South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46906	A. BUILDING: WEST B. WING	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS WEST	2903 DOUGLAS AVE YANKTON, SD 57078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 10/28/24 through 10/30/24 and on 11/1/24. Angelhaus West was found not in compliance with the following requirements: S095, S165, S200, S305, S331, S342, S450, S478, S640, and S776. A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 10/28/24 through 10/30/24 and on 11/1/24. Area surveyed included neglect. Angelhaus West was found in compliance.	S 000		
S 095	44:70:02:05 Housekeeping Cleaning Methods And Equipment The facility shall establish written housekeeping procedures for the cleaning of all areas in the facility and copies made available to all housekeeping personnel. All parts of the facility shall be kept clean, neat, and free of visible soil, litter, and rubbish. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to keep all parts of the facility free of visible soil for one randomly observed location (kitchen). Findings include:	S 095	S 095 Angelhaus administrator shall created new checklists regarding house cleaning methods to include kitchens. Kitchens to have full remodels before Spring of 2025. PoC Verification Steps: (1) Kitchen manager to monitor new checklist, weekly for four weeks, bi weekly for six weeks and monthly after that. (2) Administrator shall review assessment documentation monthly for no less than nine months. (3) QA Team shall review documentation for no less than nine months or until compliance has been achieved.	11/25/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin. — (X6) DATE: 12/04/2024

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S 095	Continued From page 1 1. Observation on 10/29/24 at 1:48 p.m. revealed the sheet vinyl floor in the kitchen had spots where it had been torn away and the bare concrete below was showing. Further observation of those spots revealed the areas where the concrete was exposed was visibly soiled. Concrete is a porous material that can harbor pathogens and is not considered a cleanable surface. Interview with administrator B at that same time confirmed that finding.	S 095	S165 Angelhaus shall conduct an all staff meeting on the last week of November to review smoking policy. Residents at West will not be able to keep cigarettes or lighters in their rooms. Residents will need to request staff to give them a cigarette and lighter. Staff will monitor resident from inside the building while they smoke. Cigarettes and lighters to be kept in a secured location. Resident 1 is the only resident that smokes in this building. PoC Verification Steps: (1) Nurse(s) to ensure no cigarettes or lighters will be kept in resident rooms. Nurses(s) will formally monitor to ensure cigarettes and lighter stored in the med-room. (2) Administrator shall review smoking assessments quarterly for nine months. (3) Administrator to bring to QA team shall review documentation for no less than nine months or until compliance has been achieved.	11/27/24
S 165	44:70:02:17 Occupant Protection Each facility must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to any occupant. The extent and complexity of occupant protection precautions are determined by the services offered and the physical needs of any resident admitted to the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and care record review, the provider failed to ensure an accurate assessment was completed and a physician's order was obtained for one of one sampled resident (1) who resided in the memory care unit was determined to be safe to smoke. Findings include: 1. Review of resident 1's care record revealed: *An admission date of 1/25/24. *Diagnoses of adult failure to thrive and anxiety. -There was not a diagnosis of dementia.	S 165		

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S 165	Continued From page 2 *There had not been a Mini Mental State Examination (MMSE) (test to determine cognitive function) completed for him since admission. *He had a physician's order to reside in the memory care unit. *The 7/30/24 Evaluation of needs indicated he was safe to smoke independently. -There was not a physician's order for him to smoke. -He was safe to keep his cigarettes and lighter in his room. Review of resident 1's 1/24/24 initiated service plan revealed: *"Is able to use tobacco products independently without adaptations or supervision." -"Can smoke UNSUPERVISED." Observation and interview on 10/29/24 at 9:45 a.m. in resident 1's room revealed: *He confirmed he went outside to smoke three times a day. -The staff would take him outside in his wheelchair. --He would smoke independently. --When he was done smoking he would push his pendant to alert the staff to bring him back inside of the building. *He kept his cigarettes and lighter in his top dresser drawer. Interview on 10/30/24 at 9:16 a.m. with chief finance officer (CFO) A and administrator B regarding resident 1 revealed: *He did not have an order to smoke independently. *He did not have a diagnosis to support him residing in the memory care unit. *They had not completed a MMSE until 10/29/24. -The MMSE had been completed by director of	S 165		

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S 165	Continued From page 3 nursing (DON) C with a score of 18 which indicated he had moderate cognitive impairment. *They had determined he was safe to keep his cigarettes and lighter in his room, even though he resided in the memory care unit.	S 165		
S 200	44:70:03:01 Fire Safety Code Requirements Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition in chapter 32 or 33. An automatic sprinkler system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat detection system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to meet applicable fire safety standards for one randomly observed electrical service (large dry goods storage room). Findings include: 1. Observation on 10/29/24 at 1:42 p.m. revealed the large dry goods storage room for the kitchen had a newer commercial upright freezer situated in between the shelving. Further observation at that same time revealed that upright freezer was being powered by the outlet on the wall opposite it using an extension cord. Extension cords meant for temporary use present an increased fire hazard when used in a permanent fashion such as this.	S 200	S200 Extension cord was removed immedatly. (1) Administrator will monitor monthly for 6 months. (2) Administrator will report to QA quarterly.	10/31/24

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S 200	Continued From page 4 Interview with administrator B and maintenance director I at the same time as the observation confirmed that finding. Ref. NFPA 101 2012 Ed. §33.2.5.1, 9.1.2 NFPA 70 2011 Ed. §590.3	S 200		
S 305	44:70:04:05 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. All personnel must be evaluated by a licensed health professional for a reportable communicable disease that poses a threat to others before assignment to duties or within fourteen days after employment including an assessment of previous vaccinations and tuberculin skin tests. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee file record review and interview, the provider failed to ensure the employee health evaluations had been completed within fourteen days of being hired for two of eight sampled newly hired employees (B and F). Findings include: 1. Review of the personnel records regarding documentation for employee health evaluations revealed: *Employee B had a 5/15/23 hired date. -There was no documentation he had been evaluated by a health professional as being free of communicable diseases. *Employee F had a 6/7/24 hired date. -He had been evaluated by a health professional as being free of communicable diseases dated 9/19/24.	S 305	S305 Angelhaus created a new checklist for all new staff and new residents coming into our buildings. Checklist will be completed for every new employee upon hire and new resident upon admission. PoC Verification Steps: (1) Administrator shall establish a new monthly checklist. (2) DON to review resident charts monthly. Administrator to review new hire checklist monthly(3) Administrator to report QA team to review checklists quarterly for no less than nine months or until compliance has been achieved.	11/27/24

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S 305	Continued From page 5 Interview on 10/30/24 at 11:10 a.m. with chief financial officer A regarding employees B and F revealed she agreed they had not been evaluated by a health professional within fourteen days of being hired and should have been.	S 305		
S 331	44:70:04:10(1) Tuberculin Screening... Requirements Tuberculin screening requirements for healthcare personnel and residents are as follows: (1) Each healthcare personnel or resident shall receive an initial individual TB risk assessment that is documented and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment are considered two-step. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin or blood assay TB testing having been completed within the prior twelve months. Skin testing or TB blood assay tests are not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any healthcare personnel or resident who has a newly recognized positive reaction to the	S 331	S331 Angelhaus created a new orientation checklist for all new employees and residents to ensure the safety of our employees and residents. PoC Verification Steps: (1) Nurse(s) to monitor checklists for all new hires upon hire date and all new residents on move in date. Administrator shall monitor checklist upon every new hire and new resident for no less than nine months. QA team shall review documentation for no less than nine months or until compliance has been achieved.	11/26/24

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S 331	Continued From page 6 skin or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on employee file review, interview, and policy review, the provider failed to ensure the two-step tuberculin (TB) skin test was completed within twenty-one days of being hired for one of eight sampled newly hired employee (F). Findings include: 1. Review of employee F's personnel file revealed: *He had a hired date of 6/7/24. *The first step TB skin test was administered on 6/7/24. *The second step TB skin test was administered on 9/17/24. Interview on 10/30/24 at 11:10 a.m. with chief financial officer A revealed employee F's required TB skin testing had not been completed within twenty-one days of being hired. Review of the provider's 5/13/15 TB Screening policy had not included the time frame for completion of the TB skin test.	S 331		
S 342	44:70:04:12 Memory Care Units Each facility with a memory care unit shall comply with the following provisions: (1) Each physician's, physician assistant's, or nurse practitioner's order for confinement that	S 342		

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S 342	Continued From page 7 includes medical symptoms that warrant seclusion or placement must be documented in the resident's chart and must be reviewed periodically by the physician, physician assistant, or nurse practitioner; (2) Therapeutic programming must be provided to residents by the facility and must be documented by the facility in the overall plan of care; (3) Confinement may not be used as punishment or for the convenience of the personnel; (4) Confinement and its necessity must be based on a comprehensive assessment of the resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement must be communicated to the resident's family; (5) Each locked door must conform to § 18.2.2.2.4 and § 19.2.2.2.4 of NFPA 101 Life Safety Code, 2012 edition; and (6) Any personnel assigned to the secured unit shall have specific training regarding the unique needs of residents in that unit. At least one caregiver must be on duty on the memory care unit at all times. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and care record review, the provider failed to ensure one of one sampled resident (1) had : *Been assessed for appropriate placement in the memory care unit. *Had a diagnosis to support admission to the memory care unit. Findings include: 1. Review of resident 1's care record revealed: *An admission date of 1/25/24. *Diagnoses of adult failure to thrive and anxiety.	S 342	S342 Angelhaus shall create a new referral checklist to include diagnoses of possible new residents. Orders for smoking and proper diagnosis were received from resident 1 doctor. Training will be provided during meeting which will be held on the last week of November 2024 to ensure proper diagnoses of possible new residents. All resident files have been reviewed to ensure they have the proper diagnosis to be in our facility. PoC Verification Steps: (1) Nurse(s) to monitor checklist for all new residents upon accepting every new resident. (2) Administrator shall review assessment documentation quarterly for nine months.(3) Administrator will report to QA team and review documentation for no less than nine months or until compliance has been achieved.	10/29/24

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S 342	Continued From page 8 -There was not a diagnosis of dementia. *They had not completed a Mini Mental State Examination (MMSE) (test to determine cognitive function) since his admission. *He had a physician's order to reside in the memory care unit. Review of resident 1's 1/24/24 initiated service plan revealed there was no Focus, Goal, or Interventions listed to reside in the memory care unit. Interview on 10/30/24 at 9:16 a.m. with chief finance officer (CFO) A and administrator B regarding resident 1 revealed: *He did not have a diagnosis to support his admission to the memory care unit. *His family had requested he be placed in the memory care unit because he required additional care with ADLs (activity of daily living). -Agreed he had been placed in the memory care unit because his family had requested it. -He had required additional staff to assist with transfers and other ADLs. *They had not completed a MMSE until 10/29/24. -The MMSE had been completed by director of nursing C with a score of 18 which indicated he had moderate cognitive impairment. *He would have been over the level of care for the assisted living because he required the assistance of two staff with transfers. *They had an optional service for requiring total ADL assistance in their current memory care assisted living license. *They had certain criteria for residents to be admitted to the memory care unit and one of them was to have a diagnosis to support it.	S 342		

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S 450	Continued From page 9	S 450	S 450	11/25/24
S 450	44:70:06:01 Dietetic Services The facility shall have an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in accordance with the provisions of § 44:70:02:06. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to maintain a safe and sanitary food service environment in one of one kitchen related to: *Maintaining one of one kitchen in a clean and sanitary manner. *Hand hygiene by one of one cook (D) during one of one meal service preparation. *Preparation and serving of food to residents by one of one cook (D) during one of one meal service time. Findings include: 1. Observation and interview on 10/29/24 at the following times in the kitchen with cook D revealed: *At 11:00 a.m.: -The large refrigerator/freezer was "buzzing." -Cook D confirmed it was not working and was to be fixed on Thursday. --They had removed all the items from the refrigerator/freezer and put them into a different one. -There were scoops stored inside the large sugar and the large flour bins. --The lids to the bins were sticky and dirty. -The inside of the microwave was dirty. -Several cutting boards were discolored and had knife slits in them making them uncleanable.	S 450	Angelhaus shall have a meeting with all kitchen staff including kitchen manager the last week of November 2024. During meeting kitchen policies shall be reviewed. Meeting shall include proper handling of all food and drinks, proper hand hygiene, how often and when to change gloves between touching different foods, surfacing, or body, proper use of tongs, and preparing plates. Demonstrations to be performed during the meeting. Deep cleaning of each kitchen to be performed the first week of December 2024. East and West kitchen full remodels to be performed before Spring of 2025 including new dining rooms tables at West. Old cutting boards were thrown out and replaced by new ones. New emergency wash stations were placed in each kitchen. PoC Verification Steps: (1) Administrator shall complete a new kitchen checklist. (2) Kitchen manager will monitor kitchen checklists weekly for four weeks, biweekly for six weeks and monthly. (3) Administrator shall review assessment documentation with QA team for no less than nine months or until compliance has been achieved.	

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S 450	Continued From page 10 -The walls were discolored and had old food stains on them. -The ceiling vents were visibly dirty. -The particle board on the side of the cupboard leading into the kitchen was warped, had cracks, and was an uncleanable surface. -The cupboards were sticky, soiled, discolored, and had uncleanable surfaces. *At 11:05 a.m.: -Cook D picked up raw hamburger patties with her gloves and placed them on the grill. -She confirmed there were 12 hamburger patties in the oven, and she made a total of 26. *At 11:10 a.m.: -With those same gloved hands she had touched the raw hamburger with she took a thermometer out of a drawer and checked the temperature of a hamburger patty on the grill. -She dropped the thermometer on the floor, picked it up, ran water on it from the sink, and then laid it on the counter. -She removed her gloves, washed her hands, and put on new gloves. *At 11:25 a.m. cook D: -Began to plate the food. -With her gloved hands she: --Picked up a bun and placed it on the plate. --Used a tong to put the hamburger patty onto the bun. --Picked up a piece of cheese with those same gloved hands, placed the cheese on top of the hamburger patty, and then placed the top part of the bun on top of the cheese. -She continued the same process throughout the plating of the meal. -She continued to touch other items in the kitchen with those same gloved hands and then returned to touching the hamburger bun and cheese. *At 11:40 a.m. interview with cook D regarding the above observation revealed:	S 450		

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S 450	Continued From page 11 -She agreed she should have: --Removed her gloves, performed hand hygiene, and then put on new gloves after touching the raw hamburger patty. --Not touched the hamburger bun and cheese with those same gloved hands after touching other items while serving the noon meal. Review of cook D's personnel training records revealed: *She had a hire date of 7/19/24. *She had completed the facilities new employee training for Dining, Nutrition, and Food Safety on 7/19/24. *The New Hire Kitchen Training with the "Purpose of this is to train all Cooks the same way" had not been signed or dated by cook D when she had completed the training. -The form had been signed by director of dietary E, but had not been dated. Interview on 10/30/24 at 10:15 p.m. with director of dietary E and chief finance officer (CFO) A regarding the above observations revealed: *Their expectations were for cook D to have performed hand hygiene between glove changes. *She should have used tongs and not her gloved hands that had touched multiple surfaces while serving out food. *The kitchen should have been clean. Interview on 11/1/24 at 9:00 a.m. with CFO A, administrator B, and director of dietary E confirmed the facility's improvement plan was to remodel the kitchen. Review of the provider's undated Food Service Sanitation policy revealed: *"Protection of foods from contamination by workers.	S 450		

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S 450	Continued From page 12 -To minimize hands touching foods, use proper utensils (tongs, spoons, plastic gloves, etc.)." *"Handwashing: -After using the toilet, food workers should wash their hands thoroughly. -After coughing, sneezing food workers should wash their hands thoroughly. -Food workers should wash hands between the handling of raw foods and ready-to-eat foods." *"Sanitary design, construction, and installation of equipment and utensils: -Food contact surfaces should be smooth, easily cleanable, properly constructed, and non-toxic." *"Cleaning, washing, and sanitizing of equipment and utensils: -Food contact surfaces of equipment and utensils should be maintained, clean, and sanitized." Review of the provider's undated Cook job description revealed: *"Job Summary: The Cook prepares regular meals, apportions servings, document accordingly, and is responsible for maintaining a clean and orderly kitchen." *"Responsibilities and Authorities: Is responsible for handling and preparing food in a sanitary manner." Review of the provider's undated Head of Dietary job description revealed: *"Job Summary: -Oversees, directs, and manages all aspects of food preparation and serving in the facility. -Prepares regular meals, apportions servings, document accordingly, and is responsible for maintaining a clean and orderly kitchen."	S 450		
S 478	44:70:06:09 Written Menus	S 478		

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S 478	Continued From page 13 A dietician shall annually approve, sign, and date each planned menu for all facilities except a facility without therapeutic diet services. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, license review, and policy review, the provider failed to ensure: *Registered dietitian (RD) (H) approved, signed, and dated the planned menus for 21 of 21 residents. *One of one cook (D) had followed the planned menu for one of one noon meal. Findings include: 1. Review of the facility's assisted living license revealed they were licensed for therapeutic diets. Review of the menus provided by the facility on 10/28/24 revealed they had been last signed by the RD in July 2023. Interview on 10/29/24 at 12:51 p.m. with director of dietary services E regarding the menu review revealed: *She confirmed the menus were last reviewed by the RD in July 2023, and RD H had just completed the annual menu review on 10/1/24. *The menus had not listed the extension sizes or portion sizes. *They did not have an alternate menu. -She was "developing one today." *Agreed RD H should have reviewed the menus annually. *Was not aware the menus should have had portion sizes listed. Review of the nutritional adequacy section of the	S 478	S 478 Angelhaus worked with dietetic services and completed new menu with extensions and portion sizes. Cook D was educated 11/25/24 and retrained on procedures along with all kitchen staff. PoC Verification Steps: (1) Kitchen manager will monitor to ensure menus are being followed on a weekly basis. (2) Administrator shall meet with kitchen manger monthly for no less than nine months. (3) Administrator will review with QA team findings for no less than nine months or until compliance has been achieved.	11/25/24

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S 478	Continued From page 14 assisted living rules, https://sdlegislature.gov/Rules/Administrative/44:70:06:03, the menu must be based on the dietary guidelines for Americans. The menu should have serving sizes in order to ensure that the menu meets the dietary guidelines. Review of the provider's undated Food Services policy revealed menus would be approved by a Registered Dietitian. 2. Observation, interview, and menu review on 10/29/24 at the following times in the kitchen with cook D revealed: *At 11:00 a.m. cook D was preparing the noon meal. Interview at that time with cook D revealed: -She had confirmed the noon menu on 10/28/24 was tuna melts. -She had decided the residents were getting too much starch for the day so she made the decision to make tuna noodle casserole instead. -The residents had one choice for meals. They had not been offered an alternative choice. *At 11:05 a.m. she had gloves on and was placing the raw hamburger patties onto the grill. *She confirmed the noon meal was going to be hamburger patties on a bun, potato casserole, macaroni salad, and fruit cup. *Review of the menu for the noon meal on 10/29/24 revealed the two choices were tavern or turkey Reuben, hash browns, and fruit cocktail. *At 11:40 a.m. cook D had finished serving the residents their noon meal. She confirmed she had"cleared changing the menu with director of dietary E on 10/29/24. *At 12:52 p.m. interview with director of dietary E regarding the above observation, interview with cook D, and menu review revealed: *She confirmed cook D had not followed the menu.	S 478		

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S 478	Continued From page 15 *She didn't like when the cooks would change the menus because she ordered the food needed to prepare each meal according to the menu. *Cook D had changed the menu without first talking to her. *Cook D had not followed the menus for the facility. *Her expectations would be for cook D to have followed the menu. Interview on 10/30/24 at 10:15 a.m. with director of dietary services E, chief finance officer (CFO) A, and administrator B regarding the menus confirmed: *The menus should have been reviewed annually by RD H. *Their expectations were for the cooks to follow the menu.	S 478		
S 640	44:70:07:05 Control And Accountability of Medications Medication brought from a resident's home may be used if ordered by the resident's physician, physician assistant, or nurse practitioner and, if prior to administration, the medication is identified as the prescribed medication. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to follow their policy to ensure one of one sampled resident's (3) scheduled two narcotic (Methadone) count had been verified after receiving it from the pharmacy. Findings include:	S 640		

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S 640	Continued From page 16 1. Observation and interview on 10/29/24 at 10:00 a.m. in the medication room with director of nursing (DON) C while completing the narcotic count of scheduled medications revealed: *Resident 3's medication bubble pack contained Methadone 10 milligram (mg) tablets. -The label on the package indicated: --The Methadone had been sent from the pharmacy to the facility on 10/25/24. --The order on the label indicated staff were to give two tablets (20 mg) by mouth two times daily (pain). --There were two bubble packs each containing one tablet of Methadone 10 mg. --Label 2 of 2 QTY (quantity) 30 of 60. -Inside each individual slot was one Methadone 10 mg tablet. -Slot two had not contained any tablet. -Interview at that time with DON C confirmed the above. *Review of the controlled drug receipt/record/disposition form revealed on 10/25/24 the certified medication aide had documented she had received 30 Methadone 10 mg tablets with the above card. -There was no other signature on the card documenting two staff had received the medication from the pharmacy. -The staff had continued to document from 10/25/24 through 10/29/24 at 6:00 a.m. there were 30 Methadone 10 mg tablets in the bubble pack. Interview at that time with DON C revealed: *She confirmed the pharmacy had sent 29 Methadone 10 mg tablets and not 30 as indicated on the controlled drug receipt/record/disposition form. *Her expectations would have been for the narcotic count to be correct from the pharmacy.	S 640	S 640 Angelhaus will perform a monthly staff meeting on the last week of November 2024. To be included in the meeting will be training on counting of mediations upon accepting them from the pharmacy. Nurse(s) to train Med Aides on properly counting the medications when accepting them from the pharmacy and to properly putting the new medications away. PoC Verification Steps: (1) Nurse(s) to monitor weekly for 3 months, then bi-weekly for the next 3 months, and then monthly after that. (2) Administrator shall review assessment documentation quarterly for nine months. (3) QA team shall review documentation for no less than nine months or until compliance has been achieved.	11/27/24

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S 640	Continued From page 17 *The CMA checking in the narcotic should have had the correct count. Phone interview on 10/29/24 at 1:24 p.m. with registered pharmacist/director of [name of pharmacy] G regarding the above observation revealed: *He confirmed the facility had contacted him after the above observation. *The pharmacy had reduced the quantity of Methadone sent to the facility from 60 tablets to 59 tablets for changes to the resident's medication bill. *He had no further comments. Review of the provider's undated Narcotics, Controlled Substances, and Preventing Drug Diversion policy revealed: *"All medications are stored in a secure manner, as outlined in other policies. -Special storage and security procedures will be followed to prevent controlled substances (narcotics, etc.) and to help prevent drug diversion." *Procedure: -"A Narcotic Count Sheet will be maintained for all narcotic medications. -When a narcotic is received in the community, it is counted by two staff members and added to the narcotic sheet with the current medications count reflected in the amount on hand." -"At the end of each shift, the staff member responsible for medication completing his/her shift, and the staff member responsible for medications who is starting his/her shift count all narcotic medications and confirm that the amount on hand matches what is listed on the Narcotic Reconciliation Sheet for each medication. Both staff members will sign a Narcotic Reconciliation Sheet confirming the accurate count of narcotics	S 640		

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S 640	Continued From page 18 on hand. -Any discrepancies are immediately reported to the DON or member of the Administrative Team."	S 640		
S 776	44:70:09:02(1) Facility To inform Resident Of Rights The information must contain: (1) The resident's right to exercise the resident's rights as a resident of the facility and as a citizen of the United States; This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure residents had an alternate choice of food at mealtime. Findings include: 1. Confidential resident interviews on 10/29/24 at different times revealed: *The residents had not been given a choice of what they wanted to eat at mealtime. *They were all served the same thing. *They had not asked for alternative choices because "they didn't want to cause any trouble." Observation, interview, and menu review on 10/29/24 at the following times in the kitchen with cook D revealed: *At 11:00 a.m. cook D was preparing the noon meal. Interview at that time with cook D revealed: -She had confirmed the noon menu on 10/28/24 was tuna melts. -She had decided the residents were getting too	S 776	S776 New menus with extensions and alternative menus were created with help from dietetic services. PoC Verification Steps: (1) Kitchen manager will monitor new menus monthly and ensure the kitchen staff is sticking to the menus for each day. (2) Administrator shall review assessment documentation quarterly for nine months. (3) QA Team shall review documentation for no less than nine months or until compliance has been achieved.	11/25/24

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S 776	Continued From page 19 much starch for the day so she made the decision to make tuna noodle casserole instead. -The residents had one choice for meals. They had not been offered an alternative choice. *At 11:05 a.m. she confirmed the noon meal was going to be hamburger patties on a bun, potato casserole, macaroni salad, and fruit cup. Review of the menu for the noon meal on 10/29/24 revealed the two choices were tavern or turkey Reuben, hash browns, and fruit cocktail. Interview on 10/29/24 at 12:52 p.m. with director of dietary E regarding the above observation, interview with cook D, and menu review revealed: *They only offered one choice/option at mealtimes to the residents. *She didn't know why except "maybe it was because they had cognition problems." *The cooks chose what option they would serve to the residents at mealtimes. Interview on 10/30/24 with chief finance officer (CFO) A, administrator B, director of nursing C, and director of dietary E regarding resident choices for meal time revealed: *DON C said some of the residents were unable to make a decision on what food choices they wanted at meal times. They would get frustrated. *Agreed some of the residents could make choices on what they would prefer for meal time. Review of the Assisted Living Community Resident Rights booklet given to each resident/resident representative upon admission revealed: *"You have the right to be fully informed in advance about care and treatment and of any changes that may affect your well-being. -You have the right to participate in planning care	S 776		

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S 776	Continued From page 20 and treatment, or be notified of changes in care and treatment." * "The ALC (assisted living center) must provide care and an environment that contributes to your quality of living."	S 776		