STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEALTH AND REHAB	1700 NORTH HIGHWAY 281 , ABERDEEN, South Dakota, 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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/2/26 through 6/4/26. Aberdeen Health and Rehab was found not in compliance with the following requirements: F641, F684, F695, F812, F880, and F919. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/2/26 through 6/4/26. The area surveyed was the quality of care and treatment of residents regarding their use of oxygen equipment and monitoring their oxygen levels. Aberdeen Health and Rehab was found in compliance.	F0000	The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on the observation, interview, and record review, the provider failed to ensure the staff responded promptly to 11 of 16 sampled residents (6, 22, 30, 34, 36, 40, 41, 62, 64, 68, and 73) call lights. Findings include: 1. Interview on 6/2/26 at 9:54 a.m. with resident 6 in his room revealed that after he turned his call light on it took the staff 15 minutes to two hours to	F0684	1. In continuing compliance with F684 Quality of Care, Aberdeen Health & Rehab corrected the deficiency by ED visiting with resident # 22, 30, 34, 36, 40, 41, 62, 64, 68, 73 and all like residents to ensure immediate needs were met. Call light systems are audible at each of the nurses' stations as verified by ED on 6/22/26. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 6/16/2026 at the employee all staff meeting regarding call light response times. Those staff not in attendance received the education in their mailboxes and verified they receive the education by written signature that it was received and understood by 6.25.26 or prior to the start of their next shift. The ED and/or designee will audit call light response times 3 times per week for 4 weeks, 1 time per week for 8 weeks and then randomly to ensure continued 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.	06/25/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kirstie Hoon, LNHA	Executive Director	06/25/2026

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F0684 SS = E	Continued from page 1 answer his call light. 2. Review of resident 6's call light log (a report that states how long it takes for staff to answer a resident call light) from 5/3/26 through 6/2/26 revealed he had to wait for over 20 minutes three times, over 30 minutes four times, and over forty minutes one time for the staff to answer his call light. 3. Review of resident 6's electronic medical record (EMR) revealed his 3/31/26 brief interview for mental status (BIMS) assessment score was 15, which indicated his cognition was intact. His 4/30/26 care plan indicated he required one staff member to assist him with getting in and out of bed, repositioning, dressing, using the bathroom, and personal hygiene care. 4. Interview on 6/2/26 at 10:15 a.m. with resident 30 in her room revealed that she "sometimes" had to wait a long time for the staff to answer her call light. 5. Review of resident 30's call light log from 5/3/26 through 6/2/26 revealed she had to wait for over 20 minutes ten times, and over 30 minutes three times for the staff to answer her call light. 6. Review of resident 30's EMR revealed her 3/31/26 BIMS assessment score was 13, which indicated her cognition was intact. Resident 30's 3/31/26 MDS assessment (used to document resident care needs) indicated she was dependent on staff for assisting her with bathroom needs, personal hygiene care, dressing, and moving in bed. 7. Interview on 6/2/26 at 10:25 a.m. with resident 64 in her room revealed that she had to wait a long time when she turned her call light on, and the staff was in a rush when they took care of her. She had to wait two hours when the staff changed shifts. When she had to wait a long time for the staff to respond to her call light, she was incontinent of urine. She stated that this made her feel upset because she could not do things herself, and she required the staff's assistance. 8. Review of resident 64's EMR revealed her 5/12/26 BIMS assessment score was 13, which indicated her	F0684		

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F0684 SS = E	Continued from page 2 cognition was intact. Her 5/12/26 MDS assessment indicated she required staff assistance with bathroom needs, personal hygiene care, dressing, moving in bed, and ambulation. 9. Review of resident 64's call light log from 5/3/26 through 6/2/26 revealed she had to wait for over 20 minutes five times and over 30 minutes four times for the staff to answer her call light. 10. Review of resident 30 and 64's bathroom call light log from 5/3/26 through 6/2/26 revealed that one of them had to wait 25 minutes once and 152 minutes and 57seconds once. 11. Interview on 6/2/26 at 11:04 a.m. with resident 34 in her room revealed that she had to wait a long time for the staff to answer her call light, and then she was incontinent of urine. She stated, "Maybe they do not take care of me because they do not like me. I am hard work". She had turned her call light on "a while ago" and no one had come to assist her. Sometimes the staff did not give her the call light device, and she had to bang on something to get their attention. 12. Review of resident 34's call light log from 5/3/26 through 6/2/26 revealed she had to wait for over 20 minutes four times, over 30 minutes five times, and over 40 minutes once for the staff to answer her call light. 13. Review of resident 34's EMR revealed her 5/4/26 BIMS assessment score was 14, which indicated her cognition was intact. Her 5/19/26 care plan indicated she required two staff to assist her with bathroom needs, moving in bed, getting in and out of bed, and dressing. 14. Observation and interview on 6/2/26 at 11:29 a.m. with resident 68 in her room revealed she was sitting in her wheelchair, and her call light device was on her bed, within arm's reach of her wheelchair. She stated the call light "doesn't seem to work all the time," so if 15 minutes have passed, "I'll go (by wheelchair) up to the main nurse's area and wait there." 15. Review of resident 68's electronic medical record (EMR) revealed her 4/10/26 Brief Interview for	F0684		

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F0684 SS = E	Continued from page 3 Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. Her 5/9/26 care plan indicated she required one staff member to assist her to and from the bathroom. 16. Interview on 6/2/26 at 2:20 p.m. with resident 41in her room revealed she waited an hour sometimes for the staff to answer her call light. The staff did not answer her call light between 1:30 p.m. and 2:00 p.m. sometimes because of the shift change, and the staff would wait for the oncoming shift to answer her call light. 17. Review of resident 41's 4/30/26 BIMS assessment score was 14, which indicated her cognition was intact. 18. Review of resident 41's call light log from 5/2/26 to 6/2/26 revealed she had twelve call light response times over 20 minutes long, and of those call light response times three were over 30 minutes long. 19. Interview on 6/2/26 at 3:29 p.m. with resident 36 in his room revealed that his call light took quite a while to be answered by the staff. He had a sore on his buttock, and he did not like having to wait 20 to 45 minutes to get help from the staff. 20. Review of resident 36's 3/12/26 BIMS assessment score was 15, which indicated his cognition was intact. 21. Review of resident 36's call light log from 5/2/26 to 6/2/26 revealed he had 29 call light response times over 20 minutes long, and of those 29 call light response times, eleven were over 30 minutes long. 22. Interview on 6/3/26 at 9:30 a.m. with resident 40 and her family member in the activity room revealed that she sometimes lost control of her bladder while waiting to be assisted to the bathroom. "We don't have enough lifts (a mechanical device used to lift a person's full body). Half the time the aides come in, turn the light off, say they'll be back in a few minutes because they have to find a lift, and they may not come back." Resident 40's family member stated, "We were told that after five minutes if they (staff) don't come back, pull the call light again."	F0684		

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F0684 SS = E	Continued from page 4 23. Review of resident 40's EMR revealed her 5/11/26 BIMS assessment score was 15, which indicated her cognition was intact. Her 5/26/26 care plan indicated that she used a sit-to-stand lift (a mechanical lift used to assist a person from a seated to a standing position) with two staff members to assist her to and from the bathroom. 24. Review of resident 40's call light log from 5/4/26 through 6/3/26 revealed that she had to wait over 20 minutes seven times, over 30 minutes three times, and over 50 minutes one time. 25. Observation and interview 6/4/26 at 10:20 a.m. in resident 34's room revealed that she could not reach her call light. It was lying on the bedside table, which was on the resident's left side. She had a sling on her left arm and the full body lift sling (a supportive fabric that attaches to a mechanical lift [a device used to lift a persons fully body]) under her. She stated that the staff were supposed to come back and had not yet, and stated, "They are probably in the breakroom, that is where they sit." 26. Observation and interview on 6/4/26 at 10:31 a.m. in resident 34's room revealed that CMA T and CNA V came into the room to get her up. Resident 34 told CMA T and CNA V that she could not reach her call light device. CMA T verified that she could not reach her call light and stated that residents' call lights were to be left within their reach when the staff left the room. 27. Interview during the Resident Council Meeting on 6/4/26 at 1:30 p.m. revealed that the residents 6, 22, 41, 62, and 73 had concerns about long call light wait times, around 15 minutes to 2.5 hours, and call lights being left where they could reach them. They expressed concern that there was no staff on the floor to answer their call lights because "they all went out to smoke together or sat in the breakroom." One resident stated that she was incontinent of urine when she had to wait to long for the staff to assist her to the bathroom, and this made her feel "terrible, and they try to make you feel bad by telling me I am not the only one here." The residents discussed their call light concerns in the Resident Council meetings before. One resident stated that her call light was left out of reach, so she had to yell for assistance, and then the staff member told her not to yell.	F0684		

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F0684 SS = E	Continued from page 5 28. Review of resident 22's 4/27/26 BIMS assessment score was 15, which indicated her cognition was intact. 29. Review of resident 62's 5/12/26 BIMS assessment score was 15, which indicated her cognition was intact. 30. Review of resident 73's 4/29/26 BIMS assessment score was 15, which indicated her cognition was intact. 31. Interview on 6/2/26 at 11:15 a.m. with RN P and ADON/LPN/IP N at the nurses' station revealed that there were no resident call lights turned on at that time. The surveyor reported to them that resident 34 stated that her call light was on for a while. RN P went to check on resident 34's call light device and stated that the call light was disconnected from the call light extender that plugged into the wall, so that was why the call light did not turn on when she pushed her call light device. 32. Interview on 6/3/26 at 1:42 p.m. with CMA T revealed he noticed several times when he came in in the morning for his scheduled shift that the residents did not have their call light devices within their reach. When he saw this, he reported it to the nurse. 33. Interview on 6/3/26 at 2:11 p.m. with RN P and ADON/LPN/IP N revealed that they would occasionally find a resident's call light device that was not within their reach. 34. Interview on 6/4/26 at 9:17 a.m. with certified medication assistant (CMA) I revealed that when call lights were activated, the room numbers were displayed on a digital screen in each hallway and announced on the staff's radios. He stated, "It's not our practice to go into the room and shut off the light and then return – we just take care of their needs right away." 35. Interview on 6/4/26 at 9:24 a.m. with assistant director of nursing (ADON)/licensed practical nurse (LPN)/infection preventionist (IP) N revealed that until the call light was deactivated in the resident's room, the staff were unable to talk over their radio. "It's good incentive to get the aides to the rooms quickly	F0684		

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F0684 SS = E	Continued from page 6 so they can use their radios again." She stated that the provider's protocol was to shut the resident's call light off and then assist the resident, but some staff assist a resident to the bathroom before deactivating the light, which could extend response time on the call light log. She expected a timely response to a resident's call light would be between five and ten minutes at the most, "but I know sometimes we're challenged on the floor." If the staff turned the resident's call light off and left to locate a lift, she said the residents were expected to turn the light on if the staff did not return within a few minutes. She was not aware of the extended response times for resident 40's room but stated that some residents experienced bladder urgency or could not verbally tell the staff when they needed to use the bathroom, so "accidents may happen." 36. Interview on 6/4/26 at 11:11 a.m. with certified nursing assistant (CNA) J revealed that she thought the resident's call lights should be answered within ten minutes. The call lights would sound over the staff's radio system to alert the staff that a resident had activated their call light and needed staff's assistance. 37. Interview on 6/4/26 at 11:24 a.m. with registered nurse (RN) E revealed she expected the resident's call lights to be answered within two minutes. She stated, "We use the walkie system, and call light alerts to go right over that system to alert staff." 38. Interview on 6/4/26 at 11:49 a.m. with ADON/LPN D revealed she considered five to seven minutes to be a reasonable time for resident call lights to be answered by the staff. 39. Interview on 6/4/26 at 1:09 p.m. with director of nursing (DON) B revealed that she expected the resident's room call lights to be answered within 15 minutes and their bathroom call lights to be answered within five minutes. Executive director A would pull random call light logs throughout the month and more frequently if residents had shared concerns about longer response times. Call light audits were also posted in the staff breakroom for the staff to review. DON B was aware of resident 40's call light response times. "I think there's only one bariatric lift (a mechanical lift use to help transfer overweight	F0684		

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F0684 SS = E	Continued from page 7 residents to the bathroom), so her response time gets delayed." She agreed that some aides turned off the resident's call lights and told residents to push it again if the staff did not return within five minutes. "It's usually something they only do if (the staff have) to wait for a lift to be available, sometimes if they're in the middle of assisting someone else." She expected the resident's call lights to always be in working order and said that most days, the maintenance staff or MDS coordinator C repaired or replaced any non-working call lights before the leadership staff arrived at 8 a.m. 40. Interview on 6/4/26 at 1:22 p.m. with executive director A revealed that she expected the resident's room call lights to be answered within 15 minutes and their bathroom call lights to be answered within five minutes. "Unfortunately, that's not the way it always goes." She asked residents to tell her when staff turned their call lights off without addressing their needs. In addition to auditing call light logs two or three times per month, she stated she had audited call light frequencies, such as when a resident's call light was repeatedly activated within a 30- or 60-minute timeframe. When lengthy response times or repeated call lights were observed, she expected DON B to address it with unit managers and the nursing staff. 41. A call light policy was requested, and the provider did not have a call light policy.	F0684		
F0880 SS = E	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,	F0880	1. In continuing compliance with F880, Infection Prevention & Control, Aberdeen Health & Rehab corrected the deficiency by checking and changing out all expired hand sanitizers by 6.3.2026. Curtain was hung on Linen closet to protect against airborne infectants on 6.22.2026. All other linen closets were audited and found to be in compliance on 6.22.2026. R26 wheelchair was fixed and cleaned on 6.3.2026. R9 & R63 were cleaned and free from odor on 6.9.26. All other resident wheelchairs were audited, cleaned and fixed as appropriate by 6.9.26. CNAR, CNAS, CNAV, CMTT, & RNW were educated by the Director of Nursing Services by 6.30.26 on ensuring enhanced barrier precautions are utilized for personal hygiene and wound care for R34 and all like residents. Assistant Director of Nursing (ADON)/licensed practical nurse (LPN)/infection preventionist (IP) (N) and RN (U) were educated by the Director of Nursing Services on 6.30.26 on ensuring appropriate hand hygiene is performed during wound care and multi-use wound care supplies are sanitized between resident use for R5, R6, R9, R10, R34 and all other like residents.	06/30/2026

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F0880 SS = E	Continued from page 8 volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §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. §483.80(f) Annual review.	F0880	2. To correct the deficiency and to ensure the problem does not recur Healthcare Services Group were educated by 6.30.26 by the Executive Director on ensuring hand sanitizer in resident rooms and common areas are checked monthly for expiration dates and changed out if appropriate. Maintenance Director was educated by Executive Director on 6.23.26 on ensuring all linen closets have coverings to protect against airborne infections. All nursing staff were educated on ensuring resident wheelchairs are cleaned per schedule and notifying maintenance of wheelchairs needing repair, utilizing enhanced barrier precautions, hand hygiene, and sanitizing multi-use items between residents by the Director of Nursing Services on 6.25.2026 or prior to the start of their next shift. The Executive Director and/or Designee will audit all hand sanitizer/soap dispenser expiration dates in resident room and common areas 1 time per month for 3 months and then randomly to ensure continued compliance. The Executive Director and/or designee will audit linen closet coverings monthly for 3 months and then randomly for continued compliance. The Director of Nursing Services and/or designee will audit R26, R9, R63 and 3 other random wheelchairs for cleanliness and good repair weekly for 12 weeks and then randomly to ensure continued compliance. The Director of Nursing Services and/or designee will audit enhanced barrier precautions for 3 staff weekly for 12 weeks and then randomly to ensure continued compliance. The Director of Nursing Services and/or designee will audit wound care for appropriate hand hygiene and sanitization of multi-use items between residents 3 times per week for 4 weeks and then weekly for 8 weeks. The Director of Nursing Services and/or designee will audit hand hygiene during personal cares for 3 staff weekly for 4 weeks, 2 staff weekly for 8 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.	

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F0880 SS = E	Continued from page 9 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, record review, and policy review the provider failed to ensure the staff followed standard infection control and prevention practices regarding: *Hand sanitizer dispensers that were past their expiration dates in 27 of 64 resident rooms. *One of one linen cupboard had a covering to protect against airborne infectants. *One of one resident wheelchair (26) was kept in good repair and had a cleanable surface on it. *Two of two observed residents (9 and 63) wheelchairs were clean and free from odor. *Three of three observed certified nursing assistants (CNA) (R, S, V,), one of one observed certified medication aide (CMA) (T), and one of one registered nurse (RN) (W) followed enhanced barrier precautions (EBP) (gown and glove use) when assisting one of one observed resident (34) with personal hygiene care and wound care. *One of one observed RN (W) who did not clean one of one observed resident (34)'s wound before applying a wound dressing. *One of one assistant director of nursing (ADON)/licensed practical nurse (LPN)/infection preventionist (IP) (N) and one of one RN (U) who failed to perform appropriate hand hygiene during all observed wound care, brought wound care supplies into multiple resident rooms, and did not sanitize wound care supplies between resident use while providing wound care for five of five sampled residents (5, 6, 9, 10, and 34) who had pressure ulcers. Findings include: 1. Observation on 6/2/26 at 10:20 a.m. revealed Spectrum Advanced foaming hand sanitizer dispensers with expiration dates of 10/25/25, 6/20/25, 8/6/25, and 4/9/26 in 29 of 64 resident rooms. 2. Interview on 6/2/26 at 4:29 p.m. with CNA O in	F0880		

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F0880 SS = E	Continued from page 10 the Country Lane hallway regarding the hand sanitizer in the resident rooms revealed she used the hand sanitizer in the resident rooms before and after providing cares for a resident. 3. Interview on 6/2/26 at 5:15 p.m. with CNA K in the Country Lane hallway revealed that she used the hand sanitizer in the residents rooms to sanitize her hands before providing resident cares and when she left the room. 4. Interview on 6/3/26 at 1:43 p.m. with CNA Q near the nurses' station revealed she usually used the hand sanitizer in the residents' room before exiting, or she washed her hands in the sink. 5. Interview on 6/4/26 at 8:53 a.m. with director of nursing (DON) B regarding the expired hand sanitizer dispensers revealed, the provider did not have a specific policy for expired hand sanitizer products. She confirmed the hand sanitizer dispensers discovered in those 29 resident rooms were past the expiration dates. She was not sure who monitored the sanitizer dispensers for expiration dates. 6. Interview on 6/4/26 at 2:10 p.m. with executive director (ED) A regarding the expired hand sanitizer revealed that she confirmed the hand sanitizer was expired in 29 resident rooms. The staff were not assigned to check the hand sanitizer for expiration dates because it should not last that long in the resident rooms. 7. Observation on 6/2/26 at 2:41 p.m. of the linen cupboard outside the transitional care unit (TCU) dining room revealed that there were blankets, sheets, bath blankets, and gowns on the shelves. There were no doors or coverings for the closet to protect the linens from airborne infectants. 8. Interview on 6/4/26 at 11:48 a.m. with RN E revealed there were no doors on the linen cupboard across from the TCU dining room since March 2026, when she started working at the facility. She did not consider those linens in the cupboard as clean. 9. Interview on 6/4/26 at 11:49 a.m. with assistant director of nursing (ADON)/licensed practical nurse (LPN) D revealed that she would not consider the linens in the cupboard outside the TCU dining room as clean. She encouraged the staff to use the linens	F0880		

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F0880 SS = E	Continued from page 11 in the shower room in the enclosed cupboard. She had observed the staff using the linens from the cupboard outside the TCU dining room. There were no doors or covering on the linen cupboard outside the TCU dining room since October of 2025. 10. Interview and observation on 6/2/26 at 3:44 p.m. revealed that resident 26's right hand was curled under the right handle of his electric wheelchair. He explained that his hand curled outward because of a diagnosis of genetic torsion dystonia (a movement disorder causing involuntary, repetitive, sustained muscle contractions that lead to painful twisting and abnormal postures). The padding on the right handle was torn and partially missing. Scotch tape that appeared scuffed and dirty was wrapped around the padding to keep it secure. Resident 26 used his left hand to point at the torn padding and raised tape edging and stated, "This is not comfortable. I have complained but they (staff) don't address my concerns." 11. Interview on 6/4/26 at 1:09 p.m. with DON B revealed that her expectation was for maintenance staff to repair or replace equipment, such as torn wheelchair padding. As the staff encountered items that needed to be repaired, they were to submit repair requests to the maintenance team, who were expected to complete the repairs "pretty quickly, usually." Minimum data set (MDS) coordinator C also helped repair broken resident equipment. DON B was not aware the padding on resident 26's wheelchair handle needed to be replaced. 12. Interview on 6/4/26 at 1:36 p.m. with maintenance director M revealed that the maintenance staff were expected to work through repair requests as quickly as they could. For resident wheelchair repairs, he stated he worked with MDS coordinator C to order replacement parts, "or if we have something we can put on it until we get a replacement part, I would do that." He was not aware that the padding on resident 26's wheelchair handle needed to be replaced. 13. Observation on 6/2/26 at 2:31 p.m. outside of residents 34 and 63's room revealed there was a high back reclining wheelchair that had a pressure relief cushion, and it smelled of urine. There was an EBP sign from the CDC outside of resident 34's room that indicated the staff were to wear gloves and a gown for high-contact resident care activities, which included dressing, providing personal hygiene, changing incontinence products, transferring, and	F0880		

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F0880 SS = E	Continued from page 12 providing wound care. 14. Observation and interview on 6/2/26 at 3:13 p.m. with resident 34 in her and resident 63's room revealed she was lying in bed, covered with a blanket, and stated she was using the bedpan. CNAs R and S sanitized their hands with hand sanitizer from the residents' room, put on a gown, and a pair of gloves, which were located in a bin in the residents' room. CNA R and S turned resident 34 on her side and removed the bedpan. CNA R obtained wipes from resident 34's bedside table and wiped her buttocks. CNA R obtained a new incontinence (involuntary leakage of bladder or bowel) brief from resident 34's bedside table, placed it under her, and fastened the tabs. Wearing those same gloves, CNA R assisted CNA S to pull up resident 34's pants, and then placed a sling (fabric tool that wraps around a resident's body and attaches to a mechanical lift used to lift and transfer the resident) under her. Resident 63, who was lying in her bed, started to cough up mucus. Without removing his gown and gloves, CNA S used resident 63's bed controller to elevate the head of her bed. CNA R removed her gown and gloves, discarded them in the trash can, did not perform hand hygiene (washing or sanitizing hands), and assisted resident 63 to sit up straighter in bed. CNA S removed his gown and pair of gloves, discarded them in the trash can, did not perform hand hygiene, and put on a new pair of gloves and a gown. CNA R did not perform hand hygiene, and put on a gown and a pair of gloves. CNA S hooked resident 34's sling to the full body lift (a mechanical lift and sling used to lift a person's full body), and the CNAs transferred resident 34 to her wheelchair, removed the sling from under the resident, removed their gowns and gloves, discarded them in the trash can, and washed their hands. CNAs R and S each put on a pair of gloves. CNA S brought in resident 63's high-back upholstered wheelchair from the hallway. Under the pressure relief cushion, there was old food, and it smelled like urine. CNA S used cleaning wipes to wipe off the seating surface of the wheelchair, under the pressure relief cushion. With those same gloves, CNA S used resident 63's bed control to lay resident 63 flat. CNA R removed her gloves,	F0880		

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F0880 SS = E	Continued from page 13 performed hand hygiene, and put on a new pair of gloves. CNA R opened resident 63's incontinence brief, obtained wipes that were on her bedside table, wiped her perineal (genital) area, and wiped her buttocks, opened a three-drawer bin drawer, grabbed an incontinence brief, and placed it under the resident. They turned the resident from side to side to get the incontinence brief under her, and they fastened the tabs. Resident 63 was agitated and did not want to get up into her wheelchair. With those same gloves, CNA S moved resident 34's bedside table. Both CNA R and CNA S removed their gloves, put them into the trash can, and washed their hands. 15. Review of resident 34's electronic medical record (EMR) revealed she required EBP due to having an open pressure ulcer (skin and/or underlying tissue injury from prolonged pressure). 16. Observation on 6/3/26 at 1:31 p.m. in resident 9's room revealed she had an upholstered high-back wheelchair that smelled of urine. 17. Interview on 6/3/26 at 3:51 p.m. with CNA S revealed he was to wash his hands before entering a room, after removing his gloves, and when leaving a resident's room. 18. Observation on 6/4/26 at 10:31 a.m. in resident 34's room revealed CMA T and CNA V sanitized their hands with hand sanitizer, put on a pair of gloves, and did not put on a gown. Resident 34 had an incontinent bowel movement. CMA T used wipes from resident 34's bedside table and wiped resident 34's bottom, including over the pressure ulcer on her right lower buttock. He called the nurse using his walkie to come put on a dressing. With those same gloves he obtained a paper towel, dabbed around her pressure ulcer area, and placed a brief under her. CMA T and CNA V removed their gloves, discarded them in the trash can, and did not perform hand hygiene. RN W came into the room already wearing a pair of gloves and had resident 34's pressure ulcer dressings in her hand. She did not put on a gown. She did not cleanse the wound, saying that the CNAs already did that. She leaned her arms and upper torso on the resident's bed, applied a skin prep (a moisture prep pad that is applied around a	F0880		

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F0880 SS = E	Continued from page 14 wound to protect the fragile skin) around the pressure ulcer, put a piece of collagen (a protein placed in wounds to promote healing) into the pressure ulcer, put the sliver (an antimicrobial agent) over the pressure ulcer, and then put on a foam dressing. With those same gloves, she took a black marker out of her pocket, dated the dressing, and put the marker back into her pocket. CMA T and CNA V did not perform hand hygiene, put on a pair of gloves, and pulled the resident's pants up. RN W removed her gloves and washed her hands. 19. Interview on 6/4/26 at 10:50 a.m. with RN W outside of resident 34's room revealed she did not cleanse the wound before putting the dressing on it because CMA T cleaned it with the wipes. She agreed that that was not what was on the treatment plan. She was not sure if she was supposed to wear a gown. After reviewing the Centers for Disease Control and Prevention (CDC) EBP sheet hanging by the resident's door, she said CMA T, and CNA V were to have worn gowns with personal hygiene care, and she should have worn a gown when applying the dressing. 20. Interview on 6/4/26 at 10:55 p.m. with CMA T revealed he was to wear a gown during personal hygiene care for residents who required EBP. He was to wash his hands when he entered a resident's room, left a resident's room, and when removing gloves and before putting on a new pair of gloves. He verified he did not perform hand hygiene between glove changes while providing personal hygiene care for resident 34. 21. Interview on 6/4/26 at 11:24 a.m. with ADON/LPN/infection preventionist (IP) N and RN U revealed they expected RN W to have cleaned resident 34's wound per the treatment record before applying a new dressing, staff to wear gowns when assisting residents with personal hygiene and wound care who were on EBP, and to perform hand hygiene before putting gloves on and when removing them. They verified that not following infection control processes can put the residents at risk for infection. 22. Interview on 6/4/26 at 3:05 p.m. with director of nursing (DON) B revealed she expected the overnight CNAs to clean the resident's wheelchair on the resident's shower day. If the wheelchair was upholstered, she expected the housekeeper to use an upholstery cleaner to clean them.	F0880		

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F0880 SS = E	Continued from page 15 She expected the staff to follow EBP and hand hygiene policies, and verified that not following infection control practices put the residents at risk for infection. 23. Review of the provider's 1/4/26 through 6/4/26 Infection Surveillance Report revealed 27 urinary tract/kidney infections, of which 24 were healthcare acquired infections (HAI), 13 skin and soft tissue infections, of which 11 were HAI, and 11 respiratory infections, of which nine were HAI. 24. Observation and interview on 6/3/26 at 8:06 a.m. of ADON/LPN/IP N and RN U in resident 9's room revealed RN U obtained the supplies for a wound dressing change from the treatment cart, placed a paper towel barrier on the bedside table, and placed a bottle of soap and saline (cleaning solution), gauze, and a dressing on the barrier. RN U stated she was the wound nurse. They performed wound care using appropriate infection control practices. ADON/LPN/IP removed the garbage bag from the garbage can in resident 9's room and sanitized her hands with the hand sanitizer located by resident 9's door that expired on 6/20/25. RN U washed her hands and returned the bottles of soap, saline, and the unopened package of gauze to the wound treatment cart. Review of resident 9's EMR revealed she had a stage II pressure ulcer to her left heel, and she was required to be on EBP. 25. Observation on 6/3/26 at 8:20 a.m. outside of resident 5's room revealed ADON/LPN/IP N sanitized her hands after leaving resident 9's room, which was expired. RN U got supplies out of the wound treatment cart for resident 5 and sanitized her hands. They each put on a gown and a pair of gloves and entered resident 5's room. ADON/LPN/IP N picked up the lift sling that was on the floor and put it on the resident's chair, folded a blanket, and put the blanket under resident 5's left heel. She removed resident 5's left sock, removed her gloves, discarded them in the trash can, performed hand hygiene, and put on a pair of gloves. RN U put a paper towel barrier on resident 5's bedside table, placed the same bottle of soap and saline from the wound treatment cart that was previously used in resident 9's room, a non-sterile	F0880		

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F0880 SS = E	Continued from page 16 Q-tip, gauze package, and a dressing package on the barrier. RN U removed resident 5's left heel dressing, removed her gloves, discarded them in the trash can, performed hand hygiene, put on a pair of gloves, poured soap and saline on a gauze pad, cleansed the wound, dried it with a new gauze, and applied a bordered dressing. RN U removed her gown and gloves, discarded them in the trash can, sanitized her hands, and left the room to get items from the wound treatment cart. RN U sanitized her hands, put on a gown, and a pair of gloves. RN U and ADON/LPN/IP N opened resident 5's incontinence brief and positioned her on her on her right side. Resident 5 did not have a dressing on the wound on her buttocks. RN U obtained a gauze pad that contained soap and saline from the resident's bedside table and cleansed the wound. She obtained the non-sterile Q-tip from the barrier on the bedside table, measured the depth of the wound, which was 2.5 centimeters (cm), and applied a bordered dressing. They positioned resident 5, removed their gowns and gloves, put them in the trash can, and washed their hands. Review of resident 5's EMR revealed she revealed she had a stage III pressure ulcer to her left heel, an unclassified wound to her buttocks, and was required to be on EBP. 26. Observation on 6/3/26 at 8:49 a.m. of RN U preparing for resident 6's dressing change revealed she was outside of his door with the wound treatment cart. RN U took Coban (type of wrap), kerlix (bandage roll), an opened bottle of betadine (antiseptic), soap, saline, a non-sterile Q-tip, and scissors out of the treatment cart. She entered resident 6's room and put those wound care supplies on a paper towel barrier on the resident's bedside table. RN U and ADON/LPN/IP N sanitized their hands with hand sanitizer, put on a gown, and a pair of gloves. RN U removed resident 6's left heel protective boot (a device worn on the heel to reduce pressure) and elevated his foot with a positioning device. She used the scissors to cut the tape on the dressing, and removed resident 6's dressing on his left foot. With those same gloves, she opened the gauze package,	F0880		

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F0880 SS = E	Continued from page 17 picked up the saline bottle, and poured saline on the gauze, picked up the betadine bottle, and poured it on the gauze, removed her gloves, performed hand hygiene, and put on a pair of gloves. ADON/LPN/IP N picked up the saline bottle and poured more saline on the gauze, and RN U cleansed the wound and dried it with a new gauze. RN U measured the depth of the wound with a non-sterile Q-tip, which was 0.4 cm. RN U held up resident 6's left leg while ADON/LPN/IP N took a picture of the wound using the wound documentation phone. Using those same gloves, RN U applied the betadine-soaked gauze to his wound, covered it with the abdominal pad dressing, wrapped his foot with the kerlix, and then wrapped it with Coban. Using those same gloves, she used the scissors to cut the Coban, and handed them to ADON/LPN/IP N to put on the bedside table. RN U dated the dressing with a marker and placed the marker on resident 6's bedside table. They removed their gown and gloves, discarded them in the trash can, and washed their hands. RN U picked up a packaged gauze dressing that fell on resident 6's floor and put it on the wound treatment cart. ADON/LPN/IP N picked up the scissors, marker, soap, and unused Coban from the bedside table, handed the items to RN U, and RN U put those items in the wound treatment cart in a shared resident supplies area of the cart. She did not clean the scissors, which had betadine on the cutting edge of them, or the marker. Review of resident 6's EMR revealed he had a stage II pressure ulcer to his left heel and required to be on EBP. 27. Observation on 6/3/26 at 10:06 a.m. of RN U and ADON/LPN/IP N gathering supplies outside of resident 10's room for her dressing change revealed she took out an open bottle of Hibiclens (an antiseptic), saline, and betadine from the wound treatment cart. A non-sterile Q-Tip was lying on top of the wound treatment cart, without being on a barrier. She grabbed the Q-Tip, Hibiclens, saline, betadine, and a dressing from the wound treatment cart. RN U and ADON/LPN/IP N performed hand hygiene, put on a gown, and a pair of gloves. RN U placed the Hibiclens, saline, betadine, Q-tip, gauze, and dressing on the paper towel barrier on the resident's bedside table. She poured the Hibiclens and saline on the gauze and the betadine on the gauze in a medication cup. ADON/LPN/IP N	F0880		

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F0880 SS = E	Continued from page 18 positioned resident 10 on her side. RN U removed the old dressing from her buttocks and used the non-sterile Q-tip to measure the depth of the wound, which was 2 cm. With those same gloves, she cleansed the wound with the gauze that had Hibiclens and saline on it, dried it with a new gauze, and held the resident on her side while ADON/LPN/IP N took a photo of the wound. RN U removed her gloves, performed hand hygiene, obtained the betadine gauze from the medication cup, rolled it, and packed it into the wound. She then put a bordered dressing on the wound. Wearing those same gloves, RN U helped pull up resident 10's pants and reposition her in bed. RN U removed those gloves, did not perform hand hygiene, and put on a clean pair of gloves. RN U and ADON/LPN/IP N removed their gown and gloves, disposed of them in the trash can, and washed their hands in the sink. RN U grabbed the extra gauze, the bottles of Hibiclens and saline from the resident's bedside table, and put them in the wound treatment cart. Review of resident 10's EMR revealed she had a stage IV pressure ulcer to her right buttocks and she required to be on EBP. 28. Observation on 6/3/26 at 10:31 a.m. of RN U and ADON/LPN/IP N outside of resident 34's door revealed they were gathering supplies from the wound treatment cart to complete resident 34's dressing change to her buttocks. RN U removed scissors from the cart, cleaned the cutting edge of the scissors with an alcohol pad, and set them on top of a dressing package. She took out the soap and saline bottles, gauze, dressings, non-sterile Q-tip, and set them on top of the papers on the treatment cart. RN U sanitized her hands with hand sanitizer, entered resident 34's room, placed the wound care supplies on a paper towel barrier on resident 34's bedside table, put on a gown, and a pair of gloves. ADON/LPN/IP N sanitized her hands with hand sanitizer, put on a gown and pair of gloves, put soap and saline on the gauze, and opened the bordered dressing. Using the scissors, ADON/LPN/IP N cut a piece of the collagen and silver, and placed them on top of the baggie that contained those dressings. She removed her gloves, discarded them in the trash can, sanitized her hands, and put on a pair of gloves. RN U assisted in turning the resident on her	F0880		

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F0880 SS = E	Continued from page 19 side, removed her gloves, discarded them in the trash can, and sanitized her hands. RN U put on a pair of gloves, removed the dressing to resident 34's right lower buttocks, removed her gloves, sanitized her hands, put on a pair of clean gloves, cleansed the wound with the soap and saline gauze, removed her gloves, sanitized her hands, put on pair of clean gloves, and measured the depth of the wound with the non-sterile Q-tip, which was 0.4 cm. She removed her gloves, discarded them in the trash can, sanitized her hands, put on a pair of clean gloves, put the collagen in the wound, then applied silver to the wound, and covered the wound with a foam bordered dressing. Using those same gloves, she dated the protective dressing for resident 34's sacrum with a marker. Using those same gloves, RN U opened resident 34's three-drawer plastic bin, took out an incontinence brief, and placed it under the resident. RN U handed wet wipes to ADON/LPN/IP N, and ADON/LPN/IP N wiped resident 34's perineal area, and handed the used wipes to RN U to discard in the trash can. ADON/LPN/IP N then obtained clean wipes, wiped resident 34's buttocks, handed the used wipes to RN U to discard in the trash can, attached the incontinence brief tabs, and covered resident 34 with a blanket. RN U removed her gloves, discarded them in the trash, sanitized her hands, put on a pair of clean gloves, and put the unused silver and collagen packages back into the plastic bag. She grabbed the saline and soap bottles and put them on the resident's bedside table without a barrier. They each removed their gowns and gloves, discarded them in the garbage can, and washed their hands. RN U grabbed the supplies on resident 6's bedside table and set them on top of the wound treatment cart. She put on a pair of clean gloves, wiped the cutting edge of the scissors with an alcohol pad, did not clean the handle, removed her gloves, discarded them in the trash can, did not sanitize her hands, and grabbed the keys to unlock the treatment cart. RN U opened the wound treatment cart, put the saline, soap, the baggie that contained the silver and collagen, and the unopened dressing back in the wound treatment cart. She left the unopened gauze on top of the treatment cart. 29. Interview on 6/4/26 at 11:24 a.m. with	F0880		

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F0880 SS = E	Continued from page 20 ADON/LPN/IP N and RN U revealed that they verified that the Q-tips used to measure the depth of the wounds were in a baggie with other packaged dressings, were not sterile, and should have been sterile. They verified they brought the soap bottle, saline, and betadine bottles into multiple residents' rooms, and they should not have been. They expected the scissors, including the handle, to be sanitized before use. They expected RN W to have cleaned the marker before putting it back into her pocket. They acknowledged that expired hand sanitizer might not be as effective in killing germs. They verified that not following wound care infection control processes and using expired hand sanitizer and soap put residents at risk for infection. 30. Interview on 6/4/26 at 3:05 p.m. with DON B revealed she expected the staff to follow hand hygiene policies, the Q-tips used for wound care to be from a sterile single-use package, wound care items not to be brought into multiple resident rooms, and wound care equipment to be sanitized after each use, she verified that expired hand sanitizer might not be as effective in killing germs, and verified that not following infection control practices puts the residents at risk for infection. 31. Review of the provider's 4/20/26 updated General Infection Prevention and Control-Surveillance policy revealed, "Infection surveillance will be either "whole house" (ie. include all residents), or "targeted" toward high risk/high volume, whichever is in accordance with local and sate department of health requirements. a) Healthcare-associated infections (HAI) will be defined as any infection that is not present or incubating a the time of admission." "It is the protocol of this facility that routine surveillance and monitoring of the workplace be conducted to determine if compliance with work practices and care of protective clothing and equipment be maintained." 32. Review of the provider's Nursing Weekly Cleaning Tasks revealed that resident individual use items, including wheelchairs, should be cleaned and disinfected weekly and PRN (as needed) when soiled. 33. Review of the provider's 4/20/26 EBP policy revealed, "It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms."	F0880		

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F0880 SS = E	Continued from page 21 "'Enhanced barrier precautions' (EBP) refer to infection control interventions designed to reduce transmission of multidrug-resistant organisms that employ target gown and glove use during high-contact resident care activities." "An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers)…" "High-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use…, wound care: any skin opening requiring a dressing…." 34. Review of the provider's 4/20/26 Hand Hygiene policy revealed "proper hand washing techniques should be used to protect against the spread of infection. Cleaning your hands reduces the spread of potentially deadly germs to the residents…." "Handwashing should be performed by all employees, as necessary, between tasks and procedures…." Alcohol based hand sanitizer should be used before touching a resident, before performing aseptic techniques, immediately before putting gloves on, when gloves are removed, and after touching a resident's environment. Hand washing with soap and water should be done "before moving from a soiled body site to a clean body site on [the] same resident."	F0880		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F0641	1. In continuing compliance with F641, Accuracy of Assessments, Aberdeen Health & Rehab corrected the deficiency by correcting R4 MDS on 6.22.2026 and correcting R59 MDS on 6.2.2026 by the MDSC. All other residents on GLP-1 medications MDS's were audited and updated as appropriate by MDSC on 6.22.2026.	06/25/2026

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F0641 SS = D	Continued from page 22 §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual version 1.20.1 October 2025 review, the provider failed to ensure accurate MDS (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessment coding for two of three sampled residents (4 and 59) dialysis (a medical treatment that performs the essential functions of the kidneys when they fail) medications. Findings include: 1. Review of resident 4's electronic medical record (EMR) revealed he admitted to the facility on 4/29/25. His 3/23/26 Brief Interview for Mental Status (BIMS) assessment score was 13 which indicated his cognition was intact. He had diagnoses of type 2 diabetes mellitus (a chronic condition that occurs when your body cannot properly produce or use insulin) without complications, end stage renal	F0641	2. To correct the deficiency and to ensure the problem does not recur the MDSC was educated on ensuring MDS is coded accurately for those residents taking GLP-1 medications by the Director of Nursing Services on 6.23.26. The Director of Nursing Services and/or designee will audit MDS for residents taking GLP-1 medications for accuracy 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.	

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F0641 SS = D	Continued from page 23 disease, and dependence on renal dialysis. He had a 1/24/26 physician's order for Ozempic (0.25 or 0.5 milligrams (mg)/dose) subcutaneous solution pen-injector 2 mg/1.5 milliliter (mL) (Semaglutide) (a GLP-1 receptor agonist that mimics gut hormones to suppress appetite, slow digestion, and regulate blood sugar), inject 0.25 mg subcutaneously one time a day every Saturday for diabetes. Resident 4's 3/24/26 annual MDS assessment section N0350 insulin injections in the last seven days was marked yes. Section N0415 High-Risk Drug classes: use and indications section J Hypoglycemic (including insulin) was marked yes. 2. Review of resident 59's EMR revealed she admitted to the facility on 6/16/21. Her 6/1/26 BIMS assessment score was 15 which indicated her cognition was intact. She had diagnoses of chronic kidney disease and type 2 diabetes mellitus without complications. Resident 59 had a 2/6/26 physician's order for Mounjaro subcutaneous solution auto-injector 2.6 mg/0.5 mL (Tirzepatide) (a dual GIP and GLP-1 receptor agonist that mimics gut hormones to stimulate insulin production when blood sugar rises and decreases the amount of sugar produced by the liver), inject 2.5 mg subcutaneously once weekly Friday for diabetes. Resident 59's 3/11/26 quarterly MDS assessment section N0350 insulin injections indicated she received one insulin injection during the last seven days. Section N0415 high-risk drug classes: use and indications section J hypoglycemic (including insulin) was marked yes. 3. Interview on 6/3/26 at 4:20 p.m. with Minimum Data Set (MDS) coordinator C revealed she was aware that Ozempic and Mounjaro were coded inaccurately as insulin. She learned about the inaccuracy on 4/24/26 but did not updated the MDS assessments for residents 4 and 59. 4. Interview with executive director A on 6/4/26 at 1:22 p.m. revealed she expected MDS updates to be completed within 24 to 48 hours, "or a few business days." 5. Review of the CMS Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed Section N, page 3, Coding Instructions for N0350A: "Enter…the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections	F0641		

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F0641 SS = D	Continued from page 24 were received." Section N, page N8 for N0415J1 and N0415J2, revealed, "Hypoglycemic (including insulin): Check if a hypoglycemic medication was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days)."	F0641		
F0695 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 infection control practices were followed regarding the storage of oxygen equipment for two of two sampled residents (5 and 6). Findings include: 1. Observation on 6/2/26 at 9:54 a.m. in resident 6's room revealed he had an oxygen concentrator (a device that filters room air into purified oxygen) in his room. His nasal cannula (flexible tubing with prongs that delivers oxygen through the nose) was on the floor, and it was not dated. His pre-filled humidifier (a plastic bottle that attaches to the oxygen machine to add moisture to the oxygen) was not dated. 2. Observation on 6/3/26 at 1:29 p.m. in resident 6's room revealed his nasal cannula oxygen tubing was on the floor. His nasal cannula oxygen tubing and the pre-filled humidifier were not dated. 3. Review of resident 6's electronic medical record (EMR) revealed he admitted to the facility on 7/23/25 and had a diagnoses of obstructive sleep apnea (where your throat muscles relax too much and block your airway while you sleep). He had an 8/17/25 physician's order for oxygen to be	F0695	1. In continuing compliance with F695, Respiratory/ Tracheostomy Care and Suctioning, Aberdeen Health & Rehab corrected the deficiency by replacing, storing and labeling R5 and R6 oxygen equipment appropriately on 6.3.2026. All other residents with oxygen equipment were audited and were replaced, stored and labeled as appropriate by the Director of Nursing Services on 6.3.2026. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on ensuring all oxygen equipment is replaced, stored and labeled appropriately by the Director of Nursing Services on 6.25.2026 or prior to the start of their next shift. The Director of Nursing Services and/or designee will audit oxygen equipment for 3 residents weekly for 4 weeks, 2 residents weekly for 8 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.	06/25/2026

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F0695 SS = D	Continued from page 25 administered at 3 liters (L) by a nasal cannula at bedtime while sleeping and as needed. His June 2026 treatment administration record (TAR) did not indicate when the nurse was to change the oxygen tubing. 4. Observation on 6/2/26 at 2:36 p.m. in resident 5's room revealed she had an oxygen concentrator in her room, the nasal cannula tubing was dated "6/1," and the pre-filled humidifier was empty and not dated. Her continuous positive airway pressure (CPAP) machine (a bedside device used to pump a steady, gentle stream of pressurized air through a tube and a face mask) was on her nightstand, and the mask was on the floor between her bed and nightstand. 5. Review of resident 5's EMR revealed she admitted to the facility on 6/4/24 and had a diagnoses of Chronic Obstructive Pulmonary Disease (COPD) (progressive lung disease that makes it hard to breathe). She had a 7/16/24 physician's order to wear her CPAP nightly and when napping, and an 11/18/24 physician's order for continuous oxygen at 2 L. Her June 2026 TAR indicated the nurse was to change the oxygen tubing and set it up weekly every Friday night, and to date it. 6. Observation and interview on 6/3/26 at 3:51 p.m. with certified nursing assistant (CNA) S in resident 5's room revealed that resident 5's nasal cannula oxygen tubing was on the floor. He picked the tubing up off the floor and stated that the resident's oxygen tubing was supposed to be in the bedside table drawer or hung up so it did not touch the floor. He verified that resident 5's CPAP mask was on the floor between her bed and nightstand, picked it up, and stated it should not be on the floor, and he would clean it. The nurse was responsible for changing and dating the oxygen tubing and pre-filled humidifier. 7. Interview on 6/3/26 at 4:00 p.m. with registered nurse (RN P) revealed the CPAP masks should be stored on the CPAP machine, the nasal cannulas should be stored in a bag, and the nasal cannula and pre-filled humidifier should be dated when changed by the nurse weekly. 8. Interview on 6/4/26 at 11:24 a.m. with assistant director of nursing (ADON)/licensed practical nurse	F0695		

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F0695 SS = D	Continued from page 26 (LPN)/infection preventionist (IP) N revealed that she expected oxygen tubing to not to be on the floor, and to be in a bag on the resident's concentrator when not in use. The oxygen tubing and the pre-filled humidifier were to be changed weekly, and the tubing and the pre-filled humidifier should be dated when they were opened to be used. 9. Interview on 6/4/26 at 3:05 p.m. with DON B revealed she expected oxygen tubing to not be on the floor but to be stored in a bag when not in use, and the oxygen tubing and the pre-filled humidifier should be dated when they were opened to be used. 10. Review of the provider's 4/20/26 Respiratory Equipment Cleaning Procedure policy revealed "O2 [oxygen] tubing, nasal cannula/mask will be changed weekly. O2 tubing will, also, be changed when tubing (nasal prong area) is noted lying on the floor." "The pre-filled Humidifier bottle needs to be replaced weekly & [and] prn [as needed] (date and initial)." This policy did not include information regarding cleaning or storage of the CPAP mask. 11. The provider's 11/18/25 CPAP and BiPAP policy did not include information regarding cleaning or storing the CPAP mask.	F0695		
F0812 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	F0812	1. In continuing compliance with F812 food Procurement, Store/Prepare/Serve-Sanitary, Aberdeen Health & Rehab corrected the deficiency by educating cook Y in proper hand hygiene protocol by 6.30.26. This education was given by the Dietary Manager. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 6/16/2026 at the employee all staff meeting regarding proper hand hygiene protocol. Those staff not in attendance received the education in their mailboxes and verified they receive the education by written signature that it was received and understood by 6.25.26 or prior to their next shift. An untouchable square waste receptacle with lid was ordered on 6.24.26 to allow items to be discarded without touching the lid The Dietary Manager and/or designee will audit employee hand hygiene 3 times per week for 4 weeks, 1 time per week for 8 weeks and then randomly to ensure continued 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.	06/30/2026

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F0812 SS = D	Continued from page 27 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 follow standard food safety practices for one of one observed cook (Y) who did not remove her gloves and washed her hands after touching a garbage can lid before handling resident food, and when she changed her gloves. Findings include: 1. Observation on 6/2/26 at 10:32 a.m. of cook Y in the kitchen revealed she was wearing a pair of gloves and was peeling cucumbers on a cutting board with a knife. She walked over to the garbage can, lifted the garbage can lid, and discarded the cucumber peelings in the garbage can. With those same gloved hands, she put the peeled cucumbers in a bowl, rinsed them with water, removed her gloves, and did not wash her hands. She put a bag of shredded cheese in the walk-in cooler, used pot holders to take a peach cobbler pan out of the oven, and placed it on a metal tray. She took off the pot holders, took a dirty knife to the dirty dish area, obtained a clean knife, put on a pair of gloves, and cut the cucumbers on a cutting board. With those gloved hands, she picked up the cut cucumbers and put them in a bowl, brought the dirty knife and cutting board to the dirty dish area, obtained a washcloth with sanitizer on it, and wiped the counter where she cut the cucumbers. She removed her gloves, discarded her gloves in the trash can, and washed her hands with soap and water. 2. Interview on 6/3/26 at 2:31 p.m. with cook Y revealed she was to wash her hands with soap and water when she came into the kitchen, before putting on gloves, and after taking gloves off. She should have removed her gloves and washed her hands after touching the garbage can lid. 3. Interview on 6/3/26 at 4:15 p.m. with dietary manager (DM) X revealed she expected cook Y to remove her gloves after touching the garbage can lid and wash her hands after removing her gloves.	F0812		

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F0812 SS = D	Continued from page 28 4. Review of the provider's 4/20/26 Hand Hygiene policy revealed, "proper hand washing techniques should be used to protect against the spread of infection." It indicated that hand hygiene with hand sanitizer should be completed "immediately before putting on gloves and after glove removal." 5. A policy regarding hand hygiene in the kitchen was requested, and the provider did not have a policy regarding hand hygiene specifically for the kitchen.	F0812		
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the provider failed to ensure call lights (a communication tool that enabled residents to alert staff for assistance) were functioning for three of three sampled residents (34, 41 and 73) whose call lights were not functioning. Findings include: 1. Observation and interview on 6/2/26 at 11:04 a.m. with resident 34 in her room revealed she was lying in bed. She had to wait a long time for the staff to answer her call light, and then she would be incontinent of urine. She stated, "Maybe they do not take care of me because they do not like me." I am hard work". She stated that she turned her call light on a while ago and no one had come. 2. Interview on 6/2/26 at 11:15 a.m. with registered nurse (RN) P and assistant director of nursing (ADON)/licensed practical nurse (LPN)/infection	F0919	1. In continuing compliance with F919, Resident Call Light System, Aberdeen Health & Rehab corrected the deficiency by ensuring call lights for R34, R41, and R73 were in working order by 6.19.26. All call lights in resident rooms and common areas were checked and were in proper working order on 6/23/26. 2. To correct the deficiency and to ensure the problem does not recur the Maintenance Director was educated on call light system functionality on 6.23.26. This education was given by the ED. The Maintenance Director and/or designee will audit resident 34, 41 and 73 call light mechanisms plus 4 random call lights in the building 1 time per week for 4 weeks, 1 time per month for 2 months and then randomly to ensure continued 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.	06/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEALTH AND REHAB	**1700 NORTH HIGHWAY 281 , ABERDEEN, South Dakota, 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
F0919 SS = D	Continued from page 29 preventionist (IP) N at the nurses' station revealed that there were no resident call lights turned on at that time. The surveyor reported to them that resident 34 stated that her call light was on for a while. RN P went to check on resident 34's call light and stated that the call light was disconnected from the call light extender that plugged into the wall, so that is why it did not turn on when she pushed her call light. 3. Review of resident 34's electronic medical record (EMR) revealed her 5/4/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. 4. Interview on 6/2/26 at 4:44 p.m. with resident 73 in the dining room revealed she had issues with her call light being unplugged from the wall, and she had to yell to her friend who lived across the hall to turn on his call light to get the staff's help. 5. Review of resident 73's EMR revealed her 4/29/26 BIMS assessment score was 15, which indicated her cognition was intact. 6. Observation on 6/3/26 at 10:31 a.m. in resident 34's rooms revealed ADON/LPN/IP N turned on resident 34's call light, and it turned back off on its own. ADON/LPN/IP N stated that resident 34's call light does that sometimes, and she would notify maintenance. 7. Interview on 6/3/26 at 4:00 p.m. with RN P revealed that the call lights sometimes get hooked under the resident's bed and get pulled out of the connector, then the call light does not work. 8. Interview on 6/4/26 at 1:09 p.m. with DON B revealed she expected call lights to always be in working order. She stated that most days, maintenance staff or Minimum Data Set (MDS) coordinator C have already repaired or replaced any non-working resident call lights before leadership staff arrived at 8 a.m. 9. Interview during the Resident Council Meeting on 6/4/26 at 1:30 p.m. revealed that resident 41's call light has not worked numerous times, and resident 73 had issues with her call light not working.	F0919		

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

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F0919 SS = D	Continued from page 30 10. Review of resident 41's EMR revealed her 4/30/26 BIMS assessment score was 14, which indicated her cognition was intact. 11. The provider's call light policy was requested, and they did not have a call light policy.	F0919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING **01 - MAIN BUILD...** B. WING	**06/04/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEALTH AND REHAB	**1700 NORTH HIGHWAY 281 , ABERDEEN, South Dakota, 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
K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 6/4/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Aberdeen Health & Rehab was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K321, K712 & K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000	The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law.	
K0712 SS = F Bldg. 01	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 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to maintain fire drill training for staff (lack of fire drills or documentation of fire drills from July 2025 through May 2026). Findings include: 1. Record review on 6/4/26 at 9:25 a.m. revealed fire drills from July 2025 through May 2026 for the three shifts were held as follows: On July 17, 2025 at 2:30 a.m. (Third shift - silent drill), On August 28, 2025 at 3:12 a.m. (Third shift - silent drill),	K0712	1. In continuing compliance with K0712, Fire Drills, Aberdeen Health & Rehab corrected the deficiency by educating the Maintenance Supervisor on monthly fire drill requirements, including to hold a fire drill on all 3 shifts quarterly, and to make sure the drills are varied in time, and all are verified by their monitoring company, name and time signal is received including all silent drills by activating the drills within 24 hours from the 3rd shift fire drills. This education was completed on 06/23/26 by the Executive Director. 2. To correct the deficiency and to ensure the problem does not reoccur, the Executive Director and/or designee will ensure that the Facility Tels program is being followed audit all fire drill documentation monthly for 3 months and then randomly 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	06/23/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kirstie Hoon, LNHA	Executive Director	06/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING **01 - MAIN BUILD...** B. WING	**06/04/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEALTH AND REHAB	**1700 NORTH HIGHWAY 281 , ABERDEEN, South Dakota, 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
K0712 SS = F Bldg. 01	Continued from page 1 On September 15, 2025 at 5:30 a.m. (Third shift - silent drill), On October 7, 2025 at 3:30 a.m. (Third shift - silent drill), On November 19, 2025 at 4:30 p.m. (Second shift), On December 27, 2025 at 5:30 a.m. (Third shift - silent drill), On January 28, 2026 at 12:30 p.m. (First shift), On February 27, 2026 at 1:00 p.m. (First shift), On March 31, 2026 at 4:30 a.m. (Third shift - silent drill), On April 29, 2026 at 1:40 p.m. (First shift), On May 30, 2026. There was no documentation that fire drills were held during the first shift in the third quarter or the fourth quarter of calendar year 2025. There was no documentation that fire drills were held during the second shift in the third quarter of calendar year 2025 or the second shift in the first quarter of calendar year 2026. The times of the drills that were documented were not varied. There was no documentation of fire drill call-backs to the monitoring agency to verify the fire alarm signal was received (by who and at what time). Fire drills at a minimum must be held once per shift per quarter. Interview with the administrator at the time of the record review confirmed those findings. The deficiency could affect 100% of the building occupants.	K0712	Type text here	
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to	K0321	1. In continuing compliance with K321, Hazardous Areas - Enclosure, Aberdeen Health & Rehab corrected the deficiency by adjusting soiled linen door on Arbor wing to ensure the door will self-close and latch as well as educating the Maintenance Supervisor on hazardous areas that have an automatic door closure that closes the door completely. This education was completed on 06/23/26 by the Executive Director. 2. To correct the deficiency and to ensure the problem does not recur, the facility will follow the Tels program and a monthly check was added to the monthly maintenance schedule to ensure all automatic closures are in working order. The Executive Director and/or designee will audit hazardous areas with door closures weekly for 4 weeks, monthly for 8 weeks and then randomly to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEALTH AND REHAB	1700 NORTH HIGHWAY 281 , ABERDEEN, South Dakota, 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
K0321 SS = D Bldg. 01	Continued from page 2 have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to maintain the soiled linen room corridor door (would not self-close and latch) for the Harbor wing. Findings include: 1. Observation on 6/4/26 at 8:15 a.m. revealed the corridor door for the soiled linen room in the Harbor wing was standing ajar. Testing of the door with the closer at the time of the observation revealed the door would not self-close and latch. Interview with the maintenance director at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for hazardous rooms.	K0321	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.	06/23/2026
K0918 SS = D Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K0918		

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	435041	A. BUILDING **01 - MAIN BUILD...** B. WING	**06/04/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0918 SS = D Bldg. 01	Continued from page 3 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on record review and interview, the provider failed to maintain the propane generator as required (monthly load testing documentation and monthly battery conductivity testing documentation). Findings include: Record review on 6/4/26 at 10:00 a.m. revealed monthly load runs of the propane generator were held on 1/28/26, 2/26/26, 3/30/26, and 5/14/26. The load runs were for 0.5 hours or less which did not include the mandatory 0.1 hour of cooldown time. There was no documentation a load run was held in April 2026. The generator load run documentation must also include the generator battery conductivity. Interview with the maintenance director at the time of the record review confirmed that finding.	K0918	1. In continuing compliance with K918 electrical Systems – Essential Electric System Aberdeen Health & Rehab corrected the deficiency by educating the Maintenance Supervisor on proper documentation of the generator load run time to include the 0.5 hour run time plus the mandatory 0.1 hour cooldown time on the monthly load sheets. As well as to fill out the section on battery conductivity. This education was completed on 06/23/26 by the Executive Director. The Executive Director also verified that the monthly load run was completed on April 30, 2026 and documentation was uploaded into the maintenance DS tels system that houses building maintenance tasks. It was confirmed that it was completed, however, was not placed in the Life Safety compliance binder as a paper copy. 2. To correct the deficiency and to ensure the problem does not reoccur, the Executive Director and/or designee will follow the Tels program and audit monthly generator load times for proper documentation of run time 1 time per week for 4 weeks, monthly for 8 weeks and then randomly to ensure continued 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.	06/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING B. WING	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEALTH AND REHAB	1700 NORTH HIGHWAY 281 , ABERDEEN, South Dakota, 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
E0000	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 6/4/26. Aberdeen Health & Rehab was found in compliance.	E0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kirstie Hoon, LNHA	Executive Director	06/25/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10587	A. BUILDING: _____ B. WING _____	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 44:73, Nursing Facilities, was conducted on 6/2/26 through 6/4/26. 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: 06/25/2026