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	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aberdeen Health and Rehab	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) complaint review, record review, interview, and policy review, the provider failed to thoroughly investigate resident-to-resident incidents of potential abuse by one of one sampled resident (1) who used acts of physical aggression toward two of two sampled residents (2 and 3) on separate occasions. Failure to thoroughly investigate those incidents may have placed all residents at risk for potential resident-to-resident abuse.Findings include:1. Review of the South Dakota Department of Health (SD DOH) complaint received on 8/5/25 regarding resident 1 revealed:*Resident 1 was identified by first name only.*It was reported that resident 1 would walk in the halls, enter other residents' rooms, and take items that did not belong to her from other residents' rooms.*The complainant was told that resident 1 had gone into another resident's room, and choked that resident.*The resident who had been choked reported the incident to the provider and she [resident 2] was told the incident was documented and reported.-The provider had not completed a facility reported incident (FRI) related to the choking incident.*The complainant reported that resident 1 continued to walk in the hallways and some residents were fearful of resident 1.2. Review of resident 1's electronic medical record (EMR) revealed:*She was admitted on [DATE].*She was discharged from the facility on 8/16/25.*Her 5/27/25 Minimum Data Set (MDS) indicated she was rarely understood or able to understand others and was severely cognitively impaired.*Her diagnoses included Alzheimer's (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), major depressive disorder, personality disorder (a group of mental health conditions characterized by inflexible and unhealthy patterns of behavior and thinking that differ from cultural norms), a traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), and behavioral disturbances.*A 6/24/25 progress note stated, Another resident addressed [resident 1] patting at [a] chair next to her offering her to sit by her. [resident 1] rushed over to her & [and] stated, 'I'll kill you!'. Nurse intervened &walked [resident 1] to her room & offered her a snack which she refused.*A 6/26/25 progress note stated, Resident [resident 1] went into another residents [resident 3's] room and attempted to take [that] resident's remote. [The] Resident [3] stated, 'That is my remote can I have it back?' Resident [1] said 'No' and slapped [the other] resident in the head twice before exiting her room. Reported to resident's nurse.*A 7/6/25 progress note stated, resident [1] was in [the] dining room yelling at another resident she was redirected by staff and removed from [the] dining room, will continue to monitor.*A 7/9/25 progress note stated, Resident [1] [is] verbally aggressive toward staff members and other residents at this time.*A 7/10/25 progress note stated, resident [1] [is] agitated [and] going into other resident rooms.*A 7/16/25 progress note stated, resident [1] [is] agitated [and] going into other residents' rooms.*A 7/19/25 progress note stated, resident [1] [is] being reported to have aggressive behaviors towards another resident during bingo and patted her shoulder, will continue to monitor.*A 7/20/25 progress note stated, resident 2 said that [resident 1] came into her room around 515 pm [5:15 p.m.] while [resident 2] had company. [Resident 1] went and sat on the residents [resident's] bed then got up and went to [resident 2]'s hand towels and grabbed one, when [resident 2] told her that they were her towels [resident 1] stated that they were her's then walked over to [resident 2] and put her hands around residents [resident 2's] neck, however [resident 2] said that she did not squeeze or apply pressure [resident 1] just pressed her hand around her [resident 2's] throat.*Resident 1's 7/28/25 progress notes stated,- [resident 1 is] Extremely agitated and yelling at residents [and] staff and attempting to grab them.- resident [1] was yelling out no and swearing at staff, residents, and some visitors, was trying to grab at other residents and when staff would redirect [resident 1] would yell or grab at them.3. Interview on 8/27/25 at 3:40 p.m. with resident 2 regarding the 7/20/25 incident involving resident 1 revealed:*Resident 2 stated she was talking with her visitor when resident 1 entered her room.*Resident 1 had gone over and picked up resident 2's towels.*Resident 2 told her No then resident 1 walked over to resident 2 and placed her hands on resident 2's neck.*Resident 2 stated resident 1 did not squeeze her neck. *Resident 2 denied having felt fearful of resident 1.*She stated that after that incident (on 7/20/25), if resident 1 was agitated and walking in the hallways, she would close her door.4. Review of the provider's investigation related to the incident on 7/20/25 between resident 1 and resident 2 revealed:*Administrator A spoke with resident 2 on 7/21/25 at 10:30 a.m.*Resident 2 told administrator A resident 1, came into her room and wanted her wash cloths [washcloths]- told her No- then came over and put [her] hands on front of her by neck- no squeezing or pushing *Resident 2 denied feeling threatened and stated she felt safe

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) complaint review, record review, interview, and policy review, the provider failed to have reviewed and revised the care plan for one of one sampled resident (1) needs and how to manage those needs.Findings include:1. Review of the South Dakota Department of Health (SD DOH) complaint received on 8/5/25 regarding resident 1 revealed:*Resident 1 was identified by first name only.*It was reported that resident 1 would walk in the halls, enter other residents' rooms, and take items that did not belong to her from other residents' rooms.*The complainant was told that resident 1 had gone into another resident's room, and choked that resident.*The resident who had been choked reported the incident to the provider and she [resident 2] was told the incident was documented and reported.-The provider had not completed a facility reported incident (FRI) related to the choking incident.*The complainant reported that resident 1 continued to walk in the hallways and some residents were fearful of resident 1.2. Review of resident 1's electronic medical record (EMR) revealed:*She was admitted on [DATE].*She was discharged from the facility on 8/16/25.*Her 5/27/25 Minimum Data Set (MDS) indicated she was rarely understood or able to understand others and was severely cognitively impaired.*Her diagnoses included Alzheimer's (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), major depressive disorder, personality disorder (a group of mental health conditions characterized by inflexible and unhealthy patterns of behavior and thinking that differ from cultural norms), a traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), and behavioral disturbances.*She had a 6/26/25 physician's order for LORazepam [an anti-anxiety medication] Oral Tablet 0.5 MG [milligrams] (Lorazepam) Give 1 tablet by mouth every 12 hours as needed for severe anxiety/agitation. *Resident 1 was being seen by a mental health practitioner for management of her behaviors and mental health medications.*A 6/24/25 progress note stated, Another resident addressed [resident 1] patting at chair next to her offering her to sit by her. [resident 1] rushed over to her & [and] stated, 'I'll kill you!'. Nurse intervened &walked [resident 1] to her room & offered her a snack which she refused.*A 6/26/25 progress note stated, Resident [resident 1] went into another residents [resident's] room and attempted to take resident's remote. Resident stated, 'That is my remote can I have it back?' Resident said 'No' and slapped resident in the head twice before exiting her room. Reported to resident's nurse.*A 7/6/25 progress note stated, resident was in [the] dining room yelling at another resident she was redirected by staff and removed from [the] dining room, will continue to monitor.*A 7/9/25 progress note stated, Resident verbally aggressive toward staff members and other residents at this time.*A 7/10/25 progress note stated, resident agitated going into other resident rooms.*A 7/16/25 progress note stated, resident agitated going into other residents' rooms.*A 7/19/25 progress note stated, resident being reported to have aggressive behaviors towards another resident during bingo and patted her shoulder, will continue to monitor.*A 7/20/25 progress note stated, resident 2 said that [resident 1] came into her room around 515 pm [5:15 p.m.] while [resident 2] had company. [Resident 1] went and sat on the residents [resident's] bed then got up and went to [resident 2]'s hand towels and grabbed one, when [resident 2] told her that they were her towels [resident 1] stated that they were her's then walked over to [resident 2] and put her hands around residents neck, however [resident 2] said that she did not squeeze or apply pressure just pressed her hand around her throat.*7/28/25 progress notes stated,- Extremely agitated and yelling at residents [and] staff and attempting to grab them.- resident was yelling out no and swearing at staff, residents, and some visitors, was trying to grab at other residents and when staff would redirect [resident 1] would yell or grab at them.3. Review of resident 1's 8/27/25 care plan revealed:*An identified focus area that indicated she had an Elopement [leaving the facility without staff knowledge]/wander Risk.-Interventions for that focus area included staff were to Maintain familiar items in environment, with well-lit room. Observe behavior and attempt to determine pattern, frequency, intensity and triggers. Offer/encourage activities for distraction.-Her care plan did not include her tendency to wander into other resident rooms and take items, or any identified triggers or interventions to attempt to prevent that behavior.*Her care plan did not address her agitation, verbal and physical aggression towards staff and other residents, potential triggers, or interventions related to her agitation and verbal and physical aggression. *Resident 1's care plan did not indicate she was being seen by a mental health practitioner.4. Interview on 8/27/25 at 3:40 p.m. with resident 2 revealed she had been told by staff that telling resident 1 No was a trigger for resident 1's agitation and aggression.5. Interview on 8/27/25 at 3:45 p.m. with certified nursing

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) complaint, record review, interview, and policy review, the provider failed to follow professional nursing standards to ensure:*One of one sampled resident's (1) pain was assessed according to the provider's policy.*The indication for administration of an as needed anxiety medication administered to one of one sampled resident (1) was documented.*The effectiveness and any adverse reactions were documented for the use of a newly ordered mood-altering medication (Depakote) for one of one sampled resident (1).Findings include: 1. Review of the South Dakota Department of Health (SD DOH) complaint received on 8/5/25 regarding resident 1 revealed:*Resident 1 was identified by first name only.*It was reported that resident 1 would walk in the halls, enter other residents' rooms, and take items that did not belong to her from other residents' rooms.*The complainant was told that resident 1 had gone into another resident's room, and choked that resident.*The resident who had been choked reported the incident to the provider and she [resident 2] was told the incident was documented and reported.-The provider had not completed a facility reported incident (FRI) related to the choking incident.*The complainant reported that resident 1 continued to walk in the hallways and some residents were fearful of resident 1.2. Review of resident 1's electronic medical record (EMR) revealed:*She was admitted on [DATE].*She was discharged from the facility on 8/16/25.*Her 5/27/25 Minimum Data Set (MDS) indicated she was rarely understood or able to understand others and was severely cognitively impaired.*Her diagnoses included Alzheimer's (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), major depressive disorder, personality disorder (a group of mental health conditions characterized by inflexible and unhealthy patterns of behavior and thinking that differ from cultural norms), a traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), and behavioral disturbances.*Review of her July medication administration report (MAR) revealed she did not have a physician's order for regularly scheduled or as needed pain medication until she was prescribed morphine as part of her comfort care plan.*Resident 1's 8/27/25 care plan revealed she had a focus area of has potential for pain with need for medication management R/T [related to] general discomfort with an intervention of report pain or requests for analgesics [medication to relieve pain] to nurse.3. Review of resident 1's history falling documentation from July through August 2025 revealed:*In July she fell on the 5th, the 8th, the 20th, the 28th, and the 29th.*In August she fell on the 3rd and the 4th.*As a result of her fall on 7/29/25 she sustained an indentation on her forehead. She was very agitated and her pain level was assessed to be a six on a zero to ten scale with the use of the PAINAD (a tool to assess pain assessment for people with advanced dementia) assessment scale which meant she had moderate pain.*On 8/3/25 resident 1 fell and sustained a three centimeter laceration (cut or torn skin) to her forehead and her pain level was assessed to be a four with the use of the PAINAD assessment scale, which meant she had moderate.*Review of resident 1's pain assessment revealed:-There were no documented pain assessments completed in June 2025.-On 7/15/25 resident 1's pain assessment was documented at a level four.-On 7/29/25 resident 1's pain assessment was documented at a level six.*There was no documentation of staff having contacted the physician to consider giving orders to for pain medications prior to resident 1 being placed on comfort cares (a type of medical care that focuses on providing relief from symptoms and improving the quality of life for people with serious or life-threatening illnesses) on 8/4/25.*Review of her August MAR revealed she had 8/4/25 physician's order for Morphine Sulfate [narcotic pain medication] (Concentrate) 20 MG/ML [milligrams/milliliter] Give 0.25 ml by mouth every 4 hours as needed for Pain.4. Further review of resident 1's EMR revealed she had a 6/26/25 physician's order for LORazepam [an anti-anxiety medication] Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 12 hours as needed for severe anxiety/agitation.*Resident 1's MAR documentation indicated she was administered the as needed lorazepam 47 times in July 2025.-Of those 47 documented lorazepam administrations, 28 did not indicate what the medication was administered for.*Resident 1 had a 7/22/25 physician's order for Depakote Oral Tablet [a medication used to treat seizures and bipolar disorder] Delayed Release 125 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for mood stabilization.*An 8/1/25 communication with psychiatric mental health nurse practitioner J revealed she had spoken with licensed practical nurse (LPN)/Minimum Data Set (MDS) coordinator H, who reported resident 1 continued anger/irritability and aggression at times.*On 8/1/25 a physician's order was received to change resident 1's Depakote order to Depakote Oral Tablet Delayed Release 125 MG (Divalproex Sodium)