**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 10/28/19 through 10/30/19. Aberdeen Health and Rehab was found not in compliance with the following requirements: F561, F657, F684, F688, F689, F689, F689, and F742.

A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/28/19 through 10/30/19. Area surveyed was accident prevention. Aberdeen Health and Rehab was found in compliance.

**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.

§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

---

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

Kirstie Hoon

**TITLE**

Emergency Permit Holder

**DATE**

11-22-19
F 561

Continued From page 1

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: 32335

Based on observation, interview, and record
review, the provider failed to ensure residents
were given options for bathing preferences for
one of one sampled resident (22) who wanted a
whirlpool tub bath. Findings include:

1. Observation and interview on 10/28/19 at 3:55
p.m. with resident 22 revealed:
*She had been sitting in her wheelchair in her
room.
*She had been offered a shower but not a
whirlpool tub bath.
*She would have preferred to have been given a
whirlpool tub bath instead of a shower.
*Sometimes staff approached her after 8:00 p.m.
to give her a shower, but that was too late for her.
*She wanted to have it before 8:00 p.m.

Observation on 10/30/19 at 9:23 a.m. in the tub
room in hall A revealed:
*The room could not be entered due to the
doorway being blocked by four shower chairs.
*The room was cluttered with: two folding chairs,
two plastic bins, brushes, a laundry basket lid,
rags, a Sharp's container, shoes, and broken
wheels.
*All items were scattered throughout the room.

The preparation of the following plan
of correction for these deficiencies does
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 this statement of deficiencies. The plan
of correction prepared for these
deficiencies were executed solely because
it is required by the provisions of state
and federal law.

Without waiving the foregoing statement
the facility states with respect to:
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Aberdeen Health and Rehab  
**Street Address, City, State, Zip Code:** 1760 North Highway 281, Aberdeen, SD 57401

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 561</td>
<td>Continued From page 2</td>
<td>F 561</td>
<td></td>
</tr>
</tbody>
</table>

1. All residents will be offered a choice of bathing every occurrence. Resident #22's care plan was updated on 11/21/19 to offer choice of bathing. The NAR care sheets were updated on 11-19-19 to state offer choice of bathing with each bathing occurrence.

2. All resident care plans were reviewed on 11-22-19 to ensure the resident bathing choice was documented. All nursing staff will be educated by the director of nursing by 11-22-19 to offer choice of bathing.

3. The DNS and/or her designee will audit 6 showers/baths a week for 1 month and then 4 showers/baths a week for 2 months to ensure resident choice was offered.

4. The DNS or her designee will present the data to the QAPI committee quarterly for further recommendations regarding systems and continued monitoring.

5. The DNS is responsible for this area of compliance.

Addendum KH NAR = Nurse Assistant Registry AKA C.N.A
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 561</td>
<td>Continued From page 3 completed the initial paperwork on new admissions.  *The residents did not have the option of a whirlpool bath, because both whirlpool tubs had been broken for &quot;a long time.&quot;  *She only asked them if they wanted their shower during the day or in the evening.  *The whirlpool tub on A wing was still broken and not working.  *The other whirlpool tub had just gotten fixed about a month ago.</td>
<td>F 561</td>
<td></td>
<td>11-29-19</td>
<td></td>
</tr>
<tr>
<td>F 657</td>
<td>Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to— (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of</td>
<td>F 657</td>
<td>See next page</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
F 657 Continued From page 4
the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Surveyor: 32335
Based on observation, interview, record review, and job description review, the provider failed to ensure care plans were updated and revised to reflect the current residents' needs for 5 of 20 sampled residents (22, 25, 36, 61, and 321). Findings include:

1. Review of resident 22's medical record revealed:
* She had been admitted on 5/26/19.
* Her latest Brief Interview for Mental Status assessment score was eleven indicating her cognition was moderately impaired.
* She went to dialysis on Tuesday, Thursday, and Saturday mornings.
* There was no post-dialysis monitoring documentation in the resident's chart.

Review of resident 22's current undated care plan revealed:
* She went to dialysis on Monday, Wednesday, and Friday along with going Tuesday, Thursday, and Saturday.

F 657
1. Resident #22's careplan was updated on 11-19-19 reflect KD days, the specific type of dialysis, correct arm to take BP on, care of access site, transportation used to/from dialysis, and post dialysis monitoring. On 11-19-19 resident #25's care plan was updated to reflect sore on left lower extremity. Resident #36's care plan was updated to reflect mood and behavior on 10-30-19. Resident #61 expired on 11-16-19. Resident #321's care plan was updated on 10-30-19 to reflect right foot infection.
2. All resident care plans have been reviewed for KD specific needs, mood and behavior needs, and anyone with a skin infection.
3. The DNS or her designee will audit 6 care plans a week for one month and then 4 care plans a week for 2 months to ensure all items in#2 were addressed. Audits will also include residents 22, 25, 36, and 321.
4. The DNS and/or her designee will present the data to the QAPI committee quarterly for further recommendations regarding system and continued monitoring.
5. The DNS is responsible for this area of compliance.

Addendum KH: 1. Resident #321 not resident 32.
2. All nursing staff have been educated by the MDSC in regard to care planning.
Continued From page 6

*She was unaware the resident had no depression diagnosis entered in their computer system.
-It was her responsibility to ensure residents' diagnoses were entered, updated as needed, and current.
*She was aware the resident received anti-depressant medication.
*It was her expectation the resident had a care plan related to depression.

4. Observation and interview on 10/28/19 at 3:51 p.m. of resident 61 revealed:
*He was lying in bed.
*He stated he was no longer receiving dialysis and had started hospice services.

Review of resident 61's revised 10/30/19 care plan revealed:
*There was a code status focus area that had indicated resident 61 desired cardio-pulmonary resuscitation (CPR).
*There was a discharge planning focus area that had indicated the resident desired to return to the community upon completion of therapy.

Interview on 10/30/19 at 9:30 a.m. with LPN/MDS assessment coordinator E regarding resident 61's care plan revealed:
*She confirmed the resident's code status was do not resuscitate (DNR).
*She stated the resident was receiving end of life care.
*She agreed when the hospice care plan was added she should have reviewed the entire care plan and updated it as needed.

5. Observation on 10/29/19 at 10:30 a.m. of resident 321 revealed:
<table>
<thead>
<tr>
<th>F 657</th>
<th>Continued From page 7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*There was a sign on the room door that stated gowns and gloves were to be put on prior to entering the room.</td>
</tr>
<tr>
<td></td>
<td>*She was seated in a recliner waiting for the wound care nurse.</td>
</tr>
<tr>
<td></td>
<td>Review of resident 321's revised 10/30/19 care plan revealed:</td>
</tr>
<tr>
<td></td>
<td>*There were focus areas that had indicated the resident had a lower extremity cellulitis and peripheral vascular disease.</td>
</tr>
<tr>
<td></td>
<td>-There were interventions for treatment of those conditions.</td>
</tr>
<tr>
<td></td>
<td>-There was no mention of the resident's right foot infection.</td>
</tr>
<tr>
<td></td>
<td>Interview on 10/30/19 at 9:30 a.m. with LPN/MDS coordinator E regarding resident 321's care plan revealed:</td>
</tr>
<tr>
<td></td>
<td>*She confirmed personal protective equipment was used when caring for the resident due to a right foot infection.</td>
</tr>
<tr>
<td></td>
<td>*It was her expectation that physician ordered infection control practices had been included in the care plan.</td>
</tr>
</tbody>
</table>

6. Continued interview with LPN/MDS coordinator E regarding all residents' care plans revealed: 
*She reviewed and updated care plans when she completed the admission, quarterly, annual, and significant change MDS assessments.
*She updated care plans based on resident information received at daily department meetings and from individual caregivers.
*She was the care plan process owner.
*It was her expectation care plans had accurately reflected the current needs of the residents.

Review of the March 2019 MDS Coordinator SNF
Continued From page 8

(skilled nursing facility) job description revealed:

- "Essential Job Functions:
  - "Ensure consistent, accurate and timely completion of the RAI [Resident Assessment Instrument] process which includes MDS, Care Area Assessments (CAAs) and plan of care."
  - "Work with the Interdisciplinary Team in developing a comprehensive resident assessment and care plan for each resident."

§ 483.25 Quality of care

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents’ choices.

This REQUIREMENT is not met as evidenced by:

Surveyor: 32335

Based on observation, interview, record review, and guideline review, the provider failed to properly assess and document new skin concerns for two of three sampled residents (25 and 41). Findings include:

1. Review of resident 25’s medical record revealed:

   * She was admitted on 5/23/19.
   * Her diagnoses included:
     - Type 2 diabetes mellitus.
     - Vitamin deficiency.
     - Essential hypertension.
     - Gout, unspecified.
<table>
<thead>
<tr>
<th>F 684</th>
<th>Continued From page 9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Mononeuropathy, unspecified.</td>
</tr>
<tr>
<td></td>
<td>- Heart failure.</td>
</tr>
</tbody>
</table>

Review of resident 25's 9/11/19 Minimum Data Set (MDS) assessment revealed:

* Her Brief Interview for Mental Status (BIMS) score was fifteen indicating her cognition was intact.
* She required extensive assistance of one staff member for bed mobility.
* She required limited assistance of one staff member for transferring.
* She used a wheelchair.
* She was at risk for developing pressure ulcers.

Observation and interview on 10/29/19 at 11:01 a.m. with resident 25 revealed she had a sore on the front of her left leg. It was currently covered with a band-aid. She had Ted hose on both legs.

Interview on 10/29/19 at 2:39 p.m. with the nurse consultant revealed pressure ulcers and surgical wounds were documented in the wound rounds database. Other skin issues should have been documented in the resident's progress notes.

Review of resident 25's nurses' progress notes revealed:

* 10/13/19: "CNA [certified nursing assistant] reports that patient [resident] left lower leg is weeping. Patient has two open areas that are weeping clear fluid on left lower leg; top one measures 0.6 cm [centimeters] X [by] 0.8 cm with bottom area measuring 0.8 cm X 1 cm. Areas surrounding do not show signs of infection.

Patient notes that this started yesterday and last night; no complaints of pain. Patient does receive 40 mg [milligram] Lasix twice daily at 0800 [8:00 a.m.] and 1200 [noon]. Placed triple antibiotic and

1. Resident #25's care plan was updated on 11-19-19 to reflect the skin concerns and treatment orders per physician. A daily wound flow sheet was created for resident #25. Resident #41's care plan was updated on 11-19-19 to reflect skin concerns and treatment orders per physician. A daily wound flow sheet was created for this resident.

2. Mandatory education will be provided by the DNS to all nursing department staff including the IDT team and administrator by 11-28-19. This will include the revised skin monitoring program including all findings in the 2567.

3. The DNS and/or her designee will audit 6 residents will skin concerns weekly for a month and then 4 residents a week for 2 months to ensure skin monitoring program is followed.

4. The DNS and/or her designee will present the data to the QAPI committee quarterly for further recommendations regarding system and continued monitoring.

5. The DNS is responsible for this area of compliance.

Addendum KH 2. All residents were assessed for skin concerns.
Continued From page 10

abdominal pad on the area; dressing changed after lunch. Patient is now laying in bed with legs up. Will continue to monitor."

*10/14/19: "Fax sent to [physician's name] about open areas on left lower leg. Wound nurse notified."

*10/17/19: "Noted increased redness, 1-2+ edema bi-lat [bilateral] legs, pain 7/10. Fax sent to [physician's name]."

*There was no other documentation regarding the two opened areas mentioned above or the current sore on her left leg.

Review of resident 25's current undated care plan revealed there was no documentation regarding the above areas.

Interview on 10/30/19 at 9:17 a.m. with registered nurse (RN) I regarding resident 25's skin issue revealed:

*She had changed the band-aid yesterday.

*She had not documented on the area, as it was just being covered with a band-aid.

*It was a small circular wound they covered, so her stocking would not get wet.

*The assistant director of nursing (ADON) was the wound nurse.

*She thought the wound nurse would be looking at it today.

Interview on 10/30/19 at 9:25 a.m. with the ADON regarding resident 25 revealed:

*She was not going to be looking at the resident's wound today.

*She was aware of it.

*She thought they were putting Bacitracin and a band-aid on it.

Observation and interview on 10/30/19 at 11:17
<table>
<thead>
<tr>
<th>F 684</th>
<th>Continued From page 11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a.m. with RN I in resident 25's room revealed:</td>
</tr>
<tr>
<td></td>
<td>*The resident was sitting in her wheelchair.</td>
</tr>
<tr>
<td></td>
<td>*She had Ted hose and a band-aid covering the area on her left leg.</td>
</tr>
<tr>
<td></td>
<td>*RN I did not measure the area, but stated it looked to be approximately 1.0 cm by 1.0 cm.</td>
</tr>
<tr>
<td></td>
<td>*The skin was intact with yellow-like fluid under the skin.</td>
</tr>
<tr>
<td></td>
<td>*The skin surrounding the area was red.</td>
</tr>
<tr>
<td></td>
<td>-She stated it was not warm.</td>
</tr>
<tr>
<td></td>
<td>*RN I and the resident stated it had started before this past weekend, but they were not sure exactly when.</td>
</tr>
<tr>
<td></td>
<td>*RN I had not documented on the area.</td>
</tr>
<tr>
<td></td>
<td>Interview on 10/30/19 at 3:22 p.m. with the ADON revealed she was not able to find any other documentation for resident 25 regarding the above mentioned skin issues.</td>
</tr>
<tr>
<td></td>
<td>Interview on 10/30/19 at 3:45 p.m. with the ADON, the administrator, and the nurse consultant revealed the nurse should have completed documentation on any skin alteration that was discovered. The care plan should have been updated to reflect the resident's current needs.</td>
</tr>
<tr>
<td></td>
<td>Surveyor: 41088</td>
</tr>
<tr>
<td></td>
<td>2. Review of resident 41's 10/1/19 MDS assessment revealed she had a BIMS score of nine meaning her cognition was moderately impaired.</td>
</tr>
<tr>
<td></td>
<td>Observation and interview on 10/28/19 at 4:19 p.m. with CNAs B, C, and D in resident 41's room revealed:</td>
</tr>
<tr>
<td></td>
<td>*CNAs B and D had assisted her to transfer out</td>
</tr>
</tbody>
</table>
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

<table>
<thead>
<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>(X1) Providers/Suppliers/Clinical Identification Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(X2) Multiple Construction</td>
<td>A. Building: ____________________</td>
</tr>
<tr>
<td></td>
<td>B. Wing: ____________________</td>
</tr>
<tr>
<td>435041</td>
<td>C. Date Survey Completed: 10/30/2019</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**  
ABERDEEN HEALTH AND REHAB

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
1700 NORTH HIGHWAY 281  
ABERDEEN, SD 57401

**Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LCD identifying information)**

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 684</td>
<td>Continued From page 12 of her bed and into her wheelchair.</td>
</tr>
<tr>
<td></td>
<td>*CNA C had also been in the room assisting her roommate.</td>
</tr>
<tr>
<td></td>
<td>*She had a large, raised, reddened area on the center of her upper chest. It appeared to be fluid filled</td>
</tr>
<tr>
<td></td>
<td>and about the size of a golf ball.</td>
</tr>
<tr>
<td></td>
<td>*CNAs B and D had not known when the sore had been discovered or by whom.</td>
</tr>
<tr>
<td></td>
<td>*CNA C stated it had been there for three or four days and referred to it as a boil.</td>
</tr>
<tr>
<td></td>
<td>-She stated the sore had appeared over the past weekend and thought the nursing staff were</td>
</tr>
<tr>
<td></td>
<td>aware of it.</td>
</tr>
<tr>
<td></td>
<td>-She had a history of getting boils on her skin.</td>
</tr>
<tr>
<td></td>
<td>-CNAs B, C, and D were unaware of who had discovered the boil.</td>
</tr>
<tr>
<td></td>
<td>*The CNAs should have notified the nursing staff of any new skin issues when found.</td>
</tr>
<tr>
<td></td>
<td>Interview on 10/29/19 at 8:29 a.m. and again at 1:27 p.m. with RN/MDS coordinator K regarding resident</td>
</tr>
<tr>
<td></td>
<td>41's skin boil revealed:</td>
</tr>
<tr>
<td></td>
<td>*She had been aware the resident had developed a skin boil but was not sure when it was</td>
</tr>
<tr>
<td></td>
<td>discovered.</td>
</tr>
<tr>
<td></td>
<td>*The resident had a history of developing boils on the same area of her chest.</td>
</tr>
<tr>
<td></td>
<td>*Hot packs were used on the boil to treat the area.</td>
</tr>
<tr>
<td></td>
<td>*The resident already had a dermatology appointment scheduled for an unrelated issue that morning, and</td>
</tr>
<tr>
<td></td>
<td>the physician was asked to check the boil at the same time.</td>
</tr>
<tr>
<td></td>
<td>*Body audits were done by CNAs when bathing residents and then charted on if something new or</td>
</tr>
<tr>
<td></td>
<td>concerning had been discovered.</td>
</tr>
<tr>
<td></td>
<td>*Daily wounds were to be documented in a binder at the nurses station.</td>
</tr>
<tr>
<td></td>
<td>*There was nothing noted in the binder regarding</td>
</tr>
</tbody>
</table>

FORM CMS-2567(02-99) Previous Versions Obsolete  
Event ID: 1UCV11  
Facility ID: 0065  
If continuation sheet Page 13 of 38
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| F 684 | Continued From page 13 resident 41’s boil regarding its status or discovery.  
*She stated there should have been charting or a skin assessment that identified the new wound.  
*She had been unable to find any documentation regarding the discovery of the boil or assessment of it. | F 684 | |

Interview on 10/30/19 at 3:59 p.m. with the ADON, the administrator, and the nurse consultant revealed:  
*Whoever found a skin issue should have reported it to the nurse on duty.  
*The nurses then should have notified the primary physician for any instructions.  
*The skin issue should have been documented on the daily wound flow sheet located at the nurses station and then charted on.  
*Staff members were expected to follow that procedure for all residents.

3. Review of the provider's revised February 2019 Skin Management Program Guidelines revealed:  
*Purpose: Promote the prevention of alterations in skin integrity; promote healing of current skin alteration and to prevent further loss of skin integrity.  
*Guidelines: Prevention:  
*Comprehensive evaluation of the resident clinical condition and risk factors for alteration in skin integrity upon admission and throughout the stay.  
*Identify and treat underlying causes when/if possible.  
*Recognizing and reporting changes in skin condition.  
*Interventions to prevent further skin damage.  
*Interventions for residents at high risk for skin breakdown.
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 684</td>
<td>Continued From page 14</td>
</tr>
<tr>
<td></td>
<td>*Assessment: All residents will be assessed for skin integrity alterations or changes in skin conditions upon preadmission screening, admission, daily with POC [plan of care] and weekly with bath:</td>
</tr>
<tr>
<td></td>
<td>*Establish risk for alteration in skin integrity.</td>
</tr>
<tr>
<td></td>
<td>*Establish individual interventions needed to promote and/or prevent alteration in skin integrity.</td>
</tr>
<tr>
<td></td>
<td>*Monitor for healing process of alterations in skin.</td>
</tr>
<tr>
<td></td>
<td>*Documentation: Documentation of the skin integrity, risk factors and evaluation of individualized interventions shall be done in clear and concise manner per the resident plan of care.</td>
</tr>
<tr>
<td></td>
<td>*Body audit is completed: upon admission and weekly by licensed staff, preferable on bath day, and PRN [as needed] for changes in skin integrity.</td>
</tr>
<tr>
<td></td>
<td>*Comprehensive Skin and Positioning evaluation completed: Upon admission, quarterly, and with changes in condition.</td>
</tr>
<tr>
<td></td>
<td>*Weekly skin integrity evaluation completed in PCC [point click care] or Wound Rounds for all alterations in skin integrity and for 4 weeks after alteration resolves.</td>
</tr>
<tr>
<td></td>
<td>*Individualized care plan will reflect approaches to stabilize reduce or remove risk for pressure injury development and or promoting healing of existing alterations in skin.</td>
</tr>
<tr>
<td></td>
<td>*Daily skin/Wound monitoring form will be completed for all residents on a daily basis that have any alterations in skin integrity until resolved.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 684</td>
<td></td>
</tr>
<tr>
<td>F 886</td>
<td>Treatment/Swgs to Prevent/Heal Pressure Ulcer</td>
</tr>
<tr>
<td>SS=G</td>
<td>CFR(s): 483.25(b)(1)(i)(ii)</td>
</tr>
<tr>
<td></td>
<td>§483.25(b) Skin Integrity</td>
</tr>
<tr>
<td></td>
<td>§483.25(b)(1) Pressure ulcers.</td>
</tr>
<tr>
<td></td>
<td>Based on the comprehensive assessment of a</td>
</tr>
</tbody>
</table>

See next page
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| F 686  | Continued From page 15 resident, the facility must ensure that: (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 40771 Based on observation, interview, record review, and guideline review, the provider failed to ensure a system was in place for one of two sampled residents (27) who was at risk for skin breakdown and was dependent upon staff to assist her with all of her activities of daily living (ADL) to: *Prevent pressure injuries from occurring or worsening. *Provide appropriate treatment, monitoring, and documentation of pressure injuries.
Findings include:
1. Interview on 10/25/19 at 4:00 p.m. with registered nurse (RN) I regarding residents with skin issues revealed:
*Resident 27 had a pinpoint area to her left foot that had a scab on it but had been resolved.
*She stated they were still putting a dressing on the area every three days for protection.
Observation and interview with RN I on 10/29/19 at 10:06 a.m. during resident 27's left foot dressing change revealed:
*Resident 27 was in her bed laying on her side.
*Her knees were bent and was unable to move | 1. Resident #27's care plan was reviewed on 10-30-19 and all interventions remained current. The skin assessment was brought up to date on 11-20-19 and the daily wound monitoring flow sheet was started. Skin nurse is reviewing weekly as of 10-30-19.
2. Mandatory education will be provided by the DNS to all nursing department staff including the IDT team and administrator by 11-28-19. This will include the revised skin monitoring program and all findings in the 2367.
3. The DNS and/or her designee will audits 6 residents a week for 1 month with skin concerns and then 4 residents a week for 2 months to including resident #27 to ensure the skin monitoring program was followed.
4. The DNS and/or her designee will present the data to the QAPI committee quarterly for further recommendations regarding system and continued monitoring.
5. The DNS is responsible for this area of compliance. |
**Continued From page 16**

- She did not respond to surveyor's questions.
- She had a pair of Rooko boots on her bare feet.
- RN I removed the Rooko boot and the dressing from the inner side of her left foot by her great toe.
- A dark black and purple colored approximately a quarter sized wound was observed.
- There was no crusting, drainage or swelling.
- She applied a new Mepilex dressing over the area.
- According to RN I the wound had not changed from the previous day.
- RN I stated:
  - The wound was considered resolved by the wound nurse.
  - The dressing they were doing was for protection only.
- She did not consider the appearance of the wound concerning.

Review of resident 27's medical record revealed:
- She was admitted on 1/13/11.
- Diagnoses included: dementia without behavioral disturbances, arthritis, pain, and a history of pressure injuries.
- She was not interviewable and had problems with short and long term memory recall.
- She had been dependent upon the staff to assist her with all ADLs.
- That had included bad mobility, transfers, dressing, incontinence care, and repositioning from side-to-side.
- Her Braden Scale for Predicting Pressure Injuries scores from 3/27/19, 6/17/19, and 9/12/19 ranged from six to ten indicating she was very high risk for skin breakdown.
- She was dependent upon the staff to anticipate her needs and develop a plan of care to ensure
Continued From page 17

no skin breakdown had occurred.
*She had:
  -Limited range-of-motion to her lower extremities and was not able to walk.
  -Required the use of a wheelchair (w/c) to meet all of her mobility needs.
  -A history of a stage two facility-acquired pressure injury to her left buttock.
*Her 9/27/19 comprehensive skin and positioning evaluation revealed:
  -She had a pressure injury on her left foot that was a stage 1 or greater.
  -Interventions to the left foot were listed as inspect skin weekly and apply dressings to legs.
*Interventions on her comprehensive care plan matched the above evaluation and included the Rooke boots and heel lift boots.

Continued review of resident 27's medical record and wound history documentation revealed:
*She had a facility-acquired left foot stage two pressure injury that was identified on 1/15/19.
  -It had worsened to necrotic tissue on 1/30/19, but was documented as a stage two.
  -On 2/20/19 it was still a stage two with fifty percent necrotic tissue and fifty percent pink/red tissue.
  -The length, width, and depth measurements had not changed from 1/15/19.
  -On 2/27/19 it was now an unstageable necrotic wound with drainage.
  -The measurement was now slightly different.
*On 6/26/19 they had documented the wound as closed.
  -On 7/2/19, only six days later it was again an unstageable wound.
*The unstageable wound to her left foot remained until it was documented as healed on 9/18/19.
  -There were no further notes about the status of
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CJA IDENTIFICATION NUMBER:**

<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| F 686 | Continued From page 18 the wound after 9/25/19 that listed it as healed. *For the left foot pressure injury she was seen at the wound clinic three times in July 2019. -According to the last documentation from that clinic the area was considered resolved and the facility was to call if the area reopened. -There was no further documented contact with the wound clinic regarding the pressure injury. *The documentation and assessments overall were inconsistent and unclear to support the status of the wound.

Interview on 10/29/19 at 11:03 a.m. with the assistant director of nursing (ADON) regarding resident 27’s pressure injury revealed:

*The ADON was the primary nurse that assessed pressure injuries and surgical wounds.

-She did not do the skin assessments for other skin concerns.

-She had started that role in June 2019. *She was aware the resident had a history of a facility-acquired pressure injury to her left great toe area.

-She had considered it resolved the prior week due to it being a white calloused area.

-She had not been made aware of any changes to that area since she resolved it. *Nurses should have informed her when there was a new or change to pressure injuries.

-There were two different documentation systems used for charting skin concerns.

-She primarily used one system and the charge nurses used the other.

-Those systems were not integrated.

-*Her focus was solely on the pressure injuries and surgical wounds.

-*She assessed pressure injuries weekly until they were resolved.

-*She considered pressure injuries resolved when | F 686 |
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 686</td>
<td></td>
<td></td>
<td>Continued From page 19 the wound was closed, and there was no change.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Continued interview and observation with the ADON of resident 27's left foot revealed:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*The resident was sitting in her wheelchair with the Rooke boots on.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*The ADON removed the left boot and dressing from the area.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*She said what she was observing was a change in the area, and it should have been reported to her by nursing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*The left foot area would have been considered an unstageable pressure injury at that time.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*The nurses should have charted that change in the record.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*The interventions that should have been used were either heel lift boots or the Rooke boots.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*She stated the resident should have been wearing the heel lift boots now instead of the Rooke boots because of the change in the wound.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-She was unable to locate the heel lift boots in the resident's room and said they were probably in the laundry.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Interview on 10/29/19 at 1:49 p.m. with certified nursing assistant J regarding resident 27's pressure ulcer revealed:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*She had seen the resident's left foot while doing her shower a couple of weeks ago.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*There were no skin issues at that time.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*If she had identified a change in a resident's skin she would have informsed the nurse.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*After speaking with the nurse she would have documented the injury depending on what the nurse told her to do.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Further interview on 10/30/19 at 10:06 a.m. with the ADON and the nurse consultant revealed:</td>
</tr>
</tbody>
</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
ABERDEEN HEALTH AND REHAB

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1700 NORTH HIGHWAY 281
ABERDEEN, SD 57401

**ID TAG**

<table>
<thead>
<tr>
<th>IDPREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>IDPREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 686        | Continued From page 20  
*A weekly skin assessment was to have been completed by the nurse when the resident was being showered.*  
*The DON would be expected to monitor and ensure the assessments were being completed.*  
*The ADON had training on how to use the wound rounds software program.*  
*She had not been given any specific wound assessment training.*  
-The ADON completed those weekly assessments of pressure injuries to ensure consistency occurred.  
*The staff often called the ADON the wound nurse at the facility.*  
*There was no job description for the wound nurse position, because it was a task that was assigned to the ADON.*  
Observation on 10/30/19 at 10:58 a.m. of resident 27 revealed:  
*She was sitting in her wheelchair (w/c) in the television room.*  
*She had Roke boots on her feet.*  
*The front of her feet were out of the front of the boots.*  
*Her feet were turned inward resting on each other at the area of the pressure injury.*  
*She did not have any foot pedals on her w/c.*  
*At that time the surveyor asked RN I if she had been informed to use the heel boots instead of the Roke boots.*  
-She said she had not been informed of any changes for the resident.*  
-When asked to find the boots she stated she would when she was done putting orders away.*  
-After waiting several minutes the nurse was again asked to assist with the boots. The nurse indicated she was busy.*  
*The ADON was then approached about the
**ABERDEEN HEALTH AND REHAB**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 686</td>
<td>Continued From page 21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>resident's heel lift boots and she obtained a set of boots from the supply closet.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>She went and applied those boots to the resident's feet and removed the Rooke boots.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The DON was not available for interviews throughout the survey from 10/28/19 through 10/31/19.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of the provider's February 2019 Skin Management Program guidelines revealed:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&quot;The purpose was: 'Promote the prevention of alterations in skin integrity; promote healing of current skin alteration and to prevent further loss of skin integrity.'&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Body audits should have been completed weekly.</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>The skin and wound monitoring form was to be completed daily when there was a skin integrity issue.</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Assessment guidelines were:</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| | -"Establish individual interventions needed to promote and/or prevent alteration in skin integrity."
| | -"Monitor for healing process of alterations in skin."
| | §483.25(c) Mobility. | | | | | | |
| | §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and | | | | | | |
| | §483.25(c)(2) A resident with limited range of motion, SS=D CFR(s): 483.25(c)(1)-(3) | | | | | | |

See next page
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>435041</td>
<td>A. BUILDING</td>
</tr>
<tr>
<td></td>
<td>B. WING</td>
</tr>
</tbody>
</table>

| (X3) DATE SURVEY COMPLETED | 10/30/2019 |

---

**NAME OF PROVIDER OR SUPPLIER**

ABERDEEN HEALTH AND REHAB

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 688</td>
<td>Continued From page 22 motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, and record review, the provider failed to provide range of motion (ROM) exercises for one of one sampled resident (18) reviewed who had limited mobility. Findings include: 1. Review of resident 18’s medical record revealed: *Her was admitted on 6/11/16. *Her diagnoses included: cerebral infarction, generalized muscle weakness, spastic hemiplegia affecting left nondenominant side, contracture of left hand, and unspecified lack of coordination. *She wore a brace on her left hand and another brace on her left lower leg and foot. Review of resident 18’s 9/4/19 Minimum Data Set (MDS) assessment revealed she: *Scored fifteen on the Brief Interview for Mental Status assessment indicating her cognition was intact. *Had the ability to verbally communicate her needs. *Required extensive physical assistance from two staff members for transfers and bed mobility. *Required a stand lift to transfer.</td>
<td></td>
</tr>
<tr>
<td>F 688</td>
<td>1. Resident #18 was evaluated by therapy on 11-12-19 and is currently participating. 2. Therapy will continue to do monthly screens on all residents with declines and evaluate for services if needed. 2. The Casper report will be reviewed monthly for 3 months by the IDT team and anyone flagging for a decline will be referred to therapy. 3. The DNS and/or her designee will present data to the QAPI quarterly for further recommendations regarding system and continued monitoring. 4. The DNS is responsible for this area of compliance. Addendum KH 2. Any change in condition, fall, or increased help with ADLS’ will prompt the C.N.A to report to the charge who will then bring that information to IDT for a therapy referral.</td>
<td></td>
</tr>
</tbody>
</table>

---

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1700 NORTH HIGHWAY 281
ABERDEEN, SD 57401

---

**FORM CMS-2587(02-09) Previous Versions Omitted**

Event ID: 1U0V11 Facility ID: 00665 If continuation sheet Page 23 of 38
Continued From page 23

*Was not receiving physical therapy.
*Used a wheelchair.

Observation and interview on 10/29/19 at 10:36 a.m. with certified nursing assistants (CNA) A and F with resident 18 in her room revealed:
*The CNAs had positioned a stand lift to transfer her to the toilet.
*She had no use of her left arm.
-It lay flacidly inside of the support sling.
-She used her right arm to reposition her left arm.
*Her right hand grasped onto the handle on the right side of the lift.
*The CNAs placed her left foot on the foot rest, because she was unable to lift her leg up without physical assistance.
*She could not bear weight on her left foot but stood with the support of her right foot.
*She was not participating in a restorative exercise program, because they did not have one.

Interview on 10/29/19 immediately following the above transfer with resident 18 revealed:
*She had a stroke in 2013 that had caused her to lose function of her left side.
*She had previously been in another nursing facility where she participated in an exercise program.
-She said those exercises helped her left side feel better.
*She confirmed she had not done ROM exercises here.
-She wished they would do those with her.
*Her mobility had not improved since the stroke had happened.
*She had attended some group exercise programs the activities staff had.
*No exercises with her left arm or leg had been
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 688</td>
<td>Continued From page 24 completed during those group programs. Interview on 10/30/19 at 3:20 p.m. with physical therapy (PT) assistant G regarding resident 18 revealed: *She had not received services from PT recently. *The last PT assessment had been completed 4/6/17. *She stated she would have benefited from having ROM exercises for her left hand and leg weakness. Interview on 10/30/19 at 4:17 p.m. with the administrator, assistant director of nursing, and the nurse consultant regarding resident 18 revealed: *There was not a structured restorative program in place. *They confirmed the activity staff were overseeing the Community Life program. *They agreed she would have benefited from range of motion exercises for her left side weakness.</td>
<td>F 688</td>
<td></td>
<td>11-29-19</td>
</tr>
<tr>
<td>F 689</td>
<td>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on interview, observation, record review,</td>
<td>F 689</td>
<td>See next page</td>
<td></td>
</tr>
</tbody>
</table>
F 689 Continued From page 25
and guideline review, the provider failed to ensure appropriate supervision during dining for one of four sampled residents (57) with a fall risk. Findings include:

1. Review of resident 57's medical record revealed:
   * He had been re-admitted on 2/8/19.
   * He had diagnoses of: dementia, Parkinson's disease, and obsessive compulsive disorder.
   * His 7/30/19 significant change Minimum Data Set assessment (MDS) and his 10/17/19 quarterly MDS assessment noted:
     - His cognitive skills for daily decision making were moderately impaired, his decisions were poor, and he required cues and supervision.
     - His 7/30/19 and 10/17/19 Morse Fall Scale score of 55 indicated he was at high risk for falls.

Review of resident 57’s care plan revealed:
* Focus area revised 5/3/18 related to his Parkinson's disease:
  - Intervention to observe for risk of falls.
* Focus area revised 7/23/19 related to his activities of daily living self-care performance:
  - Intervention for his eating required assistance of one staff at times.
* Focus area revised 10/17/19 related to his limited physical mobility and risk for falls due to leaning forward in his chair, his self transfers, and his impaired balance:
  - Goal to have no major injury related to a fall.
* Focus area revised 10/18/19 related to his end stage dementia with behavioral disturbance and end stage Parkinson's disease:
  - Intervention to supervise him in the dining room due to his restlessness.

Review of resident 57’s fall reports revealed:

1. Resident #57’s care plan has been updated on 11-21-19 to reflect fall interventions including being monitored while in the dining room.
2. The charge nurse will be in the dining room for all meals. The charge nurse will designate a C.N.A if he/she has to leave to stay in the back dining room until all residents are gone.
3. The DNS or her designee will audit the dinning room 3 times a week for 2 months to ensure it is monitored while residents are in there.
4. The DNS and/or her designee will present the data to the QAPI committee quarterly for further recommendations regarding system and continued monitoring.
5. The DNS is responsible for this area of compliance.

Addendum KH 1. All resident care plans were reviewed for supervision needed in while in the dining room. 2. All staff were educated by the Administrator on 11-22-19 to report if a resident is left unattended in the dining room.
**NAME OF PROVIDER OR SUPPLIER**

**ABERDEEN HEALTH AND REHAB**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1700 NORTH HIGHWAY 281

**ABERDEEN, SD 57401**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| F 689 | | | *Continued From page 26*  
-On 9/21/19 at 12:30 p.m. he had an unwitnessed fall in the dining room.  
-Staff had been taking other residents out of the dining room.  
-When staff returned he was found lying on the floor on his right side.  
-The nurse noted his feet had been nearest the table, and he had been on his right side. He had a fork in his hand, and food was laying on the floor near his feet.  
-He was unable to state what had happened.  
-No injuries had been noted.  
-On 10/1/19 at 12:50 p.m. he had an unwitnessed fall in the dining room.  
-He had been boosted up in his wheelchair prior to staff leaving the dining room.  
-When staff returned he was laying on the floor on his side, had food on his hand, and his wheelchair next to him.  
-It appeared he had slid out of his wheelchair.  
-No injuries had been noted.  
Observation on 10/28/19 at 5:39 p.m. of resident 57 in the dining room revealed:  
-He was seated in his anti-tip wheelchair with his right foot out to the side of the wheelchair.  
-With his right foot he was smearing some type of liquid around the floor.  
-He was leaning to his left with his head approximately six inches off the floor.  
-Had his drink cup in his hand and attempted to drink from it.  
-Four staff members came and repositioned him up straight in his wheelchair.  
Interview on 10/30/19 at 12:16 p.m. with the nurse consultant regarding resident 57 confirmed:  
-He had a history of falls.  
-He could be very "squirmly" due to his
### ABERdeen Heath AND REHAB

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 689             | Continued From page 27 Parkinson's disease.  
*Staff members should have been in the dining room when he was in there.  
Review of the provider's February 2019 Fall Risk and Prevention guidelines revealed: *A resident's fall evaluation consisted of the Morse Fall Scale and review of the resident's mobility status.  
*The director of nursing and/or delegate were responsible to monitor interventions and prevention measures.  
*Interventions and prevention measures would have been identified in the resident's care plan.  
-Resident risk areas would have been consistent with resident specific conditions, needs, behaviors, and preferences. | F 689 | | 11-29-19 |
| F 698 SS=D Dialysis  
CFR(s): 483.25(l) | $483.25(l) Dialysis.  
The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.  
This REQUIREMENT is not met as evidenced by:  
Surveyor: 32335  
Based on observation, record review, interview, and policy review, the provider failed to have monitoring in place post-dialysis for one of one sampled resident (22) who was on dialysis.  
Findings include:  
1. Review of resident 22's medical record revealed:  
*She had been admitted on 5/29/19. | | | | See next page |
<table>
<thead>
<tr>
<th>F 698</th>
<th>Continued From page 28</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*Her latest Brief Interview for Mental Status assessment score was eleven indicating her cognition was moderately impaired.</td>
</tr>
<tr>
<td></td>
<td>*She went to dialysis on Tuesday, Thursday, and Saturday mornings.</td>
</tr>
<tr>
<td></td>
<td>*There was no post-dialysis monitoring documentation in the resident's chart.</td>
</tr>
</tbody>
</table>

Observation and interview on 10/29/19 at 1:34 p.m. with resident 22 revealed:
*She had been sitting in her wheelchair in her room.
*She went to dialysis on Tuesday, Thursday, and Saturday mornings.
*She liked to go in the morning, so she could attend the afternoon activities.
*The site used by the dialysis center was on the right side of her chest.
*She stated the provider's staff had never looked at the site nor did any monitoring of her after she returned from dialysis.

Interview on 10/30/19 at 11:14 a.m. with the nurse consultant and the administrator revealed they did not document monitoring the site or the resident after she returned from dialysis.

Review of the provider's February 2019 Dialysis Care Plan and Treatment Sheet policy revealed:
**"The standards of care for a resident with dialysis includes the emergency steps to be taken with the dialysis access site and the monitoring interventions completed by nursing for the resident."**

**"On the treatment sheet the following are recommended:
- Monitor for complications following dialysis - febrile reaction, hypotension, bleeding and signs of infection.**

<table>
<thead>
<tr>
<th>F 698</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
</tr>
</tbody>
</table>

1. Resident #22's care plan was updated on 11-19-19 (see page 5). Post dialysis was added to the TAR.
2. All KD residents have had their care plans updated and post dialysis monitoring has been added to the TAR.
3. The DNS and/or her designee will audit 1 dialysis resident a week for 3 months to ensure dialysis monitoring is taking place.
4. The DNS and/or her designee will present the data to the QAPI committee quarterly for further recommendations regarding system and continued monitoring.
5. The DNS is responsible for this area of compliance.

Addendum KH 2. All staff were educated by the DNS on 11-22-19 regarding the monitoring of dialysis residents post dialysis.
Continued From page 29

-If the Shunt starts to bleed - elevate the arm, apply pressure and ice, if bleeding does not stop after 15 minutes, call 911, the MD and the family/responsible party.

-Monitor the shunt site by checking for the Bruit and thrill.

-Monitor the shunt site: check for redness, edema, drainage.

-Shunt site dressing to be changed at dialysis only."

Treatment/Svcs Mental/Psychosocial Concerns
CFR(s): 483.40(b)(1)

§483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that:
§483.40(b)(1)
A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by:
Surveyor: 40788
Based on observation, interview, record review, job description review, and policy review, the provider failed to identify, assess, document, and provide interventions for one of three sampled residents (36) who had mood and behavioral concerns. Findings include:

1. Review of resident 36’s medical record revealed:
*He was admitted on 7/3/19.
*His diagnoses had included: diabetes, angina
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 742</td>
<td>Continued From page 30 pectoris, gastro-esophageal reflux disease, chronic kidney disease, hyperlipidemia, hypertension, unspecified convulsions, polymyalgia rheumatica, muscle weakness, and anxiety disorder. Review of resident 36's 6/29/19 hospital history and physical revealed a psychiatric history of anxiety and depression. Review of resident 36's 7/10/19 Minimum Data Set (MDS) assessment revealed: *His Brief Interview for Mental Status (BIMS) score was fourteen indicating his cognition was intact. *His Resident Mood Interview, PHQ-9, score was eight indicating mild depression. Review of the resident 36's 9/26/19 PHQ-9 completed by the social worker revealed a score of ten indicating mild to moderate depression. Review of the resident 36's 9/28/19 MDS assessment revealed his PHQ-9 score was eleven indicating mild to moderate depression. Observation and interview on 10/28/19 at 3:35 p.m. of resident 36 revealed: *He was sitting in a recliner in his room listening to music on television. *There was a family member visiting. *He said his vision was poor, and he saw only light and darkness. *He felt he was left in places like the recliner for extended periods of time without staff checking in on him. *He said he had not always gotten verbal cues from staff during meals to know what he was eating and where it was located on his food tray.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>C 10/30/2019</td>
</tr>
</tbody>
</table>

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1700 NORTH HIGHWAY 281
ABERDEEN, SD 57401

**NAME OF PROVIDER OR SUPPLIER**

ABERDEEN HEALTH AND REHAB

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

CENTERS FOR MEDICARE & MEDICAID SERVICES

**FORM APPROVED OMB NO. 0938-0391**

**PRINTED: 11/14/2019**

**Addendum KH 1. All other residents were assessed for mental health needs and care plans were adjusted as needed.**
**F 742** Continued From page 31
   -The family member nodded affirmatively to the resident's observations.

Continued observation and interview on 10/29/19 at 8:30 a.m. of resident 36 revealed:
   *He was lying in bed, and a family member was visiting.
   *He stated he was admitted after surgery, hoped to get stronger, and to return home with his wife.
   *He had recently been treated for an infection that made it difficult to leave his room and participate in therapy.
   *He said he had not had a desire to eat but thought his appetite had improved.
   *He said he had a history of pain in his back and buttocks.
   -He thought he received Tylenol as needed but had not consistently asked for it.
   *He said he used to listen to books on tape for hours but had no motivation now to do so.
   *He thought he had depression and described it as a "hopeless state."
   -He stated he had not been offered counseling since admission, and his family member agreed.
   -He said he was interested and would like an opportunity for counseling.

Review of resident 36's interdisciplinary progress notes from 10/18/19 through 10/24/19 revealed:
   *On 10/18/19: he refused to go to the dining room for lunch and refused to feed himself.
   *On 10/20/19: he refused to get out of bed and was becoming weaker.
   *On 10/21/19: he was refusing meals.
   -His negativity was described as "worse today than I've ever seen" by the charting nurse.
   -He was asked by that same nurse if he wanted to discuss hospice.
   -He responded "I might as well, no one can help
F 742. Continued From page 32

me now anyway."
*On 10/23/19: he refused to get out of bed for meals and complained about taking his meds.
  -He stated "I would be better off if you just let me go."
  -He said he was miserable and refused to further discuss his feelings with nursing staff.
*On 10/24/19: he complained about chest pains and not feeling well.
  -He stated, "Why don't you just put that around my neck" referring to a blood pressure cuff the nurse used to take his blood pressure.
  -He stated he was joking when the nurse asked why he felt that way.

Review of resident 36's October 2019 clinic visits revealed:
*On 10/9/19: he was seen for complaints of not feeling well.
  -His diagnoses from that visit were acute abdominal pain, diarrhea, subjective fevers, and major depression.
*On 10/17/19: he was seen for difficulty sleeping and being awake for hours most nights.
  -He was started on a daily dose of Levalpro.
  -He had not previously received anti-depressant medication.
*On 10/23/19: he was seen for complaints of chest heaviness, doing nothing for himself described as sitting in his recliner or laying in bed.
  -There were no new diagnoses or physician’s orders.

Review of social service documentation from 7/3/19 through 10/29/19 regarding resident 36 revealed:
*A 9/22/19 social services Care Conference Summary note: counseling services had been offered to the resident but were declined.
F 742 Continued From page 33

* A 9/26/19 Social Service Evaluation:
  - "Mental Health: Does not have past/present mental health issues/diagnosis. Is not receiving mental health professional related services and/or programming."
  - *A 10/2/19 social services MDS Summary note: recapped the resident's BIMS score, PHQ-9 score, advance directives, and discharge plan.
  - *There were no individualized social service progress notes and no additional social services documentation since 10/2/19.

Interview on 10/30/19 at 10:00 a.m. with the social worker concerning resident 36's mood and behavior revealed:

*She had thought he had a history of depression prior to nursing home admission and knew he had anxiety.
- She was unsure why the Social Services Evaluation had not accurately reflected his current and past mental health status.

*She agreed care plans were indicated for a resident with anxiety and depression diagnoses managed with psychotropic medication.
- She was uncertain, then verified the resident did have a care plan addressing his anxiety but no care plan addressing his depression.
- She confirmed it was her responsibility to develop that care plan.

*She stated she administered PHQ-9 assessments and participated in daily interdisciplinary team meetings to keep informed of changes in resident's mood and behaviors.

*She said staff usually reported to her missing resident items and discharge planning needs but not mood and behavior concerns.

*She was unaware of the resident's recent verbalizations of helplessness and hopelessness and thought staff had reported such statements
Continued From page 34

to the assistant director of nursing or director of nursing.
*She agreed as a social worker it was something she should have been notified of as well.
*She was aware of the resident's diminished appetite, physical decline, and that a recent infection had made it difficult for him to leave his room.
-She had thought he still listened to books on tape and knew his family visited often.
-She stated the resident did not want to be at the facility and was unhappy.
*She did not feel additional social services follow-up was indicated since the 10/19 care conference.

Interview on 10/30/19 at 2:56 p.m. with the assistant director of nursing regarding resident 36's verbalizations of helplessness and hopelessness revealed:
*She was unaware of his recent negative statements.
*The director of nursing was currently on leave from the facility.

Review of resident 36's 10/29/19 Monthly Behavior Review report revealed:
*B. 2. Diagnosis for psychoactive medication:
-"Anxiety disorder, unspecified."
*B. 4. Goal for psychoactive medication:
-"Reduce anxiety and improve mood."
*C. 1. Target behavior and/or symptoms:
-"Anxiousness."
*C. 6. Psychological therapy:
-"None."
*D. 3. Progress towards goal of mood and behavior management:
-"Progressing to goal."
*F. 1. Referrals:
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 742</td>
<td>Continued From page 35</td>
<td>F 742</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&quot;None.&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*H. Summary:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&quot;Resident 36 does have anxiousness, does need re-assurance, does enjoy visiting with staff and family, will continue to monitor.&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interview on 10/29/19 at 10:30 a.m. with licensed practical nurse (LPN)/MDS coordinator E regarding monthly Mood and Behavior Rounds revealed:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*She had coordinated the monthly meeting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*The Rounds team had included the director of nursing, assistant director of nursing, social services designee, administrator, both MDS coordinators, dietary service manager, and activities coordinator.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*She said on 10/29/19 resident 36's review was not discussed with the interdisciplinary team.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*She had discussed his case with the activities coordinator.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continued interview with LPN/MDS assessment coordinator E regarding the 10/29/19 Monthly Behavior Review report revealed:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*She was responsible for completing that report, and it was used during the monthly Mood and Behavior Rounds.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*She agreed the report had not included information such as resident 36's depression diagnosis, the 10/17/19 start of a new anti-depressant medication, his statements about hopelessness made the week prior to the meeting, his sleeping and eating status, his care refusals, and his activity participation during October 2019.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*It was her responsibility to ensure resident's diagnoses were entered into the provider's computer system at admission and updated as needed.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**F 742** Continued From page 36

Interview on 10/29/19 at 2:45 p.m. with the nurse consultant regarding resident 36’s mood and behavior revealed:

*She would have expected the resident’s diagnoses list had included depression.

*It was her expectation there was a care plan focus area, goal, and interventions related to the resident’s depression diagnosis and use of anti-depressant medication.

*She would have expected to see more individualized social work assessment, monitoring, intervention, and advocacy related to the resident’s mood and behavior state.

*It was her expectation interdisciplinary team review of the resident’s mood and behavior would have been evidenced during monthly Mood and Behavior Rounds.

*She would have expected a more comprehensive review, analysis, and summary of the resident’s mood and behavior in the Monthly Behavior Review report.

*It was her expectation information from that report was used to educate staff, inform healthcare providers, update the resident’s care plans, and compare mood and behavior data month-to-month to objectively determine progress towards goals.

*She would have expected the nurse to use her clinical judgement to assess whether or not the negative statements the resident had made in the past week had been serious or not.

*She would have expected the social worker, director of nursing, and/or the assistant director of nursing would have been notified of the statements for further directive regarding the resident’s management.

Review of the provider’s March 2019 Social
**F 742 Continued From page 37**

Worker job description revealed:

*General Purpose:

"Responsible for the operations of the Social Services department, providing for each resident's social, emotional, and psychological needs and the continuing development of the resident's full potential from admission to discharge."

Review of the provider's May 2019 Mood and Behavior policy revealed:

*Goal:

"The facility supports the goal of determining the underlying cause of mood and/or behavioral symptoms so the appropriate treatment of environmental, medical and/or behavioral interventions as well as appropriate use of psychopharmacological medications can be utilized to meet the needs of the resident."

*Documentation:

"The monthly behavior review provides evidence for practice decisions; identifies mood and/or behavior indicators that may require further assessment of interventions, assists in completing the MDS, complies with all requirements for psychoactive medication monitoring, provides assessment and documentation for appropriate use of medications, and provides rationale for continued current medication regimens."
**ABERDEEN HEALTH AND REHAB**

1780 NORTH HIGHWAY 281
ABERDEEN, SD 57401

**SUMMARY STATEMENT OF DEFICIENCIES**

Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td></td>
<td>E 000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 10/28/19 through 10/30/19. Aberdeen Health and Rehab was found in compliance.

---

_Laboratory Directors or Provider/Supplier Representative's Signature_

**Kirstie Hoon**

**EP Holder**

11/22/19

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 disclosureable 90 days following the date of survey unless or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosureable 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.
ABERDEEN HEALTH AND REHAB
1700 NORTH HIGHWAY 281
ABERDEEN, SD 57401

K 000 INITIAL COMMENTS

Surveyor: 40506
A recertification survey for compliance with the Life Safety Code (LSC), (2012 existing health care occupancy), was conducted on 10/30/19. 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 K321, in conjunction with the provider's commitment to continued compliance with the fire safety standards.

K 321 Hazardous Areas - Enclosure

Hazardous Areas - Enclosure
Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9.

When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4.

Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.
19.3.2.1, 19.3.5.9

Area Automatic Sprinkler
- Separation N/A
- Boiler and Fuel-Fired Heater Rooms

1. Door closures were ordered on 11-20-19 for the Restorative Room door and shower room on long hall c-wing. These will be installed by 11-29-19. The housekeeping supply storage door was replaced on 11-19-19.
2. All other doors in the building were inspected for proper closing and holes. All were found in compliance by the Maintenance Director.
**K 321**

Continued From page 1

b. Laundries (larger than 100 square feet)
c. Repair, Maintenance, and Paint Shops
d. Soiled Linen Rooms (exceeding 64 gallons)
e. Trash Collection Rooms (exceeding 64 gallons)
f. Combustible Storage Rooms/Spaces (over 50 square feet)
g. Laboratories (if classified as Severe Hazard - see K322)

This REQUIREMENT is not met as evidenced by:

Surveyor: 40506

Based on observation and interview, the provider failed to maintain three separate hazardous storage areas (storage area labelled as Restorative Room on C wing, the shower room on the long hall of C wing, and housekeeping supply storage at the staff entrance) as required.

Findings include:

1. Observation at 8:25 a.m. on 10/30/19 revealed the room labelled as Restorative Room on C wing was over 100 square feet and had large amounts of combustibles stored in it. The door was not equipped with a closer.

2. Observation at 9:15 a.m. on 10/30/19 revealed the shower room located at the end of the hall known as long hall on wing C was over 100 square feet and had large amounts of combustibles stored in it. The door was not equipped with a closer.

3. Observation at 11:00 a.m. on 10/30/19 revealed the housekeeping supply storage located at the staff entrance was over 100 square feet and had large amounts of combustibles stored in it. The door had a 3/4-inch diameter hole that penetrated the entire thickness and was

3. The Maintenance Director will audit the doors weekly for 2 months for holes and those that don't properly close. This has been added as a task to our TELS preventative maintenance program.

4. The Maintenance Director and/or his designee will present the data to the QAPI committee quarterly for further recommendations regarding systems and continued monitoring.

5. The Maintenance Director is responsible for this area of compliance.
<p>| K 321 | Continued From page 2 |
|       | not equipped with a working closer. |
|       | Interview with the maintenance director at the times of the observations confirmed those findings. |
|       | The deficiency affected three of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment. |</p>
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>S 000</td>
<td>Compliance/Noncompliance Statement</td>
<td>S 000</td>
</tr>
<tr>
<td></td>
<td>Surveyor: 18560</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nursing Facilities, was conducted from 10/28/19 through 10/30/19. Aberdeen Health and Rehab was</td>
<td></td>
</tr>
<tr>
<td></td>
<td>found in compliance.</td>
<td></td>
</tr>
<tr>
<td>S 000</td>
<td>Compliance/Noncompliance Statement</td>
<td>S 000</td>
</tr>
<tr>
<td></td>
<td>Surveyor: 18560</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse Aide, requirements for nurse aide training programs, was conducted from 10/28/19 through</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10/30/19. Aberdeen Health and Rehab was found in compliance.</td>
<td></td>
</tr>
</tbody>
</table>