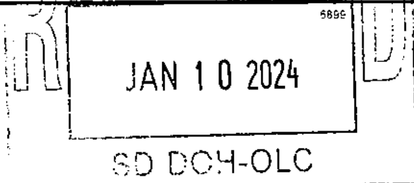
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	**50 7TH ST SE HURON, SD 57350**

(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 11/21/23 through 11/22/23. Angelhaus Huron was found not in compliance with the following requirements: S075, S200, S201, S215, S337, S415, S450, S603, S635, S642, S650, S654, S825, and S1039. A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 11/21/23 through 11/22/23. Areas surveyed included potential resident neglect and nursing services. Angelhaus Huron was found not in compliance with the following requirements: S337, S415, S642, and S654.	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, interview, and policy review, the provider failed to ensure the facility was maintained in a safe and sanitary manner for all residents related to the following areas:	S 075	S 075 Facility Engineer cut out broken tiles 11/29/23 and scraped, grouted and sanded to replace with new tiles in shower room. Facility engineer scraped, grouted and sanded down bathroom wall where paint was flaking and peeling on 11/30/23. Wall paneling was placed on 12/2/23. The rusted heating unit outside of the shower was sanded and repainted 12/2/23. The open vent area was replaced with a new vent cover on 12/3/23. Ownership obtaining quotes for replacement of lobby carpet with target installation Spring of 2024. PoC Verification Steps: (1) QA Team shall review and amend housekeeping checklists including carpet cleaning. (2) QA Team shall educate all staff on tasks related to building cleanliness and sanitation. (3) Executive Director shall perform weekly audits on housekeeping checklists for four months. (4) QA Team shall audit housekeeping checklists monthly for six months.	1/6/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nathan Gellhaus	Owner/Administrator	12/21/23



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
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 075	Continued From page 1	S 075		

*The resident lounge area carpet on the main floor was not kept clean and free from stains.
*One of two shower rooms on the third floor had concerns of:
-Broken tiles on the entry to the shower creating a sharp edge and uncleanable surfaces.
-The heating unit outside of the shower had a large amount of rust showing through the paint covering approximately seventy-five percent of the surface and making it uncleanable.
-An approximately four-foot square space on the wall above the heating unit had peeling paint and exposed sheet rock.
-The square vent in the ceiling of the shower room was opened to the duct work with no vent cover.
Findings include:

1. Observation on 11/21/23 at 9:00 a.m. of the resident lounge area carpet by the front entrance revealed:
*There were four unidentified residents sitting in the lounge area watching television.
*The carpet was very dingy and had multiple stains throughout the area.

Interview on 11/22/23 at 11:15 a.m. with executive director A, interim director of nursing (DON)/owner B, and maintenance supervisor E revealed they:
*Knew the carpet was stained and needed to be replaced.
*Had used a carpet cleaning machine to try and get the carpet clean.
*Had a bid to replace the carpet from a local contractor but it was not all inclusive for the project.
*Were trying to decide what type of flooring to replace the carpet with.
*Thought the Spring of 2024 would be a good

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 075	Continued From page 2	S 075		

time frame to replace the carpet.
2. Observation on 11/21/23 at 10:10 a.m. of the small shower room on third floor revealed:
*The room included a tiled shower and a nonfunctioning tub with an approximate five-foot by five-foot amount of space between them.
*The nonfunctioning tub had three wooden shelves above it and the plumbing was not hooked up.
*The tiled shower had several small circular-shaped holes that appeared to have been from screws in all three of the shower walls.
-The holes appeared to have been filled with a caulk-like product.
-Some holes were in better repair than others.
*The tiled ledge leading into the shower had broken tiles in two areas.
-The broken and missing tiles created sharp edges and uncleanable surfaces.
*There was a heating unit near the floor on the wall between the shower and tub that had a large amount of rust on the surface with minimal paint making it uncleanable.
*The sheet rocked wall above the heating unit had a significant amount of paint peeling and flaking type areas in the sheet rock over an approximately four-foot square area.
*The ceiling had an approximately eight inch by eight inch square-shaped vent that had no cover and it was opened to the duct work.

Interview on 11/21/23 at 9:55 a.m. and at 10:28 a.m. with resident aide I regarding the shower room above revealed:
*There were two shower rooms on third floor.
*Most of the third-floor residents preferred to use the small shower room referenced above even though the other shower room was in better condition.
*She confirmed the small shower room was not in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 075	Continued From page 3	S 075		

good repair.
*She thought the previous maintenance staff person had worked on the small shower room in the past due to the rust and paint peeling, but it looked the same way as before.
*She was unsure if there was a plan to repair the shower room.

Interview on 11/22/23 at 11:30 a.m. with executive director A, interim DON/owner B, and maintenance supervisor E regarding the third floor shower room revealed:
*They felt it was a moisture issue in the room.
-The previous maintenance person had worked on repairing that area in the past.
*They confirmed the room had not been maintained in a safe, clean, and sanitary condition for the residents who were using that space on a regular basis.

3. Review of the provider's undated Housekeeping policy revealed:
*"All staff are responsible for keeping a clean and clutter-free environment...Deep cleaning of the facility is taken care of by designated housekeepers. Housekeepers clean and disinfect all resident rooms at least once per week. Housekeepers are responsible for:
-Disinfecting resident bathrooms including sinks, countertops, and commodes.
-Cleaning and/or disinfecting resident room floors.
-Dusting surfaces.
-Vacuuming all carpeting in the facility.
-Cleaning windows and window dressings.
-Cleaning vents."
*It had not mentioned a process for sanitation and maintenance concerns related to the areas identified in the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 075	Continued From page 4 Review of the provider's undated Resident Rooms and Bathrooms policy revealed "...Efforts shall be taken to keep these areas clean and free from safety hazards." Review of the provider's undated Preventative Maintenance policy revealed: *"The facility undergoes routine maintenance inspections." *A schedule for daily, weekly, monthly, quarterly, semiannually, annually, and bi-annually items and areas were listed. -The schedule had not included the flooring or bathing rooms.	S 075		
S 200	44:70:03:01 Fire Safety Code Requirements Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition in chapter 32 or 33. An automatic sprinkler system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat detection system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain three feet of clear working space in front of the electrical panels in one of one area (the maintenance office). The provider must comply with the National Fire Protection Association (NFPA 70), National Electrical Code (NEC) article 110.26(A)(1) Depth of Working	S 200	S 200 Facility Engineer placed additional red tape around the current yellow tape on 11/29/23 to provide a clearer guide for staff to maintain a clear working space of three feet from the electrical panel. Additionally, a sign was posted on the door to the electrical closet on 12/13/23 as a reminder to staff to maintain three feet of clearance from electrical panel. PoC Verification Steps: (1) Executive Director and/or Facility Engineer shall educate all staff on electric closet safety and clearance guidelines. (2) Facility Engineer shall monitor electrical closet no less than weekly and document to ensure compliance for four months. (3) QA Team shall monitor compliance documentation monthly for four months.	1/6/24

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
	71778	A. BUILDING: ____ B. WING ____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 200	Continued From page 5 Space. Findings include: 1. Observation on 11/21/23 at 11:15 a.m. revealed the electrical room had a yellow line painted on the floor in front of the electrical panels. Interview with maintenance supervisor E at the time of the observation revealed the line was there to indicate the area was to be kept clear of storage items for access to the electrical panels. A large plastic tote was on the floor within the marked area directly in front of one of the electrical panels. There was not a minimum three feet of clear working space provided at any electrical panel in the room. Interview with maintenance supervisor E at the time of the observation confirmed that finding.	S 200		
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 the required bi-annual inspection of the kitchen range exhaust ductwork. Findings include:	S 201	S 201 A self-closing device was placed on the door to the oxygen supply room on 11/23/23. Red tape was placed around the oxygen supply to ensure a five-foot clearance radius. Signs were placed on the door and on the wall of the oxygen supply room as a reminder to keep five feet of clearance from the oxygen on 12/13/23. A self-closing device was placed on the door to the kitchen pantry on 11/23/23. PoC Verification Steps: (1) Executive Director and/or Facility Engineer shall educate all staff on oxygen storage safety and clearance guidelines. (2) Facility Engineer shall monitor oxygen storage no less than weekly and document to ensure compliance for four months. (3) All staff shall be educated on the policy to keep pantry room closed at all times. (4) Head of Dietary shall monitor no less than weekly to ensure pantry door is remaining closed. (5) Facility Engineer shall be trained by Building Sprinkler, Inc. on how to perform quarterly flow system tests and document quarterly tests for six months. (6) QA Team shall review all weekly documentation on oxygen storage, pantry door, and flow system testing monthly for six months to ensure compliance.	1/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 201	Continued From page 6	S 201		

1. Document review on 11/21/23 at 12:45 p.m. of the kitchen hood system inspections revealed there was no documentation indicating the entire exhaust ductwork had been inspected for cleanliness/grease build-up within the last year.

Interview with maintenance supervisor E at the time of the document review revealed he was unaware of the inspection/cleaning bi-annual requirement.

The deficiency affected the requirements for the kitchen range hood and exhaust system..

B. Based on observation and interview, the provider failed to maintain two randomly observed hazardous areas (oxygen/storage room and kitchen pantry) as required. Findings include:

1. Observation on 11/21/23 at 11:20 a.m. revealed the oxygen/storage room was over 100 square feet and had large amounts of combustible items stored in it. The corridor door from that room was not equipped with a self-closing device.

2. Observation on 11/21/23 at 11:35 a.m. revealed the kitchen pantry storage room was over 100 square feet and had large amounts of combustible items stored in it. The door for the pantry was held open with a floor wedge.

Interview with maintenance supervisor E at the time of the observations confirmed those findings.

The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of those smoke compartments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 201	Continued From page 7 C. Based on documentation review and interview, the provider failed to verify the required quarterly flow testing of the automatic fire sprinkler system had been performed. Findings Include: 1. Review of the provider's sprinkler maintenance records on 11/21/23 at 12:25 p.m. revealed no documentation the required quarterly flow testing of the automatic fire sprinkler system had been performed. Interview with maintenance supervisor E at the time of the document review revealed he was not aware of the quarterly flow-testing requirment. The deficiency affected a single component of the building's automatic fire sprinkler system required annual maintenance.	S 201		
S 215	44:70:03:03 Fire Extinguisher Equipment Fire extinguisher equipment shall be installed and maintained to the following standards: (1) Portable fire extinguishers must have a minimum rating of 2-A:10-B:C; (2) Fire extinguisher equipment must be inspected monthly and maintained yearly; and (3) Approved fire extinguisher cabinets must be provided throughout the building with one cabinet for each 3,000 square feet or 278.7 square meters of floor space or fraction thereof. The fire resistance rating of corridor walls must be maintained at recessed fire extinguisher cabinets. The glazing in doors of fire extinguisher cabinets must be wire glass or other safety glazing material. Fire extinguisher cabinets must be identified with a sign mounted perpendicular to the wall surface above the cabinet. This Administrative Rule of South Dakota is not	S 215	S 215 Facility Engineer educated on company policy to inspect fire extinguishers monthly and to be formally inspected by an outside professional annually. Facility Engineer inspected each fire extinguisher in the building on 11/22/23 and again on 12/13/23. All extinguishers were dated, signed and documented per inspection. PoC Verification Steps: (1) Executive Director shall audit and document on monthly fire extinguisher inspections monthly for four months. (2) QA Team shall review documentation of audits monthly for six months.	1/6/24

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
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 215	Continued From page 8 met as evidenced by: Based on observation and interview, the provider failed to maintain one randomly observed fire extinguisher (K-type extinguisher in the kitchen) as required as part of a preventative maintenance plan. Findings include: 1. Observation on 11/21/23 at 11:30 a.m. revealed the K-type fire extinguisher in the kitchen had not been signed off for required monthly inspections since April 4, 2023. Interview with maintenance supervisor E at the time of the observation confirmed that finding. He stated the remainder of the building's fire extinguishers were also non-compliant. This deficiency could potentially affect all residents of the facility.	S 215		
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, interview, record review, and job description review, the provider failed to ensure medications had been given according to the practitioners' orders and the scheduled time frame for one of one random resident (13) and two randomly reviewed residents (5 and 14) during a medication pass by one of one observed unlicensed medication aide (UMA) F. Findings include:	S 337	S 337 Unable to correct prior noncompliance for residents 5, 13, 14, or any others affected. Administrator shall create job description specific to UMA's role and have document signed by each UMA and placed in their file. QA Team shall review and modify policies and procedures as needed to ensure compliance specific to medications passed in time window per orders. The DON and/or Nurse(s) shall train all UMA's on the following topics: The Six Rights of Med administration, Residents' rights to privacy, delegation and UMA's scope of practice, medication refusal and proper documentation, managing expiring medications, and following physician orders. PoC Verification Steps: (1) Nurse(s) shall meet with all UMA staff to educate on the aforementioned topics. (2) Nurse(s) shall meet individually with all UMA's no less than quarterly to educate and reinforce understanding of the aforementioned topics. (3) The licensed nurse will audit two random UMA's for appropriate medication administration practices and documentation weekly for four weeks, then one weekly for one month, then monthly until the QA Team determines compliance is achieved.	1/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 71778	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 9	S 337		

1. Observation, interview, and electronic record review during the medication pass on 11/21/23 at 11:25 a.m. with UMA F revealed:
*Residents came to the dining room for meals and to get their medications.
*If a resident did not come to the dining room the staff would just wait to give their medications at a later time.
*She indicated there were some residents who liked to sleep in.
-Most times their morning medications were not given until later when they came down to the dining room for lunch.
*Resident 13 arrived to the medication cart. UMA F indicated he had not come to the dining room for his medications yet so she administered all of his 8:00 a.m. and morning scheduled medications at that time. Those medications included the following:
-Calcium carbonate plus vitamin D ordered for three times a day at 8:00 a.m., noon, and 5:00 p.m.
-Baclofen ordered for morning and bedtime.
-Certavite ordered for daily at 8:00 a.m.
-Cetirizine ordered for daily at 8:00 a.m.
-Diclofenac sodium delayed release ordered for morning and bedtime.
-Guaifenesin extended release ordered for morning and bedtime.
--The pharmacy label indicated it should have been given every twelve hours.
-Omeprazole ordered for daily at 8:00 a.m.
-Potassium chloride two tablets ordered for daily in the morning.
-Sertraline ordered for daily in the morning.
*She marked a hold for the resident's scheduled noon dose of Calcium since she was administering his morning dose at that time.
-She stated she did not want to double them up.
*She indicated the above process was her normal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ____ B. WING ____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 10	S 337		

practice.
*There were two other residents that had not been given their morning medications yet that day since they had not come down to the medication cart.
-They were residents 5 and 14.
-Some of their medications were time sensitive including resident 5's insulin that was scheduled for three times daily with meals.
*When asked about the staff going to the residents' rooms or finding the resident in order to administer their medications she indicated that was not the process.
-All residents were supposed to come to the dining room for their medications.
-When the resident did eventually come to the dining room then staff would administer their medications.
-If the resident did not come down for their medications during the UMA's shift then staff would have documented them as refused.
*When asked about the decision making for determining if and when certain medications should have been given late or held she indicated she just determined that on her own.
-She did not indicate any involvement or consultation with the nurse for direction.
*She had been trained that medications should have been given within a time frame of one hour before or after their scheduled time.
-She agreed that time frame had not been followed for residents 5, 13, and 14.

Interview on 11/21/23 at 3:45 p.m. with executive director A and registered nurse (RN) G regarding the above revealed:
*They confirmed the facility's process of encouraging all resident's to come to the dining room for meals and for their medications.
*If a resident did not come to the dining room for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ____ B. WING ____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 11	S 337		

their medications the expectation was for the staff to administer their medications in their rooms.
*Medications should have been given within the time frame of one hour before or after their scheduled times.
*Practitioner's orders should have been followed.
*The UMAs should have asked for direction and guidance from the licensed nurse to determine which medications could have been given late or needed to be held.
-It was not within the UMA role to make those decisions.
*The licensed nurse was responsible for the oversight of the UMAs.

Interview on 11/22/23 at 8:30 a.m. with interim director or nursing (DON)/owner B regarding the above process revealed:
*She was aware of the facility's process to have residents come to the dining room for their scheduled medications.
-She felt that process worked well to keep the residents more independent.
*She was aware medication administration was a service they were licensed to provide.
-Staff should have been providing that service anywhere within the facility.
*Herself and the other licensed nurses were responsible for the oversight of the UMAs.
-UMAs should not have been determining when it was okay to give medications outside of their scheduled times or when to hold medications.
*She indicated they had tried to schedule medication times for generalized times of the morning, at meals, or bedtime due to the residents' preferences and to allow some flexibility with the time frames.
-Not all residents medications were scheduled that way and some had specific times due to their dosing and orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ____ B. WING ____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 12	S 337		

*She confirmed medications should have been given according to the practitioner's orders and within one hour before or after the scheduled time frame.

Review of the provider's Medication Admin (Administration) Audit Report for the dates of 11/1/23 through 11/22/23 for medications that were administered two or more hours after their scheduled time frames revealed:
*It was a report generated from the residents' medication administration records.
*The report was 134 pages in length.
*Twenty-nine residents were listed in the report.
*Several of those residents had multiple days and different times of the day when medications were not given in the scheduled time frames.

Review of the provider's undated DON job description revealed their responsibilities included the following:
*Assuring coordination of resident care within the facility.
*Implementing and regularly evaluating the scope of practice for services provided to the residents.
*Monitoring resident records to assure that all cares were being performed in a timely and proper manner.
*Checking for proper initialing and dating of all entries.
*Monitoring all medications, to include administration, labeling, storage and the performances of the UMAs.
*Assuring that all practices were within the scope of practices as outlined in regulations.

Review of the provider's undated RN job description revealed their responsibilities included the following:
*Administering medications and treatments as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 necessary. *Maintaining proper surveillance of medications and records. There was no job description for the UMA role. That was confirmed through interviews with executive director A during the survey.	S 337		
S 415	44:70:05:03 Resident Care The facility shall employ or contract with a licensed nurse who assesses and documents that the resident's individual personal care, and medical, physical, mental and emotional needs, including pain management, have been identified and addressed. Any outside services utilized by a resident shall comply with and complement facility care policies. Each resident shall receive daily care by facility personnel as needed to keep skin, nails, hair, mouth, clothing, and body clean and healthy. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure the individual care needs for two of four sampled residents (4 and 5) had been assessed and documented by licensed nursing staff related to their unique medical conditions. Findings include: 1. Observation on 11/21/23 at 10:20 a.m. outside resident 4's room revealed: *A box of gloves and a bottle of hand sanitizer were setting on the handrail outside of his room. *There was no sign or other indication of the reason for those items to be there.	S 415	S 415 Unable to correct prior noncompliance for residents 4, 5, or any others affected. QA Team shall create a new procedure with a flow chart to ensure proper follow-up activity and proper documentation when a resident has a medical concern and/or is seen by a medical professional. Procedure to include timelines for nurse assessments, documentation requirements, staff education needs, and resident treatments. PoC Verification Steps: (1) QA Team to create new procedure for compliance regarding medical follow-up and to educate all nurses on said procedure. (2) QA Team to monitor new and ongoing procedural flows in real time to ensure residents are having their individual medical needs met, and will document on said flows no less than three days per week via random audit for one month, then 1 per week until QA Team determines compliance is achieved.	1/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ____ B. WING ____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 415	Continued From page 14	S 415		

Interview on 11/21/23 at 10:28 a.m. with resident aide I regarding the gloves and sanitizer outside of resident 4's room revealed:
*Those items were there for staff to use when caring for the resident.
*She indicated he had an infection with a drug resistant organism in a wound on his thigh.
*She did not deal with the wound, but thought the medication aides and the nurses would have.
*She was unsure if the wound was covered with a dressing or not as the resident was independent with his own care.

Interview on 11/21/23 at 10:30 a.m. with resident 4 who was just leaving his room revealed:
*He was doing well and was heading outside.
*When asked about his skin he pulled up his pant leg and showed the surveyor an approximately one centimeter round area above his knee on his right leg.
-The area was not covered with a dressing and it appeared dry and scab-like.
*He indicated he had found the wound approximately four or five weeks ago.
-At that time it was sore, red, and looked like a pimple.
*He had gone to the doctor for the wound and had taken antibiotics.
-Staff also had put an ointment on the wound for awhile.
*The staff did not cover the area with a bandage anymore.
-He was unsure when the staff had stopped putting the ointment and bandage on it.
*He felt the area was healed now.

Review of resident 4's electronic medical record (EMR) revealed:
*A physician visit note indicated he was seen on 10/9/23 for a skin issue on his right leg with

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
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 415	Continued From page 15	S 415		

orders received for the following antibiotics:
-Mupirocin ointment twice daily for ten days.
-Bactrim DS orally twice daily for ten days.
-There was no nursing assessment documentation related to a skin issue or the physician visit.
*On 10/13/23 he had an Assisted Living Resident Evaluation done by the licensed nurse with no skin issues identified.
*On 10/16/23 there was a nurse note that he had a one centimeter opened area above his right knee that had a culture showing an infection by a drug resistant organism.
-The staff were applying Mupirocin twice daily and keeping the area covered.
*There was no mention of a skin concern on his current care plan.
*There were no other nurse notes regarding the skin concern or follow up that supported nursing assessments had occurred for his skin concern or the current status of it.

2. Review of resident 5's EMR revealed:
*He was admitted on 7/25/23.
*His diagnoses included: type 1 diabetes mellitus, kidney failure, chronic kidney disease, pancreatitis, weight loss, mood disorder, and epilepsy.
*He was sent to the emergency room on 8/6/23 and on 8/7/23 and was hospitalized on 8/7/23 due to an abnormal potassium level, clostridium difficile infection, and hypoglycemia.
*He returned to the facility on 8/14/23.
-There were no licensed nurse notes indicating he was assessed or what his condition was upon his return from the hospital.
*On 8/25/23 an unlicensed medication aide (UMA) documented the resident had an emesis, increased facial swelling, lips protruding, and tongue inflammation. She notified interim director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ___ B. WING ___	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 415	Continued From page 16	S 415		

of nursing (DON)/owner B and he went to the clinic.
-It was unclear if the nurse had assessed the resident or who had arranged for the resident to go to the clinic.
-There was no documentation to support when he had returned to the facility or that a nurse had assessed him on 8/25/23, 8/26/23, or 8/27/23.
--The next licensed nurse note was on 8/28/23 regarding an elevated blood glucose level.
*An 8/25/23 physician's visit note indicated he had an elevated potassium level and several orders including the following:
-To give his antibiotic medications with food.
-To use Zofran for nausea up to twice a day as needed.
-To start Prednisone every day for ten days.
-To not use Pepto-Bismol.
-To not eat potatoes, bananas, oranges, cantaloupe, and raisins due to his elevated potassium level.
-To increase his water intake,
-To follow up in three days with more lab work.
*There were no licensed nurse notes indicating an assessment and follow up to his condition and all the new orders from 8/25/23.
*On 9/16/23 evening, a UMA documented the resident was feeling sick, refused supper, his blood pressure was 180/133 and rechecked at 178/113, he complained of a sore throat and his stomach, and he was noted to be shaking.
-She reported that to licensed practical nurse (LPN) J.
-A UMA note later indicated he had an elevated temperature of 99.6 degrees.
-There was no documentation of the nurse's direction or guidance to the UMA.
*On 9/17/23 at 11:49 a.m. a UMA documented the resident was weak, shaken, had a blood glucose level of 53 and was given glucose gel.

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
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 415	Continued From page 17	S 415		

-There was no indication of notification or assessment of the nurse.
*On 9/17/23 at 6:01 p.m. there was a note by LPN J indicating the resident had an elevated temperature of 103.7 degrees, he was ill, and he refused to go the emergency room.
-LPN J indicated he was tested for COVID and was negative. She had updated his practitioner and was directed to give acetaminophen, hold his insulins, to monitor his glucose that night, and to send him to the clinic the next day.
*On 9/17/23 from 11:51 p.m. through 9/18/23 at 4:11 a.m. UMAs documented he had temperatures of 100.2, 100.7, and 102 degrees and normal blood glucose levels.
-On 9/18/23 at 11:42 a.m. there was a UMA note indicated he went to an unspecified appointment.
-On 9/18/23 a physician's order indicated he was started on an antibiotic.
*There were no follow up licensed nurse notes or assessments on 9/18/23, 9/19/23, or 9/20/23 related to his condition.

Continued review of resident 5's EMR revealed:
*On 10/28/23 at 10:58 a.m. a UMA documented the resident had not come out for breakfast and was laying in his bed groaning.
-The resident told her he was unable to urinate and it had been over 24 hours since he had last emptied his urinary catheter bag. He had an emesis, an elevated temperature of 99.6, and had pain in his back and rib cage.
-The UMA notified interim DON/owner B who directed her to encourage fluids and to check his catheter every two hours for output.
-She documented interim DON/owner B told her the resident had an H. Pylori infection caused by bacteria in his stomach which could cause pain, weight loss, vomiting, and loose stools and it was spread through saliva and bowel movements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ___ B. WING ___	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 415	Continued From page 18	S 415		

*There had been no documentation indicating when that infection had been identified or treatments specific to it.
*There were no licensed nurse notes or assessments on his health condition on 10/28/23, 10/29/23, 10/30/23, or 10/31/23.
*A 10/31/23 registered dietitian assessment indicated he had multiple medication changes related to H. Pylori and that he had been refusing meals, supplements, and medications at times.
-The licensed nurse notes had not clearly identified those same concerns.
*On 11/3/23 a UMA documented an incident note of "resident collapsed to the floor beside nurse's station."
-There were no further details documented by the UMA.
*On 11/3/23 at 6:30 p.m. LPN J documented she was called up to third floor and assessed the resident. He had not been eating for two days, was dry heaving and belching, had vital signs and a blood glucose level taken, and refused to go to the hospital.
-They brought him a tray of food and encouraged him to eat.
-LPN J followed up with him at 8:15 p.m. and a UMA updated interim DON/owner B at 11:00 p.m. on 11/3/23.
*The next licensed nurse note was not until 9:30 p.m. on 11/4/23.
-That note indicated he had refused medication and had eaten two sandwiches.
-The note had not included a nursing assessment of his condition.

Continued review of resident 5's EMR revealed:
*On 11/7/23 a UMA documented the resident had fasting labs that morning and was at the clinic most of the day receiving fluids. Upon his return he refused his medications and insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ____ B. WING ____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 415	Continued From page 19	S 415		

-The UMA documented updating interim DON/owner B on the resident's status.
-There were no follow up licensed nurse notes indicating an assessment of his condition had occurred on 11/7/23, 11/8/23, or 11/9/23.
*On 11/10/23 at 1:45 a.m. a UMA documented the resident had reported his catheter tubing was clogged. She updated interim DON/owner B who "examined it virtually [via video call]."
-There were no notes of what the UMA was directed to do by the nurse.
*On 11/10/23 registered nurse (RN) G had a note of calling the resident's practitioner to order more catheter tubing.
-There was no documentation of the resident's catheter or health status at that time to support a licensed nursing assessment had occurred.

Continued review of resident 5's EMR revealed:
*On 11/18/23 a UMA documented the resident reported his left eye was bothering him and his eyesight was blurry.
-There were no follow up notes by a licensed nurse regarding that concern until 11/23/23.
*The 11/23/23 a licensed nurse note included him reporting his left eye was throbbing. She encouraged him to use his prescribed eye drops and offered to make him an appointment which he refused.
-There was no evidence of a nursing assessment of his eye or other follow up.

3. Interview on 11/21/23 at 8:45 a.m. with executive director (ED) A during entrance conference revealed:
*Interim DON/owner B was currently on vacation and would be unavailable to be interviewed during the survey.
*Interim DON/owner B had been in the DON role since the previous DON had left.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ____ B. WING ____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 415	Continued From page 20	S 415		

-They had not hired a new DON yet.
*They also had other licensed nurses.
*LPN J worked full time, mostly during evenings and nights.
*RN G worked on an as needed basis and had been in the building more while interim DON/owner B was on vacation.
-RN G had been working an average of three days a week.
*RN H had just been hired and was still in training.

Interview on 11/22/23 at 8:30 a.m. with interim DON/owner B revealed:
*She had arrived to the facility that morning.
*Licensed nurses documented their assessments and notes in the EMR for each resident.
*She confirmed the information provided by ED A during entrance conference for licensed nurse staffing.

Interview on 11/22/23 at 12:45 p.m. with ED A and interim DON/owner B revealed:
*Nursing assessments and documentation should have supported that the residents' care and condition was identified and addressed.
-All nursing documentation should have been in the EMR for each resident.
*Unlicensed staff were able to document as part of their medication administration and other areas, but the licensed nurses conducted assessments and documented progress notes.
*Resident 4's skin condition should have had clear documentation of when it was identified, what the treatment was, and follow up of it until it was officially healed.
*Resident 5's changes in condition and health status should have identified the nurses' assessment and involvement to ensure his medical needs were being identified and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ____ B. WING ____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 415	Continued From page 21	S 415		

addressed.
-He had a significant amount of medical changes and needs since he was admitted in August 2023.

Review of the provider's undated Resident Care Records policy revealed:
*The DON was responsible for creating, updating, and maintaining the information vital to the health, safety, and wellbeing of residents.
-Others that contributed to the records included the administrator and other licensed nurses.
*Care records should have contained observations by personnel, nursing progress notes, and documentation to assure the individual needs of the residents were identified and addressed.

Review of the provider's undated Care Plans policy revealed:
*"The purpose of the Care Plan is to provide a centralized coordination of the services that will be provided to each resident, based on his or her individual needs, abilities, and preferences."
*Care plans could only be created by registered nurses (RN), but could have been modified by RNs and licensed practical nurses (LPN).
*Care plans should have addressed the following:
-Skin integrity.
-Impairments.
-Unique needs.

Review of the provider's undated DON job description revealed their responsibilities included the following:
*Creating and updating resident care plans.
*Assuring coordination of resident care.
*Monitoring resident records and makes adjustments as necessary.

Review of the provider's undated RN and LPN job

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 415	Continued From page 22 descriptions revealed their responsibilities included the following: *Evaluating residents regularly for evidence of changes in condition using assessment skills based on accepted nursing standards. *Receiving and processing orders and updating the care plans as necessary. *Charting treatments, medications, assessments, care plans, and summaries of residents' progresses.	S 415		
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 related to food storage and the dating of packaged food in one of one kitchen. Findings include: 1. Observation and interview on 11/21/23 at 10:45 a.m. with cook D in the kitchen revealed: a. Inside the walk-in refrigerator there was the following: *A Ziplock bag with roast beef slices dated 6/18/23. *18 unopened Yoplait original harvest peach yogurt cups with a use by date of 10/20/23. b. Inside the upright kitchen refrigerator there was the following: *An undated can of Fritos bean dip that had ice	S 450	S 450 All dietary staff shall be reeducated on company policies for labeling, storing, and discarding food in compliance with ServSafe and DOH standards. PoC Verification Steps: (1) Administrator and/or Executive Director shall educate dietary staff on company policies for labeling, storing and discarding food. (2) Executive Director shall monitor dietary staff compliance and proper documentation on the dietary checklists weekly for four months. (3) QA Team shall review daily and weekly activity and documentation for dietary compliance monthly for six months.	1/6/24

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
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 450	Continued From page 23 crystals built up inside the can with a use by date of 10/24/23. *An unopened Johnsonville smoked sausage in a Ziplock bag dated 3/9/23. *A can of Jimmy's Ranch Veggie Dip with an open date of 10/10/22 and expiration date of 3/11/23. *Cook D agreed the above food items had not been dated when opened or were past their expiration date. -She stated she was not good at going through and clearing that refrigerator. -She agreed the food items should have been thrown away. Interview with executive director A on 11/22/23 at 10:00 a.m. regarding the food package dating process revealed: *It was her expectation that food packages would have an opened date on them to track quality and freshness. *The cook was responsible for dating a package when opened. *She agreed food package dating was not completed on a consistent basis. Review of the undated Food Storage policy revealed: *"All containers must be legible and accurately labeled and dated." *"Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within three days or discarded."	S 450		
S 603	44:70:07:01(4) Policies And Procedures Each facility shall establish and implement written policies and procedures for medication control	S 603		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	**50 7TH ST SE HURON, SD 57350**

(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 603	Continued From page 24 that include: (4) The proper disposition of medicines due to: (a) Resident discharge; (b) Resident death; (c) Outdated medication; or (d) The prescription being discontinued by the physician, physician assistant, or nurse practitioner. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure effective processes were in place to identify and destroy expired medications for six random residents' (4, 8, 9, 10, 11, and 12) medications found in three of three medication carts. Findings include: 1. Observation and interview on 11/21/23 at 12:10 p.m. with unlicensed medication aide (UMA) F revealed: *The second floor medication cart had the following: -A bag of Halls cough drops for resident 8 with an expiration date of 10/8/23. -A box of Cepacol lozenges for resident 9 with an expiration date of August 2023. *The treatment cart had the following: -Two bottles of Clobetasol solution for resident 10 with expiration dates of September 2023 and October 2023. *The third floor medication cart had the following: -A blister pack of ibuprofen tablets for resident 11 that had expired on 10/31/23. -A blister pack of cyclobenazaprine tablets for resident 12 that had expired on 11/17/23. -A blister pack of ibuprofen tablets for resident 4	S 603	S 603 All medications were reviewed by nurse(s), and all expired mediations have been properly disposed of. PoC Verification Steps: (1) Nurse(s) shall educate all UMA's on how to monitor for expired mediations in the building. (2) Nurse(s) shall be responsible for auditing the med carts and med rooms for expired meds no less than monthly and shall document audits. (3) QA Team shall monitor activity and nurse documentation monthly until compliance is achieved.	1/6/24

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
	71778	A. BUILDING: ____ B. WING ____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 603	Continued From page 25	S 603		

that had expired on 10/31/23.
*UMA F did not think they had a process to regularly check for expired medications.
*She tried to watch for expired medications and pull them from the cart when she found them.
*Expired medications should have been taken to the medication room to be destroyed by the nurse and not left on the cart.

Observation and interview on 11/21/23 at 3:15 p.m. with registered nurse (RN) G, RN H, and UMA F in the third floor medication room revealed:
*RN G stated noncontrolled expired medications could have been destroyed by two nurses or a nurse and a witness.
-Expired medications should have been destroyed in a timely manner.
-Expired medications should not have been stored with the current and active medications.
*They were not aware of a process to routinely check for expired medications.

Interview on 11/21/23 at 3:45 p.m. with executive director A revealed expired medications should have been destroyed in a timely manner and should not have been kept on the medication cart.

Interview on 11/22/23 at 8:30 a.m. with interim director of nursing/owner B revealed she confirmed expired medications should have been destroyed in a timely manner.

Review of the provider's undated Medication Management policy revealed it was the DON's responsibility to ensure medications were not expired and that they were properly destroyed.

Review of the provider's undated Expired

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
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 603	Continued From page 26 Medications policy revealed: *"All expired medications are destroyed following the same procedure as detailed in [another policy]." *The policy had not mentioned a process for ensuring expired medications were removed from the medication cart or active medication supplies. Review of the provider's undated Discontinued or Unused Nonnarcotic Medication and Patches policy and Discontinued Narcotics, Narcotic Patches and Hazardous Drugs policy revealed neither had mentioned the timeframe for destruction to have occurred.	S 603		
S 635	44:70:07:04 Storage And Labeling Of Medications Any container with a worn, illegible, or missing label must be destroyed pursuant to § 44:70:07:06. Licensed pharmacists are responsible for the labeling, relabeling, or altering of labels on medication containers. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, label review, and policy review, the provider failed to ensure one of one randomly observed resident's (7) controlled medication pack's pharmacy label had not been altered by facility staff. Findings include: 1. Observation, medication pack label review, and interview with unlicensed medication aide (UMA) F during review of the controlled medications in the second floor medication cart revealed: *A blister pack of Tramadol 50 milligrams for resident 7 had been labeled by the pharmacy to	S 635	S 635 Resident 7's medication with the altered pharmacy label was changed by pharmacy. All other medications were reviewed by a nurse to ensure proper pharmacy labeling. Policy and Procedure manual has been updated to contain the following verbiage for Medication Labels: Medication labels are to remain affixed to all medication containers. Medication labels may only be altered by a pharmacist. If a label becomes worn, illegible, or missing, contact the DON or nurse on call immediately. The nurse shall then contact the pharmacy for appropriate action. PoC Verification Steps: (1) Nurse and/or Executive Director shall educate staff on updated policy regarding medication labels. (2) Nurse(s) shall audit medication cart for faulty labels monthly in conjunction with their expired medication audits for four months. (3) QA Team shall review documentation of medication audits to ensure compliance monthly until compliance is achieved.	1/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 635	Continued From page 27	S 635		

give one to two tablets orally every six to eight hours as needed.
*There was a pen mark crossing off the two tablets and handwritten notes of "only 1 tab" and "[1 tablet] QD [every day] per her POC [plan of care] [with] goals pain" on the label.
*There was also sticker indicating the directions had changed and to refer to the chart.
*UMA F indicated the handwriting on the pharmacy label was done by one of the licensed nurses after the resident's orders had changed.
-The orders used to be as it was printed on the pharmacy label.
*UMA F opened up the resident's electronic medical record and confirmed the current orders were for the resident to receive only one tablet of Tramadol every six hours as needed.
-That order had been effective 10/12/23.

Interview on 11/22/23 at 8:30 a.m. with interim director of nursing/owner B regarding the above revealed:
*She confirmed she had been the one to write the changes on the pharmacy label of the resident's blister pack of Tramadol.
*She was not aware of the requirement for only a pharmacist to alter the label of a resident's medication.

Review of the provider's undated Medication Labels policy revealed: "Medication labels are to remain affixed to all medication containers and shall not be altered."

S 642 44:70:07:05 Control And Accountability of Medications (ID Prefix Tag: S 642)

The facility must receive written authorization from the resident's physician, physician assistant,

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
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 642	Continued From page 28 or nurse practitioner before releasing any medication to a resident upon discharge, transfer, or temporary leave from the facility. The release of medication must be documented in the resident's record, indicating quantity, drug name, and strength. The facility shall maintain records that account for all medications and drugs from receipt through administration, destruction, or return. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure an effective system had been in place for security, accountability, and timely destruction of numerous controlled medications at high risk for diversion or theft that were being stored in two of two medication rooms. Findings include: 1. Observation, interview, and record review on 11/21/23 at 2:45 p.m. with unlicensed medication aide (UMA) F regarding controlled medications in the 2nd floor medication room revealed: *For current controlled medications the UMAs verified the count of each medication between each shift. -Those current and in-use controlled medications were stored on the medication carts. *For controlled medications that were discontinued, expired, or for discharged residents the UMAs did not count those controlled medications. -Those controlled medications were placed into a locked cabinet in the medication room to be destroyed. --There was no process to ensure accountability of those medications while they were awaiting destruction.	S 642	S 642 All medication locking devices have been checked, replaced if needed, and are in fully functioning order. All discontinued, controlled medications currently in storage that are designated for disposal shall be properly destroyed before 1/6/24. This protocol includes medication count and verification of all discontinued medications by two licensed nurses, or one nurse and one pharmacist. A new process for medication storage and destruction shall be implemented. This practice includes the use of pharmacy approved carbon-copy disposition forms. One copy of the completed disposition forms shall be maintained in designated area of nurse office/records, separate from stored medications awaiting proper disposal. The second carbon-copied disposition form will remain with (or affixed to) the counted and verified medications awaiting destruction. PoC Verification Steps: (1) All nurses and UMA's shall be educated on the updated policy to notify a nurse or the Executive Director if they find medications that have been DC'd, are expired, or belong to a former resident. (2) Executive Director shall coordinate with pharmacy and nurses to ensure any controlled medications can be destroyed during pharmacist's monthly onsite visit. (3) Nurse(s) and Executive Director shall document education of all nurses and UMA's on destruction policies and procedures. (4) Nurse(s) and/or Executive Director shall monitor and track medications due for destruction on a weekly basis for four months. (5) QA Team shall perform monthly audits of records, on hand medications, and scheduled medication destruction events to ensure compliance for six months.	1/6/24

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 71778	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 642	Continued From page 29	S 642		

*Using a key from her UMA set of keys she unlocked the cabinet above the countertop where those controlled medications were being stored until they were destroyed.
-The cabinet had numerous blister packs of controlled medications for multiple residents.
-Dates on those blister packs ranged from August 2023 through November 2023.
*She was not sure why there were so many controlled medications in that cabinet and thought the nurse was responsible for destruction of them.
*On the counter in the medication room there was a small plastic tote that held multiple blister packs of different residents' medications including for resident 3 who had been discharged from the facility on 10/4/23.
*Resident 3's controlled medications had been sitting out on the counter with other medications with no process for accounting for them until their destruction. There were seven packs of clonazepam tablets including the following:
-A pack with 15 tablets.
-A pack with 14 tablets.
-A pack with 10 tablets.
-A pack with 8 tablets.
-A pack with 7 tablets.
-A pack with 6 tablets.
-A pack with 2 tablets.
*She agreed all controlled medications were at risk for potential diversion and should have had processes in place to ensure they were accounted for and secured at all times.

Observation and interview on 11/21/23 at 3:00 p.m. with registered nurse (RN) H and UMA F in the second floor medication room revealed:
*RN H had just started working there a few weeks ago.
-She was unsure what the facility's processes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ____ B. WING ____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 642	Continued From page 30	S 642		

were for destruction of controlled medications.
*She knew there were a lot of medications being stored in the medication room and had started working on returns to the pharmacy and figuring out what was happening with all those medications.

Observation and interview on 11/21/23 at 3:15 p.m. with RN G, RN H, and UMA F in the third floor medication room revealed:
*UMA F's key did not work properly for the controlled medication cabinet's lock but she was unable to unlock the cabinet anyway.
-She confirmed the cabinets would unlock without use of keys for this cabinet and for the controlled medication cabinet in the second floor medication room.
-She reported the locks had been that way for quite a while.
*RN G and RN H had not been aware the cabinets could have been unlocked without the specific keys and confirmed that was not a secure system.
-The locks should have been accessible only with their specific keys.
*They confirmed there was no process for accountability of the controlled medications from the time they were removed from the medication cart and placed into the cabinets until they were destroyed.
*The cabinet in this room had approximately twice the amount of controlled medication blister packs for multiple residents than the second floor cabinet had held.
-Dates on the controlled medication blister packs awaiting destruction ranged from November 2022 through November 2023.
*RN G stated controlled medications should have been destroyed by the nurse and the pharmacist during the pharmacist's monthly visit to the

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
	71778	A. BUILDING: ____ B. WING ____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 642	Continued From page 31	S 642		

facility, or they could have been destroyed by two licensed nurses.
-The medications should have been destroyed in a timely manner and should not have been held in the cabinets for several months.
*They confirmed controlled medications were a high risk for potential diversion and should have had a monitoring process in place until they were destroyed.

Interview on 11/21/23 at 3:45 p.m. with executive director A regarding the above revealed:
*She had not been aware the controlled medication cabinets in the second and third floor medication rooms were not locking or unlocking properly.
-The locks should have accessible only with their specific keys.
*Medications should have been destroyed in a timely manner and should not have been stored in those medication rooms for months.
*She felt medication destruction had become an issue due to their changes in licensed nurses over the last several months.

Interview on 11/22/23 at 8:30 a.m. with interim director of nursing/owner B regarding the above revealed:
*She was aware there was a large amount of medications being stored in the second and third floor medication rooms.
-That had not been one of her priorities to address due to other areas she was working on in the facility.
*She confirmed controlled medications should have been stored securely with processes to ensure accountability of them.
*She confirmed the locks on the cabinet should have been functioning properly to be considered secured.

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
	71778	A. BUILDING: ____ B. WING ____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 642 Continued From page 32 S 642

Review of the provider's undated Medications that are Permanently Discontinued policy revealed "Permanently discontinued medication will not be retained in the community. Nonnarcotic medications and narcotics are handled differently when discontinued."

Review of the provider's undated Discontinued Narcotics, Narcotic Patches and Hazardous Drugs policy revealed:
*"...nurse shall remove medication and collect it in a plastic baggie properly labeled with the resident name, date, description of medication and count."
*The medication should have been held in the medication room in the narcotics drawer.
-It had not mentioned a cabinet with separate locks.
*The nurse should have documented the count in the Medication Destruction Record.
*"Narcotics can only be destroyed by a licensed nurse with another nurse, or by a licensed nurse with licensed pharmacist."
*The policy had not mentioned the timeframe for destruction to have occurred.

S 650 44:70:07:06 Drug Disposal S 650

Legend drugs not controlled under SDCL chapter 34-20B shall be destroyed or disposed of by a nurse and another witness. Destruction or disposal of medications controlled under SDCL chapter 34-20B shall be witnessed by two persons, both of whom are a nurse or pharmacist, as designated by facility policy.

This Administrative Rule of South Dakota is not met as evidenced by:

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
	71778	A. BUILDING: ____ B. WING ____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 650	Continued From page 33	S 650		

S 650 Continued From page 33

Based on observation, interview, record review, and policy review, the provider failed to ensure one of one randomly observed resident's (6) controlled medication had been disposed of by two authorized personnel. Findings include:

1. Observation, interview, and record review on 11/21/23 at 2:45 p.m. with unlicensed medication aide (UMA) F in the 2nd floor medication room revealed:
*A large plastic tote of medication blister packs was on the counter.
*Inside the tote there were multiple blister packs of different residents' medications waiting to be returned to the pharmacy.
*There was also a Medication Disposition sheet for resident 6 that indicated eleven tablets of clonazepam had been destroyed by registered nurse (RN) H and a UMA K.
-UMA K had signed with a date of 11/16/23 and RN H had signed with a date of 11/21/23.
*UMA F thought controlled medications were supposed to have been destroyed by the nurse and the pharmacist, not a UMA.

Observation and interview on 11/21/23 at 3:00 p.m. with RN H and UMA F in the second floor medication room revealed:
*RN H had just started working there a few weeks ago.
-She was unsure what the facility's processes were for destruction of controlled medications.
*She knew there were a lot of medications being stored in the medication rooms and had started working on returns to the pharmacy and figuring out what was happening with all the medications.
*She confirmed she had destroyed resident 6's clonazepam and the other signature being UMA K.
*She was not aware controlled medications

Provider's Plan of Correction:

S 650
All Nurses and UMA's shall be reeducated on Angelhaus policies and procedures related to medication storage and destruction in compliance with DOH standards. — Complete date: 1/6/24

PoC Verification Steps: (1) DON shall educate all nurses and UMA's on the proper destruction processes for controlled and noncontrolled medications. (2) Executive Director shall coordinate with pharmacy and nurses to ensure any controlled medications can be destroyed during pharmacist's monthly onsite visit. (3) Nurse(s) and Executive Director shall document education of all nurses and UMA's on destruction policies and procedures. (4) QA Team shall perform monthly audits of records, on-hand medications, and scheduled medication destruction events to ensure compliance for six months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 650	Continued From page 34	S 650		

should have been destroyed by a nurse and the pharmacist or two nurses.

Observation and interview on 11/21/23 at 3:15 p.m. with RN G, RN H, and UMA F in the third floor medication room revealed:
*RN G stated controlled medications should have been destroyed by the nurse and the pharmacist during the pharmacist's monthly visit to the facility, or they could have been destroyed by two licensed nurses.
*RN H was helping with the medications that were in the medication rooms and should not have destroyed resident 6's controlled medication with a UMA.

Interview on 11/21/23 at 3:45 p.m. with executive director A revealed:
*Controlled medications should have been destroyed by a nurse and the pharmacist or two nurses.
*RN H was new to her role and should have been directed by the other nurses on appropriate processes for destruction.

Review of the provider's undated Discontinued Narcotics, Narcotic Patches and Hazardous Drugs policy revealed "Narcotics can only be destroyed by a licensed nurse with another nurse, or by a licensed nurse with licensed pharmacist."

S 654 44:70:07:06 Drug Disposal — S 654

Any medication held for disposal must be physically separated from the medications being used in the facility and locked with access limited in an area with a system to reconcile, audit, or monitor them to prevent diversion.

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
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 654	Continued From page 35 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure accountability and separate storage of multiple medications awaiting destruction or return to the pharmacy in two of two medication rooms. Findings include: 1. Observation, interview, and record review on 11/21/23 at 2:45 p.m. with unlicensed medication aide (UMA) F in the 2nd floor medication room revealed: *For current controlled medications the UMAs verified the counts between each shift. -Current and in-use controlled medications were stored on the medication carts. *For controlled medications that were discontinued, expired, or for discharged residents the UMAs did not count those controlled medications. -Those controlled medications were placed into a locked cabinet in the medication room to be destroyed. *There were multiple controlled medications in the cabinet and on the counter that were not being monitored until they were destroyed. *Other cabinets in the medication room held multiple residents' prescription and over-the-counter medications. -Some of those medications had been discontinued or had changes in their orders and should have been destroyed or returned to the pharmacy. -Those medications were being stored with currently ordered medications. *There was no process to ensure accountability of the medications awaiting destruction or return to the pharmacy.	S 654	S 654 All medication locking devices have been checked, replaced if needed, and are in fully functioning order. All discontinued, controlled medications currently in storage that are designated for disposal shall be properly destroyed before 1/6/24. This protocol includes medication count and verification of all discontinued medications by two licensed nurses, or one nurse and one pharmacist. A new process for medication storage and destruction shall be implemented. This practice includes the use of pharmacy approved carbon-copy disposition forms. One copy of the completed disposition forms shall be maintained in designated area of nurse office/records, separate from stored medications awaiting proper disposal or return to pharmacy. The second carbon-copied disposition form will remain with (or affixed to) the counted and verified medications awaiting destruction or return to pharmacy. PoC Verification Steps: (1) All nurses and UMA's shall be educated on the updated policy to notify a nurse or the Executive Director if they find medications that have been DC'd, are expired, or belong to a former resident. (2) Executive Director shall coordinate with pharmacy and nurses to ensure any controlled medications can be destroyed during pharmacist's monthly onsite visit. (3) Nurse(s) and Executive Director shall document education of all nurses and UMA's on destruction policies and procedures. (4) Nurse(s) and/or Executive Director shall monitor and track medications due for destruction on a weekly basis for four months. (5) QA Team shall perform monthly audits of records, on hand medications, and scheduled medication destruction events to ensure compliance for six months.	1/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 654	Continued From page 36	S 654		

*She reported some of those medications had been sitting in the medication room for several months.

Observation and interview on 11/21/23 at 3:00 p.m. with registered nurse (RN) H and UMA F in the second floor medication room revealed:
*RN H had just started working there a few weeks ago.
-She was unsure what the facility's processes were for destruction of controlled medications.
*She knew there were a lot of medications being stored in the medication rooms and had started working on returns to the pharmacy and figuring out what was happening with all the medications.

Observation and interview on 11/21/23 at 3:15 p.m. with RN G, RN H, and UMA F in the third floor medication room revealed:
*They confirmed there was no process for accountability of the controlled medications from the time they were removed from the medication cart and placed into the cabinets until they were destroyed.
*RN G stated controlled medications should have been destroyed by the nurse and the pharmacist during the pharmacist's monthly visit to the facility, or they could have been destroyed by two licensed nurses.
-Non controlled medications could have been destroyed by two nurses or a nurse and a witness at any time.
-The discontinued or expired medications should have been destroyed or returned to the pharmacy in a timely manner.
-Those discontinued and expired medications should not have been held in the cabinets for several months or left in the medication carts.
*Discontinued and expired medications should not have been stored with the current and active

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ____ B. WING ____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 654	Continued From page 37	S 654		

medications.

Interview on 11/21/23 at 3:45 p.m. with executive director A regarding the above revealed discontinued and expired medications should have been destroyed or returned to the pharmacy in a timely manner. They should not have been stored in those medication rooms for months. Those medications should have been stored separately from the current medications.

Interview on 11/22/23 at 8:30 a.m. with interim director of nursing/owner B regarding the above revealed:
*She was aware there was a large amount of medications being stored in the second and third floor medication rooms.
-That had not been one of her priorities to address due to other areas she was working on in the facility.
*She confirmed discontinued and expired medications should have been destroyed or returned to the pharmacy in a timely manner.

Review of the provider's undated Expired Medications policy revealed:
*"All expired medications are destroyed following the same procedure as detailed in [another policy]."
*The policy had not mentioned a process for ensuring expired medications were removed from the medication cart or active medication supplies.

Review of the provider's undated Medications that are Permanently Discontinued policy revealed "Permanently discontinued medication will not be retained in the community. Nonnarcotic medications and narcotics are handled differently when discontinued."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 654	Continued From page 38 Review of the provider's undated Discontinued Narcotics, Narcotic Patches and Hazardous Drugs policy revealed it had not mentioned the timeframe for destruction to have occurred. Refer to S642.	S 654		
S 825	44:70:09:08(5) Privacy And Confidentiality A facility shall permit residents: (5) To have only authorized personnel present during treatment or activities of personal hygiene; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure privacy and dignity for three of three observed residents (8, 15, and 16) during treatments related to their medication administration with one of one unlicensed medication aide (UMA) (F). Findings include: 1. Observation on 11/21/23 at 12:05 p.m. with UMA F during resident 15's lunch time blood glucose check revealed: *The resident came up to the cart in the dining room and the UMA assisted the resident to set up his blood glucose testing supplies. *The resident performed the finger stick test for his blood glucose reading at the medication cart. *He had scheduled sliding scale insulin for three times daily but did not need any insulin due to his blood glucose level. *UMA F indicated the process was their normal practice. *There were several residents in the dining room	S 825	S 825 Unable to correct prior noncompliance for residents 8, 15, 16, or any others affected. Angelhaus shall protect and promote its residents' needs for privacy by offering secure settings during treatments with the following alternatives for care delivery: Administration in resident rooms, in the nurse's office, in the bathroom, or via utilization of the privacy curtain in the activity section of the community area. There are multiple scales, one located on each floor, that are used to obtain residents weights. The scale near the medication cart was requested by a disabled resident with balance impairment. Resident rights shall be promoted with options for obtaining weight including location and timing. PoC Verification Steps: (1) All staff shall be reeducated on residents' rights to privacy by members of the QA Team. (2) Nurse(s) and/or UMA staff shall educate residents on their right to privacy, and offer residents the treatment location alternatives listed above. Staff shall document the treatment wishes of each resident and add it to their Care Plan and/or eMAR. (3) QA Team shall audit 2 random residents' weekly for 4 weeks, then 1 per week until QA Team determines compliance is achieved.	1/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 71778	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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 825	Continued From page 39	S 825		

at that time within viewing distance.

Observation on 11/21/23 at 12:25 p.m. with UMA F during resident 16's eye drop administration revealed:
*The resident came up to the medication cart in the dining room and the UMA handed him the bottle of eye drops.
*The resident administered his own eye drop and handed the bottle back to the UMA.
*UMA F indicated this was their normal practice.
*There were several residents in the dining room at that time within viewing distance.

Observation on 11/21/23 at 12:27 p.m. with UMA F during resident 8's blood glucose testing and insulin administration revealed:
*The resident came up to the medication cart in the dining room and used a machine that electronically provided his blood glucose level from an implanted device.
*He had a scheduled dose of insulin for lunch time daily.
*UMA F set up his insulin pen device for him and he lifted his shirt to administer his own injection into his abdomen.
*UMA F indicated this was their normal practice.
*There were several residents in the dining room at that time within viewing distance.

Interview with UMA F following the above observations revealed:
*All treatments and medications for residents were performed in the dining room at the medication carts.
-That included insulin injections, blood glucose testing, eye drops, inhalers, nasal sprays, and oral medications.
*There was a scale to obtain residents' weights near the medication carts as well.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	**50 7TH ST SE HURON, SD 57350**

(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 825	Continued From page 40	S 825		

*All those treatments were in the open and easily viewable by residents, staff, and visitors who were in the dining room at the time of the treatment or administration.
*She felt the processes were not done with the residents' privacy in mind.
*She confirmed privacy was a resident's right that should have been followed.

Interview on 11/21/23 at 3:45 p.m. with executive director A and registered nurse (RN) G regarding the above observations revealed:
*They confirmed privacy and dignity should have been maintained for all residents during treatments and cares.
*Performing blood glucose testing, insulin administration, weighing residents, and other medication administration tasks such as nasal sprays, eye drops, and inhalers should have been done in a private location and not in the open space of the dining room.

Review of the provider's undated Resident Rights and Supportive Services policy revealed:
*"The facility shall protect and promote the following rights of each resident. All employees are educated on the following rights as part of their new hire orientation, and at least annually thereafter."
-"The resident has the right to personal privacy..."
*"Each resident has the personal right to be accorded dignity in his/her personal relationships with staff, residents, and other persons. Angelhaus shall care for each resident in a manner and environment that promotes maintenance or enhancement of the resident's quality of life..."
-"Privacy is provided to avoid creating a sense of humiliation or embarrassment for a resident."

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
	71778	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

(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
S1039	Continued From page 41	S1039		
S1039	44:70:10:32 Electrical Distribution System A facility with 17 beds or larger shall be equipped with an emergency electrical service that includes an automatic generator set and automatic transfer switches serving emergency panels. A facility with 17 beds or larger shall have automatic emergency lighting for each exit way, staff work areas, dining room, medication room, dietary department, medication room, room where main entrance electrical panels are located, boiler room, and exterior lighting serving required exits. A facility with 17 beds or larger shall have automatic emergency power for the fire alarm system, electrical receptacle servicing computers containing resident care records, telephone system, door alarms, and staff call system. This Administrative Rule of South Dakota is not met as evidenced by: Based on document review and interview, the provider failed to document weekly generator inspections. Findings include: 1. Document review at 1:15 p.m. on 11/21/23 revealed no documentation of required weekly generator preventive maintenance inspections. Interview with maintenance supervisor E at the time of the document review revealed he was doing the inspections, but was not aware of the documentation requirements. The deficiency affected one of numerous generator maintenance requirements.	S1039	S 1039 Facility Engineer has been educated on required weekly generator maintenance checks. PoC Verification Steps: (1) Facility Engineer shall document weekly generator checks. (2) Executive Director shall monitor generator checks weekly for four months. (3) QA Team shall review documentation monthly to ensure compliance for six months.	1/6/24