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
	80811	A. BUILDING: _____ B. WING _____	C 10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEA RETIREMENT LIVING	540 MORGAN LANE TEA, SD 57064

(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 An initial 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 10/7/25 through 10/8/25 and on 10/10/25. Tea Retirement Living was found not in compliance with the following requirements: S130, S201, S296, S305, S331, S352, S405, S503, S506, and S1011. 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 10/7/25 through 10/8/25 and on 10/10/25. Area surveyed included elopement and nursing services. Tea Retirement Living was found not in compliance with the following requirement: S169.	S 000	Created policy on glucometer cleaning and disinfection. Administrator or designee will educate all nursing staff on proper glucometer cleaning and disinfection. Administrator or designee will audit glucometer cleanings weekly for 4 weeks and monthly for two additional months.	11/24/25
S 130	44:70:02:09 Infection Prevention And Control The infection prevention and control program must utilize the concept of standard precautions as the basis for infection prevention and control. Bloodborne pathogen control must be maintained according to the requirements contained in 29 C.F.R. § 1910.1030, in effect on April 3, 2012. The facility shall designate healthcare personnel to be responsible for the implementation of the infection prevention and control program including monitoring and reporting activities. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and manufacturer's review, the provider failed to ensure infection prevention and control practices	S 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S 130	Continued From page 1 were implemented for the cleaning of one of one shared-glucometer after multiple resident use. Findings include: 1. Observation, interview, and manufacturer's recommendations review on 10/8/25 at 10:00 a.m. with certified medication aide (CMA) D regarding the 100 hall medication cart revealed: *In the top drawer of the medication cart was a glucometer. *CMA D confirmed: -The glucometer was shared between six residents. -She cleaned the glucometer between each resident use by using a wipe from a container labeled "Disposable Germicidal Surface Wipes." *She had completed the diabetic course but could not recall going through how to clean the glucometer between each resident use. *Review of the manufacturer's recommendations on the label of the Disposable Germicidal Surface Wipes revealed: -"Cleaning Procedure: --Blood and other body fluids must be thoroughly cleaned from surface/objects for disinfection. --Allow non-porous surfaces to remain wet for two minutes to kill HIV-1, HBC, and HCV." Interview on 10/8/25 at 10:30 a.m. with registered nurse (RN) B regarding the cleaning and disinfection of the glucometer revealed: *Several of the residents had a Dexacom blood sugar monitoring device on themselves. If the Dexacom had a "strange reading" they would check the resident's blood sugar level with the facility's glucometer. -"They used the glucometer in emergencies." *They had five residents who had their blood sugars checked routinely with the glucometer, and a few residents on oral diabetic medication	S 130		

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S 130	Continued From page 2 who had their blood sugars checked when needed. *They had the potential to use the glucometer daily. *She was unaware of the manufacturer's recommendations for disinfecting the glucometer. *She agreed they were using the Disposable Germicidal Surface Wipes and it was a problem. Request for the glucometer cleaning/disinfecting policy was given to administrator A on 10/8/25 at 2:30 p.m. A policy was received on 10/10/25 at 9:00 a.m. from administrator A. The Glucometer Cleaning and Disinfection policy revealed: *The effective date of the above policy was 10/8/25. *"Clean and Disinfect: -Immediately after use, wrap the glucometer completely in a Sani-Cloth Germicidal Wipe (or facility-approved disinfectant). -Ensure all surfaces of the device, including buttons and sides, are thoroughly covered. -Contact time: Keep the device wrapped and visibly wet for a minimum of 2 minutes to allow for proper disinfection." *The policy had been developed after the 10/8/25 at 10:30 a.m. interview with RN B.	S 130	Alarm put into use at all times. Will review and revise door alarm policy as necessary. Administrator or designee will educate all staff on door alarm policy. Administrator or designee will audit weekly for 4 weeks and monthly for two additional months.	11/24/2
S 169	44:70:02:17(5) Occupant Protection The facility shall: (5) Install an electrically activated audible alarm, if required by other sections of this article, on any unattended exit door. Any other exterior door must be locked or alarmed. The alarm must be audible at a designated staff station and may not	S 169		

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S 169	Continued From page 3 automatically silence if the door is closed; This Administrative Rule of South Dakota is not met as evidenced by: Based on optional service license review, observation, care record review, interview, and policy review, the provider failed to ensure the safety of: *One of one cognitively impaired resident (5) who eloped (left the facility without staff knowledge). *Eight of eight sampled residents (4, 5, 9, 10, 11, 12, 13, and 14) who were cognitively impaired and at risk for elopement. Findings include: 1. Review of the provider's Facility Reportable Incident (FRI) received by the South Dakota Department of Health (SD DOH) on 3/18/25 at 3:45 p.m. revealed: *Resident 5 eloped from the facility on 3/14/25 at 4:45 p.m. *He was upset and had walked 3 blocks away. *Registered nurse (RN) B brought him back to the facility in her car. *The facility's conclusion was to have the front exit door locked that required a code to enter. Review of the provider's optional service license revealed they were licensed to care for cognitively impaired individuals. This would require all unattended exterior doors to be equipped with an electrically activated audible alarm. Observation on 10/7/25 at 9:00 a.m. as the surveyor entered the facility revealed the front door had not alarmed. Multiple observations throughout the survey	S 169		

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S 169	Continued From page 4 revealed residents, staff, and visitors would enter and exit through the front door without the alarm sounding. At one time the door was propped open. Interview on 10/7/25 at 9:30 a.m. with administrator A regarding the facility's census revealed 30 residents resided there. A new resident admission was planned for later that day. Review of the resident roster list received from the facility on 10/7/25 revealed residents 4, 5, 9, 10, 11, 12, 13, and 14 were identified as being cognitively impaired. Review of resident 5's care record revealed: *He was admitted on 1/14/25. *His diagnoses included dementia, COPD (chronic obstructive pulmonary disease) with increased agitation/aggression episode. *The following Mini Mental State Examination (MMSE) revealed: -On 1/14/25 he had scored 22 out of 30. -On 2/13/25 he had scored 21 out of 30. -On 9/8/25 he had scored 19 out of 30. -A score of 18-23 indicated mild cognitive impairment. Interview on 10/7/25 at 10:15 a.m. with administrator A and registered nurse (RN) B regarding the front exit door revealed: *The front exit door had not been alarmed at the time resident 5 had eloped from the facility on 3/14/25. *Resident 5 had been assessed for elopement prior to his admission to the facility. *He would sit out front of the facility and had not tried to elope *They had alarmed the front exit door after resident 5's elopement.	S 169		

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S 169	Continued From page 5 *They had deactivated the front exit door alarm about a month ago. -It was not alarmed in the day time but was alarmed at night time. *Cognitively impaired residents resided in the facility. *RN B had evaluated each resident for being at risk for elopement prior to admission. *The three other exit doors in the facility were alarmed all the time. *They agreed that anyone including residents could enter or exit through the front exit door without it alerting the staff. *They agreed the alarm notification of the door opening was deliberately disabled thereby compromising the staff's ability to monitor traffic through the front exit door. Continued interview on 10/8/25 at 11:00 a.m. with RN B regarding the front exit door alarm revealed resident 5 had never attempted to elope from the facility. He had been admitted on 1/14/25. The son had taken resident 5 out of the facility the day before to go to his wife's gravesite. On 3/14/25 resident 5 had been upset. He had decided to walk to his wife's gravesite again. The facility had visited with resident 5's son regarding the possibility of him needing a memory care unit if the behavior had continued. Review of the provider's 3/17/25 Door Alarm policy revealed: *"Purpose: -To ensure the safety and security of all residents, particularly those with cognitive impairments, by providing clear guidance on staff response procedures when a door alarm is activated." *"All exterior doors at [name of facility] --including the front door, side doors, and dining room door--are equipped with alarms to prevent unsafe	S 169		

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S 169	Continued From page 6 resident exits and to maintain building security. *All staff members are responsible for responding promptly and appropriately to any door alarm activation." *"All staff in the building must respond immediately when a door alarm is heard." *"Reinforce that these alarms are in place for resident safety."	S 169		
S 201	44:70:03:02 General Fire Safety Each facility must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, the facility must conduct monthly drills to provide training for all personnel. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview the provider failed to: *Conduct two fire drills during the sleeping hours between 9:00 p.m. and 6:00 a.m. *Conduct fire drills during the 6:00 p.m. to 6:00 a.m. shift each quarter. Findings include: 1. Review of the fire drill logs revealed: *The fire drill log indicated three shifts, from 6:00 a.m. to 4:00 p.m., 4:00 p.m. to 10:00 p.m., and 10:00 p.m. to 6:00 a.m. *Fire drills were documented as completed during 6:00 a.m. to 4:00 p.m. shifts for the months of	S 201	Unable to correct prior noncompliance. Administrator or designee will audit fire alarm logs and drills monthly for 3 months. Fire Drill Log Form has been updated. Administrator or designee will audit weekly for 4 weekly and monthly for 2 additional months.	11/24/25

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S 201	Continued From page 7 February, March, May, July, August, September 2025. *Fire drills were documented as completed during 4:00 p.m. to 10:00 p.m. shifts in April 2025. *There were no fire drills documented in June. *There were no fire drills documented for the 10:00 p.m. to 6:00 a.m. shifts Interview on 10/7/25 at 11:00 a.m. with maintenance C revealed *He had been the part time maintenance person for the facility since February 2025. *He worked four hours a day, five days a week. *He conducted the fire drills. *The facility was operating with two shifts. one from 6:00 a.m. to 6:00 p.m. and one from 6:00 p.m. to 6:00 a.m. *The only drill conducted after 6:00 p.m. was the April 2025 drill. *The other six documented drills were conducted during the 6:00 a.m. to 6:00 p.m. shift. *There was no drill documented in June 2025. *He knew that fire drills were to be conducted on each shift but was not aware fire drills were to be conducted one per shift per quarter. *He was not aware two fire drills should have been conducted during sleeping hours. *The provider had been unsuccessful in training a person who worked on the 6:00 p.m. to 6:00 a.m. shift to conduct fire drills.	S 201		
S 296	44:70:04:04(1-11) Personnel Training These programs must be completed within thirty days of hire for all healthcare personnel and must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness,	S 296		

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S 296	Continued From page 8 including responding to resident emergencies and information regarding advanced directives; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Resident rights; (6) Confidentiality of resident information; (7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (8) Nutritional risks and hydration needs of residents; (9) Abuse and neglect; (10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility; and (11) Any additional healthcare personnel education necessary based on the individualized resident care needs provided by the healthcare personnel to the residents who are accepted and retained in the facility. Any personnel whom the facility determines will have no contact with residents are exempt from the training required by subdivision (8). 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 six of six newly hired employees reviewed (A, B, E, F, G, and H) had completed eleven of the eleven required personnel training topics within 30 days of hire. Findings include:	S 296	Personal training completed on 10/3/25 fo employees A, B, E, F, G and H. Personal training audited and completed f all other staff. New Employee/Annual Refresher Educatio Training Checklist reviewed and revised. Administrator or designee will audit new employee and annual training weekly for 4 weeks and monthly for 2 additional month and upon new hires.	11/24/25

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S 296	Continued From page 9 1. Review of the following sampled employees revealed: *Employee A had a hire date of 10/16/24. She had been hired as the administrator. *Employee B had a hire date of 11/20/24. She had been hired as a registered nurse. *Employee E: -Had a hire date of 6/27/25. She initially had been hired to be a resident assistant but had transitioned into the role as the main cook. -Documentation revealed she had completed new employee training on 10/3/25. That was past 30 days of her hire date. *Employee F had a hire date of 1/28/25. She had been hired as a certified medication aide (CMA). *Employee G had a hire date of 11/19/24. He had been hired as a CMA. *Employee H had a hire date of 12/12/24. She had been hired as a CMA. *There was no documentation that employees A, B, F, G, and H had completed training within 30 days of hire on: -Fire prevention and response. -Emergency procedures and preparedness. -Infection control and prevention. -Accident prevention and safety procedures. -Resident rights. -Confidentiality. -Incidents and diseases subject to mandatory reporting and the facility's reporting mechanism. -Nutrition risks and hydration. -Abuse, neglect, and misappropriation of resident property and funds. -Problem solving and communication techniques related to residents with cognitive impairment or challenging behaviors. -Education based on the resident care needs (diabetes and oxygen). 2. Interview on 10/7/25 at 2:20 p.m. with	S 296		

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S 296	Continued From page 10 administrator A regarding the above employees revealed: *They had not received any training on the eleven listed topics within the first 30 days of hire. *Some of the employees had received some training but they had not documented it. *She was responsible to ensure the training had been completed. *She agreed the training should have been completed with each employee within 30 days of hire. On 10/8/25 at 2:30 p.m. a request for the provider's training policy had been made to administrator A. The undated policy provided by administrator A had listed the above eleven topics and indicated that the training on those topics were "To be completed within 30 days of hire date and once annually."	S 296		
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 personnel file review and interview, the provider failed to ensure five of six newly hired employees reviewed (A, B, E, F, and H) were evaluated for communicable diseases by a licensed health professional within 14 days of hire.	S 305		

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S 305	Continued From page 11 Findings include: 1. Review of the provider's employee personnel files revealed: *Employee A had a hire date of 10/16/24. Her health evaluation was documented as completed on 11/20/24. *Employee B had a hire date of 11/20/24. Her health evaluation was documented as completed on 1/19/25. *Employee E had a hire date of 6/27/25. Her health evaluation was documented as completed on 8/22/25. *Employee F had a hire date of 1/28/25. Her health evaluation was documented as completed on 9/18/25. *Employee H had a hire date of 12/12/24. Her health evaluation was documented as completed on 8/11/25. Interview on 10/8/25 at 11:30 a.m. with administrator A revealed she agreed employees A, B, E, F, and H were not evaluated by a licensed health professional within 14 days of hire, and should have been. On 10/8/25 at 2:30 p.m. a request for the provider's Health Evaluation policy was made to administrator A. A policy was not received by the end of the survey.	S 305	Unable to correct prior noncompliance. Communicable Disease Policy has been created and implemented. Administrator or designee will audit nev employee health documentation for 4 weeks and monthly for 2 additional months and upon new hires.	11/24/25
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	S 331		

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S 331	Continued From page 12 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 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 two-step tuberculin (TB) screening was completed within twenty-one days of hire for five of six sampled newly hired employees reviewed (A, B, E, F, and H). Findings include:	S 331		

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S 331	Continued From page 13 1. Review of employee A's personnel file revealed she had a hire date of 10/16/24. Documentation indicated she had completed the QuantiFERON-TB Gold test on 1/20/25. 2. Review of employee B's personnel file revealed she had a hire date of 11/20/24. Her two-step TB test had been completed on 1/19/25 and on 1/21/25, 3. Review of employee E's personnel file revealed she had a hire date of 6/27/25. Her two-step TB test had been completed on 8/22/25 and on 9/10/25. 4. Review of employee F's personnel file revealed she had a hire date of 1/28/25. Her two-step TB test had been completed on 9/18/25 and on 9/25/25. 5. Review of employee H's personnel file revealed she had a hire date of 12/12/24. Her two-step TB test had been completed on 8/11/25 and on 8/20/25. 6. Interview on 10/8/25 at 11:30 a.m. with administrator A revealed she agreed employees A, B, E, F, and H had not received TB screening within twenty-one days of being hired, and should have. 7. Review of the provider's revised 9/30/25 Tuberculosis (TB) Screening, Testing, and Education policy revealed: *"Each new employee shall receive an initial individual TB risk assessment and either a two-step tuberculin (TST) or a TB blood assay test to establish a baseline within twenty-one (21) days of hire."	S 331	Unable to correct prior noncompliance Administrator or designee will audit TI documentation for 4 weeks and mont for 2 additional months and upon new hires.	11/24/25

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S 352	44:70:04:13 Resident Admissions The facility shall evaluate and document each resident's care needs at the time of admission, thirty days after admission, and annually thereafter, to determine if the facility can meet the needs for each resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review and interview, the provider failed to evaluate and document the care needs for one of five sampled resident (5) thirty-days after their admission. Findings include: 1. Review of resident 5's care record revealed: *He was admitted on 1/14/25. *His initial evaluation of care needs was completed on 1/17/25. *His thirty-day evaluation of care needs was completed on 3/20/25. Interview on 10/8/25 at 11:00 a.m. with registered nurse (RN) B revealed: *She had not completed resident 5's thirty-day evaluation of needs within the required time frame after his admission to the facility and should have. *It was her responsibility to complete the evaluation of needs for residents upon admission, thirty-days after admission, and annually.	S 352	Resident Care Plan Policy will be created and implemented. Administrator or designee will train all nursing staff on the basis of this policy and when a resident needs to be evaluated for their care needs. Administrator or designee will audit Resident Care Plans weekly for 4 weeks and monthly for 2 additional months.	11/24/25
S 405	44:70:05:02 Resident Care Plans, Service Plans, And Progr The facility shall provide safe and effective care from the day of admission through the	S 405		

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S 405	Continued From page 15 development and implementation of a written care plan or service plan for each resident. The care plan or service plan must address personal care, and the medical, physical, mental, and emotional needs of the resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, care record review, and policy review, the provider failed to ensure the written service plan addressed the current care needs for one of five sampled resident (4). Findings include: 1. Review of resident 4's care record review: *An admission date of 5/2/25. *Her diagnoses included Bipolar (chronic mental health condition) disorder, Alzheimer's dementia, Major neurocognitive disorder, and seizures. *Her Mini Mental State Examinations (MMSE) revealed: -On 5/5/25 her MMSE score was 30 out of 30 which indicated her cognition was intact. -On 6/4/25 her MMSE score was 26 out of 30 which indicted her cognition was intact. -On 9/12/25 her MMSE score was 22 out of 30 which indicated her cognition was impaired. *On 6/15/25 she made accusations of sexual misconduct regarding another resident of the opposite sex. *She was hospitalized on 7/16/25 for left sided weakness and returned to the facility on 7/17/25. *She was hospitalized on 8/27/25 at a behavioral health facility and returned to the facility on 9/12/25. -She began receiving ECT's (electric shock treatments). The 6/16/25 charting notes revealed: *"Administrator call to family regarding incident	S 405		

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S 405	Continued From page 16 report from the weekend regarding [resident 4's name] and another resident. *Daughter [name] stated that her [mom] just cannot say no and she knows that [resident 4's name] starts a lot of the communication with the other resident. *I stated that I do need to file a state report regarding the incident since [resident 4's name] stated she felt assaulted. *Daughter understands this and will encourage her [mom] to stay away." Review of resident 4's 6/20/25 service plan revealed there was no specific problem, goal, or plan regarding the above incident for staff to know what to do to help resident 4 if she reported a similar incident. Interview on 10/7/25 at 4:20 p.m. with registered nurse (RN) B regarding resident 4's service plan revealed: *She agreed the service plan had not been updated to reflect resident 4's current status regarding her cognitive score, accusations made towards another resident of the opposite sex, and what interventions the staff were to use to implement to redirect/monitor her. *Follow-up to the 6/26/25 allegation revealed they had offered resident 4 the choice to move to another room far away from the alleged perpetrator. *She had declined to move. *She felt safe around the other resident. *Resident 4's family was in agreement to let her stay in the current room. Interview on 10/8/25 at 1:30 p.m. with administrator A and RN B regarding resident 4 revealed the staff had received verbal education on interventions in case another similar alleged	S 405		

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S 405	Continued From page 17 incident occurred. Some of the staff were not present and had not received the education. The education had not been documented. All staff had access to the service plan. Both agreed the service plan did not include any problem, goal, or interventions on how the staff were to care for resident 4 if she reported a similar incident. Review of the provider's revised 10/1/25 Capabilities to Meet Resident Needs policy revealed "Care plans will be adjusted based on reassessments and staff observations."	S 405	Resident 4's care plan will be reviewed an revised. Going forward, we will make sure we document all communication given verbally to staff and have them sign off or Administrator or designee will educate nursing staff on the basis of when a reassessment needs to reoccur. Administrator or designee will audit Resident Care Plans weekly for 4 weeks and monthly for 2 additional months.	11/24/25
S 503	44:70:06:16(1-3) Person In Charge Of Dietary Services The person in charge of dietary services shall possess a current certificate from: (1) A ServSafe Food Protection Course; (2) The Certified Food Protection Professional's Sanitation Course from the Dietary Managers Association; or (3) Equivalent training as determined by the department. This Administrative Rule of South Dakota is not met as evidenced by: Based on document review and interview, the provider failed to ensure the dietary manager and at least one employed cook had completed and possessed a current ServSafe Food Protection Program certificate. Findings include:	S 503		

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S 503	Continued From page 18 1. Review of the employee roster list revealed employee E was listed as a cook with a hire date of 6/27/25. Interview on 10/7/25 at 10:15 a.m. with administrator A regarding ServSafe certificates revealed: *Employee E had recently transitioned into the role as head cook. *She thought employee E had completed ServSafe training but would have to check with her. *Administrator A had not completed ServSafe training and thought no one else had. *All the staff were trained to work in the kitchen to cook and prepare the residents' food. Interview on 10/7/25 at 12:40 p.m. with cook E confirmed she had not completed the ServSafe course. Follow-up interview on 10/8/25 at 11:30 a.m. with administrator A regarding ServSafe training revealed: *She agreed no current employees had a ServSafe completion certificate. *They needed to have cook E complete the ServSafe training along with another employee. On 10/8/25 at 2:30 p.m. a request for the provider's dietary training policy was made to administer A. A policy was not received by the end of the survey.	S 503	Dietary Training Policy will be created and implemented. Employee E and Administrator will get ServSafe certified.	11/24/25
S 506	44:70:06:17 Required Dietary Inservice Training The person in charge of dietary services or the dietitian shall provide ongoing inservice training for all healthcare personnel providing dietary and	S 506		

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S 506	Continued From page 19 food-handling services. Training must be completed within thirty days of hire and annually for any dietary or food-handling personnel and must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee file review and interview, the provider failed to ensure annual dietary training was completed for six of six employees reviewed (A, B, E, F, G, and H) who were responsible for preparing and serving food to the residents. Findings include: 1. Review of the provider's employee personnel files revealed: *Employee A had a hire date of 10/16/24. She had been hired as the administrator. *Employee B had a hire date of 11/20/24. She had been hired as a registered nurse. *Employee E had a hire date of 6/27/25. She initially had been hired to be a resident assistant but had transitioned into the role as the cook/director of dietary. *Employee F had a hire date of 1/28/25. She had been hired as a certified medication aide (CMA).	S 506		

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S 506	Continued From page 20 *Employee G had a hire date of 11/19/24. He had been hired as a CMA. *Employee H had a hire date of 12/12/24. She had been hired as a CMA. *There was no documentation that employees A, B, E, F, G, and H had completed the required dietary trainings within 30 days of hire on: -Food Safety. -Handwashing. -Food handling/preparation techniques. -Serving and distribution procedures. -Leftover food handling policies. -Time and temperature controls for food preparation and service. -Nutrition and hydration. -Sanitation requirements. Interview on 10/7/25 at 2:20 p.m. with administrator A regarding employee A, B, E, F, G, and H's required dietary trainings within 30 days of hire revealed: *All staff members were trained to work in the kitchen to prepare and serve food to the residents when needed. *They had not provided any training to the above employees regarding the required dietary training topics. *They should have completed that training within 30 days of hire. On 10/8/25 at 2:30 p.m. a request for the provider's dietary training policy made to administrator A. A policy was not been received for review by the end of the survey.	S 506	Dietary Training Policy has been made and implemented. All staff will be educated and trained on it by Administrator or designee.	11/24/25
S1011	44:70:10:26 Plumbing Fixtures Handwashing facilities used by medical and care staff and food handlers must have the water	S1011		

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S1011	Continued From page 21 supply spout mounted so the discharge is a minimum of five inches or 0.13 meters above the rim of the fixture and be equipped with hands-free controls. A single lever device may be used. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to install a faucet at the kitchen hand sink that was equipped with hands free controls and discharged a minimum of five inches above the rim of the sink. Findings include: 1. Observation and interview on 10/7/25 at 10:00 a.m. with maintenance staff memeber C regarding the faucet on the hand sink located in the kitchen revealed: *The faucet was a residential bathroom style faucet with round knobs for controls and a discharge two inches above the sink. *Plumbers replaced that faucet in May 2025. *He had questioned the plumber about that faucet, but the plumber installed it anyway. *He confirmed the faucet did not have blade handles for hands free controls and the discharge was not five inches above the sink rim.	S1011	Facet located on the hand sink in the kitchen has been replaced to be in compliance with a minimum of five inches above the rim of the fixture and to have blade handles for hands free controls.	10/9/25