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
	65982	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSON CARE AND REHAB CENTER	720 PARKWAY HUDSON, SD 57034

(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 6/2/25 through 6/4/25. Hudson Care and Rehab Center was found not in compliance with the following regulations: S075, S169, S201, S202, S296, S305, and S450.	S 000		
S 075	44:70:02:01 Sanitation The facility shall be designed, constructed, maintained, and operated to minimize the sources and transmission of infectious diseases to residents, personnel, visitors, and the community at large. This requirement shall be accomplished by providing the physical resources, personnel, and technical expertise necessary to ensure good public health practices for institutional sanitation. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper sanitation practices in six observed areas where food and resident use items were stored. Findings include: 1. Observation and interview on 6/3/2025 at 1:17 p.m. with adiministrator A in the food pantry revealed approximately one-quarter of the room's ceiling to have peeling paint. Administrator A confirmed the finding and agreed it was a deficiency. 2. Observation and interview on 6/3/2025 at 1:30 p.m. with maintenance supervisor C in the maintenance room revealed:	S 075	Administrator and interdisciplinary team will review and revise as necessary the policy and procedure for proper sanitation practices. Maintenance personnel or designee will address peeling paint in food pantry, clean linen room, & bathing/shower room on or before 07/19/2025.* All boxes** will be picked up from the floor and discarded on or before 07/19/2025.**** ***** Administrator or designee will provide education to all staff responsible for following proper sanitation practices*** on 07/11/2025 & 07/18/2025. Administrator or designee will perform audits on all sanitation practices to ensure the policy is being followed once a week for four weeks and once per month for two more months. Administrator or designee will present findings from these audits monthly for three months at the interdisciplinary team meetings for review until the interdisciplinary team advises to discontinue monitoring. * By removing the paint and repainting these areas. ** containing straws, paper towel rolls, gloves, incontinence briefs, plastic cups, and toiletry items; including but not limited to, toilet paper, linen and trash items.	07/19/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy Lewis — TITLE: Administrator — (X6) DATE: 6/25/2025

Judy Lewis — Administrator — 7/2/2025

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S 075	Continued From page 1 *One cardboard box containing flex wrapped straws. -That box was placed at the end of the bench where a bench grinder was located. -The box had been opened and contained 22 smaller boxes of flex wrapped straws. -Inside the box and on top of the boxes of straws was sawdust and at least one mouse dropping. -Maintenance supervisor C confirmed the finding and stated a mouse may have accessed the box when it was previously stored "outside." -He was not sure how long the straws had been there. -He agreed they were not stored in a sanitary manner. *One unopened case of paper towel rolls was on the floor in the maintenance room. -Maintenance supervisor C confirmed the finding. -Housekeeping was responsible for the rolls of paper towels. -He agreed the towels should not have been stored on the floor. 3. Observation and interview on 6/3/2025 at 3:05 p.m. with administrator A in the clean linen room between rooms 203 and 205 revealed the room ceiling above the clean linen to have peeling paint. Administrator A confirmed the finding and agreed it was a deficiency. 4. Observation and interview on 6/3/2025 at 3:10 p.m. with administrator A in the soiled utility room revealed: *A case of vinyl exam gloves was stored on the floor. *Administrator A was aware the box of gloves should not have been stored on the floor. *Administrator A stated the box of gloves had been there "since COVID."	S 075	*** and appropriate placement of boxes in storage areas ****The maintenance personnel or designee will address the stained grout joints by removing the old grout and reapplying new grout in any area that is discolored on or before 7/19/2025. ***** The uncapped sewer drainpipe in the brief storage room has been capped off effective 7/2/2025.	

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S 075	Continued From page 2 5. Observation and interview on 6/3/2025 at 3:48 p.m. with maintenance supervisor C in the bathing/showering room revealed the room ceiling to have peeling paint and the shower to have stained grout joints which appear to contain mold/mildew. Maintenance supervisor C confirmed those findings. 6. Observation and interview on 6/3/2025 at 4:01 p.m. with administrator A and maintenance supervisor C in the brief storage room revealed: *Multiple cases of adult incontinence briefs were stored on the floor. *Multiple packages of adult incontinence briefs were stored on the floor. *Maintenance supervisor C confirmed the brief storage room was previously a shower room. -The water service into the room had been capped off, but -he did not think the sewer drain piping had been capped, and -the drain was hidden under the cases of briefs. *Administrator A agreed the cases and pacakages of adult incontinence briefs should not have been stored on the floor. *Administrator A was not aware the sewer drain piping may had not been capped off. 7. Observation and interview on 6/3/2025 at 4:14 p.m. with maintenance supervisor C in the supply room by the nurse's station revealed several boxes on the floor that contained patient care supplies (plastic cups). Maintenance supervisor C confirmed those findings. 8. Observation and interview on 6/3/2025 at 4:18 p.m. with maintenance supervisor C in the clean linen room revealed one case of toilet paper on the floor along with various linens and trash items. Maintenance supervisor C confirmed those	S 075		

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S 075	Continued From page 3 findings. 9. Interview with administrator A on 6/3/2025 at 4:30 p.m. revealed she was aware patient care items such as adult incontinence briefs, vinyl gloves, plastic cups, toilet paper, and paper towels should not have been stored on the floor.	S 075		
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 automatically silence if the door is closed; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, care record review, interview, and license review, the provider failed to ensure the safety for three of three cognitively impaired residents (1, 7, and 8) who were at risk for elopement. Findings include: 1. Observation on 6/2/25 at 2:00 p.m. in the north hallway lounge/recreation room revealed: *A door leading to an outside enclosed courtyard. *Resident 1: -Walked into the room and out the door leading to the above area. -Returned through the same door and walked back into the north hallway.	S 169	Administrator and interdisciplinary team will review and revise as necessary the policy and procedure for audible alarms. Administrator or designee will ensure alarms are on at all times for residents at risk for elopements. Administrator or designee will provide education to all staff responsible for following the proper procedure for activating/deactivating alarms on 07/11/2025 & 07/18/2025. Administrator or designee will perform audits on all door alarms to ensure the policy is being followed once a week for four weeks and once per month for two more months. Administrator or designee will present findings from these audits monthly for three months at the interdisciplinary team meetings for review until the interdisciplinary team advises to discontinue monitoring.	07/19/2025

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S 169	Continued From page 4 Continued random observations of resident 1 throughout 6/2/25 and 6/3/25 while the surveyor was in the building revealed she would wander throughout the facility and at times sit down on the floor. She had also opened the east exit door once, causing the door alarm to sound. Review of resident 1's care record revealed: *She had diagnoses of schizophrenia and anxiety. *The 3/8/25 Mini Mental State Examination (MMSE) score was twenty-one out of thirty which indicated she had mild cognitive impairment. *The 5/13/25 physician's note stated "Problem list: Unspecified dementia with behavioral disturbance onset 5/12/25." *On 10/12/23 at 4:00 p.m. she had eloped from the facility, went to the neighbor's house, and was redirected back into the facility. Interview on 6/2/25 at 3:40 p.m. with administrator A regarding resident 1 revealed: *She had recently had a change in behaviors. *She was being treated for a urinary tract infection (UTI). *She would sit down on the floor whenever she wanted to, but was able to get back up. *They were monitoring her condition to ensure she wasn't over an assisted living level of care. *She was more confused. Interview on 6/3/25 at 3:00 p.m. with registered nurse B regarding resident 1 revealed: *She agreed they had seen a change in resident 1's behaviors and cognition. *They were monitoring her for a significant change in condition. *Resident 1: -Had been started on an antibiotic for a UTI.	S 169		

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S 169	Continued From page 5 -Continued to sit down on the floor in random areas and wander throughout the facility. Interview and care record review on 6/4/25 at 12:10 p.m. with administrator A regarding the north hallway lounge/recreation room and residents who were cognitively impaired revealed: *One person from Home and Community Based Services (HCBS) which was part of the Department of Human Services (DHS) told them residents were required to know the code to get out of the exit doors. *That was their home and that was their right to come and go as they wanted. *There were three residents who were cognitively impaired. -Resident 1. -Resident 7 who scored twenty-three out of twenty-seven on an undated MMSE. -Resident 8 who scored twenty-one out of twenty-nine on the 9/3/24 MMSE. --A score of eighteen to twenty-three on a MMSE indicated mild cognitive impairment. 2. License review, observation, and interview on 6/3/25 at 3:31 p.m. with administrator A regarding unit room/patient lounge exit door security revealed: *The facility is licensed to care for cognitively impaired individuals which would require all unattended exterior doors to be equipped with an electrically activated audible alarm. *The exterior door to the secure courtyard was equipped with an electrically activated audible alarm. -The door alarm notification of the door opening was deliberately disabled (unplugged) thereby compromising the staff's ability to monitor traffic through that exit door.	S 169		

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S 169	Continued From page 6 *Administrator A confirmed the finding. *They had unplugged the alarm because that door was used by the smoking residents frequently, which caused nuisance alarms. *That door was locked from the outside during the night after 10:30 p.m. *Administrator A had stated that a resident had gone out the door after it had been locked and was locked in the courtyard without staff's knowledge. That resident had to knock on the door to gain the staff's attention to let the resident back inside. Following that incident, the provider installed a doorbell in the courtyard so residents could get staff's attention more easily.	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 observation and interview, the facility failed to ensure general fire safety requirements related to door/gate conditions/functionality, storage, fire extinguishing systems, and cigarette waste disposal. Findings include: 1. Observation and interview on 6/3/2025 at 1:20	S 201	Maintenance personnel or designee will ensure proper working of all doors and gates, adequate clearance of sprinkler heads, and flammable cleaners will be moved on or before 07/19/2025. Kitchen hood extinguishing system was scheduled and completed on 6/12/2025. A schedule for emptying out the cigarette butts frequently was created on 6/25/2025.** Maintenance personnel or designee will address gate in the courtyard to ensure it is easily open and closeable on or before 7/19/2025. Administrator or designee will provide education to all staff responsible for following the above procedures*on 07/11/2025 & 07/18/2025. Administrator or designee will perform audits on all doors, alarms, sprinkler heads, storage of cleaners, and cigarette butts, once a week for four weeks and once per month for two more months. * and importance of not propping doors open ** Maintenance personnel or designee will empty the cigarette butt container monthly or as needed.	07/19/2025

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S 201	Continued From page 7 p.m. with maintenance supervisor C of a door between the kitchen and the staff (rear) exit corridor revealed the door was wedged open with a screwdriver. Maintenance supervisor C confirmed the finding, acknowledged that was its normal state, and agreed that it was a deficiency. 2. Observation, testing, and interview on 6/3/2025 at 1:26 p.m. with maintenance supervisor C of a door between the employee lounge and the staff (rear) exit corridor revealed the door was open, had no closer, and, when tested, did not close into the door frame. Maintenance supervisor C confirmed the findings and acknowledged that was its normal state, but was unaware that it was a deficiency. 3. Observation and interview on 6/3/2025 at 1:33 p.m. with maintenance supervisor C of the maintenance room revealed: *Each of the two sprinkler heads within the room had clutter stored on top of the storage shelving below the sprinkler heads that was within 6 inches of each head. - The storage shelves contained a variety of flammable cleaners, including alcohol-based hand cleaner, and compressed gas spray can cleaners. Approximately seven feet across the room from the cleaners was a bench grinder which would be capable of propelling ignition sparks toward/on those flammable cleaner containers. Maintenance supervisor C confirmed the findings and agreed that they were deficiencies. 4. Review of the fire extinguisher testing records and interview on 6/3/2025 at 1:33 p.m. with maintenance supervisor C revealed that the kitchen stove hood fire extinguishment system	S 201	Administrator or designee will present findings from these audits monthly for three months at the interdisciplinary team meetings for review until the interdisciplinary team advises to discontinue monitoring.	

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S 201	Continued From page 8 was due for inspection in January 2025, but there was no record of the inspection. Maintenance supervisor C confirmed the finding. 5. Observation, testing, and interview on 6/3/2025 at 2:24 p.m. with maintenance supervisor C of the northern exit double door assembly revealed only the east leaf of the double door assembly was operational. Maintenance supervisor C confirmed the finding and acknowledged that was its normal state. 6. Observation and interview on 6/3/2025 at 2:27 p.m. with maintenance supervisor C of an exit door directly from the boiler room revealed the door would not open without applying significant force. Maintenance supervisor C confirmed the finding, acknowledged that was its normal state, and agreed that it was a deficiency. 7. Observation and interview on 6/3/2025 at 3:05 p.m. with administrator A of the clean linen room between rooms 203 & 205 revealed the presence of clutter within 18 inches of the sprinkler head. Administrator A confirmed the finding and agreed that it was a deficiency. 8. Observation and interview on 6/3/2025 at 3:26 p.m. with administrator A of a cigarette butt can in the patient smoking area revealed the can was full, cigarette butts had accumulated within the can neck, and that several cigarette butts were still smoldering. Administrator A indicated the procedure for disposal of the can's contents was to place them directly into the trash dumpster as needed. 9. Observation and interview on 6/3/2025 at 3:28 p.m. with administrator A of the wooden gate used to exit the secure court yard revealed:	S 201		

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S 201	Continued From page 9 *The fencing gate which controlled access to and from the secured facility courtyard/smoking area (as well as the fire exit to the public way) was in disrepair. It did not swing easily which required the staff to partially lift the very heavy wooden gate which compromised their ability to open and close the gate as needed. *Administrator A agreed that not all of the staff would be capable of opening the gate in the state it was in. 10. Observation and interview on 6/3/2025 at 3:31 p.m. with administrator A of the unit room/patient lounge revealed the presence of clutter within 18 inches of the sprinkler head in the game closet. Administrator A confirmed the finding and agreed that it was a deficiency.	S 201		
S 202	44:70:03:02 General Fire Safety At least two personnel must be on duty at all times, unless the department has approved a staffing exception requested by the facility. In a multilevel facility, at least one personnel must be on duty on each floor containing occupied beds. This Administrative Rule of South Dakota is not met as evidenced by: Based on facility license review, nursing schedule review, interview, and policy review, the facility failed to ensure there were two staff on duty at all times. Findings include: 1. Review of the provider's current assisted living license and interview on 6/2/25 at 9:00 a.m. with administrator A confirmed: *The facility was licensed for twenty-nine residents.	S 202	Administrator and interdisciplinary team will review and revise as necessary the policy and procedure for staff scheduling. Administrator or designee will ensure two staff members are on at all times. Administrator or designee will provide education to all staff responsible for following the proper procedure for staff scheduling on 07/11/2025 & 07/18/2025. Administrator or designee will perform audits on the staff schedule to ensure the policy is being followed once a month for three months. Administrator or designee will present findings from these audits monthly for three months at the interdisciplinary team meetings for review until the interdisciplinary team advises to discontinue monitoring.	07/19/2025

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S 202	Continued From page 10 *There were currently twenty-one residents who resided in the facility. Review of the March 2025 through May 2025 nursing schedule revealed in: *March 2025: -Twenty out of thirty-one shifts had only one staff member on duty for the overnight shift (midnight through 6:00 a.m.). *April 2025: -Twenty-one out of thirty shifts had only one staff member on duty for the overnight shift. *May 2025: -Twenty out of thirty-one shifts had only one staff member on duty for the overnight shift. Interview on 6/3/25 at 2:20 p.m. with administrator A regarding the above nursing schedule revealed: *They had only one staff member on duty at times. *She had been told by upper management they didn't need two staff members on duty at all times. *Three residents (1, 7, and 8) who were cognitively impaired currently resided there. Review of the provider's undated Scheduling policy and procedure revealed: *"Purpose: -To ensure consistent, safe, and high-quality care for all residents by maintaining appropriate and compliant nursing staff coverage 24/7 through structured and efficient scheduling practices." *"3. Staffing Requirements: -The facility must maintain minimum staffing levels in accordance with state and federal regulations. -A licensed nurse (RN or LPN) must be available at all times.	S 202		

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S 202	Continued From page 11 -Resident assistants, med aides, and/or dietary aides shall be scheduled based on resident acuity and census to meet care needs." *"4. The nursing schedule shall operate on a two-shift system: -Day Shift: 6:00 AM - 6:00 PM. -Night Shift: 6:00 PM - 6:00 AM."	S 202		
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, 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	S 296	Administrator and interdisciplinary team will review and revise as necessary the policy and procedure for personnel training. Unable to timely complete the training requirements within 30 days of hire for employees D, E, and F. Administrator or designee will complete all necessary paperwork by 7/19/2025. Administrator or designee will provide education to all staff responsible for following the proper procedure for personnel training on 07/11/2025 & 07/18/2025. Administrator or designee will perform audits on all new hire training to ensure the appropriate paperwork is being completed once a month for three months. Administrator or designee will present findings from these audits monthly for three months at the interdisciplinary team meetings for review until the interdisciplinary team advises to discontinue monitoring.	07/19/2025

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(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 296	Continued From page 12 the training required by subdivision (8). This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel file review, interview, and new hire orientation checklist review, the provider failed to ensure the required training was completed within 30 days of hire for three of five newly hired sampled employees (D, E, and F) for any of the eleven personnel training topics. Findings include: 1. Review of employee D's personnel file revealed: *A hire date of 1/13/25. *He had been hired as a registered nurse. *There was no documentation that he had completed required the 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 residents' care needs	S 296		

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	65982	A. BUILDING: _____ B. WING _____	06/04/2025

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S 296	Continued From page 13 (oxygen and hospice). 2. Review of employee E's personnel file revealed: *A hire date of 10/2/24. *She had been hired as a certified medication aide (CMA). *There was no documentation that she had completed the required 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 residents' care needs (oxygen and hospice). 3. Review of employee F's personnel file revealed: *A hire date of 10/2/24. *She had been hired as a CMA and cook. *There was no documentation that she had completed the required 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.	S 296		

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S 296	Continued From page 14 -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 residents' care needs (oxygen and hospice). 4. Interview on 6/4/25 at 10:30 a.m. with administrator A regarding employee training revealed: *Employees D, E, and F: -Had been given the new employee packet with training information upon date of hire. -Had not returned the signed form indicating they had read the information. -Should have returned the signed form indicating they had read the information. *The facility did not go over the information in the packet with the new hires, they assumed the new hires had read the information. *She was responsible for ensuring the new employee training was completed. 5. Review of the provider's reviewed and revised 4/3/25 Staff Education and Competency policy and procedure revealed: *"Will provide, at a minimum, eleven topics for ongoing educational programs. Every staff member is required to attend to be re-educated. If a staff member is unable to make it to the meeting, handouts and/or competency checks will be required. These topics include the following subjects: -(1) Fire prevention and response; -(2) Emergency procedures and preparedness; -(3) Infection control and prevention;	S 296		

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S 296	Continued From page 15 -(4) Accident prevention and safety procedures; -(5) Proper use of restraints; -(6) Patient and resident rights; -(7) Confidentiality of patient or resident information; -(8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanism; -(9) Care of patients or residents with unique needs; Medication Administration; Residents Dependent on Supplemental Oxygen; AND -(10) Dining assistance, nutritional risks, and hydration needs of residents. -(11) Oxygen and Medication administration."	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, interview, and policy review, the provider failed to ensure one of five sampled employees (F) health status for communicable diseases was evaluated by a licensed health professional within 14 days of hire. Findings include: 1. Review of employee F's personnel file revealed: *Her date of hire was 10/2/24. *There was no health evaluation in her personnel	S 305	Administrator and interdisciplinary team will review and revise as necessary the policy and procedure for new hire personnel paperwork. Unable to timely complete the health status for communicable diseases for employee F. Administrator or designee will complete all necessary paperwork by 7/19/2025. Administrator or designee will provide education to all staff responsible for following the proper procedure for new hire personnel paperwork on 07/11/2025 & 07/18/2025. Administrator or designee will perform audits on all new hire paperwork to ensure the appropriate paperwork is being completed once a month for three months. Administrator or designee will present findings from these audits monthly for three months at the interdisciplinary team meetings for review until the interdisciplinary team advises to discontinue monitoring.	07/19/2025

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S 305	Continued From page 16 file. Interview on 6/4/25 at 10:30 a.m. with administrator A regarding the health evaluation for employee F revealed she confirmed employee F's health evaluation had not been completed should have been. Review of the provider's undated Communicable Disease Reporting policy and procedure revealed: *"Purpose: to reduce the transmission of communicable diseases." *"Policy: Comply with state and local health department requirements for reporting communicable diseases."	S 305		
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 lounge/recreation room and one of one kitchen. Findings include: 1. Observation on 6/2/25 at 2:00 p.m. in the north hallway lounge/recreation room revealed: *A counter with a sink. On top of the counter was a microwave. Inside of the microwave was old, dried on food debris.	S 450	Administrator and interdisciplinary team will review and revise as necessary the policy and procedure for kitchen cleaning and sanitation. The kitchen and lounge area will be cleaned including, but not limited to, food debris, sticky and soiled drawers and floors, discolored walls and ice, leftover residue, dust, spillage, and crumbs on or by 6/27/2025. Administrator or designee will create a kitchen cleaning checklist to be completed by staff by 7/19/2025. Administrator or designee will provide education to all staff responsible for cleaning and sanitation of the kitchen and lounge area on 07/11/2025 & 07/18/2025. Administrator or designee will perform audits on kitchen and lounge cleanliness once a week for four weeks and once a month for two more months.	07/19/2025

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S 450	Continued From page 17 *The walls surrounding the counter were discolored and dirty. *The outsides and the insides of the cupboard drawers were sticky and soiled. *There was a refrigerator/freezer next to the cupboard. -The refrigerator section had a padlock on the side of it. -The freezer had old, discolored ice on the bottom shelf. The top rack was visibly dirty. *The floor was dirty and sticky. 2. Observation on 6/2/25 at 2:40 p.m. in the kitchen revealed: *The door leading into the kitchen from the employee hallway was propped open with a screwdriver. *The dry storage room had paint peeling from the ceiling. *The hand washing station next to the three compartment sink had a dried substance on the soap dispenser. *The towel holder next to the hand sink was visibly dirty. *The ceiling vents were dusty. *There was a large white binder on the counter titled "Spring and Summer" menu book. The outside of the binder was visibly soiled. -The inside of the binder contained clear plastic sheets with the menus listed. --Those clear plastic sheets were visibly dirty and stained. *The windowsill on the west side of the kitchen was dusty and had a few dead bugs on it. *The ceiling tiles were discolored and stained. *The hood above the stove was dusty. *The bottom shelf of the refrigerator on the left side of the stove had a fifty-cent sized blood spill next to a package of hamburger stored on a tray. *The freezer to the right of the stove had old food	S 450	Administrator or designee will present findings from these audits monthly for three months at the interdisciplinary team meetings for review until the interdisciplinary team advises to discontinue monitoring.	

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S 450	Continued From page 18 crumbs on the bottom shelf. Interview on 6/4/25 at 10:30 a.m. with administrator A regarding the above observations revealed: *The certified medication aide was responsible for cleaning the north hallway lounge/recreation room. *The cook was responsible for cleaning the kitchen. *They did not have a kitchen cleaning flow sheet that would have indicated the staff had completed the cleaning. -"It was done on the honor system." Review of the provider's undated Sanitation of Dietary Department policy revealed: *"Policy: -The dietary staff shall maintain the sanitation of the Dietary Department through compliance with a written, comprehensive cleaning schedule." *"Procedure: -1. The Administration, or designated personnel, shall record all cleaning and sanitation tasks for the department. -2. Tasks shall be designated to the responsibility of specific portions in the department. -3. All tasks shall be addressed as as to the frequency of cleaning. -4. The method of procedures to be used and agents used for cleaning shall be developed for each task or piece of equipment to be cleaned. -5. A cleaning schedule shall be posted weekly for all cleaning tasks, and employees will initial tasks as completed."	S 450		