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
	11037	A. BUILDING: ______ B. WING ______	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS EAST	2905 DOUGLAS AVENUE 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 East was found not in compliance with the following requirements: S145, S165, S201, S305, S331, S337, S450, and S478.	S 000		
S 145	44:70:02:12 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain the required exhaust ventilation in two randomly observed locations. (north wing laundry/soiled room and bathroom in resident room number three) Findings include: 1. Observation and testing on 10/29/24 at 10:38 a.m. revealed the laundry/soiled room of the north wing had a noticeable odor when entering it. Testing of that room's exhaust ventilation with a piece of tissue paper at the same time as the observation revealed the exhaust system was not drawing air out of the room. Interview with administrator B and maintenance director I at the same time as the testing confirmed those findings. 2. Observation and testing on 10/29/24 at 10:52	S 145	S 145 Angelhaus contacted Reliance Heating & Cooling 11/22/24 and met with Chris. Reliance sent us a quote and intends to repair the ventilations system the first week of December. Three new exhaust fans have been purchased for the laundry rooms and are also scheduled for installation the first week of December 2024. Ventilation system/fan check have been added to the maintenance checklist PoC Verification Steps: (1) Head of Maintenance shall monitor and document ventilation system/fan operations for bi-weekly. (2) Administrator shall review documentation and monitor ventilation system/fans monthly for no less than four months or until compliance has been achieved.	12/16/24

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

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S 145	Continued From page 1 a.m. revealed the exhaust ventilation for the bathroom in resident room number three was not properly operating. When tested with a piece of tissue paper that exhaust was shown not to be drawing any air out of the room. Interview with administrator B and maintenance director I at the same time as the testing confirmed that finding.	S 145		
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: A. Based on observation, interview, and policy review, the provider failed to have ongoing monitoring of: *Two of two observed resident (1 and 5) room's exit doors leading to the outside of the building. *One of one observed exit door (exit door east of the conference room) leading to the outside of the building. Findings include: 1. Observation and interview on 10/28/24 at 9:55 a.m. in resident 1's room revealed: *A door leading to the outside of the building to a patio. *The door had a lock on the inside of it.	S 165	S 165 Angelhaus East will be notifying the SD DOH that it no longer will carry the Cognitively Impaired endorsement on its license thus nullifying the need for every door to be alarmed and/or secured. Nurses shall complete quarterly assessments on all resident smokers to ensure safety for residents and staff. PoC Verification Steps: (1) Nurse(s) shall establish a quarterly checklist to complete quartly assessments. (2) Administrator shall review assessment documentation for no less than nine months or until compliance has been achieved. (3) QA Team shall review documentation at monthly meetings for no less than four months or until compliance has been achieved.	12/3/24

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*The surveyor unlocked the door and opened the door leading to the outside patio.
-There was no alarm that sounded after the door had been opened.
-No staff had come into her room to check on the open exit door.
*Resident 1 thought the door was locked most of the time.

2. Observation and interview on 10/28/24 at 10:45 a.m. in resident 5's room revealed:
*A door leading to the outside of the building to a patio.
*The door had a lock on the inside of it.
*The surveyor unlocked the door and opened the door leading to the outside patio.
-There was no alarm that sounded after the door had been opened.
*Certified medication aide (CMA) G:
-Was in the room completing a glucose check with resident 5.
-She had not looked or made any comments about the door leading to the outside patio being opened.

Interview on 10/28/24 at 2:10 p.m. with chief financial officer (CFO) A regarding the above door observations revealed:
*The resident room patio doors were alarmed at all times.
*There was a high pitch noised alarm located at the front area of the building that would sound when the patio doors were opened alerting the staff to check on them.

Interview on 10/29/24 at 9:05 a.m. with CFO A and director of nursing (DON) C regarding the above exit door observations revealed:
*There were five residents with doors in their rooms leading to the outside of the building to a

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patio.
*When the doors were opened the alarms had to be manually shut off.
*Their expectations were for the staff to check on the doors when the alarms sounded.

2. Observation on 10/29/24 at the following times in the southeast wing revealed:
*At 12:25 p.m. an exit door leading to the outside of the building.
*At 12:26 p.m. a surveyor opened the exit door causing the door alarm to sound, and then the surveyor exited the building. Another surveyor was observing the exit door.
*At 12:28 p.m. the door alarm continued to sound.
-No staff had checked on the door.
-Resident 7 came out of his room, put the code into the box, and turned the alarm off.
-Interview at that time with resident 7 revealed:
-He said he often turned the door alarm off.
-"That was the longest the door alarm had sounded."

Interview on 10/30/24 at 10:15 a.m. with CFO A, administrator B, and DON C regarding the above observation revealed:
their expectations would have been for a staff member to check on the door.

Review of the provider's undated Resident Door Alarms policy revealed:
*"All fire exit doors are outfitted with audio alarms monitored and controlled at the nurses station."
*The policy had not included what staff were to do if the door alarms were activated.

B. Based on interview and record review, the provider failed to ensure ongoing assessment, documentation, and physician's orders for two of two sampled residents who smoked (4 and 5).

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S 165	Continued From page 4 Findings include: 1. Review of resident 4's care record revealed: *He was admitted on 12/2/22. *He independently went outside to smoke. *He was considered to be cognitive. *The last smoking assessment had been completed on 12/2/23 to ensure he was physically and mentally capable of safely smoking unsupervised. *He was able to store his smoking supplies independently. *He did not have a physician's order to smoke. 2. Review of resident 5's care record revealed: *She was admitted on 9/15/18. *She was independent with smoking. *She was considered to be cognitive. *The last smoking assessment had been completed on 6/24/24 to ensure she was physically and mentally capable of safely smoking unsupervised. *She was able to store her smoking supplies independently. *She did not have a physician's order to smoke. Interview on 10/30/24 at 10:15 a.m. with DON C regarding resident 4 and 5's smoking revealed her expectations would have been: *To obtain a physician's order for both residents to smoke. *For quarterly smoking assessments to have been completed on both residents. Interview on 10/30/24 at 11:30 a.m. with licensed practical nurse (LPN) D regarding resident 4 and 5 smoking revealed: *She confirmed: -Residents 4 and 5 did not have a physician's order to smoke and should have.	S 165		

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S 165	Continued From page 5 -She had not been aware a physician's order was needed for a resident to smoke. -She had not completed resident 4 and 5's smoking assessments quarterly and should have.	S 165		
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: A. Based on document review and interview, the provider failed to conduct monthly fire drills for six months so far in 2024 (January, February, March, April, August, and September). Findings include: 1. Document review on 10/29/24 at 1:00 p.m. revealed fire drill log sheets were not available for January, February, March, April, August, and September of 2024. Additionally other than the fire drill conducted as part of the South Dakota Department of Health, a fire drill had not been conducted for the month of October. Fire drills must be conducted monthly, two of which must occur during the night shift. Interview on 10/29/24 at 2:52 p.m. with Chief Financial Officer (CFO) A and administrator B confirmed that finding. CFO A stated she was	S 201	S 201 Smoke detectors older than 10 years have been replaced with new models. Angelhaus shall complete monthly fire drills in accordance with Life Safety Code. Fire drill reminders have been added to the monthly Admin and Maintenance calendars. PoC Verification Steps: (1) Fire alarms shall be conducted by the Administrator and /or Head of Maintenance. (2) Monthly alarms shall be documented by the Administrator and/or Head of Maintenance. (3) QA Team shall review documentation at monthly meetings for no less than four months or until compliance has been achieved.	11/11/24

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S 201	Continued From page 6 aware they were missing a few fire drills. B. Based on observation and interview, the provider failed to maintain the facility to avoid undue danger to the lives and safety of the occupants, by not replacing one randomly observed smoke detector (room number 11). Findings include: 1. Observation on 10/29/24 at 4:00 p.m. revealed the single station battery back-up smoke detector in room number eleven. Single-station battery back-up smoke detectors are required to be replaced every ten years. That smoke detector was dated "2012 June 14" and would be out of date after June 14th of 2022. Interview with CFO A and administrator B at the same time as the observation confirmed that finding. Administrator B indicated he was aware that style of smoke detectors had a lifespan of ten years, but he had just recently become the administrator and had not been aware how old the room smoke detectors were.	S 201	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.	11/27/24
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	S 305	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) Administrtor to report QA team to review checklists quartley for no less than nine months or until compliance has been achieved.	

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S 305	Continued From page 7 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. 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 done.	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	S 331		

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S 331	Continued From page 8 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 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.	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 9 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 for employees.	S 331		
S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, care record review, interview, and policy review, the provider failed to: *Ensure insulin pen preparation and administration for one of one sampled resident (5) by one of one observed certified medication assistant (CMA) (G) had been completed. *Ensure the monitoring of one of one sampled resident (5) self-administration of insulin by one of one observed CMA (G) had been completely accurately. *Document one of one Tresiba insulin pen had been opened. *Appropriately document the death of one of one closed sampled resident (6) by one of one licensed nurse (D). Findings include: 1. Observation on 10/28/24 at 12:15 p.m. with	S 337	S 337 Angelhaus has a scheduled monthly staff meeting for 11/27/24. Nurse(s) shall be going over policies regarding insulin pens. Nurse(s) shall demonstrate how to properly prime and date an insulin pen. Nurse(s) shall train staff to ensure they make sure to watch each resident perform the insulin injection. Our facility performed a meeting on November 18th 2024 with are Nurse(s)reviewed policies to ensure they have the correct verbiage in our reports during a resident's death. PoC Verification Steps: (1) Nurse(s) review polices and procedures regarding proper handling of an insulin pen, including how to prime and date an insulin pen. (2) Nurse(s) will monitor twice weekly for first 3 weeks, weekly for the next 4 weeks, and quarterly after that. (3) Administrator shall review documentation for nine months. (4) QA team shall review documentation for no less than nine months or until compliance has been achieved.	12/4/24

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CMA G and resident 5 during medication administration revealed:
*CMA G removed the Tresiba flex pen from the medication cart located in the medication room.
-Dialed the insulin pen to 20 units.
-Handed the insulin pen to the surveyor to verify she had dialed the insulin pen to 20 units.
--The date the pen was opened had not been documented on the pen.
-CMA G had not primed the pen prior to handing the insulin pen to resident 5.
*She then:
-Went to the dining room table and handed the insulin pen to resident 5.
-Walked away from the table without observing resident 5 self-administering the insulin.

Interview at that time with CMA G regarding the above insulin administration observation of resident 5 revealed:
*She had not been trained on priming the insulin pen by wasting two units of insulin prior to administering the allotted amount of insulin from the pen.
*Resident 5 usually self-administered the insulin while she sat at the table.
*Confirmed there was not a date on the insulin pen when it had been opened, and should have.

Review of resident 5's care record revealed:
*She was to receive Tresiba Flex Pen 20 units subcutaneous once daily at noon.
*A 9/24/24 self-administration assessment indicated she was safe to continue with self-administration of the Tresiba Flex Pen insulin injections.

Interview on 10/30/24 at 10:15 a.m. with director of nursing C regarding the above observation revealed her expectations would have been for:

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*CMA G to have primed the insulin pen by wasting two units of insulin prior to dialing the pen to the allotted amount of insulin to be administered by the resident.
*Insulin pens were to be dated by the person when opened for the first time.
*CMA G should have stayed and monitored resident 5 self-administering the insulin.

Interview on 10/30/24 at 11:20 a.m. with licensed practical nurse (LPN) D regarding the above observation revealed CMA G should have:
*Primed the insulin pen by wasting two units of insulin prior to dialing the pen to the allotted amount of insulin to be administered.
*Continued to observe resident 5 as she self-administered the insulin.
*Documented on the insulin pen when it had been opened.
*Asked resident 5 if she wanted to self-administer the insulin in a public area or go to a private area.

Review of the provider's undated Insulin Labeling policy revealed:
*"Insulin pens must be labeled with the resident's name, the date the pen was opened.
*Insulin pens must be discarded within 28 days of opening, or per manufacturer instructions."

Review of the provider's undated Insulin policy had not included how to prime the insulin pen by wasting two units of insulin prior to dialing the pen to the allotted amount of insulin to be administered.

2. Review of resident 6's progress notes revealed the following entry:
*On 9/6/24 at 8:12 p.m.:
-"Late entry:
-Received a call that the resident was having a

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hard time breathing.
-Came into check on resident, she was given lorazepam [a sedative] 0.25 to relax her.
-Resident passed away peacefully after relaxing.
-Notified [person name] in regards to her passing.
-"She cme [came] in and we notified the funeral home."

Interview on 10/30/24 at 10:15 a.m. with director of nursing C regarding the above documentation for resident 6 revealed the:
*Nurse should have only documented that no breath sounds or heartbeat were noted.
*Nurse should not have stated "passed."
*Provider did not have a policy related to the documentation of a resident's death.

Pursuant to SDCL 23-14-18.1 Determination of death - Any individual who has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death shall be made in accordance with accepted medical standards.

SDCL 34-25-18 and 34-25-18.1 - intent is to designate the signing of the Death certificate as a medical act by a physician, physician's assistant, or nurse practitioner.

SDCL 36-4A-22(11) Physician's assistant and SDCL 36-9A-12 Nurse Practitioner act were amended to provide that such practitioners may perform the overlapping medical function. There is no South Dakota law specific to the act of pronouncement of death; current state laws only address who may sign the death certificate; for pronouncement of death to be effective it must be accompanied by a certificate, and since a nurse

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS EAST	2905 DOUGLAS AVENUE 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 337	Continued From page 13 cannot sign a death certificate, a nurse cannot pronounce death.	S 337		
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 and one of one dining room in a clean and sanitary manner. *Hand hygiene by one of one cook (F) during one of one meal service preparation. *Preparation and serving of food to residents by one of one cook (F) during one of one meal service time. Findings include: 1. Observation and interview on 10/28/24 at the following times in the dining room and the kitchen with cook F revealed: *At 11:00 a.m. in the dining room: -The popcorn popper interior walls were dirty. -The bottom of the handsink was dirty. -The inside of the microwave had dried on food and crumbs. *At 11:05 a.m. in the kitchen: -Frozen food crumbs were on the inside floor of the large refrigerator/freezer. -Small areas of dried food were stuck on the	S 450	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 for no less than nine months or until compliance has been achieved. Administrtor will share results wit QA team quarterly.	11/25/24

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S 450	Continued From page 14 outside of the above refrigerator/freezer. -The cupboards were sticky, stained, and had uncleanable surfaces. *At 11:10 a.m. cook F had been preparing the food for the noon meal. He had on gloves. -With those gloved hands he removed several pieces of bread from the package and placed them on the counter. -Took slices of cheese and cold meat from the packages with those gloved hands and placed them onto the bread. -During that time he was touching the handles of the refrigerator and the cupboards. *At 11:20 a.m. continued observation of the kitchen revealed: -There was no solution in the emergency wash kit hanging on the wall. -The side of the cupboard next to the hand sink had pieces of vinyl missing and the particle board was discolored and warped. -There was a scoop left inside of the large flour and the large sugar containers. --The lids of both containers were sticky and dirty. -Two cutting boards were discolored and had several cut-marked areas in them making them uncleanable. *At 11:34 a.m. cook F continued to have the same gloves on. -He sniffled and put his elbow up to his nose. --No hand hygiene or changing of his gloves had been observed. -With those same gloved hands: --He took bread out of the package and placed the bread on two cookie sheets --Removed slices of single serving cheese out of a plastic bag, and placed a piece of cheese on top of each slice of bread. --Took several food wraps from a package and placed them on top of the grill on the stove. --Touched his forehead with his gloved hand.	S 450		

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--Removed a scoop from the cupboard drawer.
--Took the scoop and placed tuna salad on each piece of bread.
--When asked by the surveyor what size scoop he was using, it took him a while to find the scoop size.
---He responded two ounces.
*At 11:39 a.m. cook F went over to the grill and flipped the wraps with his bare hands. He:
-Placed more wraps from the package onto the grill.
-Returned to the counter and placed a piece of bread over each of the bread, cheese, and tuna salad slices.
-Opened the oven door and placed the two cookie sheets into the oven.
*At 11:47 a.m. cook F removed his gloves and without performing hand hygiene stated he was going to the restroom.
*At 11:48 a.m. cook F returned to the kitchen and without performing hand hygiene put on new gloves.
*At 11:49: a.m. cook F removed a cookie sheet from the oven and placed it on top of the grill.
*At 11:50 a.m. cook F:
-Took the food temperature log and thermometer but had not checked any temperatures of the prepared food items.
-With those same gloved hands he touched multiple areas of the kitchen.
-Wiped his forehead with his arm.
*At 11:58 a.m. cook F began to plate the food for the noon meal. He:
-Opened the oven door and picked up the tuna melt and potato wedges with those same gloved hands and placed the food on the plate, and then used a scoop to place the hot vegetable mixture on the plate.
-Went to the oven and picked up a piece of chicken breast with his gloved hand and placed it

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on a cutting board on the counter.
--Took a knife and cut the chicken into several smaller pieces, and then with his gloved hand placed the chicken on the wrap.
--Took shredded cheese and placed on top of the chicken, and then rolled up the wrap and placed it onto a plate.
--He continued the same process with the tuna melt sandwiches and the chicken wraps as he plated the food with those same gloved hands throughout the serving of the noon meal.
*Cook F had never been observed to wash his hands throughout the meal preparation observation.

Interview on 10/29/24 at 9:05 a.m. with cook F regarding the observation on 10/28/24 preparing the noon meal revealed his usual practice was to wear gloves while plating the food unless using beef or chicken, then he would have used tongs.

Review of cook F's personnel training records revealed:
*He had a hire date of 6/7/24.
*He had completed the facility's new employee training for Dining, Nutrition, and Food Safety on 6/7/24.
*The New Hire Kitchen Training with the "Purpose of this is to train all Cooks the same way" was signed and dated by cook F on 10/28/24.
-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 F to have:
-Performed hand hygiene between glove changes.
*To use tongs and not his hands while serving out

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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.
-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."

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S 450	Continued From page 18 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 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 27 of 27 residents which included the optional service license for therapeutic diets. 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.	S 478	S 478 Angelhaus worked with dietetic services and completed new menu with extensions and portion sizes. PoC Verification Steps: (1) Kitchen manager will monitor menus on a monthly basis. (2) Administrator shall review assessment documentation 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

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*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.

Interview on 10/30/24 at 10:15 a.m. with director of dietary services E, chief finance officer A, and administrator B regarding the menus confirmed the menus should have been reviewed annually by RD H.

Review of the nutritional adequacy section of the 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.