% of the occupants of the building.	K 712		

South Dakota Department of Health

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	10587	A. BUILDING: _____ B. WING _____	02/06/2025

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ABERDEEN HEALTH AND REHAB	1700 N HWY 281 ABERDEEN, SD 57401

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 2/4/25 through 2/6/25. Aberdeen Health and Rehab was found in compliance.	S 000		
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 2/4/25 through 2/6/25. Aberdeen Health and Rehab was found not in compliance with the following requirements: S443 and S447.	S 000		
S 443	44:73:12:34 Vacuum Breakers An antisiphon device or backflow preventer shall be installed on any hose bib and on any fixture to which hoses or tubing can be attached such as janitor sink, bedpan flushing attachment, and handheld shower. An antisiphon device or backflow preventer shall be installed on all plumbing and equipment where any possibility exists for contamination of the potable water supply. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain antisiphon devices for hand-held hoses in one location (C wing tub room). Findings include: 1. Observation on 2/6/25 at 9:45 a.m. revealed the hand-held hose for the shower in the C wing tub room was not equipped with a vacuum	S 443	1. In continuing compliance with S0443, Vacuum Breakers, Aberdeen Health & Rehab corrected the deficiency by ordering vacuum breaker for the shower head in C wing tub room on 2/21/2025. This was installed on 02/28/25. 2. To correct the deficiency and to ensure the problem does not recur, the Maintenance Supervisor was educated 02/20/25 on the requirement of antisiphon devices or backflow preventors installed on all plumbing and equipment where any possibility exists for contamination of the potable water supply. Executive Director and/or designee will audit all hand held hoses for antisiphon devices monthly for 3 months and then randomly to ensure continue compliance. 3. As part of Aberdeen Health & Rehabs' ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	02/28/25

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

Kirstie Hoon, LNHA | Executive Director | 03/01/25

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S 443	Continued From page 1 breaker. Interview with the administrator at that same time confirmed that finding. She stated the tub room shower had been remodeled recently and the vacuum breaker must not have been replaced at that time.	S 443		
S 447	44:73:12:38 Lighting A facility shall provide artificial lighting approved by the department in any space occupied by people, machinery, or equipment within a building, approach to the building, and any parking lot. Each resident bedroom must have general lighting of at least ten footcandles, or .929 lumens per square meter, and night lighting. If task illumination is required, a light with an intensity of at least thirty footcandles, or 2.79 lumens per square meter, at the work surface must be provided for each resident. At least one luminaire for night lighting must be switched at the entrance to each resident room. Any resident's reading light and other fixed light not switched at the door must have a switch control convenient for use at the luminaire. Each switch for control of lighting in a resident area must be of the quiet operating type. Illumination of at least one hundred footcandles, or 9.29 lumens per square meter, must be provided at the medication set-up area. Illumination of at least fifty footcandles, or 4.65 lumens per square meter, must be provided at an activity room work table. Illumination of at least thirty footcandles, or 2.79 lumens per square meter, must be provided in each dining area, physical and restorative therapy area, and at any bathing facility.	S 447	1. In continuing compliance with S0447, Lighting, Aberdeen Health & Rehab corrected the deficiency by contacting an electrical contractor to repair lighting in re sident rooms. The contractor was onsite 2/26/25 to review the work needed and will submit a quote to the facility. Work is estimated to be completed in the 30 days after quote is received and approved. 2. To correct the deficiency and to ensure the problem does not recur, the Maintenance Supervisor was educated 02/20/25 on the requirement of resident lighting in rooms and rights of residents for privacy while using lighting. Executive Director and/or designee will audit all resident rooms to ensure appropriate l ighting is available and allows for privacy. 3. As part of Aberdeen Health & Rehabs' ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	02/26/25

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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 447	Continued From page 2 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain lighting as required in three random locations (C wing east shower, resident room 147, and resident room 158). Findings include: 1. Observation on 2/6/25 at 9:25 a.m. revealed the east C wing shower had two light fixtures. The double-lamp four-foot fluorescent light ceiling light had both lamps flickering and not providing the required 30 foot-candles of illumination. Interview with the administrator at that same time confirmed that finding. 2. Observation on 2/6/25 at 10:10 a.m. revealed resident rooms 147 and 158 were double rooms with curtain partitions separating the two resident areas. Both areas had a wall-mounted light fixture with two lamps on separate circuits controlled by two switches on the wall at the entrance to the room. Testing of the lights with the switches revealed both resident area lights turned on with the operation of the wall switches. The lighting would interfere with the privacy of either resident in each room due to the wiring arrangement. Interview with the administrator at those same times confirmed those findings.	S 447		