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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	C 07/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 7/6/21 through 7/9/21. Aberdeen Health and Rehab was found not in compliance with the following requirements: F550, F561, F725, F755, F842, F867, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 7/6/21 through 7/9/21. Areas surveyed included quality of care and infection control. Aberdeen Health and Rehab was found not in compliance with the following requirements: F550, F725, and F867.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550	Aberdeen Health and Rehab denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristie Hoon	LNHA	7/30/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Surveyor: 42750 Based on interview and admission packet review, the provider failed to ensure residents were treated with dignity from confidential interviews with five of five residents. Findings include: 1. Confidential interview on 7/6/21 at 4:50 p.m. with a resident who adamantly requested to remain anonymous revealed: *"Sometimes when I put my [call] light on because I want to go to bed, I wait a long time, over half an hour. *One time when I put my light on to use the bathroom, it took so long I wet my pants and had a bowel movement too [in my pants]. *It was very embarrassing.	F 550	1. In continuing compliance with F 550, Resident Rights/Exercise of Rights Aberdeen Health and Rehab corrected the deficiency by reviewing and revising staffing levels. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 7/20/21 on resident cares and providing dignity by DNS. The DNS and/or designee will audit cares 3 times per week for 1 month and 1 time per week for 1 month and then randomly to ensure continued compliance. 3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process. 4. The DNS is responsible for this area of compliance.	7/30/21

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F 550	Continued From page 2 *When asked if the surveyor could use her name, stated, "I wish you wouldn't. If they find out it's me, they'll take it out on me." *They do the best they can with the staff they have." Review of resident's most recent Minimum Date Set (MDS) assessment revealed: *Brief Interview for Mental Status (BIMS) score was 15, indicating cognition was intact. *The resident was occasionally incontinent of bladder and was always continent of bowel. *The resident required extensive assistance from staff for bed mobility, transferring from one surface to another, dressing, toileting, and personal hygiene. *The resident used a wheelchair for mobility with limited assistance. Review of resident's revised care plan had indicated the resident had been encouraged to use the call light for assistance. Surveyor: 18560 2. Confidential interview on 7/7/21 at 10:00 a.m. with a resident who adamantly requested to remain anonymous revealed: *Have had accidents because have had to wait for help. *"When I need help, I need it." *"Really hate accidents." *"Accidents make me feel like a child." *Made to feel bad because staff have had to wash and clean me up. Review of resident's most recent MDS assessment revealed: *BIMS score of 15 indicating cognition had been intact.	F 550		

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F 550	Continued From page 3 *The resident required extensive assistance from staff for bed mobility and personal hygiene. *The resident was dependent on staff for transferring and toileting. 3. Confidential interview on 7/7/21 at 3:20 p.m. with a resident who adamantly requested to remain anonymous revealed: *"Some staff are snooty." *"Don't say too much and try to keep quiet." *"Feel like I have to shut up and take it sometimes." *Told by a certified nursing assistant (CNA) to clean up urine that had spilled on the floor. Review of resident's most recent MDS assessment revealed: *BIMS score of 15 indicating cognition had been intact. *The resident required limited assistance from staff for bed mobility, transferring, and personal hygiene. *The resident required extensive assistance for toileting. 4. Confidential interview on 7/7/21 at 4:11 p.m. with a resident who adamantly requested to remain anonymous revealed: *Staff members were "Nosy and go through my packages." *Nosy staff have "attitude." *In the past when they have had to clean me up they have thrown my things on the floor. Review of resident's most recent MDS assessment revealed: *BIMS score of 15 indicating cognition had been intact. *The resident required assistance from staff for	F 550		

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F 550	Continued From page 4 bed mobility, transferring, and toileting. *The resident required extensive assistance from staff for personal hygiene. 5. Confidential interview on 7/8/21 at 9:00 a.m. with a resident who adamantly requested to remain anonymous revealed: *Staff members have gone through dresser drawers asking "what do you have to eat." *Staff members have stolen snacks. *Hates to push call light. *Has had numerous accidents a week. *Staff members only seem to do "what they can get away with." Review of resident's most recent MDS assessment revealed: *BIMS score of 15 indicating cognition had been intact. *The resident required extensive assistance from staff for bed mobility, transferring, toileting, and personal hygiene. 6. Interview on 7/9/21 at 10:43 a.m. with administrator A revealed: *She had not been aware of the comments received by this surveyor. *Nursing staff were to bring any resident concerns to her *When she had been made aware of resident or family concerns, she followed up with the resident or family member. *During a recent meeting with CNAs and nursing staff, the interim director of nursing services and herself had explained their expectations: -This was the resident's home. -Staff members needed to make sure they were having the correct conversations with residents when assisting them.	F 550		

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F 550	Continued From page 5 -"If you say something in a resident's room, would you say it in front of me as ED (executive director)?" Review of the provider's August 2018 Resident Handbook revealed: *Mission Statement "Enrich the lives of those we serve." *"Commitments: -Respect...everyone for who they are and who they may become. --Greet everyone with a smile and call them by name. --Treat everyone with courtesy, dignity, and respect. --Maintain a positive attitude. -Recognize...that every person is unique and has their own set of values, beliefs, ideas and own way of doing things. --Offer people as many choices as we can. --Address people's needs with a sense of urgency. --Anticipate people's needs. -Respond...to all your concerns, needs, and ideas. --Only make promises we can keep. --Give no excuses, apologies only. --Resolve everyone's concerns. --Be part of the team."	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F 561	See next page.	

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F 561	Continued From page 6 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on observation, interview, and policy review, the provider failed to ensure two of two sampled residents (20 and 21) were able to exercise their right to continue to smoke. Findings include: 1. Interview on 7/8/21 at 9:17 a.m. with resident 21 revealed he: *Had been a resident for "a couple of years." *Stated, "I came here because I could smoke, now they want to take our privileges away. I am an ex-marine and I don't want my privileges taken away." *Had not wanted to quit smoking.	F 561	1.In continuing compliance with F 561 Self Determination Aberdeen Health and Rehab corrected the deficiency by interviewing all current smokers to determine smoking cessation plan by 7/19/21. Resident #20 was interviewed on 7/16/21 and the care plan was updated on 7/28/2021. Resident #21 was interviewed on 7/19/21 and the care plan was updated on 7/28/2021. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 7/20/21 on smoking cessation plans by DNS. The DNS and/or designee will audit cessation plans and resident cessation progress weekly for 2 months and then randomly to ensure compliance. 3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process. 4. The DNS is responsible for this area of compliance.	7/30/21

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F 561	Continued From page 7 Review of resident 21's medical record revealed: *He had been admitted on 9/9/19. *His Brief Interview for Mental Status score was 13, meaning he was cognitively intact. *His 5/22/19 care plan had a focus of a traumatic life event with interventions including providing a calming environment through being in room playing games on a computer and smoking. *A 5/6/21 progress note stated: "Resident is a smoker, was notified per meeting with Administrator, Social Worker and Community Life Director that as of 8/1/21 current residents that smoke will no longer be allowed to smoke on facility grounds. Resident was offered counseling, smoking cessation and offered other facilities in [the] area that possibly allow smoking. Resident received [a] letter outlining [the] new policy and family will be notified as well." *There was no documentation regarding the resident's response to the new policy or what would replace the smoking in his trauma care plan. Interview on 7/9/21 at 8:19 a.m. with administrator A revealed: *They would not allow any resident to smoke beginning on 8/1/21. *Alternatives to smoking had been offered to residents, these included: -Nicotine patches, lozenges, gum, or inhalers. -Counseling. -Assistance in finding another facility to live. *The provider's plan for residents who chose not to exercise their rights to any of the options mentioned above would be for them to not be allowed to smoke. *Continued smoking would be considered unauthorized.	F 561		

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F 561	Continued From page 8 -Unauthorized smoking would initiate the provider into considering giving a 30-day discharge notice. *They would not "grandfather in" any residents. *She was unaware of any residents having concerns about not being able to smoke. Surveyor: 41088 2. Observation and interview on 7/7/21 at 9:34 a.m. with certified nursing assistant O while she supervised residents smoking revealed: *Five smokers had been outside waiting for her to arrive to supervise them. *Residents were not allowed to smoke without staff staying with them. *The staff that supervised were to keep possession of the cigarettes and lighter that were kept in a plastic blue container she called the smoking kit. *The cigarettes and lighters were kept inside the smoking kit at the nurses station when not in use. *There was a note written in black ink on the smoking kit that stated not to give the lighters or cigarettes to the residents. *There were five residents in total who smoked. *She took the cigarettes and lighter out of the smoking kit and assisted each of the residents with lighting up. *She remained with the residents while they smoked. Observation and interview on 7/8/21 at 1:55 p.m. with resident 20 revealed: *He was a recent admission and had started smoking a few weeks after he came to the facility. *Staff supervised the smokers at designated times and stayed with them while they smoked. *The cigarettes and lighter were kept at the nurses station. *Recently he was notified the provider had changed the policy and would no longer allow any	F 561		

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F 561	Continued From page 9 smoking at the facility starting in August. *He felt that it was unfair and a violation of his rights that he would no longer be able to smoke. *The other four residents who smoked had voiced similar concerns to him. Interview on 7/8/21 at 2:15 p.m. with nursing assistant H regarding the new smoking policy confirmed: *The smokers were unhappy with the new no smoking policy and had voiced their concerns to him. *The policy was to take effect 8/1/21. *The smokers had kept track of how many days remained until they were no longer allowed to smoke. *The residents had confided they really enjoyed the smoke breaks and the socialization they had while they smoked. *One of the residents was seeking placement at another nursing home facility that would allow him to smoke. Review of provider's January 2017 smoking policy revealed: "Residents may smoke/use smokeless tobacco outside of the building on the back patio." Review of providers 5/6/21 letter to residents and family members revealed: *Newly admitted residents would not be allowed to smoke on facility grounds. *Beginning 8/1/21 current residents who smoke would no longer be allowed to smoke on facility grounds. *Options were available to current resident smokers to assist them with cessation. *There were no options for current residents who wanted to continue to smoke and remain a	F 561		

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F 561	Continued From page 10 resident at the facility.	F 561		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on interview and call light log review, the provider failed to ensure timely call light response to address resident needs. Findings include:	F 725	1.In continuing compliance with F 725, Sufficient Nursing Staff Aberdeen Health and Rehab corrected the deficiency by checking all call light phones, chargers and pagers and were found to be in working order as of 7/14/21. Call light marquees were ordered on 7/14/21 and will be placed outside of each nurses' station for visual confirmation of current call lights. Pagers have been programmed and given to leadership team members to alert on 7/29/21. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 7/20/21 on timely response to call lights by DNS. The ED and/or designee will audit call light response times 3 times per week for 1 month and 2 times per week for one month and then randomly to ensure continued compliance.	

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F 725	Continued From page 11 1. Interview on 7/7/21 at 11:30 a.m. with a random group of residents revealed: *They were short staffed and needed more certified nursing assistants (CNA). *Calls lights were not answered soon enough. *Staff would come in and turn off the call lights and say they would be right back. *They knew residents had accidents because they had to wait too long. Surveyor: 42750 2. Confidential interview on 7/6/21at 4:50 p.m. with a resident who adamantly requested to remain anonymous revealed: *"Sometimes when I put my [call] light on because I want to go to bed, I wait a long time, over half an hour. *One time when I put my light on to use the bathroom, it took so long I wet my pants and had a bowel movement too [in my pants]. *It was very embarrassing. *They do the best they can with the staff they have. *I have talked to them (administration) many times about the call lights, but haven't filled out a grievance form." *When asked if the surveyor could use her name, stated, "I wish you wouldn't. If they find out it's me, they'll take it out on me." Surveyor: 18560 3. Confidential interview on 7/7/21 at 10:00 a.m. with a resident who adamantly requested to remain anonymous revealed: *Have had accidents because have had to wait for help. *"When I need help, I need it." *"Really hate accidents." *"Accidents make me feel like a child."	F 725	3.As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process. 4. The ED is responsible for this area of compliance.	7/30/21

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F 725	Continued From page 12 *Made to feel bad because staff have had to wash and clean me up. Review of resident's most recent Minimum Data Set (MDS) assessment revealed: *Brief Interview for Mental Status (BIMS) score of 15 indicating cognition had been intact. *The resident required extensive assistance from staff for bed mobility and personal hygiene. *The resident required total assistance from staff for transferring and toileting. 4. Confidential interview on 7/7/21 at 3:20 p.m. with a resident who adamantly requested to remain anonymous revealed: *"Some staff are snooty." *"Don't say too much and try to keep quiet." *"Feel like I have to shut up and take it sometimes." *Have had to wait sometimes quite awhile for call lights and have had accidents. *Told by a CNA to clean up urine that had spilled on the floor. Review of resident's most recent MDS assessment revealed: *BIMS score of 15 indicating cognition had been intact. *The resident required limited assistance from staff for bed mobility, transferring, and personal hygiene. *The resident required extensive assistance from staff for toileting. 5. Confidential interview on 7/7/21 at 4:11 p.m. with a resident who adamantly requested to remain anonymous revealed: *Staff members were "Nosy and go through my packages."	F 725		

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F 725	Continued From page 13 *Nosy staff have "attitude." *Have had accidents because have had to wait for call light to be answered. *"You gotta go you gotta go." *In the past when they have had to clean me up they have thrown my things on the floor. Review of resident's most recent MDS assessment revealed: *BIMS score of 15 indicating cognition had been intact. *The resident required total assistance from staff for bed mobility, transferring, and toileting. *The resident required extensive assistance from staff for personal hygiene. 6. Confidential interview on 7/8/21 at 9:00 a.m. with a resident who adamantly requested to remain anonymous revealed: *Staff members have gone through dresser drawers asking "what do you have to eat." *Staff members have stolen snacks. *Hates to push call light. *Has had numerous accidents a week. *They were too short staffed. *Staff members only seem to do "what they can get away with." Review of resident's most recent MDS assessment revealed: *BIMS score of 15 indicating cognition had been intact. *The resident required extensive assistance from staff for bed mobility, transferring, toileting, and personal hygiene. Surveyor: 43844 7. Interview on 7/7/21 at 9:45 a.m. with resident	F 725		

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F 725	Continued From page 14 22 revealed: *It takes a minimum of one half hour for her call light to be answered during the night and she often falls back to sleep without anyone responding to the call light. *She believes there has been several times when only one nursing assistant had been on duty during the night for the entire building. Continued interview on 7/9/21 at 9:12 a.m. with resident 22 revealed: *Her roommate, resident 42, does not use her call light. -Staff do not check on her roommate during the night shift. --She would know this as she wakes up if the staff come into the room. --She turns on her call light when she knows her roommate needs assistance. *She does not always get a bath as scheduled and has never refused one. -Had a staff member tell her someone charted that she had refused a bath last week. --Her voice became higher pitched and her face started to get red. "I absolutely did not refuse any bath and I was not very happy." *Someone had not closed the clip on her catheter spigot this morning and she was "all wet." -Had notified staff after breakfast at 8:45 a.m. as "it would not do any good and they would not have changed me until after breakfast anyway." --By 9:15 a.m. she had not been assisted to change her soiled clothing. 8. Interview on 7/7/21 at 10:20 a.m. with resident 42 revealed: *She had quit using her call light because "it doesn't [does not] help anyway." *At night she "gets really cold and just keeps	F 725		

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F 725	Continued From page 15 peeing [in the bed], I like to sleep but can't [cannot] when I am wet in the bed [from urinating]." Interview on 7/8/21 at 3:48 p.m. with an anonymous staff member regarding resident 42 revealed: *They had come to work the morning of 7/7/21 and resident 42 was soaked from urinating in her bed and had complaints of being cold. "I could smell the urine from the bedroom doorway, it was about 6:30 a.m." *There had been times when one CNA worked during the night shift. "There should be at least two and preferably three." *"Nurses have had to work twenty-four hours straight and are over-worked." Surveyor: 41895 9. Interview on 7/7/21 at 3:27 p.m. with registered nurse G revealed: *Residents sat in soiled clothes because they did not get assisted to the bathroom regularly. *Bathing was not being done or a bed bath was given instead because CNAs did not have time to give all the baths. *She had resigned her position as the assistant director of nursing because they could not staff the facility sufficiently. *Residents 9, 13, 22, 28, 33, and 54 call lights were often ignored by CNAs. *On 7/4/21 resident 22's call light had been on twice for over an hour. *The nurses could only monitor call lights from the nurses station so when she was out on the floor working she could not see when a call light was on. *The CNAs monitored the call lights with phones or pagers.	F 725		

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F 725	Continued From page 16 *There had not been enough phones or pagers for all the working staff to carry one. *At times the phones or pagers did not work correctly. Surveyor: 43844 10. Interview on 7/9/21 at 8:35 a.m. with CNA M revealed she: *Believed call lights should be answered within 5 to 7 minutes of being activated. -Knew sometimes call lights were not responded to for at least 20 minutes. *Had been notified when a call light was activated through a phone system. *Had automatically been logged off the system after 30 minutes and had not been aware she was logged off. *Had hoped a co-worker would respond to call lights if she was busy giving a resident a bath. -Had been understaffed at times and gave bed baths if they did not have time to give a regular bath to a resident. 11. Interview on 7/9/21 at 9:06 a.m. with resident 7 revealed she: *Urinated while sitting in her wheelchair. *Stated: " I don't know how long I have to wait [for help] it is a very long time and then I just pee." *Had asked for a new seat cushion for her wheelchair as she had "peed so much in it, I can smell it." *Was not sure who she had asked for a new seat cushion. *Had not received a new seat cushion. Surveyor: 41088 12. Confidential interview on 7/7/21 at 3:11 p.m with a resident who requested to remain anonymous revealed:	F 725		

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F 725	Continued From page 17 *"The call lights do not get answered quickly." *"They don't have enough help." *"This happens all the time." *Has had accidents in the past due to length of time before a call light was answered. *"I'm supposed to have help to use the restroom but go on my own to avoid any accidents." *"The staff have their favorites and answer those call lights first. The rest of us have to wait." *"Some staff are not that nice. They don't say anything but show how they feel in the way they act." *Resident was afraid of retaliation for voicing concerns about call lights and staffing issues. 13. Review of the provider call light record dated 6/8/21 through 7/8/21 revealed: *Surveyors had requested the last 30 days of call light records. *The documents received began on 6/23/21. *Entries from 6/8/21 through 6/23/21 were not provided. *Results of the audit included: -3457 total call light entries. -1067 of those entries had recorded call time response time waits of over 15 minutes with the longest wait time being 137 minutes. -88 of those triggered call lights had been located in bathrooms with the longest wait time being 62 minutes. Interview on 7/9/21 at 11:17 a.m. with administrator A revealed: *Their call light system was an aerial wireless system connected to phones and a computer monitor at the nurse stations. *They had five phones available on Country Lane and two on Arbor Lane. *There were enough phones available for all	F 725		

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F 725	Continued From page 18 CNAs working the floor each shift. *The phones were primarily meant for CNA use. *Nurses did not typically use the phones. *When a call light was pressed, that room number would pop up on the computer monitor at the nurses station and on those phones. *She agreed the nurses would be unaware of a triggered call light if they were away from the nurses station passing medications or assisting a resident. *If the internet went down, the call light phones did not alert that a call light had triggered. -CNAs would be unaware if the internet was down and there were residents needing assistance. -The monitors at the nurses station would continue to work and the CNAs would be informed. -Nurses passing medications would be alerted on their iPads that the internet was down and then inform CNAs. *Their internet service had sporadic outages with most being scheduled upgrades by the service company and they were contacted in advance. *In the event there was a service outage CNAs were instructed to check on residents every 15 minutes. *She was aware there had been long response times to the call lights. *They were working on addressing the problem. *The provider did not specify call light response within a certain time frame. *The interim director of nursing services (DNS) had given a suggested guideline or goal for all call lights to be answered within 10 minutes. *Her expectation would be for staff to answer all call lights within 15 minutes. *She thought that would be a reasonable timeframe. *She agreed that if residents had needed to use	F 725		

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F 725	Continued From page 19 the restroom 15 minutes could seem like a long wait. *They could pull call light audits as needed. *She had been checking them about twice a month or when there were concerns. *The last time it had been reviewed was last week with the ombudsmen. *That information would be discussed with the interim DNS and investigated if needed. *The information was reported to Quality Assurance and Performance Improvement committee. *She felt they had enough staff to care for the residents but were always looking at balancing staffing according to their resident census. -They had used temp agencies to address nursing shortages and currently had one temp nurse scheduled and another contracted to come soon. *If short, the leadership staff were filling roles when needed. *Most of the office staff had been CNA and medication certified to help out if needed. *She verbalized confidence they had the amount of staff needed to provide the quality of care that was needed by the residents. *They did not have a policy regarding call lights.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755	See next page.	

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F 755	Continued From page 20 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on interview, record review, and policy review, the provider failed to ensure accountability of controlled medications by ensuring: *Controlled medications had been destroyed with two nurses and documented. *Counts of controlled medications had been documented by two nurses at shift change for 4 of 36 shift changes. Findings include: 1. Interview on 7/7/21 at 3:27 p.m. with registered nurse (RN) G revealed:	F 755	1.In continuing compliance with F 755, Pharmacy srvcs/Procedures/Pharmacist/ Records Aberdeen Health and Rehab corrected the deficiency by providing coaching/education on 7/3/2021 to LPN J on the process for destruction of narcotics and signing narcotic book when coming onto or leaving shift after counting with second nurse. 2. To correct the deficiency and to ensure the problem does not recur all nurses were educated on 7/20/21 on shift-to-shift medication counts requiring 2 nurses and their signatures. Education was also given on 7/20/21 on the process of destroying narcotics by DNS. The DNS and/or designee will visually audit the shift-to-shift count 3 times per week for 1 month, 1 time per week for 1 month and then randomly to ensure continued compliance. The DNS and/or her designee will audit the individual narcotic destruction sheets to ensure destruction by 2 nurses 1 time per week for 3 months and then randomly to ensure continued compliance.	

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F 755	Continued From page 21 *On the evening of 7/2/21 she had helped give medications for the evening shift and had given resident 13 a lorazepam and resident 33 a Tramadol. -On the morning of 7/3/21 she had noted that licensed practical nurse (LPN) J had signed out a dose of those same medications for the same two residents. *While she was passing medications on the morning of 7/3/21 resident 24 had approached her and stated he had not received his pain medication. *Resident 24's Tramadol had not been signed out on the medication administration record but it had been signed out by LPN J on the Controlled Drug Receipt/Record/Disposition Form. *LPN J had told her she had taken out a dose of: -lorazepam for resident 13 and a Tramadol for resident 33 on 7/2/21 and then realized they had already received their doses for the evening so she destroyed them. -Tramadol for resident 24 on 7/3/21 and when she attempted to administer the medication she could not get him to wake up so she had destroyed the dose. *She had reported the above events to assistant director of nursing (ADON)/LPN C on 7/3/21. Review of the provider's 7/3/21 investigation completed by ADON/LPN C revealed: *The investigation did not indicate which medications were being investigated. *LPN J had punched the medications out of the punch cards on accident and destroyed them on her own without another nurse. *LPN J was educated controlled medications were to be wasted with two nurses. Interview on 7/8/21 at 11:23 a.m. with ADON/LPN	F 755	3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process. 4. The DNS is responsible for this area of compliance.	7/30/21

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F 755	Continued From page 22 C regarding the above investigation revealed: *There was no documentation to support the destruction of the lorazepam or Tramadol. *She stated she had audited all of the controlled medication on 7/3/21 but did not have documentation of this. *She had not audited controlled medications since 7/3/21. *She did not know if LPN J had a drug panel done after the investigation. *She had been working on the floor 7/3/21. -Administrator A and interim director of nursing (DNS) B were not working and had asked her to start the investigation by interviewing the three residents involved and LPN J. Interview on 7/8/21 at 11:46 a.m. with interim DNS B regarding the above investigation revealed: *RN G had helped LPN J pass evening medications on 7/2/21. *LPN J had punched the lorazepam for resident 13 and Tramadol for resident 33 out of the medication cards because it appeared they had not been given. *When LPN J realized they had been documented on the medication administration logs as being administered she had destroyed the lorazepam and Tramadol. -She had not documented the lorazepam or Tramadol had been destroyed. *When LPN J had attempted to administer resident 24's Tramadol on 7/3/21 he had been sleeping and would not wake up to take the medication so LPN J had destroyed it. -She had not documented the Tramadol had been destroyed. *LPN J did not seem nervous when questioned about the above incident so she did not think she	F 755		

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F 755	Continued From page 23 was diverting medications. -LPN J had disposed of resident 24's Tramadol into a sharps container. -Residents 13 and 24 could not remember if they took the medications. *There had not been audits of controlled medications. *She would look at the controlled medications daily and had found no discrepancies. -She did not have documentation of this. *She did not know if there was a policy on when to complete a drug panel for an employee but thought it would be at the provider's discretion. *She said she would look to see if the provider had a policy on performing a drug panel on an employee and get back to this surveyor. -She had not came back to this surveyor by the end of the survey. *She believed the nurse was telling the truth and did not see any signs that she took the medications. *The nurse was very apologetic and indicated she did not know she should have destroyed the medications with another nurse. Interview on 7/8/21 at 12:17 p.m. with administrator A regarding the above investigation revealed: *She had audits of the medication carts and controlled medication counts for the month of July. *The police were not called on the missing medications. *She felt like it was a miscommunication and LPN J just needed more education. Review of the provider's revised November 2011 Disposal of Medications and Medication-Related Supplies policy revealed:	F 755		

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F 755	Continued From page 24 *"When a dose of a controlled medication was removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container." *Controlled medications were to be destroyed in the presence of two licensed nurses. *Disposal of controlled medications was to be documented on the accountability record/book. 2. Review of the 6/22/21 through 7/8/21 Country Lane long hall medication cart Narcotic and Hypnotic Inventory Sheet revealed: *Two out of thirty-six missing signatures for the off duty nurse. *Two out of thirty-six missing signatures for the on duty nurse. 3. Review of the provider's July 2021 Medication Cart Audit forms from 7/1/21 through 7/7/21 revealed: *Audits included controlled medication discrepancies. *Audits were done daily on all four medication carts. *RN D had completed all seven audits. *There had been no concerns found during the audits. Interview on 7/8/21 at 3:09 p.m. and on 7/9/21 at 10:00 a.m. with RN D regarding the medication cart audits revealed: *She had done all of the July 2021 audits. *Over the weekend she would come in every day to complete the audits. *She did not audit the Narcotic and Hypnotic Inventory Sheet where the shift-to-shift counts were documented. -Indicated she should add them to her audit.	F 755		

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F 755	Continued From page 25 Interview on 7/9/21 at 10:15 a.m. with administrator A regarding the audits and missed documentation on the Country Lane long hall Narcotic and Hypnotic Inventory Sheet revealed she: *Agreed the Narcotic and Hypnotic Inventory Sheet should have been included in the audits. *Would have RN D add it to her daily audits. Interview on 7/9/21 at 10:40 a.m. with interim DNS B revealed: *She was not aware the Narcotic and Hypnotic Inventory Sheet had not been part of the audit. *She would have RN D add it to the audit. *Agreed there should not have been missed signatures on the Narcotic and Hypnotic Inventory Sheet. 4. Review of the provider's revised November 2011 Controlled Substance Storage policy revealed: *An inventory of all controlled substances was to be done at each shift change or when keys were transferred. *Two licensed nurses were to document this verification on the Shift Verification of Controlled Substances Count.	F 755		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842	See next page.	

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F 842	Continued From page 26 to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or	F 842	1. In continuing compliance with F 842, Resident Records – Identifiable Information, Aberdeen Health and Rehab corrected the deficiency by uploading all required documentation on 7/9/21. Resident 13, 53 and 54 and all like residents medical records were updated with the counseling notes on 7/9/21. 2. To correct the deficiency and to ensure the problem does not recur medical records employee was educated on 7/15/21 on documentation requirements by DNS. The DNS and/or designee will audit the resident records to ensure NEMH dictation is received and uploaded/documented in the resident permanent medical file 1 time per week for 2 months and then randomly to ensure continue compliance. 3.As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process. 4. The DNS is responsible for this area of compliance.	7/30/21

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F 842	Continued From page 27 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on interview, record review, and policy review, the provided failed to have a system in place for complete medical record documentation for three of three residents (13, 53, and 54) who were seen by an outside counseling agency. Findings include: 1. Interview on 7/8/21 at 8:41 a.m. with resident 13 revealed she saw a counselor from an outside agency. Interview on 7/9/21 at 8:31 a.m. with social worker R regarding the counselor from the outside agency revealed: *Resident 13 was seen by her usually twice a week. *Residents 53 and 54 were also seen by her. *She normally would not leave notes in residents' charts.	F 842		

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F 842	Continued From page 28 *She stopped and visited with social worker R before and after her visits with residents. Interview on 7/9/21 at 8:35 a.m. with medical records clerk T regarding the counselor from the outside agency revealed: *No notes were located from her visits with the three residents. *She was not aware of when the counselor was last in the facility. Interview on 7/9/21 at 8:45 a.m. with Minimum Data Set assessment coordinator S revealed the counselor from the outside agency had started coming back to the facility in either January or February of this year. Interview on 7/9/21 at 10:19 a.m. with medical records clerk T regarding the counselor from the outside agency revealed: *Her last paper notes in residents' charts were from February 2020. *Notes since February 2020 had been dictated by the counselor. -The dictated notes on the three residents had not been sent to the provider. Review of resident 13's medical record confirmed the last paper note from the counselor had been dated 1/15/20. Interview on 7/9/21 at 2:25 p.m. with administrator A revealed there was no policy related to documentation from outside services.	F 842		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867	See next page	

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F 867	Continued From page 29 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on interview, record review, and policy review, the provider failed to ensure an effective quality assurance and performance improvement (QAPI) program had been followed to ensure concerns were addressed and investigated. Findings include: 1. Interview on 7/9/21 at 2:15 p.m. with administrator A regarding QAPI Program revealed: *The committee met monthly. *The medical director attended quarterly. *No certified nursing assistants, dietary staff, housekeeping staff, or residents participated in the QAPI meetings. *They had developed a performance improvement plan (PIP) for call lights not being answered timely in November 2020. -They had no documentation showing call light times had been reviewed and investigated since the beginning of the PIP. -They had implemented a system for staff to be notified if a resident's call light was activated. --The system had included pagers and phones, CNAs had utilized the system, and professional nurses utilized a monitoring system at the nurses' desk. --CNAs had not always carried a system pager or phone with them. ---They had started random audits for this the prior week, and there was no documentation of	F 867	1.In continuing compliance with F 867, QAPI/QAA Improvement Activities, Aberdeen Health and Rehab corrected the deficiency by indicating specific action plan dates and documentation on measurement of data on 7/29/21. 2.To correct the deficiency and to ensure the problem does not recur the ED was educated on 7/30/2021 on proper QAPI/QAA process and procedure by VP of Operations. All staff were educated on 7/20/2021 on their roles and responsibility in the quality performance and improvement by the DNS. The ED and/or designee will audit QAPI data 2 times per month for 2 months and then randomly to ensure continued compliance. 3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process. 4. The ED is responsible for this area of compliance.	7/30/21

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F 867	Continued From page 30 audits being performed. --She agreed nurses should have been utilizing the system pagers and phones to ensure call lights were answered timely. --The system had operated with Wi-Fi which had not always been reliable. --The system had logged staff off after 30 minutes if it had not been used. ---Staff had not been aware when the system logged them off and would not have known if a resident's call light was activated. Staff had to log back into the system for it to work. --The pagers and phones had required batteries to operate and charging of this equipment had been an issue. "We have enough chargers, they just don't always charge them." -A "ticket with IT [information technology] had been submitted in April" 2021 to obtain daily call light response time reports and to resolve the automatic log off time. --IT had not been able to resolve these issues. --Call light response time reports could have been printed at "any time" and were "printed when there was a concern or at least twice each month." -She indicated the provider could have installed marquis into the hallways to provide staff a visual alert when a call light was activated. --These had not been installed. -The provider had not reviewed call light times at the 7/2/21 QAPI meeting. -Insufficient staffing had not been identified through the QAPI process. Review of the provider's undated Quality Assurance and Performance Improvement Plan policy revealed: *"The Quality Assurance and Performance (QAPI) Program is to utilize an on-going, data	F 867		

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F 867	Continued From page 31 driven, pro-active approach to advance the overall quality of life and quality of care for all residents at Aberdeen Health and Rehab. Quality Assurance and Performance Improvement principles will drive our community's decision making to promote excellence in all resident and employees related areas. All community employees, families and residents will be encouraged to be involved in identifying opportunities for improvement, partake in QAPI teams, embed QAPI activities in all core processes and provide ongoing feedback." *"Aberdeen Health and Rehab uses a systematic approach to determining the root cause of an issue and any contributing factors." *"Each PIP team determines the timing for conduction of periodic measurements and reviews to evaluate whether new actions/interventions are being followed/performed consistently." *The committee should have implemented appropriate plans of actions to correct identified quality deficiencies. Refer to F550, F561, F725, F755, F842, and F880.	F 867		
F 880 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.	F 880	See next page	

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F 880	Continued From page 32 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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	F 880	1.In continuing compliance with F 880, Infection Prevention & Control, Aberdeen Health and Rehab corrected the deficiency by replacing batteries in the non-working hand sanitizer dispensers on 7/9/21. Non-working dispensers were removed on 7/9/21, replacements were ordered on 7/9/21. Individual sit-to-stand slings were ordered on 7/29/2021. Whirlpool chair armrest replacement were ordered on 7/28/2021. Cabinet in whirlpool room has been cleaned and chemicals stored properly on 7/28/2021. Damaged w/c removed from whirlpool room and taken out of service on 7/9/2021. All items stored on floor in clean utility room removed and placed on shelving on 7/9/2021. Incontinence cart and supply cart removed from service and new carts ordered on 7/29/2021. Floor mat for resident #26 was replaced on 7/9/2021. Keypad was placed on Arbor shower room on 7/29/2021. Arbor shower room was de-cluttered, chemical cleaned and stored correctly on 7/9/2021. Biohazard door had keypad lock placed on 7/29/2021. All incorrect signage was removed from resident rooms on 7/9/21.	

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F 880	Continued From page 33 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. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 A. Based on observation, interview, manufacturer's review, and policy review, the provider failed to ensure: *Two of two hand sanitizing dispensers were in working order. *Manufacturer's recommendations were followed for cleaning of one of one mechanical sit-to-stand lift sling. *Six of six pieces of equipment had cleanable surfaces. *One of one cabinet was kept clean. *Resident care supplies were properly stored. Findings include: 1. Observation on 7/6/21 between the hours of 4:14 p.m. and 4:49 p.m. revealed two hand sanitizing dispensers located in one hallway on Country Lane had not been in working order.	F 880	2.To correct the deficiency and to ensure the problem does not recur all staff were educated on 7/20/21 on measures to prevent spread of disease and infection reporting, reporting non-working hand sanitizer dispensers, proper signage on resident doors, individual lift slings for each resident, locking keypads on doors, proper chemical storage and reporting cracked or non-cleanable surfaces by DNS. The DNS and/or designee will audit all hand sanitizer dispensers for functionality weekly for 2 months, monthly for 2 months and then randomly to ensure continued compliance. The DNS and/or designee will audit sit-to-stand lift sling usage to ensure each induvial has a sling 3 times per week for 1 month, 2 times per week for 1 month, monthly for 2 months and then randomly to ensure continued compliance. The DNS and/or designee will audit all doors with keypads to ensure doors are locked 3 times per week for 1 month, weekly for 1 month, monthly for 2 months and then randomly to ensure continued compliance. The DNS and/or her designee will audit resident equipment to ensure cleanable surfaces weekly for 2 months, monthly for 2 months and then randomly to ensure continued compliance.	

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F 880	Continued From page 34 Interview on 7/7/21 at 9:19 a.m. with administrator A regarding the non-working hand sanitizer dispensers revealed they should have been working and she would have any non-working ones removed. 2. Observation on 7/7/21 at 8:53 a.m. revealed a Volaro mechanical sit-to-stand lift had been located in the hallway with the body sling necessary for operation sitting on top of it. Interview on 7/7/21 at 9:46 a.m. with unidentified staff revealed: *Three residents had shared the lift and the sling. *Lift slings had been wiped down with a sanitizing cloth. -She would have had to go to the soiled utility room or employee locker room to obtain a sanitizing cloth. Review of manufacturer's cleaning instructions for a Volaro Sit-to-Stand Sling revealed: *Padding was neoprene and polyfill. *Sling recommended washing instructions were: -Brush with warm, soapy water and non-chlorine disinfectant. -Rinse. -Drip dry only. 3. Observation on 7/7/21 at 9:45 a.m. of the whirlpool room on Country Lane revealed: *The chair that residents sit in to slide into the whirlpool had torn black foam on both armrests. *The covering for the controls of the whirlpool had been peeling off in an area of approximately two inches by two inches. *There had been a gray plastic cabinet with four shelves located in the corner of the room, and the bottom shelf contained two pairs of black rubber	F 880	The DNS and/or designee will audit clean storage rooms to ensure no items are stored on the floor weekly for 2 months, monthly for 2 months and then randomly to ensure continued compliance. The DNS and/or designee will audit all shower rooms to ensure chemicals are stored properly and rooms are decluttered weekly for 2 months, monthly for 2 months and then randomly for continued compliance. 3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process. 4. The DNS is responsible for this area of compliance.	7/30/21

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F 880	Continued From page 35 boots. -A brown crusty residue that was approximately six inches long and one-half inch wide had been dried onto one of the rubber boots. -Chemicals had been stored on the shelf above the rubber boots. *A wooden brown cabinet had an open shelf and a drawer which had the edges peeled off and had been covered in dust and a white powdery substance. *A bariatric wheelchair covered with dust and with a blue seat cushion with a tear measuring approximately one inch long had been stored. The damaged equipment would not have been cleanable. 4. Observation on 7/7/21 at 3:30 p.m. revealed resident 26's floor fall mat had numerous cracks from end to end and exposed the interior material making it an uncleanable surface. 5. Observation on 7/7/21 at 3:44 p.m. of the clean storage room on Country Lane revealed: *Disposable shampoo caps had been stored in a cardboard box on the floor. *Two boxes of paper towels had been stored on the floor under a sink pipe. *A delivery cart had edging missing on all three shelves with pressed board exposed. *A white plastic cart which stored incontinent supplies had duct tape holding the ripped areas of the plastic covering over it together in numerous areas. 6. Interview on 7/9/21 at 10:46 a.m. with interim director nursing services (DNS) B revealed: *The sling for the Volaro mechanical lift: -Had been shared among residents. -Had been wiped down between uses.	F 880		

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F 880	Continued From page 36 -Would not have caused cross-contamination between residents. *They had additional slings available for each resident to have their own but had not given each resident their own. *Supplies should not have been stored on the floor. *She agreed damaged surfaces would make the area an uncleanable surface. 7. Review of provider's Infection Prevention Practice Guideline and Procedure revealed: *"Purpose: to establish and maintain a program designed to provide a safe and sanitary environment for all residents/tenants/patients, their families, volunteers, visitors and staff." *"q. All resident care items shall be cleaned, disinfected or sterilized according to the use of the item." Surveyor: 41088 B. Based on observation, interview, and policy review, the provider failed to ensure: *One of two tub/shower room had chemicals labeled, stored securely, and not accessible to residents and was maintained in a safe and sanitary manner. *Infection precaution signs had been removed from 9 of 18 occupied resident rooms (105, 106, 109, 119, 122, 129, 130, 131, and 133) when no precautions were in place. Findings include: 1. Observation on 7/7/21 at 10:29 a.m. of tub/shower room located across from the nurses station in the Arbor Lane hall revealed: *The door was unlocked. *An open storage shelf in the hall that led to the	F 880		

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F 880	Continued From page 35 boots. -A brown crusty residue that was approximately six inches long and one-half inch wide had been dried onto one of the rubber boots. -Chemicals had been stored on the shelf above the rubber boots. *A wooden brown cabinet had an open shelf and a drawer which had the edges peeled off and had been covered in dust and a white powdery substance. *A bariatric wheelchair covered with dust and with a blue seat cushion with a tear measuring approximately one inch long had been stored. The damaged equipment would not have been cleanable. 4. Observation on 7/7/21 at 3:30 p.m. revealed resident 26's floor fall mat had numerous cracks from end to end and exposed the interior material making it an uncleanable surface. 5. Observation on 7/7/21 at 3:44 p.m. of the clean storage room on Country Lane revealed: *Disposable shampoo caps had been stored in a cardboard box on the floor. *Two boxes of paper towels had been stored on the floor under a sink pipe. *A delivery cart had edging missing on all three shelves with pressed board exposed. *A white plastic cart which stored incontinent supplies had duct tape holding the ripped areas of the plastic covering over it together in numerous areas. 6. Interview on 7/9/21 at 10:46 a.m. with interim director nursing services (DNS) B revealed: *The sling for the Volaro mechanical lift: -Had been shared among residents. -Had been wiped down between uses.	F 880	DPOC: Aberdeen Health and Rehab contacted the QIN on 7/29/21. Root cause analysis was conducted and system changes are in place for: appropriate maintenance repair/replacement of hand sanitizers; cleaning and maintenance of mechanical lift slings; maintenance of items stored in whirlpool rooms(s), clean storerooms(s), and individual storage mats to retain cleanable surface; appropriate storage and security of items in tub/shower room(s); and appropriate usage or discontinuation for use of isolation precaution signage. Monitoring will continue as indicated by response to F880 listed above.	

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	435041	A. BUILDING _____ B. WING _____	C 07/09/2021

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F 880	Continued From page 38 in the tub room. Observation on 7/9/21 at 9:51 a.m. of tub/shower room located across from the nurses station in the Arbor Lane hallway revealed no change from the 7/8/21 observation. The door remained unlocked with footprints as described above. Interview on 7/9/21 at 3:44 p.m. with interim DNS B and administrator A revealed: *They were unaware the tub/shower room had been unlocked. *They agreed that room should remain locked. *They follow the manufacturer's recommendations for storing chemicals. *They had no policy for chemical storage. 2. Observation and interview on 7/6/21 at 4:37 p.m. with certified nursing assistant (CNA) N upon initial entrance of the facility revealed: *Several posted signs on occupied and unoccupied resident rooms on the Arbor Lane wing that stated, "Infection control precautions in place. Please see nurse before entering." *An isolation cart with a plastic container of disinfecting wipes and a bottle of hand sanitizer on top. -There were bio-hazard bags inside one of the drawers. *When asked which residents were on transmission based precautions (TBPs) and required personal protection equipment (PPE): -She stated she was not sure why the signs were on the doors or if PPE was required but would ask the nurse on duty. -She returned a short time later and reported the nurse said no PPE was required for the rooms with the signs. -There were no residents on precautions in the	F 880		

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F 880	Continued From page 39 short Arbor hall. -She did not know why the signs had been on the doors. The following occupied resident rooms had infection control precaution signs posted on their door: *Room 105, 106, 109, 119, 122, 129, 130, 131, and 133. *None of the residents in the above listed rooms were on precautions. The following unoccupied resident rooms had an infection control precautions sign posted on their door: Room 107, 111, 112, 113, 114, 121, 123, 124, 127, and 128. Interview on 7/9/21 at 10:02 a.m. with interim DNS B revealed: *The infection control precautions had been left on the doors for those residents who were presumptive for COVID-19 when they had an outbreak. *Now that COVID -19 vaccinations were available there was no need to quarantine residents unless they had not been vaccinated. *Both of the wings in the Arbor halls were turned into a COVID unit during the outbreak. *They had one resident currently on TBPs for C-dif. *The signs should have been taken down. Interview on 7/9/21 at 10:24 a.m. with administrator A confirmed the above information. Interview on 7/9/21 at 10:41 a.m. with registered nurse Q revealed he: *Had recently come back from an absence from the facility.	F 880		

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F 880	Continued From page 40 *Passed medications that day. *Noticed the infection control precautions on the residents' doors but did not know why they had been there or if anyone had been on precautions. *Attended regular meetings for staff updates about resident changes. *Agreed he had not been informed about the signs on the resident doors since he returned to work. *Asked assistant DNS C to clarify about the signs during this interview. Interview on 7/9/21 at 10:49 a.m. with CNA P revealed: *The infection control precautions on the resident doors had been up for quite some time. *Agreed it could be a problem and confusing for new staff to know if they needed to wear PPE or not in those rooms. *The signs had been removed just prior to this interview by administration. The provider was unable to find a policy related to posting of TBP signage.	F 880		

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E 000	Initial Comments Surveyor: 18560 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities, was conducted from 7/6/21 through 7/9/21. Aberdeen Health and Rehab was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kirstie Hoon
TITLE: LNHA
(X6) DATE: 7/30/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	435041	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/07/2021

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC), (2012 existing health care occupancy), was conducted on 7/7/21. Aberdeen Health and Rehab was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC, for existing health care occupancies, upon correction of deficiencies identified at K712 and K918, in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 712 SS=D	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 REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation, interview, and document review, the provider failed to ensure fire drill procedures included transmission of the fire alarm (provider fire drill procedure stated to turn off the signal). Findings include:	K 712	1. In continuing compliance with K 712, Fire Drills, Aberdeen Health Rehab corrected the deficiency by updating the fire drill process on 7/8/21. 2. To correct the deficiency and to ensure the problem does not acure again Environmental Services Director was educated on fire drill process on 7/9/2021 by ED. The ED and/or designee will audit the fire drills monthly for 2 months and then randomly to ensure continued compliance. 3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process. 4. The ED is responsible for this area of compliance.	7/30/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kirstie Hoon
TITLE: LNHA
(X6) DATE: 7/30/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 712	Continued From page 1 1. Observation on 7/7/21 at 9:20 a.m. revealed the start of the fire drill procedure by the environmental services supervisor included shutting off the fire alarm signal to the monitoring agency and the fire department. Interview with the environmental services supervisor at the time of the observation revealed he was a new employee within the last six months and was following the written procedure for the fire drill. Review of the fire drill procedure document confirmed the procedure was as being performed. The fire alarm signal can't be turned off and must be transmitted and confirmed by the provider. The deficiency had the potential to affect 100% of the occupants.	K 712		
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 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	K 918		

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K 918	Continued From page 2 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 REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to ensure the generator would operate under test startup conditions (generator failed to start within ten seconds during testing). Findings include: 1. Observation on 7/7/21 at 8:30 a.m. during a test startup of the generator revealed the generator failed to start within ten seconds. Interview with the environmental services supervisor at the time of the observation revealed the battery had been changed by the contractor on 6/28/21 and thought that fixed the problem. He stated he thought the automatic battery charger for the generator was malfunctioning. The generator service contractor was called to re-check the problem. The deficiency affected 100% of the building occupants.	K 918	1. In continuing compliance with K 918, Electrical Systems – Essential Electric System, Aberdeen Health and Rehab corrected the deficiency by replacing the automatic battery charger on 7/9/21. 2. To correct the deficiency and to ensure the problem does not recur the weekly task in TELS maintenance logs were reviewed to ensure weekly tests are completed on 7/23/21. The ED and/or designee will audit the generator starting process 3 times per week for one month and then weekly to ensure continued compliance. 3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process. 4. The ED is responsible for this area of compliance.	7/30/21

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S 000	Compliance/Noncompliance Statement Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/6/21 through 7/9/21. Aberdeen Health and Rehab was found not in compliance with the following requirements: S121, S127, and S236.	S 000		
S 121	44:73:02:01 Sanitation The facility shall be designed, constructed, maintained, and operated to minimize the sources and transmission of infectious diseases and ensure the safety and well-being of residents, personnel, visitors, and the community at large. This requirement shall be accomplished by providing the physical resources, personnel, and technical expertise necessary to ensure good public health practices for institutional sanitation. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain sanitary conditions in two areas (service wing janitor closet and the resident C wing shower next to nurse station area). Findings include: 1. Observation on 7/7/21 at 8:45 a.m. revealed the janitor floor sink in the service wing had a black substance appearing to be mold on it. The room also had an area one foot by two feet showing exposed wood studs. The wood studs are an absorbent surface. 2. Observation on 7/7/21 at 10:55 a.m. revealed the resident C wing shower location under	S 121	1.In continuing compliance with S 121, Sanitation, Aberdeen Health and Rehab corrected the deficiency by cleaning the janitor floor sink in the service wing on 7/7/21 and exposed wood studs were covered with Killz paint on 7/9/21. Resident C wing shower room sheet rock and exposed wood was covered with Killz paint on 7/9/21. 2. To correct the deficiency and to ensure the problem does not recur maintenance staff was educated on 7/9/2021 the importance of keeping exposed wood covered and/or replacing as soon as possible by ED. The ED and/or designee will audit facility janitor closets and construction areas for sources of possible transmission of infectious disease weekly for 2 months and then randomly to ensure continued compliance. 3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process. 4. The ED is responsible for this area of compliance.	7/30/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kirstie Hoon — TITLE: LNHA — (X6) DATE: 7/30/21

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S 121	Continued From page 1 construction next to the nurse station had a black substance appearing to be mold on exposed sheetrock and wood studs. The completion of the construction was not immediately known. The wood studs and paper on the sheetrock were absorbent surfaces. 3. Interview with the environmental services supervisor at the time of the observations confirmed those findings. The deficiency affected 100% of the building occupants.	S 121		
S 127	44:73:02:06 Housekeeping Cleaning Methods and Equipment The facility shall establish written housekeeping procedures for the cleaning of all areas in the facility and copies made available to all housekeeping personnel. All parts of the facility shall be kept clean, neat, and free of visible soil, litter, and rubbish. Equipment and supplies shall be provided for cleaning of all surfaces. Such equipment shall be maintained in a safe, sanitary condition. Hazardous cleaning solutions, chemicals, poisons, and substances shall be labeled, stored in a safe place, and kept in an enclosed section separate from other cleaning materials. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 41088 Based on observation and interview, the provider failed to ensure one of one unused shower room (Arbor Lane hall) designated as a biological hazard (bio-hazard) storage room remained locked and not accessible to residents. Findings	S 127	Please see next page.	

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S 127	Continued From page 2 include: 1. Observation on 7/7/21 at 8:45 a.m. of the shower room at the north end of the Arbor Lane hall revealed: *The door had a bio-hazard sign posted on it. *The door was unlocked. *Inside and just to the right of the doorway there was a soiled surgical glove laying on the floor. *Several stacked, unassembled bio-hazard boxes leaned up against the wall on the left. *One assembled box with a red bio-hazard bag of unidentified contents. *Four taped bio-hazard boxes stacked in the hallway leading into the shower area. *In the shower area there were six large uncovered plastic garbage containers with red bio-hazard liners inside and several empty garbage containers stacked inside each other. *A shelf with red bio-hazard liners. *That hallway included several rooms occupied by residents. Further observation on 7/7/21 at 9:50 a.m. of the above shower room revealed: *An unidentified office employee was observed entering the shower room and then left the room. *She removed some boxes that had been located right across the hall from the shower room. *Upon her exit from the area, the shower room was observed to be in the same condition as described above. *Four taped bio-hazard boxes that appeared to be the same as observed above. *The door was unlocked. Observation on 7/8/21 at 9:07 a.m. of the shower room at the north end of the Arbor Lane hall revealed: *The door to the room was unlocked.	S 127	1.In continuing compliance with F S127, Housekeeping Cleaning Methods and Equipment. Aberdeen Health and Rehab corrected the deficiency by installing a keypad entry door lock on Arbor Long Hall biohazard room on 7/27/21. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 7/20/21on biohazard storage procedure by DNS. The DNS and/or designee will audit all keypad locks 3 times per week for 1 month, weekly for 1 month and then randomly to ensure continued compliance. 3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process. 4. The DNS is responsible for this area of compliance.	7/30/21

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S 127	Continued From page 3 *A used surgical glove that appeared to be the same as described above was on the floor. *The four taped bio-hazard boxes had been removed. *The one opened bio-hazard box with a red bio-hazard plastic bag remained. *In the shower area, the same six large uncovered plastic garbage containers with red bio-hazard liners inside along with several empty garbage containers stacked inside each other next to the south wall. Observation on 7/9/21 at 9:51 a.m. of the shower room at the north end of the Arbor Lane hall revealed: *No change in the condition of the room from the above 7/8/21 observation at 9:07 a.m. *The room was unlocked. Throughout the survey unattended residents had been observed in the hall next to the shower room at the north end of the Arbor Lane. Interview on 7/9/21 at 10:02 a.m. with interim director of nursing services B regarding the above shower room at the north end of the Arbor Lane hall revealed: *Bio-hazard materials were to have been boxed up by staff and placed in that room to be picked up weekly. She was not sure how often they were picked up. *The tubs with the red liners had not been used recently, but were used when they had a COVID-19 outbreak. *Bio-hazard used to be stored in another area prior to COVID-19. *She was unaware the room was unlocked and agreed it should have been locked. Interview on 7/9/21 at 10:15 a.m. with	S 127		

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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 _____	07/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 127	Continued From page 4 administrator A revealed: *Each wing had a soiled utility room that was locked. *Any bio-hazard bags should have been stored in the soiled utility room until it was time to be picked up by the company they contracted with. *The contracted company picked up the bio-hazard materials every other week on Wednesdays. *Bio-hazard had been picked up the morning of 7/8/21. *According to the receipt four bio-hazard boxes had been picked up. *She confirmed those boxes would have contained sharps. *She agreed the door should have been locked. A bio-hazard storage policy had been requested and had not been provided.	S 127		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to	S 236	Please see next page.	

South Dakota Department of Health

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S 236	Continued From page 5 another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 41895 Based on record review and interview, the provider failed to ensure one of five sampled employees (H) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being hired. Findings include: 1. Review of employee H's personnel file revealed: *He was hired on 5/11/21. *His TB symptom screen and first step TB skin test was not administered until 7/8/21. Interview on 7/8/21 at 3:10 p.m. with registered nurse D revealed he had not received his TB skin tests upon hire, so she had given him his first step. Interview on 7/8/21 at 4:10 p.m. with interim director of nursing services B revealed: *She had expected all employees to have the first TB skin test prior to contact with residents. *The first TB skin test was usually completed on hire date.	S 236	1.In continuing compliance with S 236, Tuberculin Screening Requirements, Aberdeen Health and Rehab corrected the deficiency by starting Employee H's TB test on 7/8/21 and completed on 7/17/2021. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 7/20/21 on TB testing requirements by DNS. The DNS and/or designee will audit new hire TB tests weekly for 2 months and then randomly to ensure continued compliance. 3. As part of Aberdeen Health and Rehab's ongoing commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process. 4. The DNS is responsible for this area of compliance.	7/30/21

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S 236	Continued From page 6 Review of the provider's revised July 2017 TB [Tuberculosis] Infection Control Plan revealed: *Tuberculosis screenings were required for all employees at the time of hire. *An employee was to have a negative TB symptom screen and a negative first TB skin test.	S 236		
S 000	Compliance/Noncompliance Statement Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/6/21 through 7/9/21. Aberdeen Health and Rehab was found in compliance.	S 000		