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 08/28/2025

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 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/27/25 through 8/28/25. Areas surveyed included quality of care related to the receipt of pain medication, call light wait times, and the sizing of compression socks, and resident safety related to potential resident-to-resident abuse. Aberdeen Health and Rehab was found not in compliance with the following requirements: F610, F657, and F658.	F0000	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.	
F0610 SS = E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint review, record review, interview, and policy review, the provider failed to thoroughly investigate resident-to-resident incidents of potential abuse by one of one sampled resident (1) who used acts of physical aggression toward two of two sampled residents (2 and 3) on separate occasions. Failure to thoroughly	F0610	1. In continuing compliance with F610, Investigate/Prevent/Correct Alleged Violation, Aberdeen Health and Rehab corrected the deficiency by educating the Executive Director and Director of Nursing on conducting a thorough investigation on alleged violations by the Senior Vice President of Operations on 9/17/205. Nurse C was educated on 9/22/2025 and Nurse D was educated on 9/19/2025 regarding immediate reporting of alleged violations and required skin assessments by the Director of Nursing. 2.To correct the deficiency and ensure this doesn't re-occur all staff were educated on the Accura Vulnerable Adult Policy by 9/22/25. The Executive Director and/or designee will audit all allegations for thorough investigation and timely reporting weekly for 12 weeks and 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 quarterly through the community's QA Process until substantial compliance as determined by QA.	09/22/2025

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 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	9/30/2025

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 08/28/2025

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
F0610 SS = E	Continued from page 1 investigate those incidents may have placed all residents at risk for potential resident-to-resident abuse. Findings include: 1. Review of the South Dakota Department of Health (SD DOH) complaint received on 8/5/25 regarding resident 1 revealed: *Resident 1 was identified by first name only. *It was reported that resident 1 would walk in the halls, enter other residents' rooms, and take items that did not belong to her from other residents' rooms. *The complainant was told that resident 1 had gone into another resident's room, and "choked" that resident. *The resident who had been choked reported the incident to the provider and she [resident 2] was told the incident was documented and reported. -The provider had not completed a facility reported incident (FRI) related to the choking incident. *The complainant reported that resident 1 continued to walk in the hallways and some residents were fearful of resident 1. 2. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on 4/15/25. *She was discharged from the facility on 8/16/25. *Her 5/27/25 Minimum Data Set (MDS) indicated she was rarely understood or able to understand others and was severely cognitively impaired. *Her diagnoses included Alzheimer's (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), major depressive disorder, personality disorder (a group of mental health conditions characterized by inflexible and unhealthy patterns of behavior and thinking that differ from cultural norms), a traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), and behavioral disturbances. *A 6/24/25 progress note stated, "Another resident addressed [resident 1] patting at [a] chair next to her	F0610		

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 08/28/2025

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
F0610 SS = E	Continued from page 2 offering her to sit by her. [resident 1] rushed over to her & [and] stated, 'I'll kill you!'. Nurse intervened &walked [resident 1] to her room & offered her a snack which she refused." *A 6/26/25 progress note stated, "Resident [resident 1] went into another residents [resident 3's] room and attempted to take [that] resident's remote. [The] Resident [3] stated, 'That is my remote can I have it back?' Resident [1] said 'No' and slapped [the other] resident in the head twice before exiting her room. Reported to resident's nurse." *A 7/6/25 progress note stated, "resident [1] was in [the] dining room yelling at another resident she was redirected by staff and removed from [the] dining room, will continue to monitor." *A 7/9/25 progress note stated, "Resident [1] [is] verbally aggressive toward staff members and other residents at this time." *A 7/10/25 progress note stated, "resident [1] [is] agitated [and] going into other resident rooms." *A 7/16/25 progress note stated, "resident [1] [is] agitated [and] going into other residents' rooms". *A 7/19/25 progress note stated, "resident [1] [is] being reported to have aggressive behaviors towards another resident during bingo and patted her shoulder, will continue to monitor." *A 7/20/25 progress note stated, resident 2 "said that [resident 1] came into her room around 515 pm [5:15 p.m.] while [resident 2] had company. [Resident 1] went and sat on the residents [resident's] bed then got up and went to [resident 2]'s hand towels and grabbed one, when [resident 2] told her that they were her towels [resident 1] stated that they were her's then walked over to [resident 2] and put her hands around residents [resident 2's] neck, however [resident 2] said that she did not squeeze or apply pressure [resident 1] just pressed her hand around her [resident 2's] throat." *Resident 1's 7/28/25 progress notes stated, -"[resident 1 is] Extremely agitated and yelling at residents [and] staff and attempting to grab them". -"resident [1] was yelling out no and swearing at staff, residents, and some visitors, was trying to grab at other residents and when staff would redirect [resident 1] would yell or grab at them".	F0610		

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 08/28/2025

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
F0610 SS = E	Continued from page 3 3. Interview on 8/27/25 at 3:40 p.m. with resident 2 regarding the 7/20/25 incident involving resident 1 revealed: *Resident 2 stated she was talking with her visitor when resident 1 entered her room. *Resident 1 had gone over and picked up resident 2's towels. *Resident 2 told her "No" then resident 1 walked over to resident 2 and placed her hands on resident 2's neck. *Resident 2 stated resident 1 did not squeeze her neck. *Resident 2 denied having felt fearful of resident 1. *She stated that after that incident (on 7/20/25), if resident 1 was agitated and walking in the hallways, she would close her door. 4. Review of the provider's investigation related to the incident on 7/20/25 between resident 1 and resident 2 revealed: *Administrator A spoke with resident 2 on 7/21/25 at 10:30 a.m. *Resident 2 told administrator A resident 1, "came into her room and wanted her wash cloths [washcloths]- told her "No"- then came over and put [her] hands on front of her by neck- no squeezing or pushing". *Resident 2 denied feeling threatened and stated she felt safe. *Resident 2 stated it had only happened the one time and she had no other concerns or issues. *On 7/25/25 administrator A followed up with resident 2 and she continued to deny concerns at that time. *There was no documentation that the staff had been interviewed related to the reported incident on 7/20/25. *There was no documentation that other residents had been interviewed. *There was no documentation that a skin assessment for resident 2 had been completed after the incident.	F0610		

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 08/28/2025

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
F0610 SS = E	Continued from page 4 5. Interview on 8/28/25 at 10:55 a.m. with administrator A revealed, there was no investigation completed regarding the 6/26/25 resident to resident incident involving resident 1 and resident 3, because she had not been informed of the incident. 6. Interview on 8/28/25 at 11:30 a.m. with licensed practical nurse (LPN) C revealed: *She worked on 6/26/25 and had taken care of resident 3. *She did not witness resident 1 slap resident 3. *Resident 3 told her that resident 1 wanted her remote and when resident 3 told resident 1 "No", resident 1 slapped her. *LPN C stated she documented the incident, and then reported it to the other nurse on duty. -She was not sure who she had reported the incident to but recalled it was a male nurse. 7. Interview on 8/28/25 at 11:35 with registered nurse (RN) D revealed: *He had worked on 6/26/25. *He did not recall being informed that resident 1 had slapped resident 3. 8. Interview on 8/28/25 at 11:45 a.m. with administrator A and director of nursing (DON) B revealed: *They were aware resident 1 had displayed verbal and physical aggression towards other residents. *Administrator A had completed an investigation on 7/21/25 related to the 7/20/25 incident when resident 1 had placed her hands on resident 2's neck. -She had not interviewed staff or other residents at that time to determine if there had been other residents who had been affected or felt unsafe from resident 1. *Administrator A nor Interim DON B had not been notified that resident 1 had slapped resident 3 on 6/26/25. *Administrator A stated she would have investigated the incident if she had been notified.	F0610		

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 08/28/2025

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
F0610 SS = E	Continued from page 5 9. Review of the provider's 10/19/22 Vulnerable Adult policy revealed: *"Resident to resident altercations; including physical, mental, or verbal abuse are reportable to the state agency. The facility should have a system in place to identify resident's whose personal history render them at risk for abusing other residents." *"Not all incidents or events sustained by a vulnerable adult are required to be reported, even if they appear to meet the technical definition of maltreatment. These events must be reported internally to the immediate supervisor who will notify the Administrator and the Director of Nursing Services." *"The Supervisor, Director of Nursing or Administrator will immediately institute an internal investigation of the reported allegation or incident. The investigation may include: -1) Interview of staff -2) Resident interviews -3) Witness interviews -4) Environmental review -5) Resident health status -6) Behavior review -7) Medication review". *"All incidents will be investigated thoroughly by administration." *"Further, the facility shall ensure that all alleged violations involving abuse, neglect, mistreatment, misappropriation of resident property including injuries of unknown source are reported immediately to the Administrator and to other agencies in accordance with state law through established procedures. [The provider] shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress. -Written Report --a) Who was interviewed	F0610		

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 08/28/2025

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
F0610 SS = E	Continued from page 6 --b) Content of interview --c) Resident Diagnosis --d) ADL [activities of daily living] capabilities and a determination if the resident is interview-able --e) Resident reactions --f) Circumstances pertaining to the incident".	F0610		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint review, record review, interview, and policy review, the provider failed to have reviewed and	F0657	1. In continuing compliance with F657, Care Plan Timing and Revision, Aberdeen Health & Rehab corrected the deficiency by reviewing all current resident care plans to ensure all needs and how to manage those needs are care planned. R1 discharged from facility on 8/16/2025. 2. To correct the deficiency and to ensure the problem does not recur DNS, MDSC, Unit Managers, Director of Life Enrichment, Social Services and Dietary Manager were educated on ensuring Care Plans are updated timely when changes occur and all needs and how to manage those needs are care planned by the Executive Director on 9/22/2025. Director of Nursing and/or designee will audit 3 residents weekly for 12 weeks and then randomly to ensure Care Plans include all needs and how to manage those needs. 3. As part of Aberdeen Health & Rehabs' ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns quarterly through the community's QA Process until substantial compliance as determined by QA.	9/22/2025

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 08/28/2025

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
F0657 SS = D	Continued from page 7 revised the care plan for one of one sampled resident (1) needs and how to manage those needs. Findings include: 1. Review of the South Dakota Department of Health (SD DOH) complaint received on 8/5/25 regarding resident 1 revealed: *Resident 1 was identified by first name only. *It was reported that resident 1 would walk in the halls, enter other residents' rooms, and take items that did not belong to her from other residents' rooms. *The complainant was told that resident 1 had gone into another resident's room, and "choked" that resident. *The resident who had been choked reported the incident to the provider and she [resident 2] was told the incident was documented and reported. -The provider had not completed a facility reported incident (FRI) related to the choking incident. *The complainant reported that resident 1 continued to walk in the hallways and some residents were fearful of resident 1. 2. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on 4/15/25. *She was discharged from the facility on 8/16/25. *Her 5/27/25 Minimum Data Set (MDS) indicated she was rarely understood or able to understand others and was severely cognitively impaired. *Her diagnoses included Alzheimer's (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), major depressive disorder, personality disorder (a group of mental health conditions characterized by inflexible and unhealthy patterns of behavior and thinking that differ from cultural norms), a traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), and behavioral disturbances. *She had a 6/26/25 physician's order for "LORazepam [an anti-anxiety medication] Oral Tablet 0.5 MG [milligrams] (Lorazepam) Give 1 tablet by mouth every	F0657		

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 08/28/2025

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
F0657 SS = D	Continued from page 8 12 hours as needed for severe anxiety/agitation". *Resident 1 was being seen by a mental health practitioner for management of her behaviors and mental health medications. *A 6/24/25 progress note stated, "Another resident addressed [resident 1] patting at chair next to her offering her to sit by her. [resident 1] rushed over to her & [and] stated, 'I'll kill you!'. Nurse intervened &walked [resident 1] to her room & offered her a snack which she refused." *A 6/26/25 progress note stated, "Resident [resident 1] went into another residents [resident's] room and attempted to take resident's remote. Resident stated, 'That is my remote can I have it back?' Resident said 'No' and slapped resident in the head twice before exiting her room. Reported to resident's nurse." *A 7/6/25 progress note stated, "resident was in [the] dining room yelling at another resident she was redirected by staff and removed from [the] dining room, will continue to monitor." *A 7/9/25 progress note stated, "Resident verbally aggressive toward staff members and other residents at this time." *A 7/10/25 progress note stated, "resident agitated going into other resident rooms." *A 7/16/25 progress note stated, "resident agitated going into other residents' rooms". *A 7/19/25 progress note stated, "resident being reported to have aggressive behaviors towards another resident during bingo and patted her shoulder, will continue to monitor." *A 7/20/25 progress note stated, resident 2 "said that [resident 1] came into her room around 515 pm [5:15 p.m.] while [resident 2] had company. [Resident 1] went and sat on the residents [resident's] bed then got up and went to [resident 2]'s hand towels and grabbed one, when [resident 2] told her that they were her towels [resident 1] stated that they were her's then walked over to [resident 2] and put her hands around residents neck, however [resident 2] said that she did not squeeze or apply pressure just pressed her hand around her throat." *7/28/25 progress notes stated,	F0657		

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 08/28/2025

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
F0657 SS = D	Continued from page 9 -"Extremely agitated and yelling at residents [and] staff and attempting to grab them". -"resident was yelling out no and swearing at staff, residents, and some visitors, was trying to grab at other residents and when staff would redirect [resident 1] would yell or grab at them". 3. Review of resident 1's 8/27/25 care plan revealed: *An identified focus area that indicated she had an "Elopement [leaving the facility without staff knowledge]/wander Risk". -Interventions for that focus area included staff were to "Maintain familiar items in environment, with well-lit room. Observe behavior and attempt to determine pattern, frequency, intensity and triggers. Offer/encourage activities for distraction." -Her care plan did not include her tendency to wander into other resident rooms and take items, or any identified triggers or interventions to attempt to prevent that behavior. *Her care plan did not address her agitation, verbal and physical aggression towards staff and other residents, potential triggers, or interventions related to her agitation and verbal and physical aggression. *Resident 1's care plan did not indicate she was being seen by a mental health practitioner. 4. Interview on 8/27/25 at 3:40 p.m. with resident 2 revealed she had been told by staff that telling resident 1 "No" was a trigger for resident 1's agitation and aggression. 5. Interview on 8/27/25 at 3:45 p.m. with certified nursing assistant (CNA)/certified medication aide (CMA) F revealed: *When resident 1 was initially admitted she was pleasant and easy to redirect. In the past year her dementia had progressed, and she could become aggressive and difficult to redirect. *He stated that resident 1 would become more agitated when staff attempted to redirect her. *Resident 1 wandered into other resident rooms. *He had witnessed times when resident 1 had become physically aggressive with staff without staff having	F0657		

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 08/28/2025

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
F0657 SS = D	Continued from page 10 interacted with her prior to the aggression. *Resident 1 would grab other residents by their arms if they told her "No" or if staff were attempting to redirect her. *Other residents had expressed to him that they were fearful of resident 1. *Staff encouraged other residents to close the doors to their rooms when resident 1 was agitated because resident 1 did not usually go into rooms with closed doors. *He used resident care plans as a resource to provide care for the residents. *He did not recall resident 1's care plan having addressed her verbal and physical behaviors, interventions or triggers. 6. Interview on 8/27/25 at 3:55 p.m. with registered nurse (RN) G revealed: *When resident 1 was wandering into other resident rooms, staff would watch her more closely. *Resident 1 would not sit long enough to participate in activities. *She recalled that resident 1's care plan included that she wandered, but she did not recall if there were any identified behaviors or interventions for her behaviors identified in her care plan. 7. Interview on 8/27/25 at 4:28 p.m. with licensed practical nurse (LPN)/Minimum Data Set (MDS) coordinator H revealed: *Care plans were to be updated by the interdisciplinary team (activities, nursing, social services, administration, and dietary). *She had been told resident 1 had episodes of verbal and physical aggression with staff and residents, but she had not witnessed that. *Resident 1 would become more agitated if someone repeatedly said her name. *Resident 1's care plan indicated she was a risk for elopement related to her wandering. *LPN/MDS coordinator H stated that staff were to turn	F0657		

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 08/28/2025

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
F0657 SS = D	Continued from page 11 the Andy Griffith show on resident 1's television as an intervention for resident 1's wandering. *Upon review of resident 1's care plan, she confirmed resident 1's care plan indicated she had a preference of watching the Andy Griffith show, but it was not listed as an intervention for her wandering. *She verified resident 1's care plan did not address her verbal and physical aggression. *She did not know if there were any interventions put into place related to resident 1 wandering into other residents' rooms. *She agreed it may have been helpful for staff to care for resident 1's wandering and behaviors if there were interventions addressed in her care plan. 8. Interview on 8/28/25 at 8:10 a.m. with administrator A revealed all interventions that were attempted with resident 1 related to her aggressive verbal and physical behaviors would have been documented in her care plan. 9. Interview on 8/28/25 at 11:45 a.m. with administrator A and director of nursing (DON) B revealed: *When resident 1 was admitted she did not display any aggressive behaviors. *In the beginning of 2025 resident 1's dementia progressed, and she began to display increased wandering as well as verbal and physical behaviors. *Due to resident 1's increased behaviors a mental health practitioner was consulted for her care. *Staff would provide one to one observation of resident 1 whenever they were able to prevent her from wandering into other resident rooms and avoid altercations between resident 1 and other residents. *Staff would also ask and encourage residents to have their doors closed when resident 1 had episodes of increased agitation. *Resident 1 ate her meals with a staff member instead of in the dining room to decrease the stimulus in an attempt to get resident 1 to eat her meal. *Administrator A and DON B expected the interventions in place for resident 1's wandering and aggressive	F0657		

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 08/28/2025

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
F0657 SS = D	Continued from page 12 behaviors to have been included in her care plan. *Administrator A and DON B verified resident 1's care plan had not been updated to include interventions for her aggressive behaviors or wandering into other residents' rooms. *LPN/MDS coordinator H was primarily responsible for updating the nursing portion of residents' care plans but anyone on the interdisciplinary team (IDT) team could update the residents' care plans. *Administrator A and DON B expected that the residents' care plans would be updated with each quarterly and annual MDS as well as with any changes in the residents' care needs. 10. Review of the provider's April 2025 Comprehensive Care Plan policy revealed: *"It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality." *"The comprehensive care plan will describe, at minimum, the following: -a) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being… -f) Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated." *"The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed."	F0657		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as	F0658		

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 08/28/2025

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
F0658 SS = D	Continued from page 13 outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint, record review, interview, and policy review, the provider failed to follow professional nursing standards to ensure: *One of one sampled resident's (1) pain was assessed according to the provider's policy. *The indication for administration of an as needed anxiety medication administered to one of one sampled resident (1) was documented. *The effectiveness and any adverse reactions were documented for the use of a newly ordered mood-altering medication (Depakote) for one of one sampled resident (1). Findings include: 1. Review of the South Dakota Department of Health (SD DOH) complaint received on 8/5/25 regarding resident 1 revealed: *Resident 1 was identified by first name only. *It was reported that resident 1 would walk in the halls, enter other residents' rooms, and take items that did not belong to her from other residents' rooms. *The complainant was told that resident 1 had gone into another resident's room, and "choked" that resident. *The resident who had been choked reported the incident to the provider and she [resident 2] was told the incident was documented and reported. -The provider had not completed a facility reported incident (FRI) related to the choking incident. *The complainant reported that resident 1 continued to walk in the hallways and some residents were fearful of resident 1. 2. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on 4/15/25.	F0658	1. In continuing compliance with F658, Services Provided meet Professional Standards, Aberdeen Health & Rehab corrected the deficiency by reviewing all residents to ensure pain is observed/documented every shift, as needed medications have reasons for administration and documentation of effectiveness, and mood altering medications are being observed/ documented for effectiveness after initiation/change. R1 discharged from facility on 8/16/2025. 2. To correct the deficiency and to ensure the problem does not recur all licensed nurses were educated by the Director of Nursing and/or designee by 9/22/2025 on ensuring pain is observed/ documented on every shift, PRN medications administered have documented reason and effectiveness, and all mood altering medications are observed/documented after initiation/change. The Director of Nursing and/or designee will audit documentation of pain observation, PRN administration/effectiveness, and documentation of mood altering medication initiation/change observation of 3 residents weekly for 12 weeks and 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 quarterly through the community's QA Process until substantial compliance as determined by QA.	9/22/2025

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 08/28/2025

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
F0658 SS = D	Continued from page 14 *She was discharged from the facility on 8/16/25. *Her 5/27/25 Minimum Data Set (MDS) indicated she was rarely understood or able to understand others and was severely cognitively impaired. *Her diagnoses included Alzheimer's (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), major depressive disorder, personality disorder (a group of mental health conditions characterized by inflexible and unhealthy patterns of behavior and thinking that differ from cultural norms), a traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), and behavioral disturbances. *Review of her July medication administration report (MAR) revealed she did not have a physician's order for regularly scheduled or as needed pain medication until she was prescribed morphine as part of her comfort care plan. *Resident 1's 8/27/25 care plan revealed she had a focus area of "has potential for pain with need for medication management R/T [related to] general discomfort with an intervention of report pain or requests for analgesics [medication to relieve pain] to nurse". 3. Review of resident 1's history falling documentation from July through August 2025 revealed: *In July she fell on the 5th, the 8th, the 20th, the 28th, and the 29th. *In August she fell on the 3rd and the 4th. *As a result of her fall on 7/29/25 she sustained an indentation on her forehead. She was "very agitated" and her pain level was assessed to be a six on a zero to ten scale with the use of the PAINAD (a tool to assess pain assessment for people with advanced dementia) assessment scale which meant she had moderate pain. *On 8/3/25 resident 1 fell and sustained a three centimeter laceration (cut or torn skin) to her forehead and her pain level was assessed to be a four with the use of the PAINAD assessment scale, which meant she had moderate. *Review of resident 1's pain assessment revealed:	F0658		

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 08/28/2025

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
F0658 SS = D	Continued from page 15 -There were no documented pain assessments completed in June 2025. -On 7/15/25 resident 1's pain assessment was documented at a level four. -On 7/29/25 resident 1's pain assessment was documented at a level six. *There was no documentation of staff having contacted the physician to consider giving orders to for pain medications prior to resident 1 being placed on comfort cares (a type of medical care that focuses on providing relief from symptoms and improving the quality of life for people with serious or life-threatening illnesses) on 8/4/25. *Review of her August MAR revealed she had 8/4/25 physician's order for "Morphine Sulfate [narcotic pain medication] (Concentrate) 20 MG/ML [milligrams/milliliter] Give 0.25 ml by mouth every 4 hours as needed for Pain". 4. Further review of resident 1's EMR revealed she had a 6/26/25 physician's order for "LORazepam [an anti-anxiety medication] Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 12 hours as needed for severe anxiety/agitation". *Resident 1's MAR documentation indicated she was administered the as needed lorazepam 47 times in July 2025. -Of those 47 documented lorazepam administrations, 28 did not indicate what the medication was administered for. *Resident 1 had a 7/22/25 physician's order for "Depakote Oral Tablet [a medication used to treat seizures and bipolar disorder] Delayed Release 125 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for mood stabilization. *An 8/1/25 communication with psychiatric mental health nurse practitioner J revealed she had spoken with licensed practical nurse (LPN)/Minimum Data Set (MDS) coordinator H, who reported resident 1 "continued anger/irritability and aggression at times." *On 8/1/25 a physician's order was received to change resident 1's Depakote order to "Depakote Oral Tablet Delayed Release 125 MG (Divalproex Sodium) Give 1 tablet by mouth in the morning for mood stabilization" and "Depakote Oral Tablet Delayed Release 250 MG	F0658		

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 08/28/2025

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
F0658 SS = D	Continued from page 16 (Divalproex Sodium) Give 1 tablet by mouth at bedtime for anger/irritability/aggression". *There was no documentation regarding the effectiveness or adverse effects of the newly ordered Depakote in resident 1's EMR. *There was no documentation regarding the effectiveness or adverse effects of the Depakote after the dose was increased on 8/1/25. 5. Interview on 8/28/25 at 11:40 a.m. with registered nurse (RN) I revealed: *It was the expectation that a reason for the administration of an as needed medication was to be documented at the time the medication was administered. *If there was no documented reason for that medication administration, the staff would not be able to follow-up to determine if the medication was effective. 6. Interview on 8/28/25 at 11:45 a.m. with administrator A and director of nursing (DON) B revealed: *Administrator A stated the provider used Perry and Potter as a resource for professional standards. *In February or March of 2025, the staff had noticed resident 1's gait began to change, and she became more anxious. *She was given physician ordered acetaminophen 500 mg two tables three times per day from 4/28/25 through 5/23/25. *DON B stated that beginning in May 2025 resident 1 began to further decline in her physical and cognitive abilities. *DON B was not sure why the scheduled acetaminophen was discontinued. *She stated pain could be difficult to evaluate with residents who had dementia and for some residents their pain could be expressed through behaviors. *DON B stated pain assessments were to be completed and documented by the staff with the administration of a pain medication, anytime a resident fell, if a resident had skin concerns, if there was a change in a resident's condition, or there was a change in the resident's cognition.	F0658		

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 08/28/2025

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
F0658 SS = D	Continued from page 17 *DON B verified there were no pain assessments documented in June 2025. *She would have expected there had been a pain assessment completed in June but since the resident did not have any skin issues or documented falls the staff were not prompted to complete a pain assessment. *DON B verified resident 1 had no physician's orders for pain medication in July 2025. *She stated the provider had standing orders for acetaminophen as needed but verified there was no documentation of acetaminophen having been administered until 8/12/25, after resident 1 was placed on comfort cares. *DON B stated she expected that the staff would document a reason for administration of an as needed medication at the time of administration. *DON B expected the effectiveness and any adverse effects from a mood altering medication, such as Depakote, to be documented every shift for the first 14 days after the first administration of the medication. *The staff had a "hot charting" form at the nurses' stations that instructed them to complete that charting for residents with those types of new medications. *She verified there was no documentation related to the effectiveness or any adverse reactions related to resident 1's use of the Depakote medication that was started on 7/22/25, and had a physician's ordered dose increase on 8/1/25. Review of the provider's April 2025 Pain Management policy revealed: *"The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences." *"The facility will utilize a systematic approach for recognition, assessment, treatment and monitoring of pain. *"Facility staff will observe for nonverbal indicators which may indicate the presence of pain. These indicators include but are not limited to: ...	F0658		

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 08/28/2025

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
F0658 SS = D	Continued from page 18 -c) Fidgeting, increased or recurring restlessness -d) Facial expressions (e.g. grimacing, frowning, fright, or clenching of the jaw) -e) Behaviors such as: resisting care, distressed pacing, irritability, depressed mood, or decreased participation in usual physical and/or social activities… -g) Weight loss -h) Difficulty sleeping (insomnia) -i) Negative vocalizations (e.g. groaning, crying, whimpering, or screaming) *"The interdisciplinary team is responsible for developing a pain management regimen that is specific to each resident who has pain or who has the potential for pain." A medication administration policy was requested on 8/28/25 at 9:30 a.m. and was not received by the end of the survey.	F0658		