

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/10/2024
NAME OF PROVIDER OR SUPPLIER  Wheatcrest Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1311 Vander Horck St Britton, SD 57430	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>45383</p> <p>Based on record review, interview, observation, review of the facility reported incident (FRI) submitted to the South Dakota Department of Health (SD DOH), the provider failed to ensure four of four sampled residents (2, 26,32 and 34) had not been verbally berated or denied food by one of one certified food manager (CFM) D. Findings include:</p> <p>1. Review of a grievance submitted on 2/22/24 revealed:</p> <p>*Resident 34 had asked the kitchen staff for a snack.</p> <p>*Dietary had informed her they would have snack in the afternoon and did not give her anything.</p> <p>Review of CFM D's response to the grievance revealed:</p> <p>*Around 11:00 a.m. resident 34 asked for the snack basket so she could look through it for munchies.</p> <p>*CFM D explained to her that the basket was filled and put out at 7:00 p.m. for the residents that got hungry between the hours of 7:00 p.m. and 6:00 a.m.</p> <p>*CFM D also explained that the nurse's station there should be some sandwiches if she was hungry.</p> <p>*Update with the resolution by CFM D revealed she:</p> <p>-Went to talk with resident 34 about snacks.</p> <p>-Explained that if she was wanting something to eat, that she just needed to let her know.</p> <p>-Also explained to her what her requirements were as far as the snacks, we are requested to have snacks for them between supper and breakfast.</p> <p>*Had stated that if resident 34 would have needed anything in the meantime, the nurse's station should have had sandwiches if they were hungry.</p> <p>Review of a grievance submitted on 6/27/24 revealed:</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*CNA (certified nursing assistant) took meal tray to resident at 12:15 p.m. Resident requested a sandwich.</p> <p>-CNA voiced this to the kitchen staff CFM D right away.</p> <p>*The sandwich was not made by kitchen staff.</p> <p>*Nurse was notified at 1:30 p.m. that the resident was not made her requested sandwich.</p> <p>*Nurse got juice and a sandwich as soon as possible.</p> <p>*Resident has diabetic reactions and is critical that the resident has appropriate meals and correct times.</p> <p>Review of CFM D's response to the above grievance revealed:</p> <p>*We were serving the meal for the day and the CNA took the resident's meal at 12:15 p.m. we start serving at 12:00 p.m.</p> <p>*We had breaded chicken fried steak, mashed garlic cauliflower, stewed tomatoes and fruit crisp.</p> <p>*The CNA came back and requested a ham sandwich.</p> <p>*I explained we were out of ham and the ham that we still have was still frozen, however I would make her a peanut butter and jelly sandwich.</p> <p>*If the resident is diabetic and blood sugars were low, we could send a glass of orange juice with the CNA.</p> <p>*I was unaware of the sugars if that was the case.</p> <p>Review of the SD DOH FRI submitted on 7/9/24 at 1:11p.m. revealed:</p> <p>*The reporter had informed the social service director that CFM D had yelled at resident 2 on 7/8/24 for the second time that he was aware of.</p> <p>*The reporter communicated he had let the first witnessed encounter go and he felt that could have been considered a form of elder abuse.</p> <p>Interview on 7/8/24 at 3:22 p.m. with resident 26 revealed:</p> <p>*Concerns about food had been brought to the resident council.</p> <p>*She stated The food is terrible. There have been a lot of problems.</p> <p>-Nothing happens, everyone is afraid to say anything to [CFM D].</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--The other day I didn't like the dinner. I don't eat fish, so I asked for a grilled cheese, and it was burned. I refused it and it was sent back to me like that, and I had to eat it or be hungry. I ate half. It was awful.</p> <p>Interview on 7/8/24 at 4:11 p.m. with resident 2 revealed:</p> <p>*She recently had a choking episode and there were certain foods she could not eat.</p> <p>-Her son had to bring her food from home.</p> <p>--She had been unable to get a ham or turkey sandwich because they said they forgot to order it.</p> <p>---The staff in the kitchen yelled at me for asking what Teriyaki beef was. I didn't think I could eat it.</p> <p>----I am afraid to ask for food that's not on the menu because I get yelled at. It shouldn't be that way.</p> <p>Observation and interview on 7/8/24 at 5:43 p.m. with resident 32 and CNA Q in the main dining room revealed:</p> <p>*Resident 32 stated, I thought we were getting chips with our dinner.</p> <p>*CNA Q stated, I will ask for chips.</p> <p>*Resident 32 stated, Only if you want to get bitched out.</p> <p>*CNA Q replied It's ok. I'll ask anyway.</p> <p>*Resident 32 stated, The state is here so she will give them to you.</p> <p>-Resident 32 clarified that she was CFM D</p> <p>Interview on 7/10/24 at 2:15 p.m. with registered nurse (RN) G and anonymous M regarding if sandwiches had been available at the nurse's station for residents revealed:</p> <p>*They had both agreed that they would have to go to the kitchen and ask for a sandwich to be made.</p> <p>*Sandwiches were not routinely stocked in the nurse's station resident refrigerator.</p> <p>Interview on 7/10/24 at 2:36 p.m. with anonymous N regarding resident's rights revealed:</p> <p>*If residents did not want the meal that had been prepared CFM D would have berated them as to why they weren't eating the meal.</p> <p>*There used to be a group of men that would sit after supper and drink coffee and eat ice cream.</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*CFM D told those residents that they wanted the ice cream they did not need the ice cream and instructed her staff to stop giving the ice cream to those residents.</p> <p>*Anonymous N would have reported any incidents to the charge nurse on duty.</p> <p>Interview on 7/10/24 at 3:00 p.m. with RN G regarding staff reporting verbally abusive behavior toward residents revealed:</p> <p>*She has had staff tell her what they had witnessed.</p> <p>*She would have visited with the residents to see if they were ok and report it to the other nurses.</p> <p>*She had written up CFM D for not following instructions and nothing was ever done to correct her behavior.</p> <p>Interview on 7/10/24 4:03 p.m. with executive director (ED) A, director of nursing (DON) B, and divisional director of clinical operations (DDCO) C regarding dietary grievances and follow-up with CFM D's responses revealed:</p> <p>*ED A had believed that staff were eating the snacks out of the snack basket and that was taken away. *DON B indicated there are some rice crispy treats in the med room.</p> <p>*Nurses had the code to the kitchen to obtain food when needed.</p> <p>*If sandwiches were said to have been available then they should be available, and dietary should have made sure there were sandwiches available.</p> <p>*DON B stated nursing should speak up when they see something is missing, and that was her expectation.</p> <p>*A CNA could have requested snacks.</p> <p>*DON B stated residents should not have waited an hour and a half (1/2) for a sandwich.</p> <p>*Education had been provided to dietary staff within the last year that if a nurse or the DON B went to them with a need they need to address it right away.</p> <p>*They had not been aware of any issues with CFM D until the reportable incident they had received on 7/9/24.</p> <p>*Staff should have reported if they were aware CFM D was berating a resident.</p> <p>*They had not been aware that staff had been fearful of retaliation by CFM D if they would have to reported anything.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>45383</p> <p>Based on observation and interview the provider failed to ensure that four of four sampled residents (3, 7, 32, and 43) had their call lights answered in a timely manner. Findings include:</p> <p>Observation and interview on 7/8/24 at 3:23 p.m. with resident 3 while she was seated in her wheelchair regarding call light wait time revealed:</p> <p>*She had been left on a commode for almost an hour.</p> <p>*That happened during the day shift.</p> <p>-That same thing happened again a few days later.</p> <p>Observation and interview on 7/8/24 at 3:48 p.m. with resident 32 while she was seated in her recliner regarding call light wait time revealed:</p> <p>*She had sat on the toilet for 45 minutes and waited to get help when she had pulled her call light.</p> <p>*Staff do not round on her at night.</p> <p>Interview on 7/9/24 at 2:21 p.m. with the director of nursing (DON) B regarding the call light system revealed:</p> <p>*If a resident were to pull down on the call light cord once it would sound once out at the nurse's station.</p> <p>*If a resident were to keep the cord pulled down it would make a constant buzzing sound at the nurse's station.</p> <p>*If a resident was in the bathroom and pulled the call light cord, it would make an intermittent buzzing sound at the nurse's station.</p> <p>Request for a call light policy had been made prior to exit. The provider did not have a call light policy.</p> <p>45683</p> <p>Observation and interview on 7/8/24 at 4:36 p.m. with resident 7 in his room regarding call light wait time revealed:</p> <p>*He was seated in his recliner.</p> <p>*His call light cord was on the arm of his recliner.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*He stated sometimes he had to wait a while for staff to answer his call light.</p> <p>*He turned his call light on at 7:00 a.m. this morning.</p> <p>*He needed help getting dressed and to use the bathroom.</p> <p>*Staff did not come in to answer the call light until after 7:30 a.m.</p> <p>Observation and interview on 7/9/24 at 10:54 a.m. with resident 43 in her room regarding call light wait times revealed:</p> <p>*She was seated in her recliner.</p> <p>*Her call light cord was on the nightstand next to her recliner.</p> <p>*She stated she had waited up to 25 minutes for someone to answer her call light when she was in the bathroom.</p> <p>*On 7/8/24 in the evening she had turned her call light on to request a Tylenol for pain.</p> <p>*A staff member answered her call light and said she would be back with the Tylenol.</p> <p>*The staff member never did bring the Tylenol to her that evening.</p> <p>*She finally got her Tylenol at 6:30 the next morning.</p> <p>Resident council meeting minutes review and interview on 7/9/24 at 2:00 p.m. with residents 2, 3, 7, 16, 19, 20, 22, and 32 regarding call light wait times revealed:</p> <p>*They all agreed they had to wait for someone to answer their call light.</p> <p>*It was not uncommon to wait more than 20 minutes to have someone respond to the call light.</p> <p>*Staff would be at the nurse's station while call lights were going off and would not answer the call lights promptly.</p> <p>*Call light issues had been discussed at the resident council meetings and were to be addressed by DON B.</p> <p>*Resident 32 stated they bring it up at the resident council meetings and it will get addressed, and would be better for a while, but now it was an issue again.</p> <p>*Review of the 5/21/24 resident council meeting minutes revealed residents said there were a lot of CNAs at the nurse's station visiting when lights were on during the 2:00 p.m. to 10:00 p.m. shift.</p> <p>*Review of the 6/18/24 resident council meeting minutes revealed:</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Residents expressed concerns about staff sitting at the nurse's station visiting and not answering call lights on the 2:00 p.m. to 10:00p.m. shift.</p> <p>-The director of nursing educated CNAs and nurses that no one should be sitting at the desk when the call lights are on.</p> <p>-Residents agreed call lights had gotten better and felt it was resolved.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>49958</p> <p>Based on observation, interview, resident council meeting, and policy review the provider failed to offer nine of twelve sampled residents (2, 3, 7, 16, 19, 20, 22, 26 and 32) meal alternatives. Findings include:</p> <p>1. Interview on 07/08/24 at 3:22 p.m. with resident 26 revealed:</p> <ul style="list-style-type: none"> <li>*Concerns about food had been brought to the resident council.</li> <li>*She stated The food is terrible. There have been a lot of problems.</li> <li>-Nothing happens, everyone is afraid to say anything to certified food manager [CFM D].</li> <li>--The other day I didn't like the dinner. I don't eat fish, so I asked for a grilled cheese, and it was burned. I refused it and it was sent back to me like that, and I had to eat it or be hungry. I ate half. It was awful.</li> </ul> <p>2. Interview on 07/08/24 at 4:11 p.m. with resident 2 revealed:</p> <ul style="list-style-type: none"> <li>*She recently had a choking episode and there were certain foods she could not eat.</li> <li>-Her son had to bring her food from home.</li> <li>--She had been unable to get a ham or turkey sandwich because they said they forgot to order it.</li> <li>---The staff in the kitchen yelled at me for asking what Teriyaki beef was. I didn't think I could eat it.</li> <li>----I am afraid to ask for food that's not on the menu because I get yelled at. It shouldn't be that way.</li> </ul> <p>3. Observation and interview on 7/08/24 at 5:43 p.m. with resident 32 and CNA Q in the main dining room revealed:</p> <ul style="list-style-type: none"> <li>*Resident 32 stated, I thought we were getting chips with our dinner.</li> <li>*CNA Q stated, I will ask for chips.</li> <li>*Resident 32 stated, Only if you want to get bitched out.</li> <li>*CNA Q replied It's ok. I'll ask anyway.</li> <li>*Resident 32 stated, The state is here so she will give them to you.</li> </ul> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45683</p> <p>Based on observation, interview, and policy review the provider failed to ensure:</p> <p>*Proper glove use and hand hygiene were performed during two meal services by two of two dietary staff (dietary cook I and certified food manager D).</p> <p>*The food thermometer was sanitized appropriately during two meal services by three of four dietary staff (dietary cook I, certified food manager D, and dietary cook O). Findings include:</p> <p>1.Observation and interview on 7/8/24 from 5:07 p.m. through 5:40 p.m. with dietary cook I and certified food manager (CFM) D revealed:</p> <p>*Dietary cook I:</p> <ul style="list-style-type: none"> <li>-Picked up a thermometer and took the temperature of a pot of white rice.</li> <li>-Set the thermometer on a cleaning rag.</li> <li>-Put on a pair of gloves without washing his hands.</li> <li>-Opened a drawer and took out a spoon and stirred a pot of beef tips.</li> <li>-Took that same thermometer from the rag and put it in the beef tips.</li> <li>-Wiped the thermometer off with that same rag.</li> <li>-Put that same thermometer in a pan of beets.</li> <li>-Wiped that thermometer off with that same rag and set it on the counter.</li> <li>-Took off his gloves and put on another pair of gloves without washing his hands.</li> <li>-Picked up that same rag and scrubbed a spot on the range.</li> <li>-Opened the cupboard and retrieved a measuring cup.</li> <li>-Added ground meat to the measuring cup.</li> <li>-Used the blender to grind the meat.</li> <li>-Took off his gloves and washed his hands.</li> <li>-Picked up that same thermometer and took the temperature of the rice and beef tips again.</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/10/2024
NAME OF PROVIDER OR SUPPLIER  Wheatcrest Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1311 Vander Horck St Britton, SD 57430	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Used that same rag again to wipe off the thermometer.</p> <p>-Took a hamburger out of the oven.</p> <p>-Picked up that same food thermometer from the counter.</p> <p>-Inserted it into the hamburger to get the temperature.</p> <p>-Used that same rag to wipe off the thermometer.</p> <p>*Interview with dietary cook I at that time confirmed:</p> <p>-He had used the cleaning rag to wipe off the thermometer.</p> <p>*The cleaning rag was in the bucket that had a sink and surface cleaner in it.</p> <p>-He agreed he should have used the alcohol pads to sanitize the thermometer between food items.</p> <p>-He should have washed before he put gloves on and when he changed them.</p> <p>*CFM D:</p> <p>-Put on a pair of gloves without washing her hands.</p> <p>-Opened a drawer to get a strainer.</p> <p>-Opened a refrigerator and took out a head of lettuce.</p> <p>-Pulled off a leaf of lettuce with those same gloved hands and put it on a plate.</p> <p>-Retrieved a jar of pickles from the refrigerator.</p> <p>-Used tongs to get out two pickle slices and put them on the lettuce.</p> <p>-With those same gloved hands she picked up the lettuce and pickles and put them in a bowl.</p> <p>-Removed her gloves and did not wash her hands.</p> <p>-Put on a new pair of gloves and moved the meal trays to the serving window.</p> <p>-Placed fruit cups onto the trays with those same gloved hands.</p> <p>2. Observation and interview on 7/9/24 from 7:52 a.m. through 8:15 a.m. with CFM D and dietary cook O revealed:</p> <p>*CFM D:</p> <p>-Took her gloves off and got a yogurt out of the refrigerator.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Wheatcrest Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1311 Vander Horck St Britton, SD 57430	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>-Set the yogurt on a plate and threw her gloves away.</li> <li>-Without washing her hands, she put on a new pair of gloves.</li> <li>-Went to the stove and cracked four eggs onto the stove top.</li> <li>-Picked up the food thermometer and checked the temperature of one of the fried eggs.</li> <li>-Set the food thermometer back on the counter without sanitizing it.</li> <li>-Went to the toaster and grabbed two pieces of toast with those same gloved hands.</li> <li>-Handed the toast to cook O who put them on a plate.</li> <li>-Used a spatula to pick up all four eggs.</li> <li>-Held the eggs on the spatula with those same gloved hands.</li> <li>-Placed the eggs in a warming tray.</li> <li>-Removed her gloves and went to the dining room to help deliver trays to residents.</li> <li>-Did not wash her hands.</li> <li>*Dietary cook O: <ul style="list-style-type: none"> <li>-Was wearing gloves.</li> <li>-Poured water and a packet of oatmeal into a bowl.</li> <li>-Placed the bowl in the microwave.</li> <li>-Used the food thermometer CFM D had used to temp the fried eggs to check the temperature of the oatmeal.</li> <li>-Used a sanitizer wipe to clean the thermometer.</li> <li>-Placed two fried eggs on one of the pieces of toast.</li> <li>-Used her gloved hand to place the other piece of toast on the eggs.</li> <li>-Picked up a knife and held the egg sandwich down with her gloved hand to cut it into two pieces.</li> <li>-Placed the egg sandwich on a plate.</li> <li>-Never did change her gloves.</li> </ul> </li> <li>*Interview with CFM D revealed:</li> </ul> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/10/2024
NAME OF PROVIDER OR SUPPLIER  Wheatcrest Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1311 Vander Horck St Britton, SD 57430	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-They should have washed their hands when changing their gloves.</p> <p>-She would have expected staff to use the alcohol wipes when cleaning the food thermometer.</p> <p>Interview on 7/9/24 at 4:07 p.m. with regional dietitian E regarding proper glove use and food thermometer sanitizing revealed:</p> <p>*Dietary staff had completed an in-service for hand washing on 4/29/24.</p> <p>*She expected dietary staff to follow the policy for proper glove use and food thermometer sanitizing.</p> <p>*She agreed these observations had the potential to affect all the residents.</p> <p>Review of the provider's updated December 2021 glove use policy revealed:</p> <p>*Gloves are worn to maintain safe and sanitary food preparation and service.</p> <ol style="list-style-type: none"> <li>1. Proper utensils are used for food handling.</li> <li>2. Bare hand food contact is prohibited.</li> <li>3 Proper use of gloves:               <ol style="list-style-type: none"> <li>a. Wash hands thoroughly before and after wearing or changing gloves.</li> </ol> </li> </ol> <p>Review of the provider's July 2009 cleaning and sanitizing a thermometer policy revealed:</p> <ol style="list-style-type: none"> <li>*1. Dietary staff use alcohol swabs to sanitize thermometers.</li> <li>*2. Open the alcohol swab packet with clean hands and wipe down the sides of the thermometer.</li> <li>*3. When taking the temperature during meal service, if food debris is still on the thermometer, dietary staff uses a clean paper towel to wipe off excess debris.</li> <li>*4. When taking the temperature during meal service, the thermometer is re-sanitized before taking the next temperature.</li> <li>*5. To prevent cross contaminating, clean and sanitize the thermometer and its case before replacing the thermometer back into the case.</li> </ol>