## Statement of Deficiencies and Plan of Correction

### Aberdeen Health and Rehab

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<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Providers' Plan of Correction</th>
<th>Completion Date</th>
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</table>
| F 000 | INITIAL COMMENTS | F 000 | Surveyor: 35121  
A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/12/17 through 9/13/17. Aberdeen Health and Rehab was found not in compliance with the following requirements: F278 and F441. 
Surveyor: 33285  
A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/12/17 through 9/13/17. Areas surveyed included nursing services answering of call lights, response to resident needs, ambulation of residents, longevity of staff, and prevention of accidental falls. Aberdeen Health and Rehab was found in compliance. | See next page | |
| F 278 | 483.20(g)(i) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED | F 278 | (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.  
(h) Coordination  
A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  
(i) Certification  
(1) A registered nurse must sign and certify that the assessment is completed.  
(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. | |

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**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**  
Megan Kleinsasser: Executive Director  
10/4/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patient. (See instructions.) Except for nursing homes, the findings stated above are reportable 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 reportable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continue program participation.
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<th>F 278</th>
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<th>F 278</th>
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<tbody>
<tr>
<td>(j) Penalty for falsification</td>
<td>The preparation of the following plan of correction for this deficiency 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 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.</td>
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<td>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</td>
<td>Without waiving the foregoing statement, the facility states with respect to:</td>
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<td>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or</td>
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<td>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.</td>
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<td>(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:</td>
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<td>Surveyor: 35237</td>
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<td>Based on observation, record review, interview, and manual review, the provider failed to ensure the Minimum Data Set (MDS) assessments had been coded accurately for three of ten sampled residents (4, 10, and 11) related to their condition. Findings include:</td>
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<td>1. Observation and interview on 9/12/17 at 9:40 a.m. with resident 10 in her room revealed she:</td>
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<td>*Was in a private room.</td>
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<td>*Was on isolation precautions for her C. difficile (C. diff) infection.</td>
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<td>*Stayed in her room mostly other than to go to dialysis three times a week.</td>
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<td>-Her meals were brought to her in her room, and she did not go out to any activities.</td>
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<td>*Did not take many medications but was currently receiving an oral and intravenous (IV) antibiotics</td>
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<td>ABERDEEN HEALTH AND REHAB</td>
<td>1700 NORTH HIGHWAY 281</td>
<td>ABERDEEN, SD 57401</td>
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for her infection.

Review of resident 10's medical record revealed:

* She had been admitted on 8/21/17.
* Her diagnoses included: endocarditis, end-stage renal disease, and C. diff infection.
* Since she was admitted she had:
  - Been on oral and IV antibiotics.
  - Been on contact isolation precautions.
  - Not received any anti-anxiety medications.

Interviews on 9/12/17 from 9:35 a.m. through 12:30 p.m. with physical therapist C, certified nursing assistant C, and registered nurse E regarding resident 10 revealed:

* She was in a room by herself and on contact isolation precautions for her C. diff infection.
* She stayed in her room other than to go to dialysis three times a week.
* She was still having loose incontinent bowel movements and was receiving IV and oral medications for her infection.

Review of resident 10's 8/28/17 admission MDS revealed:

* For section N related to medications it indicated she had received zero days of antibiotics.
* For section O related to special treatments, procedures and programs: isolation or quarantine for active infectious disease was not marked.

Review of resident 10's 9/7/17 fourteen day MDS revealed:

* Section N indicated she had received seven days of anti-anxiety medications.
  - There had been no anti-anxiety medications ordered for her by the physician.
* Section O was not marked for isolation for her infectious disease.

1. Resident #4's MDS has been corrected and resubmitted. Residents #10 and #11 have been discharged but their MDS's were modified and resubmitted.
2. MDS section N,O and P have been reviewed on all residents with MDSs submitted in the last quarter of 2017 Jul-Sept.
3. On October 9th, 2017 the DNS and MDS Coordinator will be educated on the use of the MDS data collection tool by the RAI Consultant to ensure accuracy and coding of MDSs. RN A is no longer an MDSC.
4. The DNS and/or her designee will audit 4 MDS per week for 2 months.
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.
6. The DNS is responsible for this area of compliance.

11/2/17
Record review and interview on 9/12/17 at 3:50 p.m. and again on 9/13/17 at 1:30 p.m. with the MDS coordinator nurse regarding resident 10’s MDS assessments revealed:

*She had incorrectly coded the 8/28/17 MDS for her antibiotic use and isolation.
- The resident had been receiving antibiotics since admission.
- The resident fit the criteria for isolation or quarantine, and it should have been coded that way.

*She had incorrectly coded the 9/17 MDS for her anti-anxiety medication and isolation.
- The resident had not received anti-anxiety medications, and it should have listed zero days.
- The resident was in isolation for her infection, and it should have been coded that way.

*She followed the RAI manual as a reference for coding the MDS.

Interview on 9/13/17 at 9:30 a.m. with the director of nursing confirmed the above incorrect coding for resident 10’s MDS assessments.

Surveyor: 33235
2. Interview and observation on 9/12/17 at 10:55 a.m. with resident 4 in her room revealed:

*She was on bedrest.
*There were repositioning bars on the upper half of each side of her bed.
*She used the repositioning bars to move herself in bed.

Review of resident 4’s medical record revealed:
* A 11/12/14 admission date.
* She had an annual MDS completed on 12/17/16.
* Section P part A completed by registered nurse A identified and documented the repositioning bars
| F 276 | Continued From page 4 as restraints. Interview on 9/13/17 at 1:30 p.m. with the MDS coordinator regarding the above revealed: *Resident 4 had repositioning bars on both sides of her bed. *She used these bars to assist in moving herself in bed. *The repositioning bars were not a restraint. *Registered nurse A had coded the MDS incorrectly. Surveyor: 29354 3. Review of resident 11's medical record revealed: *A 6/09/17 admission date. *A 6/27/17 physician's order for hospice services. *A 6/30/17 hospice start date. *Hospice diagnosis of: embolism and thrombosis of other arteries. *A 6/30/17 nursing progress note "Admitted pt [resident] to Hospice today." Review of the 7/11/17 care plan revealed "Has a terminal prognosis requiring hospice involvement R/T [related to] arterial wounds to toes." Review of the 7/6/17 significant change MDS, Section O, 0100, K: hospice care was coded no indicating the resident had not been receiving hospice services. Interview on 9/13/17 at 8:00 a.m. with the MDS coordinator regarding the above revealed: *Resident 11 had been on hospice. *She had coded the MDS incorrectly. *She used the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.13 as: |
Continued From page 5
-Her reference for completing the MDSs.
-The policy and procedures manual for completing the MDSs.

Medications, revealed:
"**The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection (subcutaneous, intramuscular, or intradermal), insulin, and/or select medications were received by the resident.**"
*Steps included to review the resident's medical record for documentation that any of those medications had been received during the 7-day look-back period.

Review of the RAI manual, MDS 3.0, Version 1.13, pp. O-4 through O-5, Section O: Special Treatments, Procedures, and Programs, revealed:
*Page O-4 for 00100K, Hospice care included:
-"Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions.
- The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider."
*Pages O-4 to O-5 for 00100M, Isolation for active infectious disease included:
-"Code for 'single room isolation' only when all of the following conditions are met:
-1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquire by physical
F 278 Continued From page 6

contact or airborne or droplet transmission.

--2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.

--3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.

--4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.)."

"If the facility transports a resident who meets the criteria for single room isolation to another healthcare setting to receive medically needed services (e.g. dialysis, chemotherapy, blood transfusions, etc) which the facility does or cannot provide, they should follow CDC guidelines for transport of patients with communicable disease, and may still code O0100M for single room isolation since it is still being maintained while the resident is in the facility."

Review of the RAI Manual, MDS 3.0, Version 1.13, pages 1 through 8, and J-27 through J-34, revealed:

"An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident’s medical record, physician, and family, guardian, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:
436041

A. BUILDING

NAME OF PROVIDER OR SUPPLIER
ABERDEEN HEALTH AND REHAB

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

(X1) PROVIDER/SUPPLIER/CIA
(X2) MULTIPLE CONSTRUCTION
(X3) DATE SURVEY COMPLETED

C
09/13/2017

B. WING

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LOCAL IDENTIFYING INFORMATION)

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Continued From page 7
period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [interdisciplinary team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment."

F 441
SS=E
483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS

(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of

See next page
F 441 Continued From page 8
communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

Surveyor: 35237

1. The gloving and hand washing guidelines have been reviewed. A guideline has been updated for the technique and requirements for c-diff precautions while in isolation and during/after dressing changes.

2. All employees including LPN-B, PT-C, RN-E, CNA-D, have been educated by the DNS on October 11th 2017, on proper hand washing including during a dressing change, gloving, and technique while in a C-diff isolated room.

3. The DNS and/or her designee will audit three times per week proper hand washing, hand hygiene, and glove use for 3 months. There are no isolation rooms currently, but future isolation rooms will be included in the audits.
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<th>COMPLETION DATE</th>
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| F 441 | Continued From page 9 | Based on observation, interview, record review, and policy review, the provider failed to ensure appropriate infection control techniques had occurred for:  
* Hand hygiene of three of three observed staff (physical therapist (PT) C, certified nursing assistant (CNA) D, and registered nurse (RN) E) who cared for one of one sampled resident (10) with an active infectious disease.  
* One of one dressing change procedure by one of one licensed practical nurse (LPN) B for randomly observed resident (17).  
Findings include:  
1. Review of resident 10's medical record revealed she:  
* Had been admitted on 9/21/17.  
* Had a C. difficile (C. diff) infection and was receiving antibiotics for it.  
* Was on contact isolation precautions.  
Observation and interview on 9/12/17 from 9:20 a.m. through 9:35 a.m. with PT C who was assisting resident 10 revealed:  
* There was a sign outside the resident's room door.  
* It stated she was in contact isolation, and  
* "Resident must stay in room!!!"  
* In the hallway outside of the resident's room there was a cart of isolation supplies.  
* Those supplies included gowns, gloves, shoe covers, bleach disinfectant wipes, and two types of hand sanitizers.  
* After the PT staff person assisted the resident back into her recliner she removed her gloves and left the room.  
* She applied hand sanitizer from the cart in the hallway.  
* She indicated the resident had an active C. diff
| F 441 | | | | | | 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.  
5. The DNS is responsible for this area of compliance. |
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>B. WING:</td>
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**NAME OF PROVIDER OR SUPPLIER**

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<td>1700 NORTH HIGHWAY 281</td>
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<tr>
<td>ABERdeen, SD 57431</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

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

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<td>infection, and she was on contact isolation precautions for that.</td>
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<td>*She was aware C. diff was a highly infectious disease and confirmed staff should have followed appropriate infection control techniques.</td>
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Observations and interview on 9/12/17 with resident 10 from 9:40 a.m. through 10:05 a.m. in her room revealed:

*She had a bad infection and stayed in her room all the time other than to go to dialysis. *
*She received intravenous (IV) and oral antibiotics for her infection. *
*During the interview RN E had entered and left the room twice. *
  - The first time she asked the resident about her pain and took her temperature. *
  - The second time she brought in and gave her some Tylenol for her pain. *
*Both times RN E left the room she removed her gown and gloves and had not washed her hands. *
*-She used the hand sanitizer on the cart in the hallway. *

Observation and interview on 9/12/17 from 11:58 a.m. through 12:15 p.m. with CNA D in resident 10's room revealed:

*She was aware of the resident's C. diff infection, and she was on contact isolation precautions. *
*She had to leave the room once to get the resident some more personal supplies. *
*-She removed her gown and gloves but did not wash her hands prior to exiting the room. *
*She returned to the room again and collected the resident's bathroom and room garbage that included incontinence products. *
*When she left the room the second time she again removed her gown and gloves and had not washed her hands. |
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| F 441 | Continued From page 11 | Observation and interview on 9/12/17 with RN E from 12:15 p.m. through 12:30 p.m. in resident 10's room revealed: *She entered the room with her gown and gloves on. *She started the resident's IV antibiotics and gave her the oral antibiotic as well. *When she was done she removed her gown and gloves. -At that time she questioned the surveyor if it was okay to wait and wash her hands down the hallway closer to the nurses station instead of in the resident's room. *She indicated most of the staff had been using the hand sanitizer in the hallway when they left the room. -Then they would go further down the hallway to wash their hands instead of using the resident's sink in her room. *She questioned if it was okay to use the resident's sink to wash their hands, since it could have been considered contaminated. *She agreed if proper hand washing and infection control techniques had been used staff should have been okay using that potentially contaminated sink. *She was aware hand sanitizer was not effective against C. diff, only soap and water would have been. Interview on 9/13/17 at 9:30 a.m. with the director of nursing (DON) regarding resident 10 revealed: *She was aware of the resident's C. diff infection and her contact isolation precautions. *Staff should have washed their hands prior to leaving her room and after removing their gown and gloves. *Hand sanitizer was not effective against C. diff.
F 441  Continued From page 12

*Staff should have followed their policy for C. diff and had not in the above observations.

Review of the provider's January 2010 Clostridium difficile policy and procedure revealed:

"... Transmission occurs by either direct (via health care workers hands) or indirect (touching contaminated objects such as commodes, telephones, faucets or door handles)."

*Care practices included: "3. Good hand hygiene with soap and water by staff."

*"2. Utilize soap and water hand cleaning when caring for C. difficile positive patients."

Review of the provider's January 2010 Handwashing policy and procedure revealed soap and water should have been used after contact with a resident with C. diff infection. Hand sanitizer should not have been used.

2. Observation on 9/12/17 at 10:25 a.m. during resident 17's dressing changes to his feet by LPN B in his room revealed:

*She entered the room with the wound care supplies. Those included:
  - Four Betadine swab stick single packs.
  - A partially used roll of paper tape.
  - A four inch by four inch sterile package of gauze that had been cut through the outside of the package into long strips.
  - A bath towel.

*She set those supplies on his bedside table without a barrier.

*She:
  - Washed her hands for approximately four to five seconds.
  - Shut the faucet off with her bare hands.
  - Dried her hands with paper towels.
**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

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| F 441 | | | Continued From page 13  
- Put on gloves.  
  * Then she set the towel down on the floor and moved the wound care supplies from the beside stand to the towel.  
  * She removed the resident's socks and the soiled gauze dressings from his toes on both feet.  
  * She:  
    - Removed her gloves.  
    - Washed her hands for approximately ten seconds.  
    - Shut off the faucet using her elbow.  
    - Dried her hands with paper towels.  
    - Then put on another pair of gloves.  
  * She opened three different packages of swab sticks and used those to apply the Betadine to the areas on his feet.  
  * Then she applied the strips of gauze from out of the cut packages.  
    - She used paper tape to secure them and put his socks back on.  
  * She again:  
    - Removed her gloves.  
    - Washed her hands for approximately four to five seconds.  
    - Shut off the faucet using her elbow.  
    - Dried her hands with paper towels.  
    - Gathered the supplies from his room that included the soiled towel from the floor, the partial roll of paper tape, and one pack of Betadine swabs.  
  * Then she left the room then and put the towel in the soiled utility room down the hall.  
  * She brought the used roll of tape and unopened pack of Betadine to the treatment cart to put away.  
  * The surveyor questioned if the Betadine pack and tape were considered contaminated, and she did not think it would have been.  
  - The surveyor then pointed out the appearance of |

**DATE SURVEY COMPLETED**
C
09/13/2017
**F 441**  **Continued From page 14**

Betadine and contamination on the outside of the package and on the roll of paper tape from touching it during the wound care.

- She then threw those supplies into the garbage instead of putting them back into the cart with the other supplies.

* The above process was her usual practice for his dressing change.

* She indicated she had cut through the package of gauze using the scissors on the treatment cart prior to coming down the hall.

- She had not thought about the outside of the package being considered contaminated but agreed it could have been.

- Cutting through the outside could have contaminated the gauze she had used on his wound areas.

* She agreed infection control should have been maintained during dressing changes.

Interview on 9/13/17 at 9:30 a.m. with the DON regarding the above observation of resident 17’s dressing change revealed:

* She confirmed proper infection control had not been maintained.

* She expected appropriate hand hygiene and handling of wound care supplies to have occurred.

* She agreed:

- The outside of packages would have been considered potentially contaminated and should not have been cut through to cut the gauze.

- Potentially contaminated supplies should not have been brought back to the treatment cart.

- That could have contaminated the other clean supplies.

- Hand hygiene had not been done correctly.

A policy on dressing changes had been requested.
| **F 441** Continued From page 15 from the administrator and DON on 9/13/17 and had not been received by the end of survey. Review of the provider’s January 2010 Handwashing policy and procedure revealed it included to:  
* Wet hands with water.  
* Apply soap.  
* Rub hands together for fifteen to twenty seconds.  
* Rinse hands well.  
* Dry hands.  
* Then turn off the faucet with a clean paper towel. |
K 000  INITIAL COMMENTS

Surveyor: 32334
A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/13/17. 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 and K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.

K 321  NFPA 101 Hazardous Areas - Enclosure

Hazardous Areas - Enclosure
2012 EXISTING
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. 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

Area  Automatic Sprinkler
a. Boiler and Fuel-Fired Heater Rooms

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 discloseable 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 discloseable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.
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 STANDARD is not met as evidenced by:
Surveyor: 32334
Based on observation and interview, the provider failed to ensure areas designated as being a hazardous area were properly separated from the rest of the facility in two randomly observed locations (room 170 and A-wing spa room).
Findings include:

1. Observation at 1:35 p.m. on 9/13/17 revealed a resident room in the south wing identified as room 170. That room was no longer being used as a resident room and was being used for storage of miscellaneous items. That room would be classified as a hazardous room. The fire fuel load of combustible materials in that room would represent a higher hazard than otherwise typically found in a healthcare occupancy. That hazardous room should have been provided with an automatic door closer.

2. Observation at 2:15 p.m. on 9/13/17 revealed a spa room at the east end of the A-wing. That room was no longer being used as a spa room and was being used for storage of miscellaneous items. That room would be classified as a hazardous room. The fire fuel load of combustible materials in that room would represent a higher hazard than otherwise typically found in a healthcare occupancy. That hazardous room

1. The self closing door devices have been added to room 170 and also A-wing spa room as of 9/15/17. All other doors were inspected and another self closing device was added to room 125.

2. The Maintenance Supervisor and/or his designee will audit all doors in the building monthly for the need of self closing devices. This will be added to our TELS preventive maintenance program.

3. The Maintenance Director and/or his designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring.

4. The Maintenance Supervisor is responsible for this area of compliance.

11/2/17
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERs FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01</th>
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<tbody>
<tr>
<td>435041</td>
<td>B. WING</td>
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<td>09/13/2017</td>
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**NAME OF PROVIDER OR SUPPLIER**  
ABERDEEN HEALTH 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>
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<tbody>
<tr>
<td>K 321</td>
<td>Continued From page 2 should have been provided with an automatic door closer.</td>
<td>K 321</td>
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<td></td>
<td>Interview with the maintenance supervisor at the time of the above observations confirmed those conditions. He indicated he was unaware a door closer should have been provide on the doors to those rooms.</td>
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<tr>
<td>K 923</td>
<td>NFPA 101 Gas Equipment - Cylinder and Container Storag</td>
<td>K 923</td>
<td>See next page</td>
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<tr>
<td>SS=D</td>
<td>Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. &gt;300 but &lt;3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum “CAUTION: OXIDIZING GAS(ES) STORED WITH NO SMOKING.”</td>
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</table>
K 923  Continued From page 3
Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.
11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)
This STANDARD is not met as evidenced by:
Surveyor: 32334
Based on observation and interview, the provider failed to ensure designated oxygen storage locations were maintained within an enclosed designated location in one of three oxygen storage locations (maintenance garage). Findings include:

1. Observation at 10:30 a.m. on 9/13/17 revealed a maintenance garage at the east end of the A-wing. Four oxygen cylinder carts were parked in the garage bay area. Those carts were not in a designated enclosure with five feet of clearance from combustible storage. The area where stored would not prevent unauthorized access to the cylinders as the garage door was open to the outside.

Interview with the maintenance supervisor at the time of the above observation confirmed that condition. He indicated he was unaware those oxygen carts could not be stored in the current location. He indicated the facility had recently changed oxygen cylinder delivery method that lead to larger carts then previously used. The larger carts were making it difficult to find adequate storage in designated oxygen storage room locations.

1. The Oxygen storage carts have been removed from the garage. All oxygen storage carts are now placed in the designated oxygen rooms.
2. The Maintenance Supervisor and/or his designee will audit the oxygen rooms weekly to ensure all carts are kept in the oxygen rooms and are accessible to staff.
3. The Maintenance Director and/or his designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring.
4. The Maintenance Supervisor is responsible for this area of compliance.

11/2/17
Compliance/Noncompliance Statement

Surveyor: 35121
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/12/17 through 9/13/17. Aberdeen Health and Rehab was found not in compliance with the following requirement: S157.

44:73:02:13 Ventilation

Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building’s air-handling system.

This South Dakota Codified Law is not met as evidenced by:
Surveyor: 32334
Based on observation and interview, the provider failed to ensure exhaust ventilation was provided and working in three randomly observed locations (C-wing shower room, room 155, and arbor wing clean utility room). Findings include:

1. Observation at 1:15 p.m. on 9/13/17 revealed a shower room at the east end of the C-wing. Testing of the exhaust fan with a tissue revealed the exhaust fan was not working. That issue was also present in resident room right next to that shower room indicating those two rooms may be tied to a central exhaust system.

2. Observation at 2:35 p.m. on 9/13/17 revealed a clean utility storage room in the arbor wing. Upon entering that room the air was stale and musty smelling. Testing of the exhaust fan with a tissue revealed the exhaust fan was not working.

1. C-Wing exhaust fan was tested and serviced as of 9/13/17. It is now properly working.
2. Arbor-Wing exhaust fan was tested and serviced and the belt was replaced on 9/13/17. This is now working properly.
3. The Maintenance Supervisor and/or his designee will inspect and test the exhaust fans monthly. This has been added to the TELS preventative Maintenance schedule.
4. The Maintenance Director and/or his designee will present data collect to the Quality Assurance Quality Improvement Committee quarterly for further recommendations regarding system and continued monitoring.
5. The Maintenance Supervisor is responsible for this area of compliance.
**SUMMARY STATEMENT OF DEFICIENCIES**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>TAG</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>S 157</td>
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<td>Interview with the maintenance director at the time of the above observations revealed he was unaware those exhaust systems were not working. He indicated some work was recently completed on the ventilation system when a new air conditioning unit was installed which may have affected the operation of the exhaust system. He indicated he believed the exhaust systems were functioning properly as he could hear the exhaust upblast fans running on the roof. He indicated the preventative maintenance plan included testing of exhaust systems for proper function and indicated they had been working properly when they were last checked in August.</td>
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<tr>
<th>ID PREFIX TAG</th>
<th>TAG</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>S 000</td>
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<td>Compliance/Noncompliance Statement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surveyor: 35121</td>
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<tr>
<td></td>
<td></td>
<td>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 9/12/17 through 9/13/17. Aberdeen Health and Rehab was found in compliance.</td>
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</tbody>
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