STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/16/23 through 10/19/23.Aberdeen Health and Rehab was found not in compliance with the following requirements: F657, F677, F686, F755, and F880.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657	F 657 PLAN OF CORRECTION Aberdeen Health & Rehab denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 657, Care Plan Timing and Revision, Aberdeen Health & Rehab corrected the deficiency by updating R59's care plan and CNA pocket care plan to float heels on a pillow while in bed, foot board on the w/c, and if resident refuses/combative staff will ensure safety and reapproach later on 11/07/2023 by MDSC.	11/08/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kirstie Hoon, LNHA	Executive Director	11/15/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to follow, revise, and update care plans for four of nineteen sampled residents (52, 59, 60, and 48) to reflect their current needs. Findings include: 1. Observation on 10/16/23 at 4:16 p.m. of resident 52 revealed: *He was not interviewable. *He was sitting in his wheelchair with a Korean War baseball cap on. *His hair was straight and noticeably long, covering his ears, and reached approximately two inches past his earlobes. *His fingernails were not clipped and extended about one-fourth of an inch beyond his fingertips. -There was a brown substance under some of his fingernails. *He had scruffy facial hair growth that included areas down his neck. Review of resident 52's electronic medical record (EMR) revealed: *He was admitted on 7/7/23. *His Brief Interview for Mental Status (BIMS) score was one and that indicated he had severe cognitive impairment. *His diagnoses included the following: chronic kidney disease stage three, dementia, psychotic disturbance, mood disturbance, generalized anxiety disorder, congestive heart failure, atrial fibrillation and history of left femur fracture. *An admission photo of the resident revealed he was clean-shaven with short hair that was nicely groomed. -His current appearance did not look like the same person on his admission photo that had	F 657	R60's care plan and CNA pocket care plan were updated to include pressure reducing cushion in recliner, float heels in bed with heel lift boots, encourage repositioning in bed every 1-2 hours, and use body pillow as he allows while in bed on 11/07/2023 by MDSC. R48's care plan and CNA pocket care plan were updated to include catheter cares on 11/07/2023 by MDSC. R52 passed away on 11/07/2023. All CNA pocket care plans were reviewed and updated to ensure they matched the care plans on 11/07/2023 by MDSC and/or designee. Nurse K was educated on 11/07/2023 by the Director of Nursing Services on ensuring that she understands that the facility does not utilize the Kardex, but only the care plan and CNA pocket care plan and that changes are to be reported timely to the MDSC and/or unit managers. Director of Nursing Services, MDSC, and Unit Managers were educated on ensuring Care Plans/Pocket Care Plans are updated timely when changes occur by the Regional Clinical Nurse Specialist on 11/06/2023. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on 11/08/2023 that the CNA pocket care plans are to be utilized and followed as we do not use the Kardex and any discrepancies are reported timely to the MDSC and/or Unit Managers by the Director of Nursing Services.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 2 been taken a few months earlier. *He had been a Korean War veteran and had nightmares related to his military service. *He had been placed on hospice care on 10/13/23 due to dementia advancement and declining health. *There was no charting provided by the certified nursing assistants (CNAs) to indicate the resident had refused grooming assistance. Review of resident 52's revised 9/25/23 care plan revealed: *He required assistance with the following activities of daily living: bathing, dressing, meals, oral hygiene, personal hygiene, toilet use, and transfers. *The importance of his Korean War baseball cap was not listed in his care plan. *The following was added to his care plan on 10/18/23 which had been during the time of the survey. -The resident refused care and would strike out at staff. -He had been a Korean War Veteran with nightmares from his past military service. Review of the current undated pocket care plan for resident 52 revealed: *It had been received by nurse manager O on 10/19/23 at 2:20 p.m. *There was no documentation of interventions to use when the resident had refused or had challenging behaviors. Refer to F677 finding 1. 2. Review of resident 59's EMR revealed: *He was admitted on 12/23/22. *His BIMS score of zero which indicated he had	F 657	Director of Nursing Services and/or designee will audit 3 residents weekly for 12 weeks and then randomly to ensure Care Plans/Pocket Care Plans match and are being followed by staff. 3. As part of Aberdeen Health & Rehabs' ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 3	F 657		

severe cognitive impairment.
*He had diagnoses of the following: congestive heart failure, post Covid-19 condition, atherosclerotic heart disease, atrial fibrillation, type 2 diabetes, and dementia.
*An unstageable left heel pressure ulcer that was discovered on 1/4/23, which had been 12 days after his admission.

Observation on 10/17/23 at 10:35 a.m. of resident 59 revealed:
*He was seated in his wheelchair which had been just outside of the small dining room near the rehabilitation unit.
*He had gripper socks on his feet and both feet were placed on the foot-pedals of his wheelchair.
*There was a cushioned footboard placed on the top of the wheelchair foot-pedals that extended up behind his feet and legs.
*Heel boot protectors were not on his feet.

Interview on 10/18/23 at 9:30 a.m. with nurse manager O regarding resident 59 revealed :
*The pressure ulcer was discovered approximately two weeks after his admission.
*He had a footboard cushion on his wheelchair pedals that protected his heels.
*When in bed, staff were to make sure that his heals were floated with pillows positioned under his ankles.
*Staff attempted to use the heel boot protectors for a time, but the resident would not keep them on so those heel boots had been discontinued.
*There was a concern that if he wore them it could cause him to fall forward out of his wheelchair if he tried to remove them.
*If he was combative or resistive of care, the nursing staff gave him time and then would return when he was more agreeable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 4 Interview on 10/19/23 at 9:13 a.m. with CNA P and CNA Q regarding resident 59 revealed: *The pressure ulcer on his heel was there since he had been admitted. *They used two pillows positioned under his ankles to float his heels while he was resting in the bed. *When he was in his wheelchair he had a footboard cushion that was placed on top of the foot-pedals to cushion his heels and the back of his legs. *His wife visited every day to help him with his needs and to spend time with him. *When he laid down for a nap after lunch staff floated his heels off the bed with pillows positioned under his ankles. *He had used boot protectors for a short time but had not liked them and would take them off. *They no longer put the heel boot protectors on the resident. *He had been resistive of care and at times struck out at staff, but they knew him well and were able to reapproach him when his mood improved. *They used pocket care plans to know what care to provide to the residents. *Interventions were documented on the computer Kardex system when they had been completed by the CNAs. Interview on 10/19/23 at 9:38 a.m. with registered nurse (RN) K regarding resident 59 revealed: *For anyone with skin concerns it would have been her expectation to have interventions in place to prevent resident skin integrity issues from developing. *He hated the heel protector boots, so they got rid of them and got an insert for the wheelchair to	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 5 cover the back and the foot-pedals. *His heels were to have been floated with pillows positioned under his ankles while he was in bed. *CNAs were to reposition residents every two to three hours or as the physician had ordered. *The CNAs carried a pocket care plan to follow interventions for the appropriate care to complete with each of the residents. *When an intervention or a condition would change with the resident's care, the Minimum Data Set (MDS) coordinator L would update the care plan and the pocket care plan. *Staff used a computerized Kardex program with interventions for CNAs to document when the care was completed for the resident. *All the interventions should have been the same in the resident's current care plan, the Kardex, and the pocket care plan. Review of resident 59's current Kardex interventions for his care revealed: *There were no interventions to float his heels by positioning pillows under his ankles while he was in bed. *There were no interventions for staff to follow when he refused or had combative behaviors. Review of resident 59's pocket care plan revealed there was no information to float his heels off of the bed with pillows positioned under his ankles while he was in bed. Review of resident 59's revised 9/27/23 care plan revealed: *There was no information that his feet were to have been floated and positioned with pillows under his ankles while he was in bed. *His heel boot protectors were still on the care plan and had not been discontinued as an	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 6 intervention. Refer to F686 finding 1. 3. Review of resident 60's EMR revealed: *The resident was admitted on 1/31/23. *His BIMS score was 99 which indicated he was not able to answer the questions. or had given responses that made no sense. *He was not able to be interviewed. *His diagnoses included the following: dementia, benign prostatic hyperplasia, high cholesterol, spinal stenosis, heart disease, and major depressive disorder. *A stage II pressure ulcer on his right buttock area was discovered on 3/2/23. *A stage II pressure ulcer on his left buttock area was discovered on 5/30/23. *He was placed on hospice care on 7/12/23 due to advancing dementia and general decline. Observation on 10/18/23 at 2:11 p.m. of resident 60 and his unoccupied room revealed: *He had been wheeling down the hallway in his Geri chair using his hands to move around the unit. *There was a cushion in his recliner. *He had a pressure reducing mattress. Review of resident 60's revised 10/6/23 care plan revealed the following interventions: *"Daily wound monitoring in place. Date initiated: 2/19/23. *Float/offload heels. Date initiated: 2/19/23. *Give anti-pruritic medication as ordered by medical practitioner. Observe and document side effects/effectiveness. Date initiated: 2/19/23. *Keep linens dry, wrinkle-free. Date initiated: 2/3/23.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 7 *Keep skin clean and dry. Date initiated 2/19/23. Revision on: 10/11/23. *Observe for side effects of antibiotics and over the counter medications: gastric distress, rash, allergic reactions which could exacerbate skin injury. Report changes to nurse/medical practitioner. Date initiated: 2/19/23. *Observe skin during cares. Report changes to nurse. Date initiated: 2/19/23. *Pressure reducing mattress on bed and pressure reducing cushion in wheelchair. Date initiated: 2/19/23. Revision on 10/17/23." -The last two interventions were added to his care plan on 10/17/23 which was during the time of the survey. "*Weekly skin inspection and prn (as needed). Date initiated: 2/19/23. Revision on 10/17/23." *The following had been added in the care plan on 10/17/23, which was during the time of the survey: -"Focus: [Resident] has potential impairment to skin integrity r/t [related to] impaired sensory r/t his dementia, moisture r/t his incontinence, impaired mobility/activity/r/t his use of w/c [wheelchair] and general shearing/friction r/t his scooting in bed/chair and general repositioning. Date initiated: 10/17/23. -Goal: Will have no complications through the review date. Date initiated: 10/17/23. -Interventions/Tasks: --Encourage reposition/position changes during Rounds and every 2-3 hours. Date initiated: 10/17/23. --Keep linens dry, wrinkle free. Date initiated: 10/17/23. --Keep skin clean and dry. Date initiated: 10/17/23. --Observe skin during cares. Report any changes to nurse. Date initiated: 10/17/23.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 8 --Pressure reducing mattress on bed and pressure reducing cushion in w/c. Date initiated: 10/17/23. --Weekly skin inspection and prn (as needed). Date initiated: 10/17/23." Interview on 10/19/23 at 12:12 p.m. with director of nursing (DON) C, and MDS coordinator L revealed: *MDS coordinator L was responsible to update the resident care plans as changes developed with the residents. *She agreed that interventions got missed. *She would attempt to update the resident care plans as soon as there were changes to the resident's current care needs. *Interventions were to have been added to the resident's care plan when they were identified. *Nurses were to have passed on those resident changes through a change of shift huddle. *The pocket care plans were the CNAs guide for what care to have been provided for the residents. *They had started to audit three care plans a week during the interdisciplinary team meetings. *They wanted improved communication with their staff regarding resident care needs. *MDS coordinator L attempted to get pertinent information on the pocket care plans without being too wordy. *Staff had not always notified them if there had been discrepancies identified between the Kardex, the pocket care plan, and the care plan. *They were working on correcting those inaccuracies. *They agreed information should have been consistent in the resident's care plan, the Kardex information, and the pocket care plan. *The information on the care plans should have	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 9 included information that reflected the resident's current needs. Refer to F686 finding 2. 4. Observation and interview on 10/17/23 at 10:00 a.m. with resident 48 in her room revealed: *She was seated in her wheelchair. *She had a Foley catheter. *She was not sure how long she had a catheter. *Staff had checked her catheter bag regularly. *She hoped the physician would remove it soon as it was uncomfortable. Review of resident 48's EMR revealed: *She was admitted on 9/9/20. *Her Brief Interview for Mental Status (BIMS) score was 5 and that indicated she had severe cognitive impairment. Her diagnoses included the following: -Unspecified dementia, unspecified severity, without behavioral disturbance. -Delirium due to known physiological condition. -Neuromuscular dysfunction of bladder, unspecified. -Unspecified urethral stricture, female. *She had a history of urinary tract infections that started 6/21/23. *She had a physician's order for catheter care every shift and as needed dated on 7/27/23. *Her care plan review dated 8/15/23 completed by MDS coordinator L documented the following: -An indwelling catheter initiated on 8/15/23. -Will be/remain free from catheter trauma through the review date. -Will show no signs or symptoms of urinary infection through the review date. -Target date 10/31/23.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 10 Interview on 10/18/23 at 1:11p.m. with CNA H regarding resident 48's catheter revealed: *All residents have pertinent information from their care plan condensed into a pocket care plan. *Resident 48's catheter care would have been on the pocket care plan to alert staff to provide catheter care. *She agreed no information was documented on the pocket care plan regarding resident 48's catheter care. *MDS coordinator L was responsible for ensuring the pocket care plans were updated with the resident's current care needs. Interview on 10/18/23 at 2:57 p.m. with Nurse Manager D regarding resident 48's catheter revealed: *She had been employeed for three months. *She relied on the resident care plans to meet the resident's needs. *Resident 48's catheter was changed by the night shift once a month or as needed. *The CNAs were responsible for emptying her catheter drainage bag and documenting the urinary output. *She agreed the resident's pocket care plan was not updated to reflect the current care needs of resident 48. Interview on 10/19/23 at 12:19 p.m. with MDS coordinator L and DON C regarding resident 48's care plan revealed: *MDS coordinator L was responsible for ensuring the resident care plans were up to date. *The EMR provider updated the program on 10/1/23. *There were issues with the update and they were trying to work through that.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 11 *MDS coordinator L tried to keep the care plans updated but she was only one person and missed things from time to time. *She tried to put important information on the pocket care plans but not too much or the staff would become overwhelmed with all the information and then might not use them. *She agreed the catheter information should have been on the pocket care plan as soon as the resident had the catheter placed. *It was DON C's expectation the resident's care plans and pocket care plans were up to date so staff could provide the appropriate care. 5. Review of the provider's revised 10/2017 Person Centered Care Plan policy revealed: *"Person centered care planning is an on-going process which actively encourages the resident and/or the resident's representative to be an active participant in the care planning process and addresses the development and implementation of individualized person care. The Comprehensive Care Plan is comprised of but not limited to; NAR Care Plan, MAR, TAR, Flow sheets, POC/14 day ADL tracker documentation, Weekly wound documentation, and Physician orders... 1. Developed within 7 days after completion of the comprehensive MDS Assessment. Reviewed and revised annually, quarterly, with a significant change in status and as needed... *Skin Integrity Alterations or Risk for: -Pressure reducing mattresses/cushions. -Turning/repositioning schedule. -Treatment. -Wound Clinic Referrals. -Podiatry Referrals. -Adaptive equipment like Geri-sleeves. -Foot boards/heel protectors/wedges.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 12 -Alternating pressure pads. -Potential for bruising/bleeding (e.g., medications like Coumadin/injections) ... Other: -Care plan should be clear and concise. It is acceptable and sometimes may be more appropriate to address multiple issues in one care plan segment. --Altered cardiovascular status due to CHF [congestive heart failure], afib [atrial fibrilation], HTN [hypertension]. --COPD [chronic obstructive pulmonary disease] with need for continuous oxygen. -Include personal strengths. -Include refusals of care/services under appropriate focus. -Unavoidable areas included with appropriate focus. -Risk vs [versus] Benefits included in care plan and reviewed quarterly, annually, with a significant change in status and prn. -Consistent with the Nursing Assistant Care Plan."	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, resident handbook review, and resident bill of rights review, the provider failed to ensure grooming and oral care were consistently provided and accurately documented for 1 of 19 sampled residents (52). Findings include:	F 677	F 677 1. In continuing compliance with F 677, ADL Care Provided for Dependent Residents, Aberdeen Health & Rehab corrected the deficiency by providing education to CNA P & CNA Q on ensuring all ADL task refusals are charted in Point of Care for R52 and all like residents by Director of Nursing Services on 11/6/2023. Separate shaving task was added to Point of Care on 10/19/2023 to R52 and all like residents by MDSC. R52 passed away on 11/05/2023.	11/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 13 1. Observation on 10/16/23 at 4:16 p.m. of resident 52 revealed: *He was not interviewable. *He was sitting in his wheelchair with a Korean War baseball cap on. *His hair was straight and noticeably long, covering his ears, and reached approximately two inches past his earlobes. *His fingernails were not clipped and extended about one-fourth of an inch beyond his fingertips. -There was a brown substance under some of his fingernails. *He had scruffy facial hair growth that included areas down his neck. Observation on 10/17/23 at 4:15 p.m. of resident 52 in his room revealed he: *Had been sitting at the end of his bed that was placed in the lowest position. *Was wearing a shirt and an adult incontinence brief, and had no pants on. *Was fiddling with the call light. *Had hair that was unkept and long. *His baseball cap was placed next to him. *Had long fingernails that had not been clipped or cleaned. Observation on 10/18/23 at 8:51 a.m. of resident 52 revealed: *He was seated in his wheelchair after breakfast with his hair, facial hair, and fingernails in the same condition as previously stated above. *He had been wearing the same baseball cap and it had soiled areas on the bill and on the sides of the cap. *His shirt had wear-holes on his back and the navy colored undershirt he had been wearing was visible through the material and holes.	F 677	2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on 11/08/2023 on new shaving task added to Point of Care and ensuring all ADL task refusals are charted in Point of Care by the Director of Nursing Services. All new staff will be trained upon hire on correct Point of Care documentation by Nursing Staff Educator and /or designee. The Director of Nursing Services and/or designee will audit ADL POC documentation 2x/week for 12 weeks and then randomly to ensure continued compliance. 3. As part of Aberdeen Health & Rehabs' ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 14 Review of resident 52's electronic medical record (EMR) revealed: *He was admitted on 7/7/23. *A Brief Interview for Mental Status (BIMS) score was one which indicated he had severe cognitive impairment. *His diagnoses included the following: chronic kidney disease stage three, dementia, psychotic disturbance, mood disturbance, generalized anxiety disorder, congestive heart failure, atrial fibrillation and history of left femur fracture. *An admission photo of the resident revealed he was clean-shaven with short hair that was nicely groomed. -His current appearance did not look like the same person on his admission photo that had been taken a few months earlier. *He had been placed on hospice care on 10/13/23 due to advancing dementia. *There was no charting provided by the certified nursing assistants (CNAs) to indicate the resident had refused grooming assistance. Review of resident 52's 9/25/23 care plan revealed: *He required assistance with the following activities of daily living: -Bathing. -Dressing. -Meals. -Oral hygiene. *Personal hygiene. *Toilet use. *Transfers. *There was no documentation that the resident was refusing or had been uncooperative with grooming.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 15 Review of resident 52's documentation in his EMR of personal hygiene and oral care calendars revealed the following: *"Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene)." *Each day for the past 30 days had been documented as completed by the CNAs with the resident dependent on assistance for both oral care and personal hygiene. *There had been no entries of refusals for either the oral care or the personal hygiene calendars for the past 30 days. Interview on 10/18/23 at 8:59 a.m. with nurse manager O revealed: *She had been in her current role for a month, but had worked for the facility seven months. *Resident 52 had broken his left femur while living at an assisted living facility. *He had admitted for rehabilitation services and never got strong enough to return to his home. *His dementia had advanced and his cognition declined. *His son came to see him every two weeks and was very involved with his care. *He had been in the Korean war and had nightmares at night. *CNAs had difficulty at times with completing his care because he had been combative and resistive at times. *The CNAs tried their best to ensure his personal hygiene tasks were completed daily. *Any refusals should have been documented under the tasks to have been completed for personal hygiene in the computer Kardex system.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 16 Interview on 10/18/23 at 10:23 a.m. with CNA Q regarding resident 52's grooming and personal hygiene revealed: *He was more independent when he first was admitted. *He used to roam around the hallways but was not able to do that now. *Now he used a wheelchair to scoot around the hallways. *There were times he had been aggressive during care. *During the day he was sleepy because he had not slept well at night. *He used to eat well and now had not been as interested in eating. *The staff assisted to get him groomed, change his incontinence brief, wash his face, and put on his hat. *His hat had been very important to him and he would always want to wear it. *He had not liked to shower but they were able to complete that task with the help of two staff. *Shaving was a task he used to do independently but now he needed assistance. *He had not liked any changes in his routine. *He got aggressive with staff and at times refused care. Interview on 10/18/23 at 10:31 a.m. with CNA P and CNA Q regarding resident 52 revealed: *They both had a good relationship with the resident and knew him well. *They had been scheduled to work with him regularly for consistency in care. *They were supposed to document when he had refused care but had not done that for quite some time. *It had become a daily occurrence, so they just stopped documenting the refusals.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 17 *They both agreed his refusals of care should have been documented, otherwise it appeared that the grooming tasks had been completed when they were not. *They had not informed their supervisor they had stopped documenting his refusals. Further interview on 10/18/23 at 2:00 p.m. with CNA P regarding grooming care of resident 52 revealed: *He had been challenging to work with because of his advanced dementia. *The staff had taken their time with him. *Most days they could complete his grooming tasks, but other days it was a struggle. *It worked best not to rush him. *They had a nurse who had completed the fingernail and toenail care. *She was not sure when the last time he had his fingernails and toenails clipped by the nurse. *The computer Kardex system for tasks that were to have been completed had not separated out the different areas of personal care except for oral care. Request to DON C was made on 10/19/23 at 12:00 p.m. for documentation regarding resident 52's personal hygiene refusals and oral hygiene refusals and no documentation was provided. Interview on 10/19/23 at 1:01 p.m. with Minimum Data Set (MDS) coordinator L regarding resident 52 revealed: *She agreed that his refusals should have been listed on the care plan and interventions for staff to follow when he had refused should have been listed. *The care plans should reflect the current conditions and care needs of the residents	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 18 because that was how the interventions were put into place for the CNAs to follow to assist in providing the appropriate care for the residents. Review of the provider's undated Resident Handbook revealed: *"Recognize that every person is unique and has their own set of values, beliefs, ideas and own way of doing things. *Offer people as many choices as we can. *Address people's needs with a sense of urgency. *Anticipate people's needs." Review of the provider's undated Resident Bill of Rights revealed: *"You are entitled to quality of life. A facility must provide care and an environment that contributes to your quality of life."	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a 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: Based on observation, interview, record review,	F 686	F 686 1. In continuing compliance with F 686, Treatment/Svcs to Prevent/Heal Pressure Ulcer, Aberdeen Health & Rehab corrected the deficiency by adding a Prevention of Alterations in Skin Integrity Guideline to our Skin Management Protocol Process to include preventative interventions and approaches on 11/6/2023 by the Regional Clinical Nurse Specialist. R59's care plan was updated to include Dakin's wet to dry dressing on left heel daily, pumpless air mattress, cushion in w/c, place pillow under legs to float heels when in bed, footboard on w/c pedals, reposition every 1-2 hours and Prosource daily by MDSC on 11/07/2023.	11/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 19 and policy review, the provider failed to ensure:*Preventative interventions and approaches were implemented prior to the development of pressure ulcers for two of two sampled residents (59 and 60). *Interventions and approaches were consistently implemented for three of three sampled residents (25, 59, and 60) who currently had pressure ulcers. Findings include: 1. Observation on 10/17/23 at 10:35 a.m. of resident 59 revealed: *He was seated in his wheelchair outside of the small dining room area near the rehabilitation unit. *He had gripper socks on his feet and both feet were placed on the foot-pedals of his wheelchair. *There was a cushioned footboard placed on the top of the wheelchair foot-pedals that extended up behind his heels and legs. *Heel boot protectors were not on his feet. Observation and interview on 10/17/23 at 11:00 a.m. with resident 59 in his room revealed: *He had been seated in his wheelchair with gripper socks on his feet. *His wife had been with him and talking to him. *She visited him on a daily basis. *He had an area on his left heel that had developed a week after his admission. *The area had been healing but she stated she had not seen it recently because it had been covered with a dressing. *The nurses monitored it daily. *He had heel protectors for his feet. *She had not seen the nursing staff put heel protectors on his feet lately. *She was not sure what had happened to them. *He used to fiddle with the boots and would	F 686	R60's care plan was updated to include encourage repositioning every 1-2 hours, use body pillow in bed as he allows, float heels with heel boots while in bed, cushion in recliner and w/c and pressure reducing mattress on bed on 11/07/2023 by MDSC. R25's care plan was updated to include staff to reposition every 1-2 hours as allowed, off-loading heel boots at all times when in bed and up in w/c, and follows with Sanford Wound Care weekly on 11/07/2023 by MDSC. All other residents were reviewed to ensure Comprehensive Skin and Positioning Assessment was completed with identified individualized needs added to the care plan on 11/07/2023 by MDSC and/or designee. All CNA pocket care plans were reviewed and updated to ensure they matched the care plans on 11/07/2023 by MDSC and/or designee. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 11/08/2023 on Prevention of Alterations in Skin Integrity Guideline and their role in prevention of skin alterations. The Director of Nursing Services and/or designee will audit Comprehensive Skin and Positioning Assessment and Care Plan to ensure skin management interventions are individualized and being implemented consistently for 3 residents weekly for 12 weeks and then randomly to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 20 attempt to remove them. *When he rested in bed, the nursing staff would place pillows under his ankles to relieve the pressure off of his heels. Observation on 10/19/23 at 9:11 a.m. of resident 59 revealed: *He was seated in his wheelchair with the footboard cushion in place at the bottom of his wheelchair. *He had been wearing gripper socks. *There were no heel protector boots on his feet. Review of resident 59's 12/27/22 Comprehensive Skin and Repositioning Evaluations revealed: *His Braden score was 12, that indicated he was at high risk for developing pressure ulcers. --" [Resident] has no pressure areas, does have potential for altered skin integrity r/t [related to] his impaired sensory r/t his diabetes, dementia, moisture r/t his incontinence and perspiration, impaired activity/mobility r/t his use of w/c [wheelchair] and shearing/friction r/t his scooting to [the] edge of [the] bed/chair and general repositioning, pressure reducing mattress on bed and pressure reducing cushion in w/c, skin inspected weekly, does participate in therapy." Review of resident 59's electronic medical record (EMR) revealed: *He was admitted on 12/23/22. *A Brief Interview for Mental Status (BIMS) score of zero that indicated he had severe cognitive impairment. *He had diagnoses of the following: congestive heart failure, post Covid-19 condition, atherosclerotic heart disease, atrial fibrillation, type 2 diabetes, and dementia. *A left heel unstageable pressure ulcer that had been discovered after his admission on 1/4/23.	F 686	3. As part of Aberdeen Health & Rehabs' ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 21 -It had been a fluid filled blister when it was first identified that measured 4.5 centimeters (cm) by 5 cm. -It currently measured 0.8 cm by 0.8 cm on 10/11/23. Review of resident 59's current Kardex interventions for CNAs to have followed revealed: *There were no interventions to float his heels by positioning pillows under his ankles while he was in bed. *There were no interventions for staff to follow when he refused or had combative behaviors. Review of resident 59's revised 9/27/23 care plan revealed: *There was no information that his feet were to have been floated and positioned with pillows under his ankles while he was in bed. *His heel boot protectors were still on the care plan and had not been discontinued as an intervention. *"Focus: [Resident] has Pressure injury to left heel: Date initiated: 1/14/23 -Goal: Pressure injury will show signs of healing and remain free from infection by/through review date: Date initiated: 1/14/23 -Interventions/Tasks: --Administer treatments as ordered and observe for effectiveness. Date initiated: 1/14/23. --Dakins wet to dry to left heel daily. Date initiated: 10/1/23. --Glucerna 8 oz with meals BID. Date initiated: 1/13/23. --Heel lift boots when in bed. Date initiated: 1/14/23. --Notify family and medical practitioner of any new area of skin breakdown or worsening in status of current area. Date initiated: 1/14/23.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 22 --Notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration, noted during bath or daily care. Observe skin daily with cares. Date initiated: 1/14/23. --Obtain lab/diagnostic work as ordered. Report results to medical practitioner and follow up as indicated. Date initiated: 1/14/23. --Pumpless air mattress on bed and pressure reducing cushion in w/c. Date initiated: 1/14/23. *The above interventions were added to the care plan after he had acquired the pressure ulcer to his left heel on 1/4/23. *Preventative measures were not put into place even though he had been identified through the Braden scale for being at high risk for developing pressure ulcers. *No information was documented that his feet were to have been floated by positioning a pillow under his ankles when he was in bed. *His heel protector boots had not been discontinued according to the information on the care plan. Interview on 10/19/23 at 9:13 a.m. with certified nursing assistant (CNA) P and CNA Q regarding resident 59 revealed: *The pressure ulcer on his heel was there since he was admitted and had started as a blister from his heel rubbing on the wheelchair pedal. *They used two pillows positioned under his ankles to float his heels when he was rested in the bed. *When he was in his wheelchair he had a footboard cushion that was placed on top of the foot-pedals to cushion his heels and the back of his legs. *His wife visited every day to help him with his needs and to spend time with him.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 23 *When he laid down for a nap after lunch staff floated his heels off the bed with positioning pillows under his ankles. *He had used boot protectors for a short time but had not liked them and would take them off. *They no longer put the heel boot protectors on the resident. *He had been resistive of care and at times struck out at staff, but they knew him well and were able to reapproach him when his mood improved. *They used pocket care plans to know what care to provide to the residents. *Interventions were documented on the computer Kardex system when they had been completed by the CNAs. Interview on 10/19/23 at 9:38 a.m. with RN K revealed: *She had been the nurse that completed wound care for the residents. *The wound was discovered on 1/4/23 and caused by his left heel rubbing against his wheelchair that caused a blister to form. *The area was unstageable (the wound is covered by a layer of dead tissue that might be yellow, grey, green, brown, or black. The base of the wound is not visible and therefore cannot be staged) and had been healing. *The wound was monitored daily by nursing staff. *She completed weekly wound assessments. *He had a pressure reducing mattress. *For anyone with skin concerns it would have been her expectation to have interventions in place to prevent resident skin integrity issues from developing. *He hated the heel protector boots, so they got rid of them and got a cushioned insert for the wheelchair to cover the back and the foot-pedals.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 24 *They now placed a footboard cushion on his wheelchair to protect his heels. *His heels were to have been floated with positioning pillows under his ankles while he was in bed. *CNAs were to reposition residents every two to three hours or as the physician had ordered. *The CNAs carried a pocket care plan to follow for the appropriate care to complete with each of the residents. -The CNAs also documented completion of assigned tasks in the computerized Kardex system. *The care plan was to be updated with resident changes that reflected the resident's current needs. -Interventions were driven from the care plan into the computerized Kardex system. *When an intervention or a condition would change with the resident's care, the Minimum Data Set (MDS) coordinator L would update the care plan and the pocket care plan. *Staff used a computerized Kardex program with interventions for CNAs to document when the care was completed for the resident. *All the interventions should have been the same in the resident's current care plan, the Kardex, and the pocket care plan. 2. Observation on 10/17/23 at 1:58 p.m. of resident 60 revealed: *He was lying in his bed on his right side facing the wall. *He had not been wearing heel protector boots. *His body pillow was placed on top of his recliner. *His bed was in the lowest position. *There was a Geri wheelchair next to his closet. *His electric recliner was in the upright position and had a padded cushion in the seat.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 25 Observation on 10/18 23 at 2:11 p.m. of resident 60 and his unoccupied room revealed: *He was seated in a Geri wheelchair chair wheeling himself down the hallway. *He had not been wearing the heel protective boots. *His bed was made and he had a pressure reducing mattress. Review of resident 60's 2/3/23 Comprehensive Skin and Repositioning Evaluation revealed: *His Braden score of 17, that indicated he was at risk for developing pressure ulcers. --" [Resident] does have pressure areas to his buttocks, does have cream that is applied to the buttock area, does have potential for altered skin integrity r/t [related to]his impaired sensory r/t his dementia, moisture related to his perspiration, impaired activity/mobility r/t his weakness and use of FWW [front wheeled walker] and general shearing /friction r/t his scooting to edge of bed/chair and general repositioning, pressure reducing mattress on bed, skin inspected weekly." Review of resident 60's EMR revealed: *The resident admitted on 1/31/23. *He had been admitted with pressure ulcers on his buttocks that were healed. *His BIMS score was 99 and that indicated he chose not to answer, or had given responses that had not made sense. *He was not able to be interviewed. *His diagnoses included: dementia, benign prostatic hyperplasia, high cholesterol, spinal stenosis, heart disease, and major depressive disorder. *A stage II (an open wound, the skin opens and	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 26 wears away or forms an ulcer, it is usually an abrasion, blister, or a shallow crater in the skin) pressure ulcer on his right buttock area that was discovered on 3/2/23 that measured 1.5 centimeters (cm) by 0.5 cm. -It currently measured 1.5 cm by 0.8 cm. *A stage II pressure ulcer on his left buttock area that was discovered on 5/30/23 that measured 0.5 cm by 0.5 cm. -It currently measured 1.0 cm by 0.5 cm. *He was placed on hospice care on 7/12/23 for advanced dementia symptoms and increased weakness. Review of resident 60's revised 10/6/23 care plan revealed the following interventions: *"Daily wound monitoring in place. Date initiated: 2/19/23. *Float/offload heels. Date initiated: 2/19/23. *Give anti-pruritic medication as ordered by medical practitioner. Observe and document side effects/effectiveness. Date initiated: 2/19/23. *Keep linens dry, wrinkle-free. Date initiated: 2/3/23. *Keep skin clean and dry. Date initiated 2/19/23. Revision on: 10/11/23. *Observe for side effects of antibiotics and over the counter medications: gastric distress, rash, allergic reactions which could exacerbate skin injury. Report changes to nurse/medical practitioner. Date initiated: 2/19/23. *Observe skin during cares. Report changes to nurse. Date initiated: 2/19/23. *Pressure reducing mattress on bed and pressure reducing cushion in wheelchair. Date initiated: 2/19/23. Revision on 10/17/23." -The last two interventions were added to his care plan on 10/17/23 which was during the time of the survey.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 27 "*Weekly skin inspection and prn (as needed). Date initiated: 2/19/23. Revision on 10/17/23." *The following had been added in the care plan on 10/17/23, which was during the time of the survey: -"Focus: [Resident] has potential impairment to skin integrity r/t [related to] impaired sensory r/t his dementia, moisture r/t his incontinence, impaired mobility/activity/r/t his use of w/c [wheelchair] and general shearing/friction r/t his scooting in bed/chair and general repositioning. Date initiated: 10/17/23. -Goal: Will have no complications through the review date. Date initiated: 10/17/23. -Interventions/Tasks: --Encourage reposition/position changes during Rounds and every 2-3 hours. Date initiated: 10/17/23. --Keep linens dry, wrinkle free. Date initiated: 10/17/23. --Keep skin clean and dry. Date initiated: 10/17/23. --Observe skin during cares. Report any changes to nurse. Date initiated: 10/17/23. --Pressure reducing mattress on bed and pressure reducing cushion in w/c. Date initiated: 10/17/23. --Weekly skin inspection and prn (as needed). Date initiated: 10/17/23." Review of resident 60's undated pocket care plan revealed: *The pocket care plan had been received by nurse manager D on 10/19/23 at 2:40 p.m. *He had a wound to his coccyx. *He was on hospice. *He had heel lift boots. -Heel lift boots had not been seen in his room or placed on the resident during the above	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 28 previously noted observations. Interview on 10/18/23 at 2:17 p.m. with the nurse manager D and certified medication aide (CMA) R regarding resident 60 revealed: *Family members came for daily visits. *His daughter had been a nurse practitioner and was very involved with his care. *He used a Geri chair and was able to wheel himself around the area. *On admission he had used a four wheeled walker to ambulate. *His dementia had worsened and he had been placed on hospice care. *Hospice staff came on a weekly basis to provide him care. *When he needed to use the restroom he would let staff know. *His days and nights were mixed up. *He had a body pillow that they used to position him when he was in bed. Interview on 10/19/23 at 9:59 a.m. with RN K regarding resident 60 revealed: *He had a history of breakdown in that area prior to and at the time of his admission. *The area had healed and redeveloped again on 3/2/23 on the right buttock and on 5/30/23 on the left buttock. *She completed wound assessments on those areas weekly and documented the results on a weekly wound assessment form. *The dressings were changed daily. *She thought those areas had not healed due to his advancing dementia and health decline. *Any resident who had been at risk for skin breakdown should have had interventions in place prior to prevent any breakdown of the skin. *The CNAs had pocket care plans to follow and	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 29	F 686		

the Kardex for interventions to follow.
-Those interventions should have all been the same from what was on the resident's care plan.

Interview on 10/19/23 at 12:43 p.m. with director of nursing (DON) C regarding residents with current pressure ulcers revealed:
*She thought the pressure ulcers they currently had were due to the residents health declines.
*They had not had a good process in place to prevent pressure ulcers.
*They recognized that the current process was not working.
*They added two nurse manager positions recently to attempt to correct the issues with pressure ulcer prevention.
*She confirmed there had been a lack of communication and consistency in writing care plans, Kardex interventions, and pocket care plans and their oversite of those processes had been lacking.
*She agreed there had not been a clear policy and procedure in place for pressure ulcer prevention interventions.
piece.
*They used nursing care standards and the American Healthcare Association for reference and guidance.

3. Observation on 10/16/23 at 4:03 p.m. revealed resident 25 was lying on her back and sleeping in her bed. Her heel protector boots were lying beside her but were not on her feet. A pressure relieving cushion was in the wheelchair.

Observation on 10/17/23 at 1:39 p.m. revealed resident 25 was again lying on her back in her bed after lunch without her heel protector boots on her feet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 30 Observation on 10/17/23 at 1:54 p.m. with RN K providing wound care to resident 25 revealed: *The right (R) heel wound measured 1 centimeter (cm) in length and 1 cm in width. *The R ankle wound measured 1.2 cm in length and 1.8 cm in width. *The R heel and the R ankle were treated with Betadine and then covered with foam dressings. *The sacral pressure ulcer measured 2.5 cm in length, 0.6 cm in width, and 0.5 cm deep and was treated with Betadine and a wet-to-dry dressing. *When asked what other interventions were being done for the resident's pressure ulcers. RN K stated that the resident should have been wearing the heel protector boots while she was lying in bed. Observation on 10/18/2023 at 8:58 a.m. revealed resident 25 was lying on her back in bed without her heel protector boots on. Interview on 10/18/23 at 9:02 a.m. with CNA E revealed resident 25's heel protector boots should have been worn while the resident was lying in bed. Interview on 10/18/2023 at 1:15 p.m. with CNA H and CNA J revealed: *Pocket care plans were used by the CNAs to determine what care needs were required for the residents. *When the pocket care plan was reviewed, the CNAs stated that those pocket care plans were not currently updated with the resident's current pressure ulcer interventions. That included both repositioning and the heel protector boots. The pocket care plan provided no specifics as to when those heel protector boots should have been	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 31	F 686		

worn or any repositioning information. CNA H verbalized that resident 25's heel protector boots were to have been worn while the resident was in bed.

*Review of the Kardex on 10/18/23 at 1:30 p.m. with the CNA J revealed:
*The Kardex had not listed the heel protector boots as an intervention and was not included on the resident's current care plan interventions for impaired skin integrity regarding repositioning. The Kardex stated that the resident should have been repositioned every 4 to 5 hours. CNA J stated that the repositioning every 4 to 5 hours was not correct.
*CNA J. stated that pocket care plans and Kardex's were updated by the MDS nurse.

Interview on 10/18/2023 at 2:57 p.m. with nurse manager D regarding the monitoring of resident interventions revealed the monitoring of CNAs completing care plan interventions was completed by a visual inspection with eyes on the resident and was done randomly.

Interview on 10/18/23 at 3:35 p.m. with RN K revealed:
*RN K was responsible for documenting interventions in the care plan regarding the current pressure ulcer interventions for resident 25.
*A blister that measured 2.5 cm x 2.3 cm was identified on the R heel on 8/17/2023.
*A physician order was received to change Adaptic Touch dressing weekly until healed.

Review of resident 25's 9/19/23 physician's orders included the following:
*Betadine wet to dry dressing daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 32 *Low air loss mattress *Frequent repositioning every 2-3 hours *R heel - paint with Betadine, cover with foam dressing *Continue the heel protector boots, change foam dressing every 3 days. *R ankle - paint with Betadine, cover with foam dressing, and change every 3 days. *When asked how resident 25's pressure ulcers had developed, she stated, "Probably from lying in bed. She does not see well and would run into things with her ankle while in her wheelchair. Wearing her boots probably would have helped." Interview on 10/19/23 at 12:13 p.m. with director of nursing (DON) C and Minimum Data Set (MDS) coordinator L regarding resident pressure ulcers revealed: *DON C. was unable to provide a policy for the prevention of resident pressure ulcers. *She was able to verbalize in detail how the facility prevents pressure ulcers. *She was able to provide a Skin Management Protocol updated on 5/16/23, which included steps for wound notification when a skin alteration or skin ulcer was identified but there was no documentation on how to prevent pressure ulcers from occurring. * She provided a Leadership's Admission checklist updated on 6/9/23 the facility used when admitting a new resident that included a comprehensive skin assessment and a Braden scale. *She stated that the interdisciplinary team (IDT) met daily and reviewed any concerns of those residents with pressure ulcers and those residents that were at risk for developing pressure ulcers. *When asked about the discrepancy with the	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 33 resident care plans, the pocket care plans, and the Kardex, she stated that she would communicate changes with her nursing supervisors, and it was their responsibility to update the direct care staff on those changes. *DON C stated that she has had issues with RN K updating resident care plans. *When asked how nurses monitor to ensure interventions were being completed, she stated the CNAs document using the task tab in Point Click Care. Repositioning and the heel protector boots were not included in those tasks for resident 25. *MDS Coordinator L. admitted that she had at times missed putting interventions in the task tab and that she has had issues with Point Click Care and entering interventions into the resident care plans. Review of resident 25's 10/11/23 care plan revealed the following: *The care plan had not mentioned a R heel pressure ulcer. *The care plan did list interventions related to the residents non-healing chronic Stage II pressure ulcer to the sacrum. *Interventions included: - Encourage resident to reposition/position changes during rounds. -Attempt to turn and reposition off the area every 2-3 hours and as needed and/or not position on that area, when possible. -Float and off-load heels with pillows or offloading boots. *The care plan intervention had not specified when the heel protector boots were to have been used. Review of resident 25's 6/23/23 Quarterly	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 34 Comprehensive Skin and Positioning Evaluation revealed: *The Braden score was 14 indicating the resident was at moderate risk for altered skin integrity. *Interventions included: -Pressure reducing device in the chair. -Pressure reducing device in bed. -Pressure ulcer/injury care, application of non-surgical dressings (with or without topical medication) other than the feet. -Application of ointments/medications other than the feet, keep the linens dry and wrinkle-free. *Summary included, "[Name of the resident] does have a non-healing pressure area on her coccyx, treatment as ordered from MD (medical doctor), does have potential for altered skin integrity r/t her impaired sensory r/t diagnosis of depression, dementia, and diabetes, moisture r/t (related to) her perspiration, has Foley indwelling catheter, impaired activity/mobility r/t use of full mechanical lift and w/c (wheelchair) and general shearing/friction with repositioning and scooting down in bed, air mattress on bed and pressure reducing cushion in w/c, skin inspected weekly." Review of the provider's revised 10/20/17 Care Plan policy revealed: *The resident care plans were reviewed and revised annually, quarterly, with significant change in status and as needed. *The resident care plan should have been consistent with the CNAs pocket care plans.	F 686		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 35 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to establish a system to accurately reconcile controlled substances that were waiting for destruction in one of two medication rooms. Findings include: 1. Observation on 10/19/23 at 11:17 a.m. in the Country Lane medication room with nurse	F 755	F 755 1. In continuing compliance with F 755, Pharmacy Svcs/Procedures/Pharmacist/Records, Aberdeen Health & Rehab corrected the deficiency by destroying controlled medications for R19, R14, R76, R77 and all like residents on 10/19/2023 by Nurse Manager D and Nurse Manager O. Blue Lock Boxes were removed from walls of both medication rooms on 10/19/2023 by Environmental Services Director. Controlled Substance Guideline was updated to include Cactus Sink usage for destruction of narcotic medications on 11/6/2023 by Regional Clinical Nurse Specialist. 2. To correct the deficiency and to ensure the problem does not recur all licensed nurses were educated on 11/08/2023 on updated Controlled Substance Guideline. The Director of Nursing Services and/or designee will audit destruction of controlled substances weekly for 12 weeks and then randomly to ensure continued compliance. 3. As part of Aberdeen Health & Rehabs' ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	11/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 36 manager D revealed: *She was questioned about a lock box that was mounted on the wall in the medication room. *She was not aware what the lock box was used for or if there were contents in the box. *Nurse manager D was unable to locate the key initially, and after further searching, was able to locate the key in a locked box in executive director (ED) A's office. *The blue box was double locked and upon opening the box, it was discovered that the locked box contained the following medications: -A morning bubble pack of clonazepam 0.5 milligram (mg) tablets for resident 19 who was a current resident. -An evening bubble pack of clonazepam 0.5 mg tablets for resident 19 who is a current resident. -An as needed (PRN) bubble pack of lorazepam 0.5 mg tablets for resident 14 who was a current resident. -A bedtime (HS) bubble pack of lorazepam 1 mg tablets for resident 14 who was a current resident. -Morphine sulfate solution 100 mg/5 milliliters (mL) for resident 76 who was no longer residing in the facility. -Lorazepam concentrate 2 mg/mL for resident 76 who was no longer residing in the facility. -1 Fentanyl 25 microgram (mcg) patch for resident 77 who was no longer residing in the facility. *Attached to each of the above medications were controlled drug receipt/record/disposition forms with dates ranging from 11/2016 to 1/2017. *The documented counts for the medications were correct except for the morphine sulfate. *A discrepancy in the morphine sulfate solution was noted to have been off by 13.75 mL. The disposition sheet's last log dated 1/31/2017,	F 755	2. To correct the deficiency and to ensure the problem does not recur all licensed nurses were educated on 11/08/2023 on updated Controlled Substance Guideline. The Director of Nursing Services and/or designee will audit destruction of controlled substances weekly for 12 weeks and then randomly to ensure continued compliance. 3. As part of Aberdeen Health & Rehabs' ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 37 recorded the amount of 28.25 mL. *On 10/19/2023, the bottle contained approximately 14.5 mL. All other disposition sheets for the remaining controlled drugs were correct. Interview at the time of the observation with nurse manager D revealed: *She was unable to explain how or why there were controlled medications in that lockbox. *She stated: -They do not use the blue box and was not employed here at the time. -Nurses had not used the blue box since her employment had begun. *ED A was notified on 10/19/23 at 11:30 a.m. of the above discovery of controlled medications, and she was unsure when the nursing staff had stopped using the blue box. *DON C and ED A were looking into what may have occurred at the time the medications were last dispensed to those residents. *The medication storage room located on Arbor Avenue on 10/19/23 at 11:50 a.m. was audited and the wall mounted blue lock box was inspected. The blue lock box was empty. Interview on 10/19/23 at 1:47 p.m. with ED A and chief operations officer (COO) B regarding the blue lock boxes revealed: *COO B reported that the facility switched pharmacy services on 9/30/15 from another long-term care (LTC) pharmacy to a new LTC pharmacy. *The blue lock box was taken out of service at the end of 2016. *The facility switched to electronic medication orders through Point Click Care in 2016.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 38 *The facility switched to electronic medication administration record (EMAR) through Point Click Care in July 2020. *The blue lock boxes found in each medication room were used for the disposition of medications that were ready for destruction until January 2017 when the facility switched to the Cactus Sink as a recommendation from the new LTC pharmacy for all medication disposals. *The Cactus Sinks was a device that allowed the facility to safely and easily dispose of controlled substances by making the medication unrecoverable and unusable. That process was implemented in May of 2016 in the Arbor Avenue care area and in the Country Lane care area at the end of 2016. *ED A consulted pharmacist M regarding the discrepancy with the morphine sulfate. He was able to confirm that liquid morphine does evaporate, however, variables such as humidity and temperatures of the medication room would play a factor in the evaporation rate that would have made the medication unable to be calculated. Review of the provider's 10/19/22 Controlled Substance policy revealed the provider failed to update its process for destroying controlled substances to include the use of the Cactus Sinks implemented in 2016.	F 755		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880	Directed Plan of Correction Aberdeen Health and Rehab F880 Corrective Action: 1. For the identification of lack of: *Appropriate procedural technique while providing	11/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880	personal cares and glucometer checks in use of hand hygiene and glove use as well as cleaning and sanitizing multi-resident use equipment. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 11/08/2023 by Director of Nursing Services. 2. Identification of Others: ALL residents and staff have the potential to be affected by lack of: *Appropriate procedural technique while providing personal cares in use of hand hygiene and glove use as well as cleaning and sanitizing multi-resident use equipment. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks was provided by 11/08/2023 by Director of Nursing Services.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40 (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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the following: *Gloves had been used during incontinence care of resident (60). *A sit to stand mechanical lift had been cleaned in between resident use. *Hand hygiene and glove use had been used during personal care for one of one sampled resident (45). *Proper hand hygiene and glove use was performed by one of one certified medication aide (CMA) N for one of one sampled resident (27) during blood sugar testing. Findings include: 1. Observation on 10/18/23 at 11:22 a.m. with CNA F during personal care of resident 60	F 880	System Changes: 3. Root cause analysis conducted answered the 5 Whys: 1. Staff were nervous. -State surveyors were watching. Solution: Audits/Competencies will be performed routinely so staff are comfortable with procedure. 2. Staff were in a hurry. -Other call lights were going off. -Staff were trying to be efficient. -Staff were trying to provide care to more people. Solution: Audits will be routinely performed. 3. Staff were not prepared. -Staff did not bring an extra pair of gloves to the bedside. -Staff did not have hand sanitizer on their person or within reach to quickly perform hand hygiene between glove change. Solution: Audits will be routinely performed. Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/ training with demonstrated competency and documentation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41 revealed: *She was not wearing gloves when removing the resident's incontinence brief. *She had not performed hand hygiene before putting on the gloves and reapplying the resident's incontinence brief. 2. Observation on 10/18/23 at 11:30 a.m. of CNA G during above observation revealed: *She had removed the sit to stand mechanical lift from resident 60's room without disinfecting it after use. *She had moved the mechanical lift down the hall and put it in another resident's room. Interview on 10/18/23 at 4:21 p.m. with CNA G revealed: *The staff would wipe down the mechanical lifts with a disinfecting wipe as they were coming out of a resident's room. *She was not aware that she had not wiped down the lift when removing it from resident 60's room and moving it to another resident's room. Interview on 10/19/23 at 9:31 a.m. with DON C regarding the above observations and interviews revealed: *Her expectation would have been that the mechanical lifts were cleaned between each resident use. *She had instructed the staff not to walk away from any mechanical lift until it was clean, so the next staff member did not have to wonder if the lift was clean or not. Review of the provider's October 2023 Nursing Weekly Cleaning Tasks revealed: *"Multiple use items will be cleaned and disinfected between each resident use:"	F 880	Director of Nursing Services contacted the South Dakota Quality Improvement Organization (QIN) on 11/07/2023 and discussed root cause analysis and implementing mitigation tactics to ensure a relapse does not occur which included education, communication, and auditing. Provided with many tools/resources to ensure success including a video clip on transmission-based precautions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 42 *"d) Mechanical Lifts". 3. Observation on 10/18/23 at 4:10 p.m. with CNA H and CNA I during resident (45) care revealed: *There was no hand hygiene performed prior to placing gloves on their hands. *Peri care had been performed by CNA I. *CNA H helped CNA I redress the resident. *CNA H then touched the handle of the lift with those same gloved hands. *CNA H had then removed those gloves and touched the uncleaned lift handle. *CNA I assisted CNA H with positioning the resident in the wheelchair while still wearing those gloves that she had performed peri care with. Interview on 10/19/23 at 9:31 a.m. with DON C revealed: *She would expect the CNAs to have performed hand hygiene before putting on and after removing their gloves. *Her expectation for staff while performing personal care would have been that they perform hand hygiene before putting on gloves, after removing gloves, and when going from a soiled to a clean task. 4. Observation on 10/16/23 at 4:16 p.m. with CMA N completing blood glucose testing with resident 27 revealed she: *Knocked and opened the door with her bare hands. *Placed gloves on her hands without washing or performing hand hygiene. *Searched his room starting at the sink area while she moved various grooming items and papers with her gloved hands to find his glucometer and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 43 test strip supplies. *Walked to a shelf by the wall next to the sink, and moved more items with those same gloved hands. *Asked resident 27 where his diabetic supplies were located, to which he replied "I do not know." *Noticed a plastic bin with his diabetic supplies and retrieved them from a dresser shelf across the room. *Picked up that plastic bin and placed it on the bedside stand next to the resident who had been lying in his bed. *Had not placed a barrier under the plastic bin. *Using those same gloved hands took an alcohol wipe, wiped his finger, pricked it with the lancet, squeezed his finger, placed a drop of blood on the test strip, and put that test strip in the glucometer. *Announced the reading to the resident, put his diabetic supplies back into the plastic bin, and back on the shelf. *Removed her gloves and exited the room without washing or sanitizing her hands. Interview on 10/19/23 at 10:36 a.m. with DON C regarding the above observation revealed: *CMA N had been trained on the correct blood sugar testing procedure for residents and had been up to date on her competencies and training. *She had completed audits of staff for infection control purposes to ensure they had followed proper procedures. *Her expectation had been for nursing staff to follow their blood glucose testing procedure and to use good infection control practices with hand hygiene and glove usage to protect the residents. *Request was made to DON C for the provider's blood glucose testing policy and no policy had been provided prior to survey exit.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 44 Review of the provider's revised 5/11/21 Competency for Finger Stick Blood Glucose procedure revealed: *"1. Gather supplies. *2. Knock on door before entering and identify resident. *3. Provide privacy. *4. Explain procedure to resident. *5. Place supplies on a clean surface barrier. *6. Wash hands. *7. Put on gloves. *8. Turn meter on, making sure the meter is set to match the calibration code on the strips. (If code does not match, follow manufacturers guidelines for re-setting the meter.) *9. Cleanse resident's fingertip with alcohol pad or soap and water per policy. *10. Place strip into meter and pierce skin with disposable lancet. Place used lancet in sharps container. *11. Place drop of blood to the strip and allow to draw to fill area on test strip. *12. At completion of test, remove strip, turn meter off and place used strip into sharps container. *13. Remove gloves. *14. Wash hands. *15. Cleanse equipment with PDI pad, microkill, or other approved agent and put away. *16. Document results. Report blood sugars to physician as directed per parameters." Review of the provider's October 2023 Hand Hygiene policy revealed: *"Staff should always complete hand hygiene:" *"c) Before donning gloves and after removing gloves *d) After handling contaminated items and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 45 equipment ..." Review of the provider's October 2023 Using Gloves policy revealed: *"Miscellaneous" *"e) Perform hand hygiene after removing gloves." *"When to use Gloves" *"d) When handling potentially contaminated items. *e) When it is likely that hands will come in contact with blood, body fluids, or other potentially infectious material."	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments 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 10/16/23 through 10/19/23. Aberdeen Health and Rehab was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kirstie Hoon, LNHA

TITLE: Executive Director

(X6) DATE: 11/10/2023

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

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10587	A. BUILDING: _____ B. WING _____	10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73; Nursing Facilities, was conducted from 10/16/23 through 10/19/23. Aberdeen Health and Rehab was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement 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 10/16/23 through 10/19/23. Aberdeen Health and Rehab was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Kirstie Hoon, LNHA

TITLE
Executive Director

(X6) DATE
11/10/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/18/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/18/23. Aberdeen Health and Rehab was found not in compliance with 42 CFR 483.90 (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 the deficiency identified at K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 923 SS=C	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 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. >300 but <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	K 923	K923 PLAN OF CORRECTION Aberdeen Health & Rehab denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	10/24/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kirstie Hoon, LNHA
TITLE: Executive Director
(X6) DATE: 11/10/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/18/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 1 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 WITHIN NO SMOKING." 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to protect medical gas storage as required. Combustible items were stored on racks within five feet of the oxygen cylinders in both the south and the north oxygen storage rooms. Findings include: 1. Observation on 10/18/23 at 8:20 a.m. revealed 43 E-cylinder oxygen tanks and 13 half-size oxygen tanks in the south oxygen storage room and there were supplies stored in cardboard containers immediately adjacent to the half-size tanks. 2. Observation on 10/18/23 at 10:00 a.m. revealed 40 E-cylinder oxygen tanks oxygen tanks in the north oxygen storage room. Nine inches above the storage racks was a combustible shelf holding oxygen supplies. The maintenance manager was not aware of the minimum 5 feet of separation between	K 923	1. In continuing compliance with K 923, Gas Equipment-Cylinder and Container Storage, Aberdeen Health & Rehab corrected the deficiency by moving combustible items 5 feet away from oxygen storage as per regulation on 10/24/2023 by Environmental Services Director. 2. To correct the deficiency and to ensure the problem does not recur Environmental Services Director was educated on ensuring 5 feet distance between combustibles and oxygen storage by the Executive Director on 10/24/2023. Environmental Services Director and/or designee will audit oxygen storage weekly for 8 weeks to ensure compliance. 3. As part of Aberdeen Health & Rehabs ongoing commitment to quality assurance, the Environmental Services Director and/or designee will report identified concerns through the community's QA Process.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435041	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/18/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 2 combustibles and oxygen storage until explaining it during the observations. The deficiencies affected two of nine smoke compartments.	K 923		