

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Aberdeen Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 North Highway 281 Aberdeen, SD 57401	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on record review, interview, and policy review, the provider failed to ensure professional nursing standards of practice regarding timely and accurate documentation of narcotic medications for two of two sampled residents (1 and 2) to ensure accountability of high risk medications. Finding include: 1. Review of the narcotic sign-out sheet and resident 1's medication administration record (MAR) revealed: *On 7/17/25 at 9:30 a.m., one Hydrocodone-Acetaminophen 5-325 milligrams (mg) tablet was signed out on the narcotic sign-out sheet by registered nurse (RN) C, but it was not documented as administered in the MAR. *On 7/21/25 at 8:45 a.m., one Hydrocodone-Acetaminophen 5-325 mg tablet was signed out on the narcotic sign-out sheet by RN C, but it was not documented as administered in the MAR. *On 7/22/25 at 8:00 a.m., one Hydrocodone-Acetaminophen 5-325 mg tablet was signed out on the narcotic sign-out sheet by RN C, but it was not documented as administered in the MAR. *On 7/22/25 at 3:00 p.m., one Hydrocodone-Acetaminophen 5-325 mg tablet was signed out of the narcotic sign-out sheet by RN C, but it was not documented as administered in the MAR until 6:10 p.m. that day. *On 7/22/25 at 9:00 p.m., one Hydrocodone-Acetaminophen 5/325 mg tablet was signed out on the narcotic sign-out sheet by RN D, but it was not documented as administered in the MAR. *On 7/23/25 at 5:29 p.m., one Hydrocodone-Acetaminophen 5-325 mg tablet was signed out on the narcotic sign-out sheet by RN E, but it was not documented as administered in the MAR. *On 7/24/25 at 8:54 a.m., one Hydrocodone-Acetaminophen 5-325 mg tablet had been removed by RN C with no time of removal noted, RN D documented in the MAR that the tablet was administered at 7:50 a.m. that day. 2. Review of resident 2's the narcotic sign-out sheet revealed that on 7/21/25 at 4:00 p.m., RN C placed a line through the removed tablet and wrote dropped, but she did not have a second nurse's signature to verify the wasted narcotic medication. 3. Interview on 7/23/25 at 3:30 p.m. with RN F revealed: *When narcotic medications were signed out, they should be documented as administered in the MAR at that same time. *If a narcotic medication was dropped or needed to be destroyed for any reason, it should have been signed by two nurses to document the destruction of it. 4. Interview on 7/24/25 at 10:35 a.m. with director of nursing (DON) B revealed: *It was her expectation that if a narcotic medication was signed out on the narcotic sign-out sheet, it should have been documented in the MAR at that same time. 5. Review of the provider's Controlled Substances policy (updated 4/25/24) revealed: *Purpose, B. To assure controlled drugs are handled, stored, and disposed of properly. *Purpose, C. To assure proper record keeping for controlled drugs. *Administration of Controlled Substances, B. Administering a controlled substance to a resident: it must be signed out on the individualized controlled substance sheet and documented on the eMAR. *Administration of Controlled Substances, C. The controlled substance sheet and eMAR [electronic medication administration record] must match.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, and policy review, the provider failed to ensure one of one sampled resident's (1) wheelchair was secure in the facilities transport vehicle according to manufacturer's guidelines resulting in the resident's wheelchair tipping backwards and the resident sustained a spinal fracture. Findings include: 1. Review of SD DOH FRI that was submitted on 7/15/25 revealed: *At approximately 11:15 a.m. on 7/15/25, resident 1 was being transported from an appointment back to the facility in the facility's transport van by certified nursing assistants (CNA)s G and H and his wheelchair tipped backwards while the van was driving. *It was suspected that the front wheelchair locking mechanisms failed, allowing resident 1's wheelchair to tip backwards. *Resident 1 complained of pain in his back to the staff in the van. *CNAs G and H assisted resident 1 back into his wheelchair after it tipped and transported the resident back the facility. *At the facility, resident 1 was assessed by registered nurse (RN) I and was sent to the Emergency Department (ED) for further evaluation related to his back pain. *On 7/15/25, resident 1 returned to the facility from the ED with a diagnosis of a closed nondisplaced fracture of the sixth cervical vertebra (a break in one of the bones in his neck). *The provider's investigation concluded that lap belt connectors malfunctioned and did not tighten correctly which caused the resident's wheelchair to tip backwards. *The lap belt connectors suspected of malfunctioning were removed from the transport van and replaced with new parts. *CNA G was educated on correctly locking and tightening wheelchair straps in the transport van. 2. Interview on 7/22/25 at 10:55 a.m. with resident 1 revealed: *He recalled the accident that happened on 7/15/25 in the facility's transport van. *He was able to describe the injury he sustained due to the accident. *He stated he had been to several medical appointments in the past while CNA G was driving and had never had any accidents. *He could not recall if CNA G had any changes in her normal routine of securing his wheelchair that day. 3. Interview on 7/22/25 at 1:02 p.m. with CNA H revealed: *She had accompanied resident 1 to his medical appointment on 7/15/25 and rode along in the facility's transport van. *She did not assist with securing his wheelchair in the transport van. *She could not recall watching CNA G securing resident 1's wheelchair in the transport van that day. 4. Interview on 7/22/25 at 2:50 p.m. with administrator A revealed: *After resident 1's 7/15/25 incident in the facility's transport van, she had CNA G demonstrate to her what happened during the transport. *Administrator A checked the wheelchair securing straps and was not able to duplicate the malfunction that happened during the incident that day. *CNA G had been the transport van driver for the past two years and had not encountered an accident like that before. *The wheelchair securing straps were replaced with new ones. *After the incident, there had been a new section added to the van's daily checklist that would have the driver physically check the tension on the wheelchair securing straps for safety. *She felt it was an unfortunate event caused by faulty equipment. 5. Interview and demonstration on 7/23/25 at 10:45 a.m. with CNA G and administrator A in the facility's transport van related to resident 1's incident revealed: *CNA G reported on the day of the incident she loaded resident 1 into the van from the rear wheelchair ramp. *Once resident 1 was in place in the van, she locked his wheelchair brakes, then she attached two hooks to the rear of the wheelchair. She then attached two hooks to the front of the wheelchair. She then fastened resident 1's seat belt. *She then reported leaving the medical provider's parking lot. *After driving for about a block, she heard a loud noise and when she looked back she found resident 1 had tipped backwards in his wheelchair inside the van. *She reported that after pulling over the van, the two hooks attached to the rear wheelchair wheels were still attached. The hooks attached to the front of the wheelchair were no longer attached. It did not appear that the front straps had pulled out of the locking device. *She and CNA H then assisted resident 1 back into his wheelchair. *Resident 1 was taken back to the facility to be assessed by as nurse. 6. Interview on 7/23/25 at 3:30 p.m. with regional nurse consultant/acting director of nursing B revealed that she did not do the staff training for the facility van operation. 7. Interview on 7/23/25 at 4:00 p.m. with administrator A revealed: *Business Office Assistant (BOA) J does the competency testing for staff that drove and operated the facility van. *The current van driver (CNA G) provided training for new van drivers. The new driver would ride with the current driver for a couple days to learn the process. *BOA J used the Driver's Road Test Examination to verify the driver's ability to safely operate the van. 8. Interview on 7/23/25 at 4:47 p.m. with BOA J revealed: *She did not use a specific curriculum for testing a driver's ability to safely operate the van. *She used the facility's Driver's Road Test Examination, which contained a checklist of observed steps</p>		