



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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 280	<p>Continued From page 1</p> <p>review, the provider failed to revise a care plan for 1 of 13 sampled residents (2) when care changes occurred. Findings include:</p> <p>1. Review of resident 2's 8/15/16 physician's orders revealed the resident received the following medications for the management of mood, behaviors, and mental functioning: *Donezepil HCL tablet 10 milligrams (mg) for unspecified dementia with behavioral disturbance. *Mirtazapine table 30 mg for major depressive disorder. *Risperdal 1 mg two times a day for unspecified dementia with behavioral disturbance.</p> <p>Review of resident 2's weight record revealed: *On 4/19/16 he weighed 195.5 pounds (lb). *His weight on 8/11/16 was 168.7 lb, a 26.8 lb weight loss.</p> <p>Review of the consulting registered dietitian's (RD) 7/23/16 assessment revealed: *He had a pressure ulcer on his right ankle. *He was going to the wound clinic. *He was receiving Mighty Shake two times per day. *The physician had said he had failure to thrive. *The family was requesting no artificial means for nutrition be started such as a feeding tube.</p> <p>Review of resident 2's 7/20/16 care conference summary revealed: *They had discussed: -Having failure to thrive. -Consideration of hospice. -He liked ice cream and shakes.</p> <p>Review of resident 2's 7/6/16 care plan revealed:</p>	F 280	<p>The preparation of the following plan of correction for ALL deficiencies do not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states with respect to:</p> <ol style="list-style-type: none"> <li>1. Resident #2's care plans have been reviewed/revise by the MDSC to reflect current individual needs and preferences.</li> <li>2. All resident care plans will be reviewed/revise to reflect current individual needs and interventions including nutrition interventions, skin concerns, behaviors' and interventions specific to their needs.</li> <li>3. The DNS and/or her designee will audit three care plans per week including resident #2 for one month and then two care plans per week for two months for accuracy and that they reflect current needs and interventions.</li> </ol>		

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 280	<p>Continued From page 2</p> <p>*He had a nutritional problem related to GERD. *It had not addressed: -The weight loss. -The Mighty Shake as an approach to the weight loss. *It had not addressed: -Any nutritional interventions for the pressure ulcer. -That he went to the wound clinic. *It had not addressed why he was on psychotropic medications or how they managed his behavior. *It had not addressed his failure to thrive.</p> <p>Interview on 8/17/16 at 7:45 a.m. with the director of nurses regarding resident 2 revealed: *The care plan did not have all the current information regarding his care. *She would have expected the care plan to have been current. *Changes should have been made to the care plan when they occurred.</p> <p>Interview on 8/17/16 at 9:05 a.m. with the dietary manager regarding resident 2 confirmed the care plan had not been updated with nutritional interventions for his weight loss and pressure ulcer.</p> <p>Review of the provider's September 2011 and October 2015 Care Plan Guideline policy revealed: **Care Plans: All Care plans should include individual and/or combined focus problems that address the following areas: -All current acute and chronic clinical conditions for which they are receiving medications, treatments and/or care. -Any outside consultants such as mental health,</p>	F 280	<p>4. The data collected will be presented to the Quality Assurance Quality Improvement Committee by the DNS quarterly. It will be reviewed/discussed and at this time the committee will make the decision/recommendation regarding follow up or changes.</p> <p>5. The DNS is responsible for this area of compliance.</p>	10-6-16	

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 280	Continued From page 3 podiatrist, wound clinic. -How to deescalate moods/behaviors, activities that provide diversion and or how staff should intervene. *Anything that is specific to that resident/what we would need to know to provide care." -"Resident care plans are to be updated as changes occur by the MDS (Minimum Data Set/assessment) coordinator, IDT [interdisciplinary team] Team, and charge nurses."	F 280			
F 281 SS=D	<b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b>  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, profession standards, and policy review, one randomly observed licensed practical nurse (LPN) (A) failed to prime and administer insulin by the correct route for three of three residents (7, 18, and 19). Findings include:  1. Observation on 8/16/16 at 12:05 p.m. of LPN A administering insulin through a syringe to resident 18 revealed she administered 4 units of insulin intramuscularly into his left deltoid muscle rather than subcutaneously.  2. Observation on 8/16/16 at 12:27 p.m. of LPN A preparing and administering insulin through a Novolog insulin pen to resident 7 revealed she: *Removed the pen from the medication cart. *Dialed the pen to 6 units with the cap on.	F 281	<i>See next page</i>		

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 281	<p>Continued From page 4</p> <p>*Pressed the button on the insulin pen. *Pulled the cap off the insulin pen. *Put on the needle. *Walked to the resident's room and administered the medication into her left deltoid muscle.</p> <p>3. Observation on 8/16/16 at 12:35 p.m. of LPN A preparing and administering insulin through a Novolog insulin pen to resident 19 revealed she: *Removed the pen from the medication cart. *Dialed the pen to 20 units with the cap on. *Pressed the button on the insulin pen. *Re-dialed the pen to 4 units with the cap still on, and re-pressed the button on the insulin pen. *Pulled the cap off the insulin pen. *Put on the needle. *Walked to the resident's room and administered the medication into her left deltoid muscle.</p> <p>4. Interview on 8/16/16 at 12:45 p.m. with LPN A regarding the above insulin administrations revealed she: *Thought there was air left over in the pens from the last administrations. *Was unaware of how to correctly prime the Novolog insulin pen according to the manufacturer's specifications. *Could not locate any instructions that would show her how to perform that task correctly. *Was shown how to do it the way she had performed it about a year to a year and a half ago. *Was unaware insulin needed to be administered into the subcutaneous tissue in the back of the upper arm not intramuscularly into the deltoid muscle. *She had not had any competency evaluations done related to insulin pens or insulin administration.</p>	F 281	<ol style="list-style-type: none"> <li>Insulin pens are administered per manufacturer guidelines. Insulin injections are administered subcutaneously.</li> <li>LPN A was educated on 9/14/16. All other licensed Nurses' will be educated by September 15<sup>th</sup>, 2016 to review the procedure regarding administering insulin pens, priming insulin pens, and the proper location to inject insulin pens. This education will be provided by the DNS.</li> <li>The DNS and/or her designee will audit 4 licensed nurses a month for 3 months for proper usage of insulin pens and a return demonstration will be provided including residents' #18 and 19. Resident #7 has been discharged.</li> <li>The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring.</li> <li>The DNS is responsible for this area of compliance.</li> </ol>	10-6-16	

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 281	<p>Continued From page 5</p> <p>*She could not recall any in-services or education she had received or attended in the last year to year and a half regarding the administration of insulin.</p> <p>Interview on 8/17/16 at 11:00 a.m. with the director of nursing regarding the above insulin administrations revealed: *It was her expectation all nursing staff were to follow manufacturer specifications and facility policy regarding insulin priming and correct administration. *She agreed competency evaluations and training should have been performed yearly for specific tasks necessary or critical to one's role in the facility to ensure resident safety.</p> <p>Interview on 8/17/16 at 11:10 a.m. with the administrator regarding competency evaluations revealed: *She was not aware competency evaluations were a necessary part of ongoing resident safety and training with regard to medication administration. *She had no policy related to performing audits or checking competency evaluations on her staff except upon being hired.</p> <p>Review of the provider's 2012 Diabetic Medication Pen Administration Reference Sheet policy revealed steps listed for priming any insulin pen were: *To have first prepared the pen for use by removing the cap. *Next the nurse was to have wiped the rubber seal with an alcohol swab, then attach a needle. *Next she was to have dialed 2 units of insulin before each injection and remove the needle shield.</p>	F 281			

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 281	Continued From page 6 *With the pen pointed upwards she was to have pressed the injection button. *After priming the desired dose was dialed and then administered. *A note at the top of the page read "These instructions are supplied as a guide only. Before administering the medication for the first time you should read the instruction leaflet accompanying the pen."  Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, pages 582 and 583, and 604 and 605 revealed: **"Medication errors include inaccurate administration using the wrong route. *When an error occurs, the patient's safety and well-being become top priority." *Subcutaneous injection sites such as the posterior upper arm, thigh, and abdomen were recommended sites for insulin injections.	F 281			
F 329 SS=D	<b>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b>  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329	<i>See next page</i>		

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 329	<p>Continued From page 7 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure one of five sampled residents (2) who received an antipsychotic medication had an appropriate indication documented to support the use of that medication. Findings include:</p> <p>1. Review of resident 2's physician's orders revealed the resident received the following psychotropics: *Donezepil HCL tablet 10 milligrams (mg) for unspecified dementia with behavioral disturbance. Started on 7/27/16. *Mirtazapine tablet 30 mg for major depressive disorder. Started on 7/27/16. *Risperdal 1 mg two times a day for unspecified dementia with behavioral disturbance. Started on 3/31/16.</p> <p>Review of resident 2's physician's progress notes revealed the listed diagnosis was: *1/26/16: Dementia. *2/18/16: Dementia with behaviors. *4/21/16: Dementia. *5/19/16: Dementia with behaviors.</p>	F 329	<ol style="list-style-type: none"> <li>1. Resident #2 was reviewed by his primary physician for the use of Risperdal. Risperdal has been discontinued.</li> <li>2. All resident care plans will be reviewed/revised to reflect current individual needs and interventions including non pharmacological interventions, diagnosis, and behaviors' exhibited for psychoactive medication use.</li> <li>3. All nurses will have been re-educated on Antipsycotic Medications by October 5<sup>th</sup>, 2016. The Interdisciplinary team will review medications on admission quarterly and with any significant change during care conference to evaluate for appropriate diagnosis and non-pharmacological approaches to use for psychoactive medications.</li> <li>4. The DNS and/or her designee will audit the care plans and medical record documentation of residents on antipsychotic medications, two residents per week for one month then one resident per week for two months for appropriate use, diagnosis and non-pharmacological interventions for medications.</li> <li>5. The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring.</li> <li>6. The DNS is responsible for this area of compliance.</li> </ol>	10-6-16	

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
--	---	--	---

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

(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 329	<p>Continued From page 8</p> <p>*6/23/16: Dementia with behaviors. *7/21/16: Dementia with behaviors.</p> <p>Review of resident 2's mental health nurse practitioner's visit progress notes revealed: *1/22/16: -The resident received Seroquel 100 mg three times a day and an additional 100 mg before his bath. -He also received the mirtazapine and the Aricept as stated above. -"Staff have no new concerns at this time. [Resident's name] remains cooperative with meds and cares and there are no reported problems with sleep and appetite." *The diagnoses were: -"Major neurocognitive disorder, severe alcohol-induced; Alcohol-induced mood disorder with mixed features; alcohol use disorder, severe, in remission. -Borderline intellectual functioning, by history. -Seizure disorder, HTN [hypertension], neurogenic bladder, malnutrition, anemia, CVA." *6/24/16: -A review of his medications concurred with the physician's orders listed above. -"[Resident's name] was started on a trial of Risperdal in March and staff have noted no significant change in mood and/or behavior." -No changes in medications were recommended. -No changes in diagnoses.</p> <p>Review of a 3/22/16 physician communication regarding resident 2 revealed: *"has c/o [complaints of] [physician's name] order to cath [catheterize] patient per patient's request." (as written) *The physician replied: -"D/C Seroquel.</p>	F 329		
-------	---	-------	--	--

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 329	<p>Continued From page 9</p> <p>-Risperdal 1 mg po BID." *There was nothing documented regarding why the Seroquel was discontinued.</p> <p>Review of resident 2's 2016 behavior documentation revealed: *February: He exhibited behaviors one time. *March: He exhibited behaviors seven times. -Two of those times he had rejected care. *April: He exhibited behaviors one time. *May: No behaviors. *June and July: He exhibited behaviors twice. -One of those behaviors he had rejected care. *There were no behaviors documented that presented a danger to himself or others.</p> <p>Interview on 8/16/16 at 2:00 p.m. with social services designee (SSD) D regarding resident 2 revealed: *His behaviors included: -When he wanted something he wanted it "Now." -He could be rude. -He was short-tempered. -He got upset if he did not get taken back to his room immediately after he was done eating. *He had become aggressive when he had a roommate. He was in a room by himself now, so that was no longer a problem. *He had not exhibited behaviors that presented a threat to himself or others.</p> <p>Interview on 8/16/16 at 11:00 a.m. with the director of nurses regarding resident 2 revealed: *He could be very unpleasant to work with. -He frequently yelled at staff. *When he first came in he was very agitated and restless; that had been several years ago. *She did not report any physical aggression toward himself or others.</p>	F 329			

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 329	<p>Continued From page 10</p> <p>*The nurse practitioner from the mental health agency was the one who made the decisions regarding his psychotropic medication.</p> <p>*In March his physician had taken him off the Seroquel, because he had gained so much weight in a short period of time.</p> <p>-The physician thought that was causing the weight gain.</p> <p>-Since then he had lost a lot of weight.</p> <p>-She had just called the physician's office to inquire about that change, because she could not remember for sure why that had happened.</p> <p>-She could not explain why the physician had made that change if the nurse practitioner usually oversaw the psychotropic medications.</p> <p>*She thought he was schizophrenic or bipolar.</p> <p>*A later interview with her on 8/17/16 at 7:30 a.m. revealed:</p> <p>-She had been mistaken about having a diagnosis of schizophrenia or being bipolar. He did not have those diagnoses.</p> <p>-She did not have any documentation from the March visit explaining why the physician had changed his medication.</p> <p>-She could not provide any supporting documentation as to why he had been started on the antipsychotic medication.</p> <p>Review of the provider's September 2009 Guidelines for Psychoactive Medications and Gradual Dose reduction policy revealed:</p> <p>**Antipsychotics: These medications should only be used for the following conditions/diagnoses as documented in the record and as meets the definitions in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.</p> <p>*Inadequate indicators for the use of these medications include:</p> <p>-Restlessness.</p>	F 329			

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 329	Continued From page 11 -Uncooperativeness.	F 329			
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, manufacturer's specifications, profession standards, and policy review, one randomly observed licensed practical nurse (LPN) (A) failed to prime and administer insulin correctly for three of three residents (7, 18, and 19) observed insulin administrations. Findings include:  1. Observation on 8/16/16 at 12:05 p.m. of LPN A administering insulin through a syringe to resident 18 revealed she administered 4 units of insulin into his left deltoid muscle.  2. Observation on 8/16/16 at 12:27 p.m. of LPN A preparing and administering insulin through a Novolog insulin pen to resident 7 revealed she: *Removed the pen from the medication cart. *Dialed the pen to 6 units with the cap on. *Pressed the button on the insulin pen. *Pulled the cap off the insulin pen. *Put on the needle. *Walked to the resident's room and administered the medication into her left deltoid muscle.	F 332	<ol style="list-style-type: none"> <li>Insulin pens are administered per manufacturer guidelines. Insulin injections are administered subcutaneously.</li> <li>LPN A was educated on 9/14/16. All other licensed Nurses' will be educated by September 15<sup>th</sup>, 2016 to review the procedure regarding administering insulin pens, priming insulin pens, and the proper location to inject insulin pens. This education will be provided by the DNS.</li> <li>The DNS and/or her designee will audit 4 licensed nurses a month for 3 months for proper usage of insulin pens and a return demonstration will be provided. This will include residents #18 and 19. Resident #7 has been discharged.</li> <li>The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring.</li> <li>The DNS is responsible for this area of compliance.</li> </ol>	10-6-16	

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435041	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/17/2016
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  ABERDEEN HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 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 332	<p>Continued From page 12</p> <p>3. Observation on 8/16/16 at 12:35 p.m. of LPN A preparing and administering insulin through a Novolog insulin pen to resident 19 revealed she:</p> <ul style="list-style-type: none"> <li>*Removed the pen from the medication cart.</li> <li>*Dialed the pen to 20 units with the cap on.</li> <li>*Pressed the button on the insulin pen.</li> <li>*Re-dialed the pen to 4 units with the cap still on, and re-pressed the button on the insulin pen.</li> <li>*Pulled the cap off the insulin pen.</li> <li>*Put on the needle.</li> <li>*Walked to the resident's room and administered the medication into her left deltoid muscle.</li> </ul> <p>4. Interview on 8/16/16 at 12:45 p.m. with LPN A regarding the above insulin administrations revealed she:</p> <ul style="list-style-type: none"> <li>*Thought there was air left over in the pens from the last administrations.</li> <li>*Was unaware of how to correctly prime the Novolog insulin pens according to the manufacturer's specifications.</li> <li>*Could not locate any instructions that would show her how to perform that task correctly.</li> <li>*Was shown how to do it the way she had performed it about a year to a year and a half ago.</li> <li>*Was unaware insulin needed to be administered into the subcutaneous tissue in the back of the upper arm not into the deltoid muscle.</li> <li>*She had not had any competency evaluations completed related to insulin pens or insulin administration.</li> <li>*She was not aware of any in-services or education she had received or attended in the last year to year and a half regarding the administration of insulin.</li> </ul> <p>Interview on 8/17/16 at 11:00 a.m. with the</p>	F 332		
-------	---	-------	--	--

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 332	<p>Continued From page 13</p> <p>director of nursing regarding the above insulin administrations revealed:</p> <p>*It was her expectation all nursing staff were to follow manufacturer specifications and policy regarding insulin priming and administration.</p> <p>*She agreed competency evaluations and training should have been performed yearly for specific tasks necessary or critical to ones role in the facility to ensure resident safety.</p> <p>Review of the current manufacturer's specifications for Novolog FlexPen revealed:</p> <p>*Novolog should be administered by subcutaneous injection in the abdominal region, buttocks, thigh, or upper arm.</p> <p>*Pull off the pen cap. Wipe the rubber stopper with an alcohol swab.</p> <p>*Remove the protective tab from the needle and screw it onto your FlexPen tightly.</p> <p>*Pull off the big outer needle cap and then pull off the inner needle cap. Throw away the inner needle cap right away</p> <p>*Turn the dose selector to 2 units.</p> <p>*Hold your FlexPen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top.</p> <p>*Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle.</p> <p>*The dose selector should be set at 0.</p> <p>*Turn the dose selector to the number of units you need to inject. The pointer should line up with your dose.</p> <p>*Insert the needle into your skin.</p> <p>*Press the push-button all the way in until the dose selector is back to 0. Turning the dose selector will not inject insulin</p> <p>*Keep the needle in the skin for at least 6 seconds, and keep the push-button pressed until</p>	F 332			

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 332	Continued From page 14 the needle has been pulled out from the skin."  Review of the provider's 2012 Diabetic Medication Pen Administration Reference Sheet policy revealed steps listed for priming any insulin pen were: *To have first prepared the pen for use by removing the cap. *Next the nurse was to have wiped the rubber seal with an alcohol swab, then attach a needle. *Next she was to have dialed 2 units of insulin before each injection and remove the needle shield. *With the pen pointed upwards she was to have pressed the injection button. *After priming the desired dose was dialed and then administered. *A note at the top of the page read "These instructions are supplied as a guide only. Before administering the medication for the first time you should read the instruction leaflet accompanying the pen."  Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, pages 582 and 583, and 604 and 605, revealed: *"Medication errors include inaccurate administration using the wrong route. *When an error occurs, the patient's safety and well-being become top priority." *Subcutaneous injections sites such as the posterior upper arm, thigh, and abdomen were recommended sites for insulin injections.	F 332			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		See next page	

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 431	<p>Continued From page 15</p> <p>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to: *Ensure nursing staff were disposing of controlled narcotic medication appropriately for two of two</p>	F 431	<ol style="list-style-type: none"> <li>1. The med carts are to be locked at all times when left alone. Narcotics are properly disposed of if accidentally punched out or the seal breaks. Medications are properly secured when not in use. New thermometers have been placed in the medication room refrigerators. The medication room refrigerators are temped at each NOC shift change and if below temp the DNS or on call nurse is notified and medications are moved to an alternate refrigerator.</li> <li>2. The Nurses' will be educated by September 15<sup>th</sup>, 2016 to review the procedure regarding disposing of controlled narcotics, leaving medications unattended, the protocol for locking the medication carts, and medication room refrigerator temps.</li> <li>3. The DNS and/or her designee will audit the medication carts/medication room 2 times a week for two months and then 1 time a week for 1 month for proper locking, storage of medications, blister packs, and refrigerator temps.</li> <li>4. The DNS and/or her designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring.</li> <li>5. The DNS is responsible for this area of compliance.</li> </ol>	10-6-16	

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 431	<p>Continued From page 16</p> <p>residents (10 and 20) randomly observed blister packs.</p> <p>*Secure one of one randomly observed resident's (19) insulin pen laying on top of one of four medication carts that was left unattended.</p> <p>*Secure one of four medication carts from unauthorized access on the transitional care unit (TCU).</p> <p>*Maintain refrigerator temperatures to ensure critical insulin medications had not frozen in one of two medication rooms.</p> <p>Findings include:</p> <p>1. Observation and interview on 8/16/16 at 3:00 p.m. with medication aide B regarding a medication cart audit revealed:</p> <p>* Two randomly sampled blister packs had paper tape affixed to the back of them.</p> <p>*Those blister packs belonged to residents 10 and 20.</p> <p>*Those medications were controlled narcotic medications: lorazepam and diazepam.</p> <p>*She stated staff would use paper tape if a dose of medication was accidentally punched out or refused by a resident.</p> <p>*She was unaware that was not an appropriate practice.</p> <p>*She agreed if she were to give a medication that was placed back into a blister pack she would not have been able to account for its integrity.</p> <p>*She agreed that practice could lead to medication diversion and risk of resident safety.</p> <p>2. Observation on 8/16/16 at 10:24 a.m. of the top of the medication cart in the TCU revealed:</p> <p>*An insulin pen belonging to resident 19 had been left unattended and unsecured on top of the medication cart.</p> <p>*At 10:27 a.m. licensed practical nurse A retrieved</p>	F 431			

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
--	---	--	---

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

(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 431	<p>Continued From page 17</p> <p>the pen from the top of the cart and placed it back inside the medication cart.</p> <p>3. Observation, interview, and record review on 8/16/16 at 3:30 p.m. with registered nurse (RN) E regarding the medication refrigerator temperatures for the refrigerator located on Arbor wing revealed: *Temperatures on July 29, August 3 and 8, had reached thirty-two degrees Fahrenheit (F), the temperature of freezing. *She stated if temperatures fell below the appropriate range of 36 to 46 degrees F listed on the temperature log, the nurse on duty should have called maintenance. The medications should have been moved to prevent freezing.</p> <p>4. Interview on 8/17/16 at 11:00 a.m. with the director of nursing regarding the above observations revealed it was her expectation: *Nursing staff were not to have taped medication back into the medication blister packs. *Medications were to have been secured at all times and not left unattended. *Nursing staff were to have called maintenance if medication refrigerator temperatures fell below freezing. Medications such as insulin that were not to have been frozen were to have been pulled from the medication refrigerator and discarded immediately per policy.</p> <p>Review of the provider's November 2011 Specific Medication Administration Procedures policy revealed: *All medication storage areas (including carts) were to be locked at all times unless in-use and under direct observation of the medication aide/nurse. *After administration the medication was to have</p>	F 431		
-------	---	-------	--	--

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 431	<p>Continued From page 18 been returned to the cart. *Once medication was removed from the package or container unused or partial doses were to have been disposed of.</p> <p>Review of the provider's 2013 Insulin Storage Recommendations policy revealed: *Refrigerator temperatures were to have been maintained at 36 to 46 degrees F. **"Do not use any insulin products that have been frozen."</p> <p>Surveyor: 29354 5. Observation and interview on 8/16/16 from 12:30 p.m. through 12:55 p.m. in the TCU outside the dining room revealed: *Two medication carts. *From 12:30 p.m. through 12:50 p.m. one of the two medication carts remained unlocked. There were several residents and staff members who had walked past the unlocked, unattended medication cart. *At 12:52 p.m. LPN A walked over to the unlocked, unattended medication cart and locked it.</p> <p>Interview at 12:55 p.m. with LPN A regarding the unlocked, unattended medication cart confirmed she: -Had just locked the medication cart. -Had forgotten to lock the medication cart. -Agreed a medication cart should not have been unlocked when unattended.</p> <p>Interview on 8/17/16 at 8:55 a.m. with the DON regarding the unlocked, unattended medication cart revealed her expectations were for the medication carts to be locked when unattended.</p>	F 431			

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 441 SS=D	<p><b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<ol style="list-style-type: none"> <li>The identified resident use items have been removed from under the sink and are properly stored. A sign has been placed on the freezer stating "No Food Storage Allowed."</li> <li>The Director of Rehab was educated by the Executive Director on September 12<sup>th</sup>, 2016 regarding proper storage of resident use items and ice pack storage. The Director of Rehab will educate all rehab staff by October 5<sup>th</sup>, 2016.</li> <li>The Executive Director and/or her designee will audit the therapy room 1x per week for proper storage of resident use items and visual inspect the therapy freezer.</li> <li>The data collected will be presented to the Quality Assurance Quality Improvement Committee by the ED quarterly. It will be reviewed/discussed and at this time the committee will make the decision/recommendation regarding follow up or changes.</li> <li>The Executive Director is responsible for this area of compliance.</li> </ol>	10-6-16	

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>		
(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 441	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625</p> <p>Based on observation and interview, the provider failed to ensure proper infection control techniques were followed for resident care items in one of one therapy room. Findings include:</p> <p>1. Observation on 8/16/16 at 4:30 p.m. in the freezer located in the therapy room revealed: *Seven small reusable ice packs *One large reusable ice pack. *One gel eye mask. *A box of toaster pastries that had been opened.</p> <p>Observation on 8/17/16 at 7:35 a.m. in the freezer and under the sink in the therapy room revealed: *In the freezer was: -Six small reusable ice packs. -One large reusable ice pack. -One gel eye mask. -A box of of toaster pastries that had been opened. *Under the sink was: -One large box with four small unopened containers of foam dressings. -Four boxes of tubular bandages. -One large piece of gray foam.</p> <p>Interview on 8/17/16 at 8:55 a.m. with licensed physical therapy assistant C regarding the supplies revealed: *The therapy unit supervisor was out of the building and not available for interview. *The toaster pastries had already been removed from the freezer. *She was not aware the toaster pastries had been in the freezer or who had placed them in that location.</p>	F 441			

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

PRINTED: 09/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
--	---	--	---

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

(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 441	<p>Continued From page 21</p> <p>*A portion of the ice packs were also used by the nursing staff.</p> <p>*She confirmed the items under the sink were for resident use.</p> <p>*Was not aware they were being stored under the sink.</p> <p>Interview on 8/17/16 at 10:50 a.m. with the administrator revealed:</p> <p>*She did not view the reusable ice packs in the freezer along with the toaster pastries as a concern.</p> <p>*She was not aware resident care items were being stored under the sink.</p> <p>*Acknowledged the items under the sink could be compromised if there were any maintenance issues with the sink.</p> <p>Policies concerning the storage of resident care items was requested from the administrator, but none were received by the end of the survey.</p>	F 441		
-------	--	-------	--	--

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

**ORIGINAL**

PRINTED: 08/30/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/16/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ABERDEEN HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1700 NORTH HIGHWAY 281 ABERDEEN, SD 57401</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/16/16. Aberdeen Health and Rehab was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Megan Kleinsasser*

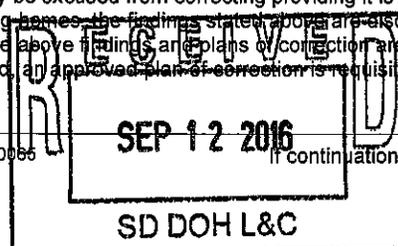
TITLE

*Executive Director*

(X6) DATE

*9-9-16*

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.



# ORIGINAL

PRINTED: 09/22/2016  
FORM APPROVED

### South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10587</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement  Surveyor: 29354 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/15/16 through 8/17/16. Aberdeen Health and Rehab was found not in compliance with the following requirement: S206.	S 000		
S 206	44:73:04:05 Personnel Training  The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment.  Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206		

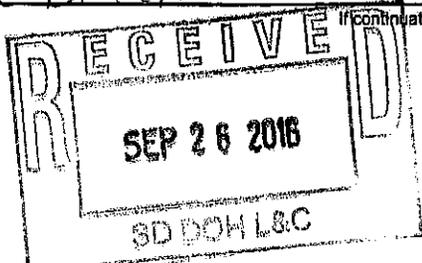
*See next page*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wegan Weinsaffer</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>9-22-16</i>
--	------------------------------------	-----------------------------

STATE FORM

6899 C3HO11

If continuation sheet 1 of 3



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10587</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
--	--	---	---

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

(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 206	<p>Continued From page 1</p> <p>Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 33488 Based on interview and record review, the provider failed to ensure an annual competency evaluation was completed for one of one medication aide (B) during a random employee file review. Findings include:</p> <p>1. Interview on 8/16/16 at 3:00 p.m. with medication aide B revealed she had not received any competency evaluation from the provider related to performing medication administration.</p> <p>Review of medication aide B's employee file revealed: *She became a medication aide on April 6, 2015. *Her employee training attendance record showed only previous training in dementia that she had received as a certified nursing assistant in 2008. *No other additional training was listed on that record.</p> <p>Interview on 8/17/16 at 11:00 a.m. with the director of nursing regarding the above competency evaluation revealed she agreed competency evaluations and training should have been performed yearly for specific tasks necessary or critical to ones role in the facility to ensure resident safety.</p> <p>Interview on 8/17/16 at 11:10 a.m. with the administrator regarding competency evaluations revealed: *She was not aware competency evaluations were a necessary part of ongoing resident safety</p>	S 206	<ol style="list-style-type: none"> <li>1. A Medication Administration training competency has been received from the SD Board of Nursing. All Medication Aides will be trained upon hire and annual using the Medication Aide Skills Performance Evaluation.</li> <li>2. By September 15<sup>th</sup>, 2016 all Medication Aides will have the skills performance evaluation completed by the DNS or ADNS and a return demonstration will be provided.</li> <li>3. A spreadsheet will be used to track the training dates needed for all annual training of Medication Aides. The DNS and or her designee will review this spreadsheet monthly to ensure the training is completed on the required annual date.</li> <li>4. The data collected will be presented to the Quality Assurance Quality Improvement Committee by the DNS quarterly. It will be reviewed/discussed and at this time the committee will make the decision/recommendation regarding follow up or changes.</li> <li>5. The DNS is responsible for this area of compliance.</li> </ol>	<p style="text-align: right;"><i>10-6-16</i></p>

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10587	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  08/17/2016
NAME OF PROVIDER OR SUPPLIER  ABERDEEN HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 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 206	Continued From page 2 and training with regard to medication administration. *She had no policy related to performing audits or competency evaluations on her staff except upon being hired.	S 206		
S 000	Compliance/Noncompliance Statement  Surveyor: 29354 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 8/15/16 through 8/17/16. Aberdeen Health and Rehab was found in compliance.	S 000		