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	06/04/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on the observation, interview, and record review, the provider failed to ensure the staff responded promptly to 11 of 16 sampled residents (6, 22, 30, 34, 36, 40, 41, 62, 64, 68, and 73) call lights. Findings include:1. Interview on 6/2/26 at 9:54 a.m. with resident 6 in his room revealed that after he turned his call light on it took the staff 15 minutes to two hours to answer his call light. 2. Review of resident 6's call light log (a report that states how long it takes for staff to answer a resident call light) from 5/3/26 through 6/2/26 revealed he had to wait for over 20 minutes three times, over 30 minutes four times, and over forty minutes one time for the staff to answer his call light. 3. Review of resident 6's electronic medical record (EMR) revealed his 3/31/26 brief interview for mental status (BIMS) assessment score was 15, which indicated his cognition was intact. His 4/30/26 care plan indicated he required one staff member to assist him with getting in and out of bed, repositioning, dressing, using the bathroom, and personal hygiene care. 4. Interview on 6/2/26 at 10:15 a.m. with resident 30 in her room revealed that she sometimes had to wait a long time for the staff to answer her call light. 5. Review of resident 30's call light log from 5/3/26 through 6/2/26 revealed she had to wait for over 20 minutes ten times, and over 30 minutes three times for the staff to answer her call light. 6. Review of resident 30's EMR revealed her 3/31/26 BIMS assessment score was 13, which indicated her cognition was intact. Resident 30's 3/31/26 MDS assessment (used to document resident care needs) indicated she was dependent on staff for assisting her with bathroom needs, personal hygiene care, dressing, and moving in bed. 7. Interview on 6/2/26 at 10:25 a.m. with resident 64 in her room revealed that she had to wait a long time when she turned her call light on, and the staff was in a rush when they took care of her. She had to wait two hours when the staff changed shifts. When she had to wait a long time for the staff to respond to her call light, she was incontinent of urine. She stated that this made her feel upset because she could not do things herself, and she required the staff's assistance. 8. Review of resident 64's EMR revealed her 5/12/26 BIMS assessment score was 13, which indicated her cognition was intact. Her 5/12/26 MDS assessment indicated she required staff assistance with bathroom needs, personal hygiene care, dressing, moving in bed, and ambulation. 9. Review of resident 64's call light log from 5/3/26 through 6/2/26 revealed she had to wait for over 20 minutes five times and over 30 minutes four times for the staff to answer her call light. 10. Review of resident 30 and 64's bathroom call light log from 5/3/26 through 6/2/26 revealed that one of them had to wait 25 minutes once and 152 minutes and 57seconds once. 11. Interview on 6/2/26 at 11:04 a.m. with resident 34 in her room revealed that she had to wait a long time for the staff to answer her call light, and then she was incontinent of urine. She stated, Maybe they do not take care of me because they do not like me. I am hard work. She had turned her call light on a while ago and no one had come to assist her. Sometimes the staff did not give her the call light device, and she had to bang on something to get their attention. 12. Review of resident 34's call light log from 5/3/26 through 6/2/26 revealed she had to wait for over 20 minutes four times, over 30 minutes five times, and over 40 minutes once for the staff to answer her call light. 13. Review of resident 34's EMR revealed her 5/4/26 BIMS assessment score was 14, which indicated her cognition was intact. Her 5/19/26 care plan indicated she required two staff to assist her with bathroom needs, moving in bed, getting in and out of bed, and dressing. 14. Observation and interview on 6/2/26 at (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:29 a.m. with resident 68 in her room revealed she was sitting in her wheelchair, and her call light device was on her bed, within arm's reach of her wheelchair. She stated the call light doesn't seem to work all the time, so if 15 minutes have passed, I'll go (by wheelchair) up to the main nurse's area and wait there. 15. Review of resident 68's electronic medical record (EMR) revealed her 4/10/26 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. Her 5/9/26 care plan indicated she required one staff member to assist her to and from the bathroom.16. Interview on 6/2/26 at 2:20 p.m. with resident 41in her room revealed she waited an hour sometimes for the staff to answer her call light. The staff did not answer her call light between 1:30 p.m. and 2:00 p.m. sometimes because of the shift change, and the staff would wait for the oncoming shift to answer her call light. 17. Review of resident 41's 4/30/26 BIMS assessment score was 14, which indicated her cognition was intact. 18. Review of resident 41's call light log from 5/2/26 to 6/2/26 revealed she had twelve call light response times over 20 minutes long, and of those call light response times three were over 30 minutes long. 19. Interview on 6/2/26 at 3:29 p.m. with resident 36 in his room revealed that his call light took quite a while to be answered by the staff. He had a sore on his buttock, and he did not like having to wait 20 to 45 minutes to get help from the staff. 20. Review of resident 36's 3/12/26 BIMS assessment score was 15, which indicated his cognition was intact. 21. Review of resident 36's call light log from 5/2/26 to 6/2/26 revealed he had 29 call light response times over 20 minutes long, and of those 29 call light response times, eleven were over 30 minutes long. 22. Interview on 6/3/26 at 9:30 a.m. with resident 40 and her family member in the activity room revealed that she sometimes lost control of her bladder while waiting to be assisted to the bathroom. We don't have enough lifts (a mechanical device used to lift a person's full body). Half the time the aides come in, turn the light off, say they'll be back in a few minutes because they have to find a lift, and they may not come back. Resident 40's family member stated, We were told that after five minutes if they (staff) don't come back, pull the call light again.23. Review of resident 40's EMR revealed her 5/11/26 BIMS assessment score was 15, which indicated her cognition was intact. Her 5/26/26 care plan indicated that she used a sit-to-stand lift (a mechanical lift used to assist a person from a seated to a standing position) with two staff members to assist her to and from the bathroom.24. Review of resident 40's call light log from 5/4/26 through 6/3/26 revealed that she had to wait over 20 minutes seven times, over 30 minutes three times, and over 50 minutes one time. 25. Observation and interview 6/4/26 at 10:20 a.m. in resident 34's room revealed that she could not reach her call light. It was lying on the bedside table, which was on the resident's left side. She had a sling on her left arm and the full body lift sling (a supportive fabric that attaches to a mechanical lift [a device used to lift a persons fully body]) under her. She stated that the staff were supposed to come back and had not yet, and stated, They are probably in the breakroom, that is where they sit. 26. Observation and interview on 6/4/26 at 10:31 a.m. in resident 34's room revealed that CMA T and CNA V came into the room to get her up. Resident 34 told CMA T and CNA V that she could not reach her call light device. CMA T verified that she could not reach her call light and stated that residents' call lights were to be left within their reach when the staff left the room. 27. Interview during the Resident Council Meeting on 6/4/26 at 1:30 p.m. revealed that the residents 6, 22, 41, 62, and 73 had concerns about long call light wait times, around 15 minutes to 2.5 hours, and call lights being left where they could reach them. They expressed concern that there was no staff on the floor to answer their call lights because they all went out to smoke together or sat in the breakroom. One resident stated that she was incontinent of urine when she had to wait to long for the staff to assist her to the bathroom, and this made her feel terrible, and they try to make you feel bad by telling me I am not the only one here. The residents discussed their call light concerns in the Resident Council meetings before. One resident stated that her call light was left out of reach, so she had to yell for assistance, and then the staff member told her not to yell. 28. Review of resident 22's 4/27/26 BIMS assessment score was 15, which indicated her cognition was intact. 29. Review of resident 62's 5/12/26 BIMS assessment score was 15, which indicated her cognition was intact. 30. Review of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident 73's 4/29/26 BIMS assessment score was 15, which indicated her cognition was intact. 31. Interview on 6/2/26 at 11:15 a.m. with RN P and ADON/LPN/IP N at the nurses' station revealed that there were no resident call lights turned on at that time. The surveyor reported to them that resident 34 stated that her call light was on for a while. RN P went to check on resident 34's call light device and stated that the call light was disconnected from the call light extender that plugged into the wall, so that was why the call light did not turn on when she pushed her call light device. 32. Interview on 6/3/26 at 1:42 p.m. with CMA T revealed he noticed several times when he came in in the morning for his scheduled shift that the residents did not have their call light devices within their reach. When he saw this, he reported it to the nurse. 33. Interview on 6/3/26 at 2:11 p.m. with RN P and ADON/LPN/IP N revealed that they would occasionally find a resident's call light device that was not within their reach. 34. Interview on 6/4/26 at 9:17 a.m. with certified medication assistant (CMA) I revealed that when call lights were activated, the room numbers were displayed on a digital screen in each hallway and announced on the staff's radios. He stated, It's not our practice to go into the room and shut off the light and then return - we just take care of their needs right away. 35. Interview on 6/4/26 at 9:24 a.m. with assistant director of nursing (ADON)/licensed practical nurse (LPN)/infection preventionist (IP) N revealed that until the call light was deactivated in the resident's room, the staff were unable to talk over their radio. It's good incentive to get the aides to the rooms quickly so they can use their radios again. She stated that the provider's protocol was to shut the resident's call light off and then assist the resident, but some staff assist a resident to the bathroom before deactivating the light, which could extend response time on the call light log.She expected a timely response to a resident's call light would be between five and ten minutes at the most, but I know sometimes we're challenged on the floor. If the staff turned the resident's call light off and left to locate a lift, she said the residents were expected to turn the light on if the staff did not return within a few minutes. She was not aware of the extended response times for resident 40's room but stated that some residents experienced bladder urgency or could not verbally tell the staff when they needed to use the bathroom, so accidents may happen. 36. Interview on 6/4/26 at 11:11 a.m. with certified nursing assistant (CNA) J revealed that she thought the resident's call lights should be answered within ten minutes. The call lights would sound over the staff's radio system to alert the staff that a resident had activated their call light and needed staff's assistance. 37. Interview on 6/4/26 at 11:24 a.m. with registered nurse (RN) E revealed she expected the resident's call lights to be answered within two minutes. She stated, We use the walkie system, and call light alerts to go right over that system to alert staff. 38. Interview on 6/4/26 at 11:49 a.m. with ADON/LPN D revealed she considered five to seven minutes to be a reasonable time for resident call lights to be answered by the staff. 39. Interview on 6/4/26 at 1:09 p.m. with director of nursing (DON) B revealed that she expected the resident's room call lights to be answered within 15 minutes and their bathroom call lights to be answered within five minutes. Executive director A would pull random call light logs throughout the month and more frequently if residents had shared concerns about longer response times. Call light audits were also posted in the staff breakroom for the staff to review.DON B was aware of resident 40's call light response times. I think there's only one bariatric lift (a mechanical lift use to help transfer overweight residents to the bathroom), so her response time gets delayed. She agreed that some aides turned off the resident's call lights and told residents to push it again if the staff did not return within five minutes. It's usually something they only do if (the staff have) to wait for a lift to be available, sometimes if they're in the middle of assisting someone else. She expected the resident's call lights to always be in working order and said that most days, the maintenance staff or MDS coordinator C repaired or replaced any non-working call lights before the leadership staff arrived at 8 a.m.40. Interview on 6/4/26 at 1:22 p.m. with executive director A revealed that she expected the resident's room call lights to be answered within 15 minutes and their bathroom call lights to be answered within five minutes. Unfortunately, that's not the way it always goes. She asked residents to tell her when staff turned their call lights off without addressing their needs. In (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	addition to auditing call light logs two or three times per month, she stated she had audited call light frequencies, such as when a resident's call light was repeatedly activated within a 30- or 60-minute timeframe. When lengthy response times or repeated call lights were observed, she expected DON B to address it with unit managers and the nursing staff.41. A call light policy was requested, and the provider did not have a call light policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and policy review the provider failed to ensure the staff followed standard infection control and prevention practices regarding:*Hand sanitizer dispensers that were past their expiration dates in 27 of 64 resident rooms. *One of one linen cupboard had a covering to protect against airborne infectants.*One of one resident wheelchair (26) was kept in good repair and had a cleanable surface on it.*Two of two observed residents (9 and 63) wheelchairs were clean and free from odor.*Three of three observed certified nursing assistants (CNA) (R, S, V,), one of one observed certified medication aide (CMA) (T), and one of one registered nurse (RN) (W) followed enhanced barrier precautions (EBP) (gown and glove use) when assisting one of one observed resident (34) with personal hygiene care and wound care. *One of one observed RN (W) who did not clean one of one observed resident (34)'s wound before applying a wound dressing.*One of one assistant director of nursing (ADON)/licensed practical nurse (LPN)/infection preventionist (IP) (N) and one of one RN (U) who failed to perform appropriate hand hygiene during all observed wound care, brought wound care supplies into multiple resident rooms, and did not sanitize wound care supplies between resident use while providing wound care for five of five sampled residents (5, 6, 9, 10, and 34) who had pressure ulcers. Findings include:1. Observation on 6/2/26 at 10:20 a.m. revealed Spectrum Advanced foaming hand sanitizer dispensers with expiration dates of 10/25/25, 6/20/25, 8/6/25, and 4/9/26 in 29 of 64 resident rooms. 2. Interview on 6/2/26 at 4:29 p.m. with CNA O in the Country Lane hallway regarding the hand sanitizer in the resident rooms revealed she used the hand sanitizer in the resident rooms before and after providing cares for a resident. 3. Interview on 6/2/26 at 5:15 p.m. with CNA K in the Country Lane hallway revealed that she used the hand sanitizer in the residents rooms to sanitize her hands before providing resident cares and when she left the room. 4. Interview on 6/3/26 at 1:43 p.m. with CNA Q near the nurses' station revealed she usually used the hand sanitizer in the residents' room before exiting, or she washed her hands in the sink. 5. Interview on 6/4/26 at 8:53 a.m. with director of nursing (DON) B regarding the expired hand sanitizer dispensers revealed, the provider did not have a specific policy for expired hand sanitizer products. She confirmed the hand sanitizer dispensers discovered in those 29 resident rooms were past the expiration dates. She was not sure who monitored the sanitizer dispensers for expiration dates. 6. Interview on 6/4/26 at 2:10 p.m. with executive director (ED) A regarding the expired hand sanitizer revealed that she confirmed the hand sanitizer was expired in 29 resident rooms. The staff were not assigned to check the hand sanitizer for expiration dates because it should not last that long in the resident rooms. 7. Observation on 6/2/26 at 2:41 p.m. of the linen cupboard outside the transitional care unit (TCU) dining room revealed that there were blankets, sheets, bath blankets, and gowns on the shelves. There were no doors or coverings for the closet to protect the linens from airborne infectants. 8. Interview on 6/4/26 at 11:48 a.m. with RN E revealed there were no doors on the linen cupboard across from the TCU dining room since March 2026, when she started working at the facility. She did not consider those linens in the cupboard as clean. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Interview on 6/4/26 at 11:49 a.m. with assistant director of nursing (ADON)/licensed practical nurse (LPN) D revealed that she would not consider the linens in the cupboard outside the TCU dining room as clean. She encouraged the staff to use the linens in the shower room in the enclosed cupboard. She had observed the staff using the linens from the cupboard outside the TCU dining room. There were no doors or covering on the linen cupboard outside the TCU dining room since October of 2025. 10. Interview and observation on 6/2/26 at 3:44 p.m. revealed that resident 26's right hand was curled under the right handle of his electric wheelchair. He explained that his hand curled outward because of a diagnosis of genetic torsion dystonia (a movement disorder causing involuntary, repetitive, sustained muscle contractions that lead to painful twisting and abnormal postures). The padding on the right handle was torn and partially missing. Scotch tape that appeared scuffed and dirty was wrapped around the padding to keep it secure. Resident 26 used his left hand to point at the torn padding and raised tape edging and stated, This is not comfortable. I have complained but they (staff) don't address my concerns. 11. Interview on 6/4/26 at 1:09 p.m. with DON B revealed that her expectation was for maintenance staff to repair or replace equipment, such as torn wheelchair padding. As the staff encountered items that needed to be repaired, they were to submit repair requests to the maintenance team, who were expected to complete the repairs pretty quickly, usually. Minimum data set (MDS) coordinator C also helped repair broken resident equipment. DON B was not aware the padding on resident 26's wheelchair handle needed to be replaced. 12. Interview on 6/4/26 at 1:36 p.m. with maintenance director M revealed that the maintenance staff were expected to work through repair requests as quickly as they could. For resident wheelchair repairs, he stated he worked with MDS coordinator C to order replacement parts, or if we have something we can put on it until we get a replacement part, I would do that. He was not aware that the padding on resident 26's wheelchair handle needed to be replaced. 13. Observation on 6/2/26 at 2:31 p.m. outside of residents 34 and 63's room revealed there was a high back reclining wheelchair that had a pressure relief cushion, and it smelled of urine. There was an EBP sign from the CDC outside of resident 34's room that indicated the staff were to wear gloves and a gown for high-contact resident care activities, which included dressing, providing personal hygiene, changing incontinence products, transferring, and providing wound care. 14. Observation and interview on 6/2/26 at 3:13 p.m. with resident 34 in her and resident 63's room revealed she was lying in bed, covered with a blanket, and stated she was using the bedpan. CNAs R and S sanitized their hands with hand sanitizer from the residents' room, put on a gown, and a pair of gloves, which were located in a bin in the residents' room. CNA R and S turned resident 34 on her side and removed the bedpan. CNA R obtained wipes from resident 34's bedside table and wiped her buttocks. CNA R obtained a new incontinence (involuntary leakage of bladder or bowel) brief from resident 34's bedside table, placed it under her, and fastened the tabs. Wearing those same gloves, CNA R assisted CNA S to pull up resident 34's pants, and then placed a sling (fabric tool that wraps around a resident's body and attaches to a mechanical lift used to lift and transfer the resident) under her. Resident 63, who was lying in her bed, started to cough up mucus. Without removing his gown and gloves, CNA S used resident 63's bed controller to elevate the head of her bed. CNA R removed her gown and gloves, discarded them in the trash can, did not perform hand hygiene (washing or (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sanitizing hands), and assisted resident 63 to sit up straighter in bed. CNA S removed his gown and pair of gloves, discarded them in the trash can, did not perform hand hygiene, and put on a new pair of gloves and a gown. CNA R did not perform hand hygiene, and put on a gown and a pair of gloves. CNA S hooked resident 34's sling to the full body lift (a mechanical lift and sling used to lift a person's full body), and the CNAs transferred resident 34 to her wheelchair, removed the sling from under the resident, removed their gowns and gloves, discarded them in the trash can, and washed their hands. CNAs R and S each put on a pair of gloves. CNA S brought in resident 63's high-back upholstered wheelchair from the hallway. Under the pressure relief cushion, there was old food, and it smelled like urine. CNA S used cleaning wipes to wipe off the seating surface of the wheelchair, under the pressure relief cushion. With those same gloves, CNA S used resident 63's bed control to lay resident 63 flat. CNA R removed her gloves, performed hand hygiene, and put on a new pair of gloves. CNA R opened resident 63's incontinence brief, obtained wipes that were on her bedside table, wiped her perineal (genital) area, and wiped her buttocks, opened a three-drawer bin drawer, grabbed an incontinence brief, and placed it under the resident. They turned the resident from side to side to get the incontinence brief under her, and they fastened the tabs. Resident 63 was agitated and did not want to get up into her wheelchair. With those same gloves, CNA S moved resident 34's bedside table. Both CNA R and CNA S removed their gloves, put them into the trash can, and washed their hands. 15. Review of resident 34's electronic medical record (EMR) revealed she required EBP due to having an open pressure ulcer (skin and/or underlying tissue injury from prolonged pressure). 16. Observation on 6/3/26 at 1:31 p.m. in resident 9's room revealed she had an upholstered high-back wheelchair that smelled of urine. 17. Interview on 6/3/26 at 3:51 p.m. with CNA S revealed he was to wash his hands before entering a room, after removing his gloves, and when leaving a resident's room. 18. Observation on 6/4/26 at 10:31 a.m. in resident 34's room revealed CMA T and CNA V sanitized their hands with hand sanitizer, put on a pair of gloves, and did not put on a gown. Resident 34 had an incontinent bowel movement. CMA T used wipes from resident 34's bedside table and wiped resident 34's bottom, including over the pressure ulcer on her right lower buttock. He called the nurse using his walkie to come put on a dressing. With those same gloves he obtained a paper towel, dabbed around her pressure ulcer area, and placed a brief under her. CMA T and CNA V removed their gloves, discarded them in the trash can, and did not perform hand hygiene. RN W came into the room already wearing a pair of gloves and had resident 34's pressure ulcer dressings in her hand. She did not put on a gown. She did not cleanse the wound, saying that the CNAs already did that. She leaned her arms and upper torso on the resident's bed, applied a skin prep (a moisture prep pad that is applied around a wound to protect the fragile skin) around the pressure ulcer, put a piece of collagen (a protein placed in wounds to promote healing) into the pressure ulcer, put the sliver (an antimicrobial agent) over the pressure ulcer, and then put on a foam dressing. With those same gloves, she took a black marker out of her pocket, dated the dressing, and put the marker back into her pocket. CMA T and CNA V did not perform hand hygiene, put on a pair of gloves, and pulled the resident's pants up. RN W removed her gloves and washed her hands. 19. Interview on 6/4/26 at 10:50 a.m. with RN W outside of resident 34's room revealed she did not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleanse the wound before putting the dressing on it because CMA T cleaned it with the wipes. She agreed that that was not what was on the treatment plan. She was not sure if she was supposed to wear a gown. After reviewing the Centers for Disease Control and Prevention (CDC) EBP sheet hanging by the resident's door, she said CMA T, and CNA V were to have worn gowns with personal hygiene care, and she should have worn a gown when applying the dressing. 20. Interview on 6/4/26 at 10:55 p.m. with CMA T revealed he was to wear a gown during personal hygiene care for residents who required EBP. He was to wash his hands when he entered a resident's room, left a resident's room, and when removing gloves and before putting on a new pair of gloves. He verified he did not perform hand hygiene between glove changes while providing personal hygiene care for resident 34. 21. Interview on 6/4/26 at 11:24 a.m. with ADON/LPN/infection preventionist (IP) N and RN U revealed they expected RN W to have cleaned resident 34's wound per the treatment record before applying a new dressing, staff to wear gowns when assisting residents with personal hygiene and wound care who were on EBP, and to perform hand hygiene before putting gloves on and when removing them. They verified that not following infection control processes can put the residents at risk for infection. 22. Interview on 6/4/26 at 3:05 p.m. with director of nursing (DON) B revealed she expected the overnight CNAs to clean the resident's wheelchair on the resident's shower day. If the wheelchair was upholstered, she expected the housekeeper to use an upholstery cleaner to clean them. She expected the staff to follow EBP and hand hygiene policies, and verified that not following infection control practices put the residents at risk for infection. 23. Review of the provider's 1/4/26 through 6/4/26 Infection Surveillance Report revealed 27 urinary tract/kidney infections, of which 24 were healthcare acquired infections (HAI), 13 skin and soft tissue infections, of which 11 were HAI, and 11 respiratory infections, of which nine were HAI. 24. Observation and interview on 6/3/26 at 8:06 a.m. of ADON/LPN/IP N and RN U in resident 9's room revealed RN U obtained the supplies for a wound dressing change from the treatment cart, placed a paper towel barrier on the bedside table, and placed a bottle of soap and saline (cleaning solution), gauze, and a dressing on the barrier. RN U stated she was the wound nurse. They performed wound care using appropriate infection control practices. ADON/LPN/IP removed the garbage bag from the garbage can in resident 9's room and sanitized her hands with the hand sanitizer located by resident 9's door that expired on 6/20/25. RN U washed her hands and returned the bottles of soap, saline, and the unopened package of gauze to the wound treatment cart. Review of resident 9's EMR revealed she had a stage II pressure ulcer to her left heel, and she was required to be on EBP. 25. Observation on 6/3/26 at 8:20 a.m. outside of resident 5's room revealed ADON/LPN/IP N sanitized her hands after leaving resident 9's room, which was expired. RN U got supplies out of the wound treatment cart for resident 5 and sanitized her hands. They each put on a gown and a pair of gloves and entered resident 5's room. ADON/LPN/IP N picked up the lift sling that was on the floor and put it on the resident's chair, folded a blanket, and put the blanket under resident 5's left heel. She removed resident 5's left sock, removed her gloves, discarded them in the trash can, performed hand hygiene, and put on a pair of gloves. RN U put a paper towel barrier on resident 5's bedside table, (continued on next page)

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Aberdeen Health and Rehab	1700 North Highway 281 Aberdeen, SD 57401

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be on EBP. 27. Observation on 6/3/26 at 10:06 a.m. of RN U and ADON/LPN/IP N gathering supplies outside of resident 10's room for her dressing change revealed she took out an open bottle of Hibiclens (an antiseptic), saline, and betadine from the wound treatment cart. A non-sterile Q-Tip was lying on top of the wound treatment cart, without being on a barrier. She grabbed the Q-Tip, Hibiclens, saline, betadine, and a dressing from the wound treatment cart. RN U and ADON/LPN/IP N performed hand hygiene, put on a gown, and a pair of gloves. RN U placed the Hibiclens, saline, betadine, Q-tip, gauze, and dressing on the paper towel barrier on the resident's bedside table. She poured the Hibiclens and saline on the gauze and the betadine on the gauze in a medication cup. ADON/LPN/IP N positioned resident 10 on her side. RN U removed the old dressing from her buttocks and used the non-sterile Q-tip to measure the depth of the wound, which was 2 cm. With those same gloves, she cleansed the wound with the gauze that had Hibiclens and saline on it, dried it with a new gauze, and held the resident on her side while ADON/LPN/IP N took a photo of the wound. RN U removed her gloves, performed hand hygiene, obtained the betadine gauze from the medication cup, rolled it, and packed it into the wound. She then put a bordered dressing on the wound. Wearing those same gloves, RN U helped pull up resident 10's pants and reposition her in bed. RN U removed those gloves, did not perform hand hygiene, and put on a clean pair of gloves. RN U and ADON/LPN/IP N removed their gown and gloves, disposed of them in the trash can, and washed their hands in the sink. RN U grabbed the extra gauze, the bottles of Hibiclens and saline from the resident's bedside table, and put them in the wound treatment cart. Review of resident 10's EMR revealed she had a stage IV pressure ulcer to her right buttocks and she required to be on EBP. 28. Observation on 6/3/26 at 10:31 a.m. of RN U and ADON/LPN/IP N outside of resident 34's door revealed they were gathering supplies from the wound treatment cart to complete resident 34's dressing change to her buttocks. RN U removed scissors from the cart, cleaned the cutting edge of the scissors with an alcohol pad, and set them on top of a dressing package. She took out the soap and saline bottles, gauze, dressings, non-sterile Q-tip, and set them on top of the papers on the treatment cart. RN U sanitized her hands with hand sanitizer, entered resident 34's room, placed the wound care supplies on a paper towel barrier on resident 34's bedside table, put on a gown, and a pair of gloves. ADON/LPN/IP N sanitized her hands with hand sanitizer, put on a gown and pair of gloves, put soap and saline on the gauze, and opened the bordered dressing. Using the scissors, ADON/LPN/IP N cut a piece of the collagen and silver, and placed them on top of the baggie that contained those dressings. She removed her gloves, discarded them in the trash can, sanitized her hands, and put on a pair of gloves. RN U assisted in turning the resident on her side, removed her gloves, discarded them in the trash can, and sanitized her hands. RN U put on a pair of gloves, removed the dressing to resident 34's right lower buttocks, removed her gloves, sanitized her hands, put on a pair of clean gloves, cleansed the wound with the soap and saline gauze, removed her gloves, sanitized her hands, put on pair of clean gloves, and measured the depth of the wound with the non-sterile Q-tip, which was 0.4 cm. She removed her gloves, discarded them in the trash can, sanitized her hands, put on a pair of clean gloves, put the collagen in the wound, then applied silver to the wound, and covered the wound with a foam bordered dressing. Using those same gloves, she dated the protective dressing for resident 34's sacrum with a marker. Using those same gloves, RN U opened resident 34's three-drawer plastic bin, took out an (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinence brief, and placed it under the resident. RN U handed wet wipes to ADON/LPN/IP N, and ADON/LPN/IP N wiped resident 34's perineal area, and handed the used wipes to RN U to discard in the trash can. ADON/LPN/IP N then obtained clean wipes, wiped resident 34's buttocks, handed the used wipes to RN U to discard in the trash can, attached the incontinence brief tabs, and covered resident 34 with a blanket. RN U removed her gloves, discarded them in the trash, sanitized her hands, put on a pair of clean gloves, and put the unused silver and collagen packages back into the plastic bag. She grabbed the saline and soap bottles and put them on the resident's bedside table without a barrier. They each removed their gowns and gloves, discarded them in the garbage can, and washed their hands. RN U grabbed the supplies on resident 6's bedside table and set them on top of the wound treatment cart. She put on a pair of clean gloves, wiped the cutting edge of the scissors with an alcohol pad, did not clean the handle, removed her gloves, discarded them in the trash can, did not sanitize her hands, and grabbed the keys to unlock the treatment cart. RN U opened the wound treatment cart, put the saline, soap, the baggie that contained the silver and collagen, and the unopened dressing back in the wound treatment cart. She left the unopened gauze on top of the treatment cart. 29. Interview on 6/4/26 at 11:24 a.m. with ADON/LPN/IP N and RN U revealed that they verified that the Q-tips used to measure the depth of the wounds were in a baggie with other packaged dressings, were not sterile, and should have been sterile. They verified they brought the soap bottle, saline, and betadine bottles into multiple residents' rooms, and they should not have been. They expected the scissors, including the handle, to be sanitized before use. They expected RN W to have cleaned the marker before putting it back into her pocket. They acknowledged that expired hand sanitizer might not be as effective in killing germs. They verified that not following wound care infection control processes and using expired hand sanitizer and soap put residents at risk for infection. 30. Interview on 6/4/26 at 3:05 p.m. with DON B revealed she expected the staff to follow hand hygiene policies, the Q-tips used for wound care to be from a sterile single-use package, wound care items not to be brought into multiple resident rooms, and wound care equipment to be sanitized after each use, she verified that expired hand sanitizer might not be as effective in killing germs, and verified that not following infection control practices puts the residents at risk for infection. 31. Review of the provider's 4/20/26 updated General Infection Prevention and Control-Surveillance policy revealed, Infection surveillance will be either whole house (ie. include all residents), or targeted toward high risk/high volume, whichever is in accordance with local and sate department of health requirements. a) Healthcare-associated infections (HAI) will be defined as any infection that is not present or incubating a the time of admission. It is the protocol of this facility that routine surveillance and monitoring of the workplace be conducted to determine if compliance with work practices and care of protective clothing and equipment be maintained. 32. Review of the provider's Nursing Weekly Cleaning Tasks revealed that resident individual use items, including wheelchairs, should be cleaned and disinfected weekly and PRN (as needed) when soiled. 33. Review of the provider's 4/20/26 EBP policy revealed, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	'Enhanced barrier precautions' (EBP) refer to infection control interventions designed to reduce transmission of multidrug-resistant organisms that employ target gown and glove use during high-contact resident care activities. An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers). High-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use., wound care: any skin opening requiring a dressing. 34. Review of the provider's 4/20/26 Hand Hygiene policy revealed proper hand washing techniques should be used to protect against the spread of infection. Cleaning your hands reduces the spread of potentially deadly germs to the residents. Handwashing should be performed by all employees, as necessary, between tasks and procedures. Alcohol based hand sanitizer should be used before touching a resident, before performing aseptic techniques, immediately before putting gloves on, when gloves are removed, and after touching a resident's environment. Hand washing with soap and water should be done before moving from a soiled body site to a clean body site on [the] same resident.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual version 1.20.1 October 2025 review, the provider failed to ensure accurate MDS (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessment coding for two of three sampled residents (4 and 59) dialysis (a medical treatment that performs the essential functions of the kidneys when they fail) medications. Findings include:1. Review of resident 4's electronic medical record (EMR) revealed he admitted to the facility on [DATE]. His 3/23/26 Brief Interview for Mental Status (BIMS) assessment score was 13 which indicated his cognition was intact. He had diagnoses of type 2 diabetes mellitus (a chronic condition that occurs when your body cannot properly produce or use insulin) without complications, end stage renal disease, and dependence on renal dialysis. He had a 1/24/26 physician's order for Ozempic (0.25 or 0.5 milligrams (mg)/dose) subcutaneous solution pen-injector 2 mg/1.5 milliliter (mL) (Semaglutide) (a GLP-1 receptor agonist that mimics gut hormones to suppress appetite, slow digestion, and regulate blood sugar), inject 0.25 mg subcutaneously one time a day every Saturday for diabetes. Resident 4's 3/24/26 annual MDS assessment section N0350 insulin injections in the last seven days was marked yes. Section N0415 High-Risk Drug classes: use and indications section J Hypoglycemic (including insulin) was marked yes. 2. Review of resident 59's EMR revealed she admitted to the facility on [DATE]. Her 6/1/26 BIMS assessment score was 15 which indicated her cognition was intact. She had diagnoses of chronic kidney disease and type 2 diabetes mellitus without complications. Resident 59 had a 2/6/26 physician's order for Mounjaro subcutaneous solution auto-injector 2.6 mg/0.5 mL (Tirzepatide) (a dual GIP and GLP-1 receptor agonist that mimics gut hormones to stimulate insulin production when blood sugar rises and decreases the amount of sugar produced by the liver), inject 2.5 mg subcutaneously once weekly Friday for diabetes. Resident 59's 3/11/26 quarterly MDS assessment section N0350 insulin injections indicated she received one insulin injection during the last seven days. Section N0415 high-risk drug classes: use and indications section J hypoglycemic (including insulin) was marked yes. 3. Interview on 6/3/26 at 4:20 p.m. with Minimum Data Set (MDS) coordinator C revealed she was aware that Ozempic and Mounjaro were coded inaccurately as insulin. She learned about the inaccuracy on 4/24/26 but did not updated the MDS assessments for residents 4 and 59. 4. Interview with executive director A on 6/4/26 at 1:22 p.m. revealed she expected MDS updates to be completed within 24 to 48 hours, or a few business days. 5. Review of the CMS Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed Section N, page 3, Coding Instructions for N0350A: Enter.the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received. Section N, page N8 for N0415J1 and N0415J2, revealed, Hypoglycemic (including insulin): Check if a hypoglycemic medication was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the provider failed to ensure infection control practices were followed regarding the storage of oxygen equipment for two of two sampled residents (5 and 6). Findings include:1. Observation on 6/2/26 at 9:54 a.m. in resident 6's room revealed he had an oxygen concentrator (a device that filters room air into purified oxygen) in his room. His nasal cannula (flexible tubing with prongs that delivers oxygen through the nose) was on the floor, and it was not dated. His pre-filled humidifier (a plastic bottle that attaches to the oxygen machine to add moisture to the oxygen) was not dated. 2. Observation on 6/3/26 at 1:29 p.m. in resident 6's room revealed his nasal cannula oxygen tubing was on the floor. His nasal cannula oxygen tubing and the pre-filled humidifier were not dated. 3. Review of resident 6's electronic medical record (EMR) revealed he admitted to the facility on [DATE] and had a diagnoses of obstructive sleep apnea (where your throat muscles relax too much and block your airway while you sleep). He had an 8/17/25 physician's order for oxygen to be administered at 3 liters (L) by a nasal cannula at bedtime while sleeping and as needed. His June 2026 treatment administration record (TAR) did not indicate when the nurse was to change the oxygen tubing. 4. Observation on 6/2/26 at 2:36 p.m. in resident 5's room revealed she had an oxygen concentrator in her room, the nasal cannula tubing was dated 6/1, and the pre-filled humidifier was empty and not dated. Her continuous positive airway pressure (CPAP) machine (a bedside device used to pump a steady, gentle stream of pressurized air through a tube and a face mask) was on her nightstand, and the mask was on the floor between her bed and nightstand. 5. Review of resident 5's EMR revealed she admitted to the facility on [DATE] and had a diagnoses of Chronic Obstructive Pulmonary Disease (COPD) (progressive lung disease that makes it hard to breathe). She had a 7/16/24 physician's order to wear her CPAP nightly and when napping, and an 11/18/24 physician's order for continuous oxygen at 2 L. Her June 2026 TAR indicated the nurse was to change the oxygen tubing and set it up weekly every Friday night, and to date it. 6. Observation and interview on 6/3/26 at 3:51 p.m. with certified nursing assistant (CNA) S in resident 5's room revealed that resident 5's nasal cannula oxygen tubing was on the floor. He picked the tubing up off the floor and stated that the resident's oxygen tubing was supposed to be in the bedside table drawer or hung up so it did not touch the floor. He verified that resident 5's CPAP mask was on the floor between her bed and nightstand, picked it up, and stated it should not be on the floor, and he would clean it. The nurse was responsible for changing and dating the oxygen tubing and pre-filled humidifier. 7. Interview on 6/3/26 at 4:00 p.m. with registered nurse (RN P) revealed the CPAP masks should be stored on the CPAP machine, the nasal cannulas should be stored in a bag, and the nasal cannula and pre-filled humidifier should be dated when changed by the nurse weekly. 8. Interview on 6/4/26 at 11:24 a.m. with assistant director of nursing (ADON)/licensed practical nurse (LPN)/infection preventionist (IP) N revealed that she expected oxygen tubing to not to be on the floor, and to be in a bag on the resident's concentrator when not in use. The oxygen tubing and the pre-filled humidifier were to be changed weekly, and the tubing and the pre-filled humidifier should be dated when they were opened to be used. 9. Interview on 6/4/26 at 3:05 p.m. with DON B revealed she expected oxygen tubing to not be on the floor but to be stored in a bag when not in use, and the oxygen tubing and the pre-filled humidifier should be dated when they were opened to be used. 10. Review of the provider's 4/20/26 Respiratory Equipment Cleaning Procedure policy revealed O2 [oxygen] tubing, nasal cannula/mask will be changed weekly. O2 tubing will, also, be changed when tubing (nasal prong area) is noted lying on the floor. The pre-filled Humidifier bottle needs to be replaced weekly & [and] prn [as needed] (date and initial). This policy did not include information regarding cleaning or storage of the CPAP mask. 11. The provider's 11/18/25 CPAP and BiPAP policy did not include information regarding cleaning or storing the CPAP mask.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the provider failed to follow standard food safety practices for one of one observed cook (Y) who did not remove her gloves and washed her hands after touching a garbage can lid before handling resident food, and when she changed her gloves. Findings include:1. Observation on 6/2/26 at 10:32 a.m. of cook Y in the kitchen revealed she was wearing a pair of gloves and was peeling cucumbers on a cutting board with a knife. She walked over to the garbage can, lifted the garbage can lid, and discarded the cucumber peelings in the garbage can. With those same gloved hands, she put the peeled cucumbers in a bowl, rinsed them with water, removed her gloves, and did not wash her hands. She put a bag of shredded cheese in the walk-in cooler, used pot holders to take a peach cobbler pan out of the oven, and placed it on a metal tray. She took off the pot holders, took a dirty knife to the dirty dish area, obtained a clean knife, put on a pair of gloves, and cut the cucumbers on a cutting board. With those gloved hands, she picked up the cut cucumbers and put them in a bowl, brought the dirty knife and cutting board to the dirty dish area, obtained a washcloth with sanitizer on it, and wiped the counter where she cut the cucumbers. She removed her gloves, discarded her gloves in the trash can, and washed her hands with soap and water. 2. Interview on 6/3/26 at 2:31 p.m. with cook Y revealed she was to wash her hands with soap and water when she came into the kitchen, before putting on gloves, and after taking gloves off. She should have removed her gloves and washed her hands after touching the garbage can lid. 3. Interview on 6/3/26 at 4:15 p.m. with dietary manager (DM) X revealed she expected cook Y to remove her gloves after touching the garbage can lid and wash her hands after removing her gloves. 4. Review of the provider's 4/20/26 Hand Hygiene policy revealed, proper hand washing techniques should be used to protect against the spread of infection. It indicated that hand hygiene with hand sanitizer should be completed immediately before putting on gloves and after glove removal. 5. A policy regarding hand hygiene in the kitchen was requested, and the provider did not have a policy regarding hand hygiene specifically for the kitchen.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the provider failed to ensure call lights (a communication tool that enabled residents to alert staff for assistance) were functioning for three of three sampled residents (34, 41 and 73) whose call lights were not functioning. Findings include: 1. Observation and interview on 6/2/26 at 11:04 a.m. with resident 34 in her room revealed she was lying in bed. She had to wait a long time for the staff to answer her call light, and then she would be incontinent of urine. She stated, Maybe they do not take care of me because they do not like me. I am hard work. She stated that she turned her call light on a while ago and no one had come. 2. Interview on 6/2/26 at 11:15 a.m. with registered nurse (RN) P and assistant director of nursing (ADON)/licensed practical nurse (LPN)/infection preventionist (IP) N at the nurses' station revealed that there were no resident call lights turned on at that time. The surveyor reported to them that resident 34 stated that her call light was on for a while. RN P went to check on resident 34's call light and stated that the call light was disconnected from the call light extender that plugged into the wall, so that is why it did not turn on when she pushed her call light. 3. Review of resident 34's electronic medical record (EMR) revealed her 5/4/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. 4. Interview on 6/2/26 at 4:44 p.m. with resident 73 in the dining room revealed she had issues with her call light being unplugged from the wall, and she had to yell to her friend who lived across the hall to turn on his call light to get the staff's help. 5. Review of resident 73's EMR revealed her 4/29/26 BIMS assessment score was 15, which indicated her cognition was intact. 6. Observation on 6/3/26 at 10:31 a.m. in resident 34's rooms revealed ADON/LPN/IP N turned on resident 34's call light, and it turned back off on its own. ADON/LPN/IP N stated that resident 34's call light does that sometimes, and she would notify maintenance. 7. Interview on 6/3/26 at 4:00 p.m. with RN P revealed that the call lights sometimes get hooked under the resident's bed and get pulled out of the connector, then the call light does not work. 8. Interview on 6/4/26 at 1:09 p.m. with DON B revealed she expected call lights to always be in working order. She stated that most days, maintenance staff or Minimum Data Set (MDS) coordinator C have already repaired or replaced any non-working resident call lights before leadership staff arrived at 8 a.m. 9. Interview during the Resident Council Meeting on 6/4/26 at 1:30 p.m. revealed that resident 41's call light has not worked numerous times, and resident 73 had issues with her call light not working. 10. Review of resident 41's EMR revealed her 4/30/26 BIMS assessment score was 14, which indicated her cognition was intact. 11. The provider's call light policy was requested, and they did not have a call light policy.