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	02/26/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, document review, record review, and policy review, the facility failed to ensure the safety for one of one sampled resident (1) who was identified at risk for elopement (leaving the facility without staff knowledge) and left the building unsupervised on 2/13/26. Immediate Jeopardy (IJ) at F 689, severity K, began on 2/13/26 at 4:10 a.m. when the provider failed to ensure the safety of resident 1 who eloped through his bedroom window and was found at 4:38 a.m. outside when outdoor temperatures were approximately 25 degrees Fahrenheit (F), for an unknown amount of time, and the safety of any other residents identified at risk for elopement (total of 11). The facility failed to implement appropriate safety measures to ensure all residents identified at risk for elopement could not exit the facility unsupervised and without staff knowledge. Executive director A was notified of the IJ on 2/24/26 at 6:03 p.m. and a removal plan was requested. The removal plan was received on 2/25/26 at 1:37 p.m., and it was accepted on 2/25/26 at 2:00 p.m. The IJ was removed on 2/25/26 at 3:25 p.m. as confirmed by onsite verification by the survey team. After the IJ removal, the severity of the non-compliance remained at an E. The current census was 73. Findings include:1. Review of the provider's 2/13/26 SD DOH FRI revealed that certified nursing assistant (CNA) R and CNA S notified registered nurse (RN) J on 2/13/26 at 4:10 a.m. that resident 1 was not in his room, and his window was open with the screen pushed out of it. They checked the rooms on resident 1's wing and had the other facility staff members check the rest of the building. When resident 1 was not found, they searched outside, and CNA R found him lying in the grass at about 4:38 a.m. He did not have any major injuries, and his vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were normal. He was wearing a long-sleeved shirt, pants, socks, shoes, and two jackets. The temperature outside was around 25 degrees Fahrenheit (F). Staff secured his window, started 15-minute safety checks for 72-hours, changed his clothes, and helped him to bed. The facility management team, the resident's physician, and the resident's family were notified of the incident. The management team had a meeting that morning of 2/13/26 about resident 1's elopement and determined that his window did not have a safety stopper in place to prevent it from sliding open all the way. Maintenance staff placed a stopper and a window alarm on resident 1's window on 2/13/26 at 10:10 a.m. The management team interviewed the staff who were working at the time of the elopement and determined the last time resident 1 was seen was around midnight. At about 10:30 a.m., director of nursing (DON) B instructed maintenance staff to check every window in the building to ensure that they were unable to be opened far enough for someone to go through. Maintenance staff was placing stoppers on all of the sliding windows to prevent them from being opened more than a few inches. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Minimum Data Set (MDS) coordinator/licensed practical nurse (LPN) H reviewed all resident care plans and pocket care plans (personalized plan that addresses a resident's care needs, goals, and interventions) to ensure they were up to date. The WanderGuards (a wearable door alarming device) were checked for placement and functionality for all residents who wore them and at risk for elopement. Executive director A ensured the elopement binders (a binder that contained a picture and description of the residents who were at risk for elopement) were current and that the elopement drills had been completed. DON B was completing all staff education regarding elopement, residents who were at risk for elopement, two-hour rounding (checking on residents' status and assistance needs) for all residents, and immediate notification of reportable incidents. The provider's five-day final investigation FRI report stated that resident 1 had not tried to elope since the 2/13/26 incident, and his physician started him on a medication for dementia (a group of symptoms affecting memory, thinking, and social abilities). Other interventions included checking that all the WanderGuard devices on the doors were functioning, and indicated that all of the other interventions were completed. 2. Observation on 2/24/26 at 8:52 a.m. of resident 1's window in his room revealed it had metal stoppers on the window so it could not be opened further than a few inches but there was no alarm on his window. 3. Observation on 2/24/26 at 9:15 a.m. of the sliding window in the tv room revealed that it did not have a metal stopper and it could be slid open far enough for a person to climb out of it. 4. Observation on 2/24/26 at 9:28 a.m. of the sliding windows in the restorative room revealed there were three windows in that room. Two of them did not have the metal stoppers and were able to be opened far enough for a person to climb out of. The window that had the stoppers on it had a sign on it that stated do not open windows. There were two doors to access the restorative room from the resident hallway that did not lock. The restorative aide left the room unattended when bringing a resident back to their room. 5. Observation on 2/24/26 at 9:34 a.m. of the sliding windows in the therapy room revealed they had three windows that had the metal stoppers. One window did not have the metal stoppers and was able to be opened far enough for a person to climb out of. 6. Observation on 2/24/26 at 9:55 a.m. of the sliding windows in the chapel revealed there were two windows that did not have the metal stoppers and were able to be opened far enough for a person to climb out of. There were two doors to access the chapel from the hallway that did not lock. 7. Observation on 2/24/26 at 1:45 p.m. of the sliding window in resident 2's room revealed that her window had a stopper on the left side of her window and did not have one on the right side. The right window was able to be opened far enough for a person to climb out of. 8. Observation on 2/24/26 at 1:47 p.m. of the surveyors' facility map that indicated resident rooms who were at risk for elopement revealed that there were four residents who were at risk for elopement whose rooms were located near the restorative room. 9. Interview and observation on 2/24/26 at 2:08 p.m. with CNA K in the nurses station revealed she had worked at the facility for about two and a half years. She was able to state the process for what to do if a resident eloped. There was an elopement binder at each nurse's station with resident's (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 2/25/2026, [name redacted], MDSC was educated on completing care plan and pocket care plans timely and/or updated as changes occur. Resident 1's care plan was updated on 2/25/2026 and all like residents care plans were updated on 2/25/2026 that require sliding window clamp locks determined by elopement risk. As per final state report all staff were educated 2/13/2026-2/18/2026 on the following topics: Elopement Process/Policy, 2 hour rounding, notification expectations of reportable events to the Administrator, Director of Nursing, Physician, and family members, and who our current wander guard residents are and how we identify them. On 2/25/2026, [name redacted], Director of Nursing contacted staff that received the mandatory education information in their work mailbox have received the training information. On 2/25/2026, [name redacted], MDSC completed elopement risk assessments for all current residents in the building. No new residents were identified as being an elopement risk. On 2/16/2026, [name redacted], Administrator reviewed the current Emergency Plan for [provider]. This review included the Elopement policy and procedure for the facility. The Emergency Operation Plan, including elopement policy was reviewed by [name redacted], Administrator on 2/25/2026 and found no changes needed to be made. Any concerns will be reported to the administrator immediately and addressed in the facility QA [quality assurance committee]. 21. Observation and interview on 2/25/26 at 2:04 p.m. with executive director A and maintenance director G while observing the facility's windows that were not previously secured, revealed that resident 5's window did not have the metal stoppers on it. They stated they did not think they needed to be on it because it slid upward and not sideways, and they verified it opened far enough for someone to climb out of. 22. Interview on 2/25/26 at 2:40 p.m. with BOA N revealed that she received education after resident 1's elopement on 2/13/26. It included the elopement policy, who needs to be notified when there is an elopement, and submitting the information to the DOH. 23. Interview on 2/25/26 at 2:42 p.m. with RN O revealed he received education after resident 1's elopement. It included the elopement policy, who needed to be notified of the elopement and when, and included follow-up interventions when an elopement occurs. 24. Observation on 2/25/26 at 2:45 p.m. with executive director A and maintenance director G of the facility's windows that were not previously secured, revealed that they all had the metal stoppers and were now secured. 25. Interview on 2/25/26 at 2:48 p.m. with CNA P revealed she received education on 2/13/26 after resident 1's elopement. It included a review of the elopement policy, rounding every two hours on all residents, and information on interventions if an elopement occurs. 26. Interview on 2/25/26 at 3:00 p.m. with DON B revealed that the staff who had not yet completed the elopement education would complete it prior to their next shift worked. 27. Record review revealed that ten random residents who were not previously identified as at risk (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	for elopement had elopement risk assessments completed on 2/25/26. The eleven residents that were previously identified as being at risk for elopement had current elopement risk assessments completed, their care plans were up to date, their pocket care plans were up to date, their WanderGuards were documented as being checked for placement and functionality, and elopement drills were completed. The survey team verified onsite, through observations, interviews, and record reviews, that the provider followed their IJ removal plan and the immediacy was removed. The scope and severity level of the noncompliance remained at an E. 28. On 2/25/26 at 3:25 p.m. executive director A was notified that the IJ had been removed. 29. Observation and interview on 2/26/26 at 9:03 a.m. with maintenance director G checking the door alarms throughout the facility revealed the door in the activity room had a magnet alarm that alarmed when it was opened, but the alarm turned off immediately after it was closed. It did not need to be reset by staff to turn the alarm off. The exit door by the laundry room and employee break room had a red alarm box with a keyhole on it, which did not alarm when it was opened. The door alarm was not activated, and he had not checked this door since he started working at the facility. Maintenance director G activated it, and it was functioning. He was unaware if anyone else had keys to turn that alarm off. There were two black doors in the dining room that opened to the courtyard that were unlocked and not alarmed. They were unable to be opened more than a few inches at this time due to snow that was packed behind them. He did not check these doors because he thought they were always locked. He started working at the facility at the end of January, and the previous maintenance director resigned before that. Executive director A and regional maintenance director Q completed his orientation. He went over the easement doors exit doors with regional maintenance director Q during his orientation, but not all of the exit doors. 30. Interview on 2/26/26 at 9:21 a.m. with activities director I revealed that the two doors that accessed the activity room from the hallway were always kept unlocked. She was not aware if the exit door in that room could be locked. 31. Interview on 2/26/26 at 9:55 a.m. with executive director A revealed she had problems with her previous maintenance director completing his duties. He was no longer working there when maintenance director G's employment there started. She and regional maintenance director Q completed maintenance director G's orientation, and he planned for him to have more education completed after three months of employment. She expected that all exit doors would be secured and checked routinely. She acknowledged that the immediate jeopardy (IJ) removal plan indicated she verified that all exit door alarms were in working order on 2/24/26 at 7:30 p.m. She stated that she must have missed checking the activity room door, the exit door by the laundry room, and the two black doors in the dining room. 32. Interview, observation, and document review on 2/26/26 at 11:30 a.m. with executive director A and maintenance director G revealed that the once unsecured doors were now secured, and they were now added to the weekly door check audit. 33. Interview on 2/26/26 at 8:17 a.m. with DON B revealed that CNAs did not complete behavior documentation on resident 1 because the nurses were completing it. She was unaware that resident 1 had (continued on next page)

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