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 01/15/2026

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

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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 1/13/26 through 1/15/26. Angelhaus Huron was found not in compliance with the following requirements: S145, S200, S201, S202, S285, S315, S337, S405, S465, S603, S654, and S685. 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 on 1/13/26 through 1/15/26. Areas surveyed included resident safety and resident rights. Angelhaus Huron was found in compliance.	S 000		
S 145	44:70:02:12 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in two randomly observed rooms (second floor east shower room and resident room 315). Findings include: 1. Observation on 1/13/26 at 1:29 p.m. revealed the exhaust ventilation for the second floor east shower room was not functioning. Testing of the grille with tissue paper at the time of the	S 145	S145 Maintenance Engineer shall replace exhaust ventilation units in the 2nd floor east shower room, and in the bathroom of room 315. Maintenance Engineer shall test each exhaust ventilation unit throughout the building prior to March 1st, 2026 and replace or repair any units that are not working properly. Maintenance Engineer shall test all exhaust ventilation units on a quarterly basis and replace or repair any units not working. Maintenance Engineer shall document tests and report to the QA Team monthly in perpetuity.	3/1/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/11/26

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S 145	Continued From page 1 observation confirmed that finding. Interview with resident assistant L at that same time confirmed that finding. She revealed she was unaware as to why the exhaust ventilation was not working at that location. 2. Observation on 1/13/26 at 1:58 p.m. revealed the exhaust ventilation for the bathroom of resident room 315 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with maintenance director M at that same time confirmed that finding. He revealed he was unaware as to why the exhaust ventilation was not working at that location. Those rooms are required to have exhaust ventilation directed to the exterior of the building.	S 145	S200 Maintenance Engineer shall replace all missing or broken ceiling tiles throughout the building. Maintenance Engineer shall monitor and document inspection of all tiles throughout the building monthly. Maintenance Engineer shall report to the QA Team monthly in perpetuity.	3/1/26
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	S 200		

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S 200	Continued From page 2 failed to continuously maintain automatic sprinklers in a reliable operating condition in three randomly observed areas (south end of the second floor, east end of the second floor, and at the third-floor west smoke doors). Findings include: 1. Observation on 1/13/26 at 1:15 p.m. on the second floor revealed the far south end had a missing lay-in ceiling tile that was been damaged above the window. The ceiling is a feature of the fire protection system that prevents smoke and heat from escaping to the space above the tiles and delaying the sprinkler response. As such, the ceiling tiles are required to be maintained. Failure to continuously maintain automatic sprinklers as required increases the risk of death or injury due to fire. Interview with resident assistant L at that same time confirmed that finding. She revealed she was unaware a ceiling tile was missing at that location. She further stated she believed that tile was missing due to it becoming wet from a water leak. 2. Observation on 1/13/26 at 1:34 p.m. on the second floor revealed missing lay-in ceiling tiles in east wing ceiling near the exit stairs. Continued observation at that same time revealed an adjacent ceiling tile was approximately 50 percent covered with a substance which appeared to be mold and a bucket was observed to be above the ceiling catching water off what appeared to be the hot water heating lines. The ceiling is a feature of the fire protection system that prevents smoke and heat from escaping to the space above the tiles and delaying the sprinkler response. As such, the ceiling tiles are required to be	S 200		

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S 200	Continued From page 3 maintained. Failure to continuously maintain automatic sprinklers as required increases the risk of death or injury due to fire. Interview with resident assistant L at that same time confirmed that finding. She revealed she was unaware a ceiling tile was missing at that location. She further stated she believed that tile was missing due to it becoming wet from the apparent water leak the bucket was in place for. She also commented she believed the moldy ceiling tile should be replaced. 3. Observation on 1/13/25 at 1:50 p.m. on the third floor revealed missing lay-in ceiling tiles on the east side of the west smoke doors. Continued observation at that same time revealed a smoke detector was mounted in place by a bracket bridging the space where the missing tile was supposed to be. Additionally, a bucket was observed to be above the ceiling catching water off what appeared to be the hot water heating lines. The ceiling is a feature of the fire protection system that prevents smoke and heat from escaping to the space above the tiles and delaying the sprinkler response. As such, the ceiling tiles are required to be maintained. Failure to continuously maintain automatic sprinklers as required increases the risk of death or injury due to fire. Interview with resident assistant L at that same time confirmed that finding. She revealed she was unaware a ceiling tile was missing at that location. She further stated she believed that tile was missing due to it becoming wet from the apparent water leak the bucket was in place for.	S 200		

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S 201	Continued From page 4	S 201		
S 201	44:70:03:02 General Fire Safety Each facility must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, the facility must conduct monthly drills to provide training for all personnel. This Administrative Rule of South Dakota is not met as evidenced by: Based on document review and interview, the provider failed to conduct monthly fire drills as required for 2025. Findings include: 1. Document review and interview on 1/13/26 at 2:15 p.m. revealed the facility operated with only two shifts. Further document review at that same time revealed the only fire drill log sheets available were for the months of January, March, April, and July for 2025. Fire drills are required to be conducted monthly for facilities not operating with three shifts. Additional interview at that same time with maintenance director M confirmed those findings.	S 201	S201 Administrator shall educate Maintenance Engineer on the procedure for conducting monthly fire drills for our two-shift operation. Maintenance Engineer shall conduct and document monthly fire drills. Fire drill documentation shall be reported to the Administrator and the QA Team monthly. Fire drill documentation shall be reviewed in our monthly QA Team meetings to ensure compliance.	3/1/26
S 202	44:70:03:02 General Fire Safety At least two personnel must be on duty at all times, unless the department has approved a staffing exception requested by the facility. In a	S 202		

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S 202	Continued From page 5 multilevel facility, at least one personnel must be on duty on each floor containing occupied beds. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, resident identification roster review, license review, schedule review, and policy review, the provider failed to maintain staffing on each resident floor of the building at all times. Findings include: 1. Review of the provider's 7/1/25 Assisted Living Center license revealed they were approved for additional services for physically impaired residents. 2. Review of the resident roster provided by the facility revealed 15 residents resided on the second floor and 17 residents on the third floor. 3. Review of the staff schedule for 1/13/26 revealed: *Resident aide (RA) E was assigned to the second floor *Unlicensed medication aide (UMA) D was assigned to the third floor. 4. Observation and interview on 1/13/26 at 12:01 p.m. with RA E on the second floor revealed: *RA E worked on both the second and third floors, where the resident rooms were located, as a resident care aide. She assisted residents with showers, ensured that residents went to the first floor for their meals and medications, answered resident call lights, and addressed any other needs the residents had. *On 1/13/26, RA E worked with UMA D. UMA D was primarily assigned to administer the	S 202	S202 All staff shall be educated on regulatory requirements regarding the on duty occupation of resident room floors. The Director of Nursing shall move her office to the 3rd floor. In the DON's absence, the Administrator-in-training shall occupy that office during standard work days. Additionally, Resident Aides shall be assigned floors for each shift including overnight shifts. The Administrator in training shall spot check staff no less than 3x per week for eight weeks to ensure staff compliance. This documentation shall be reported to the QA Team monthly for six months.	3/1/26

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S 202	Continued From page 6 residents' medications. Residents received all their medications on the first floor in the dining room around their mealtimes. *UMA D would help RA E on the second and third floors with showers, answer resident call lights, and any other tasks she needed assistance with when UMA D was done with resident medication administration. *RA E felt that residents knew how to find her throughout the day because she could hear all call lights on each floor, and she and UMA D communicated by walkie-talkie when they were not on the same floor. *RA E confirmed that UMA D was in the dining room, administering resident medications, and she was going between the second and third floors to ensure that all residents went to the dining room. There was no staff on the third floor at that time. *At 12:05 p.m., during the interview with RA E, UMA D arrived on the second floor and assisted a resident to the dining room. RA E and UMA D confirmed that there was no staff on the third floor. *At 12:10 p.m., RA E left the second floor. There were at least seven residents on the second floor, and no staff were present on the second floor. 5. Observation and interview on 1/13/26 at 12:28 p.m. in the dining room revealed that both RA E and UMA D were in the dining room. There was no staff present on the second or third floors at that time but several residents were still present on each floor. 6. Interview on 1/14/26 at 11:15 a.m. with administrator in training B and registered nurse/director of nursing (RN/DON) C regarding the staff assignments revealed: *A UMA is frequently one of the two staff	S 202		

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S 202	Continued From page 7 members who were scheduled on the second or third floor. *The UMA would attend to the medication cart for an extended period of time in the morning and for shorter periods during the midday and evening medication passes. -The medication carts were located on the first floor and do not move from that location. *They expected each staff member to return to their assigned floor if an emergency, such as a fire, occurred. *They thought there would be residents who resisted evacuation and would prefer to shelter in place (in the resident's room with the door closed) until emergency services arrived. 7. Interview on 1/14/26 at 4:30 p.m. with administrator/co-owner A regarding staff assignments revealed: *The schedule outlined the staff that were assigned to the second and third floors. *He expected the staff to return to their assigned floor for an emergency, such as a fire. *He thought the residents and staff would likely shelter in place if there was a fire at the facility. 8. Interview on 1/15/26 at 10:30 a.m. with administrator/co-owner A by telephone and RN/DON C revealed: *The facility did not request a shelter in place provision with the South Dakota Department of Health and would need to provide a request for review in writing (by email). *The expectations for staff response during a resident fire would need to be discussed by management and all staff and residents would be provided the education. 9. Review of the provider's undated Fire Alarm policy revealed:	S 202		

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S 202	Continued From page 8 *"In the event of a disaster causing total evacuation of the building, residents shall gather in front of the facility as close to the street as possible without entering the street." *The policy did not address how staff were to respond to a fire alarm or a shelter in place provision.	S 202	S285 Administrator-in-Training (AIT) shall keep a log that tracks the return of background checks for new hires. The AIT shall document all background submissions to CFO in Yankton office for six months. The AIT shall report documentation for review to QA Team monthly for six months.	3/1/26
S 285	44:70:04:03 Personnel The facility shall have a sufficient number of qualified personnel to provide effective and safe care. Personnel on duty must be awake at all times, except as provided in § 44:70:03:02.01. Any supervisor must be eighteen years of age or older. The facility shall make available written job descriptions and personnel policies and procedures to personnel of all departments and services. The facility may not knowingly employ any person with a conviction for abusing another person. The facility shall establish and follow policies regarding special duty or personnel on contract. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review, interview, and policy review, the provider failed to implement a pre-employment screening process to ensure they did not knowingly hire any person with an abuse conviction for four of six sampled employees (B, G, H, and I). Findings include: 1. Review of personnel files revealed: *Employee B's hire date as the administrator in training and unlicensed medication aide (UMA)	S 285		

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S 285	Continued From page 9 was 11/30/25. -She signed an authorization to have a background check completed on 11/30/25. *Employee G's hire date as the head of dietary services and director of resident services was 5/28/25. -She signed an authorization to have a background check completed on 5/28/25. *Employee H's hire date as a UMA was 12/1/25. -She signed an authorization to have a background check completed on 12/1/25. *Employee I's hire date as a UMA was 9/18/25. -She signed an authorization to have a background check completed on 9/18/25. *There was no documentation to support that a background check was completed before any of these employees were hired. 2. Interview with administrator/co-owner A on 1/14/26 at 4:30 p.m. regarding the personnel files revealed: *The facility utilized background checks to ensure they did not knowingly hire someone with an abuse conviction. *Chief financial officer (CFO) J was in-charge of completing the background checks. *CFO J informed administrator/co-owner A by electronic message that she had not completed the background checks for the above staff members prior to them beginning employment at the facility. 3. Review of the provider's undated Hiring Practices policy revealed: *"...candidate completes paperwork for Angelhaus to conduct a full background check." *Upon satisfactory background check and drug screening report, [the] new hire is scheduled to begin training".	S 285		

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S 315	Continued From page 10	S 315		
S 315	44:70:04:07 Prevention And Control Of Influenza Each facility shall arrange for an influenza vaccination to be completed annually for each resident. Each resident shall be offered influenza vaccine when the resident is admitted and annually during the influenza season. Documentation of the vaccination or refusal must be recorded in the resident's care record. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure documentation was completed for two of five sampled residents (2 and 3) that they were offered the influenza vaccination, or if they refused it when admitted to the facility, and annually. Findings include: 1. Review of resident 2's electronic medical record (EMR) revealed: *He was admitted on 2/29/24. *There was no documentation that he was offered or refused the influenza vaccination when he was admitted to the facility or annually. 2. Review of resident 3's EMR revealed: *She was admitted on 11/12/25. *There was no documentation that she was offered or refused the influenza vaccination when she was admitted to the facility. 3. Interview on 1/14/26 at 10:42 a.m. with registered nurse/director of nursing (RN/DON) C revealed: *The pharmacy provided an influenza vaccination	S 315	S315 Influenza vaccine shall be added to the New Admission Checklist. Additionally, the vaccine form shall be included in the new admission paperwork. Upon admission the DON shall fill out the vaccine form as per the desires of the new resident and shall document in nursing records. Hard copy of the vaccine form shall be kept in the new resident's chart. QA Team shall review new admission records monthly to ensure compliance for six months. Regarding annual flu vaccines typically given by Avera Longterm Care Pharmacy, the DON shall pre-fill all forms/waivers with all the residents' names. Thereby, ensuring documentation for all residents as to whether they received the vaccine or waived it. These documents shall be kept in resident charts and documented in PCC. QA Team shall review vaccine forms monthly to ensure compliance for six months.	3/1/26

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S 315	Continued From page 11 clinic at the facility on 10/21/25. *Resident 2 refused to receive the influenza vaccination. *RN/DON C thought that resident 3 was offered the influenza vaccination and refused it during an appointment at the clinic. *RN/DON C requested records from the clinic regarding resident 2 and resident 3's influenza vaccination status. *RN/DON C confirmed that there was no documentation that residents 2 and 3 were offered or had refused the influenza vaccination. 4. Review of the provider's undated policy packet revealed: *"Vaccinations are documented for residents in their medical chart upon admission." *"Flu (influenza) vaccines are offered to all residents and staff no less than annually ...If a resident or POA [Power of Attorney] refuses the vaccine, [documentation of the] refusal is kept in the medical chart."	S 315		
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 record review, interview, observation, and policy review, the provider failed to: *Ensure an accurate code status (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop) was	S 337	337 DON shall ensure all residents' PCC profiles are updated to reflect residents' current code status. If any documentation is missing, DON shall ensure residents' health care directives are current and on file. Administrator shall educate all staff on resident code statuses and company policy regarding appropriate procedures when a resident is coding. QA Team shall review resident profiles monthly for six months to ensure all residents' code statuses are current and accurate. DON shall educate all staff on policy and procedure for residents that refuse medication. DON shall also educate all staff on policy and procedure for applying and discarding medical patches.	3/1/26

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S 337	Continued From page 12 on record for three of three sampled newly admitted residents (2, 3, and 8). *Offer medications, ensure accurate documentation of the administration and refusal of medications, and notify the physician of refusals of medications for one of one sampled resident (1) who received eye drops, a nutritional supplement, and oral medications, and frequently refused those medications. *Ensure accurate documentation of the administration and removal of a medication patch for one of one sampled resident (6) who received a medication patch. Findings Include: 1. Review of resident 2's paper chart and electronic medical record (EMR) revealed: *He was admitted on 2/29/24. *His 8/17/25 Brief Interview for Mental Status (BIMS) assessment indicated "Incomplete-Requires further Assessment." *His paper chart indicated his code status was "DNR" (do not resuscitate). *His EMR indicated his code status was "CPR" (cardiopulmonary resuscitation). *A 6/25/24 physician's order indicated "Advance Directive [a document that expresses a person's health care wishes if they become unable to speak for themselves]: CPR." *His Power of Attorney (POA) was his brother. *There was no indication of his desired code status in his Healthcare Power of Attorney document. 2. Interview on 1/13/26 at 2:10 p.m. with resident 2 revealed he did not like to answer questions about his healthcare or current situation. 3. Interviews on 1/13/26 at 3:47 p.m. and again	S 337		

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ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

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S 337	Continued From page 13 on 1/14/26 at 8:26 a.m. with registered nurse/director of nursing (RN/DON) C regarding resident 2's advance directive revealed: *RN/DON C confirmed that his paper chart indicated that resident 2 was a DNR code status, and his EMR indicated he was a CPR code status. *RN/DON C was unsure who completed resident 2's code status in his paper chart or if his code status was changed since his admission to the facility. *The facility recently became a "NO CPR" facility, and she expected staff members to call 911 if a resident was found unresponsive. The emergency personnel who responded would determine if they should start CPR. *Staff members had access to residents' EMRs and the paper charts that were stored in the locked chart room on the first floor. She expected that the staff would refer to a resident's EMR for the most accurate information. *RN/DON C contacted resident 2's POA on 1/13/26, and he sent her a copy of resident 2's Healthcare POA document. *RN/DON C did not have a conversation with resident 2 or resident 2's POA regarding resident 2's code status and was unaware of his wishes. *RN/DON C confirmed that there was a physician's order for CPR and stated that he was considered a "full code," and CPR would be performed, if needed, by emergency personnel if they responded to a 911 call regarding resident 2. 4. Interview on 1/14/26 at 4:01 p.m. with administrator/co-owner A regarding residents' code statuses revealed: *He expected a code status order to be in the residents' EMR. *He expected that RN/DON C would have a conversation with the resident or their POA when	S 337		

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S 337	Continued From page 14 the resident was admitted to the facility, document those conversations, and obtain a physician's order for the resident's desired code status. *If there was a problem obtaining a resident code status, he expected that the physician would be notified. 5. Interview on 1/15/26 at 10:07 a.m. with RN/DON C after she spoke with resident 2's POA revealed that resident 2 was a DNR code status, and did not want CPR. RN/DON C confirmed that there was a discrepancy in the information in resident 2's medical records. 6. Review of resident 3's EMR revealed: *She was admitted on 11/12/25. *There was no documentation of resident 3's code status. 7. Review of resident 8's closed care record revealed: *He was admitted on 10/2/25 and discharged on 12/10/25. *There was no documentation of resident 8's code status. 8. Interview on 1/15/26 at 9:27 a.m. with RN/DON C regarding resident 3 and resident 8's code statuses revealed: *She confirmed there were no physician orders or documentation of a code status for residents 3 or 8. *She did not have a conversation with resident 3 or resident 8 when they were admitted to the facility, and she was unaware of their code status wishes. *She stated that residents 3 and 8 would be considered "full codes" in the absence of a DNR code status order.	S 337		

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S 337	Continued From page 15 *RN/DON C confirmed they did not have a process in place to determine a resident's code status when a resident was admitted to the facility. 9. Observation and interview on 1/14/26 at 7:55 a.m. with unlicensed medication aide (UMA) D and resident 1 in the dining room during medication administration revealed: *Resident 1 was given a bottle of eye drop solution. While supervised, resident 1 placed one drop in his left eye and returned the bottle to UMA D. *UMA D stated that resident 1 had other oral medications ordered to be given at that time but she knew that he would refuse them. She did not offer them to him because "it sets him off." *Resident 1 left the dining room after using his eye drops and was not offered the rest of his medications. 10. Review of resident 1's EMR revealed: *His 10/18/25 BIMS assessment score was 15, which indicated his cognition was intact. *His physician's orders included: -"TRIAMETERENE/HCTZ 75-50 MG [milligram] TAB [tablet]" (a medication to remove excess salt and water) give 1 TAB by mouth once a day. -Boost High Protein chocolate, give 8 ounces by mouth two times daily ordered on 6/6/25. *Review of his medication administration documentation from 5/1/25 through 1/15/26 indicated that resident 1 had refused the "TRIAMETERENE/HCTZ 75-50 MG [milligram] TAB" every day except on 5/17/25, 12/3/25, 12/16/25, and on 1/4/26. -Review of resident 1's October, November, and December 2025 TRIAMETERENE/HCTZ 75-50 MG TAB medication cards revealed that there were no doses administered during those	S 337		

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S 337	Continued From page 16 months. -There was no January 2026 medication card for resident 1's TRIAMETERENE/HCTZ 75-50 MG TAB medication. *Review of his medication administration documentation from 6/6/25 through 1/15/26 indicated that resident 1 had refused the Boost 40 out of 46 times in June 2025, every dose in July 2025, 61 out of 62 doses in August 2025, all doses in September, October, and November 2025, 60 out of 62 doses in December 2025, and all doses in January 2026. *The last documented communication to the physician regarding resident 1's refusals was a 6/13/25 progress note indicating that resident 1 "continually refuses Boost & Triamterene/HCTZ. May we discontinue these?" On 6/16/25, the physician ordered, "No changing at this time. Please encourage [resident 1] to take." 11. Interview and review of the pharmacy's 1/1/26 medication delivery Packing Slip on 1/14/26 at 11:50 a.m. with RN/DON C revealed: *Resident 1 should have been offered his medications that morning (1/14/26) and educated on the risks of refusing those medications before UMA D documented that he refused them. *RN/DON C was aware that resident 1 refused his medications and had contacted his physician regarding his refusals. *She confirmed the last notification to the provider regarding resident 1's medication refusals occurred on 6/13/25. *RN/DON C stated that resident 1 did not receive his TRIAMETERENE/HCTZ 75-50 MG TAB medication on 12/3/25 or on 12/16/25, because those medications remained in the medication card. Resident 1 did not receive that medication on 1/4/26, because he did not have a January 2026 TRIAMETERENE/HCTZ 75-50 MG TAB	S 337		

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S 337	Continued From page 17 medication card. RN/DON C stated that those would be considered documentation errors. *Resident 1's January 2026 TRIAMETERENE/HCTZ 75-50 MG TAB medication card had been "Returned to Pharmacy R/T [related to his] refusal." 12. Observation and interview on 1/14/26 at 8:05 a.m. with UMA D during resident 6's medication administration revealed: *Resident 6 sat at a table next to the medication administration cart in the dining room and opened the collar of his shirt to allow UMA D to place his Nicotine Patch (a medication to deliver a controlled dose of nicotine through the skin) on the left side of his chest. *UMA D did not inspect other areas of resident 6's chest or remove any medication patches from his skin. 13. Review of resident 6's EMR revealed: *A 6/3/25 physician's order for "Nicotine TD [transdermal] DIS 14MG/24H [hour], apply 1 patch topically once daily on every morning: off at bedtime". *Between 1/1/26 and 1/14/26, resident 6's nicotine patch was documented as administered 14 times at 8:00 a.m. on his medication administration record. *Between 1/1/26 and 1/14/26, resident 6's nicotine patch was documented as "refused" at 8:00 p.m.,13 times on his medication administration record. *There was no documentation that the administered nicotine patches were removed. 14. Interview and review of resident 6's Nicotine Patch administration documentation from 10/1/25 through 1/14/26 on 1/14/26 at 12:15 p.m. with RN/DON C revealed:	S 337		

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S 337	Continued From page 18 *Nursing staff inconsistently documented the removal of resident 6's nicotine patches. Some staff members marked the task as done in the medication administration records with a check mark, some documented a refusal, and others documented the patch removal in a progress note. *RN/DON C confirmed that resident 6 was only wearing 1 nicotine patch on his left chest on 1/14/26. *RN/DON C expected staff members to document the task completed in his medication administration record with a check mark when resident 6's nicotine patch was removed each evening. 15. Review of the provider's undated policy packet revealed: *"[Provider's name] is a "Do Not Resuscitate Facility" which means CPR shall not be performed on the resident." *"If the resident is in obvious need of an ambulance, the staff member shall call 911 immediately." *The provider's policy did not address obtaining or maintaining the resident's code status. *"Medications are managed under the direction of the DON. The DON is responsible for the following tasks in regard to the administration and control of medications, training UMAs ... Tracking documentation in the eMAR [electronic medication administration record] ... Any other tasks associated with the management of medications in the facility." *"It is the resident's right to refuse any medication ...Steps will be taken to avoid missed or refused doses of medication and related adverse reactions." *"If a resident refuses a scheduled medication, return the medication to the med room. Wait ten	S 337		

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S 337	Continued From page 19 minutes and offer the medication to the resident again ...Staff will notify [the] DON or on-call nurse of [the] missed dose. The DON or nurse-re-appraises the resident and contacts the physician and responsible party if the resident is continually refusing medication(s)".	S 337	S405 Resident 3 was deemed over the facility's level of care and moved to a skilled nursing facility. DON shall educate all staff on policy and procedure for residents that refuse medication. DON shall update all out-of-date Care Plans in PCC. QA Team shall review PCC reports monthly for six months to ensure Care Plans are up to date. Admin Team shall discuss and/or review care records of any residents with changes in condition weekly for six months. Additionally, QA Team shall discuss and/or review care records of all residents that have had a change in condition monthly for six months.	3/1/26
S 405	44:70:05:02 Resident Care Plans, Service Plans, And Progr The facility shall provide safe and effective care from the day of admission through the development and implementation of a written care plan or service plan for each resident. The care plan or service plan must address personal care, and the medical, physical, mental, and emotional needs of the resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the written care plan addressed the current care needs for seven of nine sampled residents (1, 2, 3, 4, 5, 8, and 9) related to: *One of one sampled resident (1) who was not offered his scheduled medications due to staff members' concerns about them escalating his behaviors. *One of one sampled resident (3) who had a significant change in her ability to feed herself, which was not updated in the care plan. *Three out of three residents (4, 5, and 9) who self-administered their medications. *One of one newly admitted resident (8) whose care plan was not initiated or updated in a timely manner. *One of one resident (2) who refused immunizations, cognitive testing, and to leave the	S 405		

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S 405	Continued From page 20 facility for medical appointments. Findings include: 1. Observation and interview on 1/14/26 at 7:55 a.m. with unlicensed medication aide (UMA) D and resident 1 in the dining room during medication administration revealed: *Resident 1 was given a bottle of eye drop solution. While supervised, resident 1 placed one drop in his left eye and returned the bottle to UMA D. *UMA D stated that resident 1 had other oral medications ordered to be given at that time but she knew that he would refuse them. She did not offer them to him because "it sets him off." *Resident 1 left the dining room after using his eye drops and was not offered the rest of his medications. 2. Review of resident 1's electronic medical record (EMR) revealed: *His 10/18/25 BIMS assessment score was 15, which indicated his cognition was intact. *His physician's orders included: -"TRIAMETERENE/HCTZ 75-50 MG [milligram] TAB [tablet]" (a medication to remove excess salt and water) give 1 TAB by mouth once a day. -Boost High Protein chocolate, give 8 ounces by mouth two times daily ordered on 6/6/25. *Review of his medication administration documentation from 5/1/25 through 1/15/26 indicated that resident 1 had refused the "TRIAMETERENE/HCTZ 75-50 MG [milligram] TAB" every day except on 5/17/25, 12/3/25, 12/16/25, and on 1/4/26. -Review of resident 1's October, November, and December 2025 TRIAMETERENE/HCTZ 75-50 MG TAB medication cards revealed that there were no doses administered during those	S 405		

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S 405	Continued From page 21 months. -There was no January 2026 medication card for resident 1's TRIAMETERENE/HCTZ 75-50 MG TAB medication. *Review of his medication administration documentation from 6/6/25 through 1/15/26 indicated that resident 1 had refused the Boost 40 out of 46 times in June 2025, every dose in July 2025, 61 out of 62 doses in August 2025, all doses in September, October, and November 2025, 60 out of 62 doses in December 2025, and all doses in January 2026. *The last documented communication to the physician regarding resident 1's refusals was a 6/13/25 progress note indicating that resident 1 "continually refuses Boost & Triamterene/HCTZ. May we discontinue these?" On 6/16/25, the physician ordered, "No changing at this time. Please encourage [resident 1] to take." *An 8/1/25 care plan intervention included "Administer medications as ordered ..." *A 10/25/25 care plan goal indicated that resident 1 "is noted to frequently refuse [his] ordered medication regimen. [Resident 1] will be supported to take all medications safely and as ordered through [the] next review." *There was no documentation in the written care plan regarding resident 1 not being offered his medication, or changes in resident 1's behaviors related to staff members continuing to offer his medications as ordered by the physician. *There was no documentation in the written care plan regarding resident 1's medication refusals, the physicians' recommendations to continue to educate resident 1 when he refused his medications, or interventions to prevent escalations in his behaviors when the staff offered those medications to him. 3. Observation and interview on 1/14/26 at 8:05	S 405		

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S 405	Continued From page 22 a.m. with UMA D in the main dining room revealed: *Resident 3 walked to the dining room and sat next to resident 10. *Once resident 3 was served her meal, resident 10 fed resident 3 her entire breakfast with a spoon. *UMA D stated that resident 10 fed resident 3 because resident 3 was having increased difficulty because of her full-body tremors. *Staff members were unable to assist resident 3 with feeding because they were not certified nursing assistants (CNAs). 4. Interview on 1/14/26 at 9:50 a.m. with registered nurse/director of nursing (RN/DON) C, and administrator in training B regarding resident 3 revealed: *Resident 3 experienced a significant decline since her admission, and they were aware she was having difficulty feeding herself, and that resident 10 assisted her to eat. *Resident 3 had a speech therapy evaluation approximately one week ago regarding her difficulty with feeding herself, but RN/DON C was unaware if there were any recommendations because she did not receive any documentation from the speech therapist. 5. Interview on 1/15/26 at 3:40 p.m. with resident 10 in her room revealed: *She fed resident 3 at all meal services because resident 3's arms and whole body "shake so bad." *Staff members "yelled" at her for feeding resident 3, but she was not going to "sit by and watch her starve." 6. On 1/14/26 at 10:45 a.m., a request was made to RN/DON C for a copy of resident 3's recent Speech Language Pathology Outpatient	S 405		

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S 405	Continued From page 23 Evaluation. 7. Review of resident 3's 1/8/26 Speech Language Pathology Outpatient Evaluation revealed: *Resident 3 indicated "no problems chewing or swallowing but has difficulty self feeding due to tremors." *Recommendations were made for "skilled dysphagia [difficulty swallowing] therapy to address oral and pharyngeal [throat] weakness to decrease risk [of] further decline and to decrease risk of aspiration [occurs when food, liquid, saliva, or stomach contents enter the airway and lungs]." *Resident 3 was provided "training, cues, and a printed list of oral and pharyngeal strengthening exercises, breath support exercises to increase cough production, and strategies to increase safety with oral intake. Exercises are requested to be completed daily." 8. Review of resident 3's EMR revealed: *She was admitted on 11/12/25. *Resident 3's last updated 11/23/25 care plan indicated that resident 3 was able to feed herself. *A 12/20/25 communication with the physician progress note indicated "..resident is unable to self feed except finger foods ..." -There was no documentation of the Speech Language Pathology recommendations. 9. Observation and interview on 1/14/26 at 11:32 a.m. with UMA D revealed: *UMA D stated that three or four residents had inhalers or nebulizers (a device that converts liquid medication into an inhalable mist) treatments that they self-administered. -Resident 5 kept his inhaler with him or in his room, and he self-administered that medication as needed.	S 405		

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S 405	Continued From page 24 -Resident 4 kept his inhaler in his room that he used as needed, and self-administered nebulizer treatments three times daily. The liquid nebulizer medication vials were stored in the medication cart, and she would provide them to him each day. Resident 4 was able to set them up and complete those treatments in his room independently. -Resident 9 had an inhaler in his room that he used as needed. 10. Review of resident 4's EMR revealed: *He was admitted on 5/15/23. *His 12/2/25 BIMS assessment score was 8, which indicated his cognition was moderately impaired. *There was no documentation in the written care plan that resident 4 self-administered his nebulizer or inhaler medications. 11. Review of resident 9's EMR revealed: *He was admitted on 7/9/21. *His 4/29/25 BIMS assessment score was 15, which indicated his cognition was intact. *There was no documentation in the written care plan that resident 9 self-administered his nebulizer or inhaler medications. 12. Review of resident 5's EMR revealed: *He was admitted on 11/25/25. *His 12/22/25 BIMS assessment score was 12, which indicated his cognition was moderately impaired. *There was no documentation in the written care plan that resident 5 self-administered his inhaler medication. 13. Review of resident 8's closed care record revealed: *He was admitted on 10/2/25 and discharged on	S 405		

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S 405	Continued From page 25 12/10/25. *His diagnoses included schizophrenia (a brain disorder that causes disruptions in thought, emotion, and behavior), Type II Diabetes Mellitus (a condition involving disruptions in how the body regulates blood sugar), major depressive disorder, anxiety, alcohol abuse, cannabis abuse, and fetal alcohol syndrome (a group of lifelong physical, mental, and behavioral issues caused by prenatal alcohol exposure). *His care plan was initiated on 10/21/25. -This was 19 days after his admission and included one focus area of activities of daily living related to his self-care performance deficits. *His care plan was reviewed and revised on 11/23/25 to include his emotional, behavioral, medical, dental, and smoking needs. -Those revisions were not included until seven weeks after his admission. 14. Interview on 1/14/26 at 10:42 a.m. with RN/DON C regarding resident 2 revealed: *The pharmacy provided an influenza vaccination clinic at the facility on 10/21/25, and resident 2 refused the influenza vaccination. *Resident 2 refused medications, immunizations, the BIMS assessment, and to leave the facility for medical appointments. RN/DON C scheduled providers to come to the facility to provide his care. *RN/DON C did not complete any further cognitive assessment for resident 2 and was not worried about resident 2's cognition or ability to make decisions because he was able to recall current events. 15. Review of resident 2's EMR revealed: *He was admitted on 2/29/24. *His 8/17/25 BIMS assessment indicated "Incomplete- Requires Further Assessment."	S 405		

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ANGELHAUS HURON	50 7TH ST SE HURON, SD 57350

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S 405	Continued From page 26 *A 5/14/25 communication with the physician progress note indicated that the provider would be "coming to [the] facility to see [the] resident tomorrow 5/15/25 R/T [related to the] residents refusals to leave [the] facility for appointments." *There was no documentation in the written care plan regarding resident 2's current cognitive status, his ability to make decisions, or his refusal for formal cognitive testing, immunizations and medications, and to leave the facility for medical appointments and care. 16. Interview on 1/15/26 at 10:27 a.m. with RN/DON C regarding resident care plans revealed: *RN/DON C initiated the resident care plans when the resident was admitted and would add information to the care plan as she received it. Some information was received when she completed the resident admission assessment, but other information she learned as she got to know the residents over time. *She expected resident care plans to contain the required information to meet the residents' needs and to be updated when information became available or changed. *Resident 1 had behaviors of refusing his medications, and the staff administering medications should have offered those medications to him and educated him on the risks. She felt that UMA D knew that offering resident 1 his medications would upset him. She acknowledged that information regarding resident 1's refusals of medications, behaviors, and interventions around his medication administration was important to include in his care plan. *She felt that resident 8's care plan was initiated with his activities of daily living information shortly after his admission to the facility on 10/2/25.	S 405		

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S 405	Continued From page 27 RN/DON C confirmed that resident 8's care plan did not contain all of the required information until 11/23/25, and she expected it to be completed within the required time frame. *She expected information about residents who self-administered their medication to be included in their care plan, including which medications they self-administered. *Resident 3's care plan did not include the assistance she required to feed herself or the speech therapist's recommendations. *Resident 2's care plan did not include information about his cognitive status or his refusals. 17. Review of the provider's undated policy packet revealed: *Resident Care Plans: "A resident-centered Care Plan is created and maintained for every resident. 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." *"A Registered Nurse develops a Care plan for each resident upon admission." *"The Care Plan addresses, but is not limited to, the following: ...Medication management and/or assistance required ... Behavioral challenges/needs ..." *"Mandatory review of each Care Plan takes place: Thirty days after admission, Annually, Upon significant change in resident status/condition."	S 405		
S 465	44:70:06:05 Food Supply The facility shall maintain an on-site supply of perishable and nonperishable foods to meet the requirements of planned menus for three days. A	S 465		

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S 465	Continued From page 28 facility shall maintain an additional supply of nonperishable foods as part of the facility's emergency preparedness plan. A facility may use military meals ready to eat in an emergency event according to the facility's emergency response plan. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and menu review, the provider failed to have a current planned emergency three-day menu and an on-site supply maintained of perishable and nonperishable foods to meet the requirement. Findings include: 1. Observations on 1/13/26 at 12:00 p.m. and 1/14/26 at 8:00 a.m. of the kitchen revealed there was not a three-day emergency menu available. 2. Interview on 1/14/26 at 1:30 p.m. and again at 2:15 p.m. with head of dietary services G regarding the emergency three-day food supply revealed: *She was not aware of the regulatory requirement. *She was able to find a three-day emergency "disaster" menu in her files that was reviewed and approved by a dietitian on 5/14/2017. -The facility opened in 2021, and the "disaster menu" located was from the long-term care facility that had closed at the location in 2019. 3. Interview on 1/14/26 at 4:30 p.m. with administrator/co-owner A revealed: *He acknowledged that the "disaster menu" that was provided was not for the current assisted living facility.	S 465	S465 QA Team shall review P&P Manual to reflect changes in the emergency three-day menu. Administrator shall educate all staff about the emergency menu procedure. Registered Dietician has signed off on a three-day emergency menu dated 2/10/26. Head of Dietary shall ensure all food options and appropriate quantities on the menu are on-site in case of emergency. QA Team shall monitor, document, and report monthly for six months to ensure compliance to the menu.	3/1/26

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S 465	Continued From page 29 *The facility would need to develop a current emergency three-day menu in coordination with registered dietitian K and ensure the products were available. 4. Review of the facility's undated Menu and Food Preparation policy revealed it did not address the three-day emergency menu and food supply.	S 465	S603 All expired Meds and medical supplies have been removed from the building. QA Team shall review P&P regarding the removal of DC'd and/or expired Meds and medical supplies. Administrator and/or DON shall educate all staff on the removal of DC'd and/or expired Meds and medical supplies. Admin Team shall create a monthly documentation tool to document the monthly monitoring and proper disposal of DC'd and expired Meds and medical supplies stored in all Med carts, Med rooms, refrigerators, closets or any other storage areas. DON shall oversee the monthly monitoring of aforementioned medical storage areas, and appropriate documentation, for no less than six months. QA Team shall review this documentation monthly for six months.	
S 603	44:70:07:01(4) Policies And Procedures Each facility shall establish and implement written policies and procedures for medication control 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 implement a procedure for the removal and disposal of outdated medications and medical supplies in two of two medication rooms. Findings include: 1. Observation and interview on 1/14/26 at 12:25 p.m. with registered nurse/director of nursing	S 603		3/1/26

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S 603	Continued From page 30 (RN/DON) C and administrator in training B in the second-floor medication room revealed: *The refrigerator contained two autoinjector pens of resident 9's Ademlog (injectable diabetic medication used to regulate blood sugar). One expired on 10/29/24, and the second expired on 10/16/25. -RN/DON C stated that resident 9 no longer used that medication and that the medication should have been returned to the pharmacy. *The cabinets in that medication room contained: -A catheter (flexible tubing placed in the bladder to drain urine) urine collection leg bag expired on 1/6/24, ordered for resident 12, who discharged from the facility on 1/5/25. -An open nebulizer mask (worn when using a device that converts liquid medication into an inhalable mist) marked with resident 13's name, who discharged from the facility on 5/21/23. -An open bag of resident 14's Hall's cough drops expired on 7/8/25. -An open bottle of resident 15's Milk of Magnesium expired in August 2025. -Ten catheter urine collection leg bags expired between 10/11/23 and 6/13/24. -Six nasal cannulas (flexible tubing with prongs that delivers oxygen through the nose) expired on 6/16/25. -Three green oxygen extension tubes expired on 9/3/24. -Xeroform (a sterile medicated gauze dressing) expired on 2/29/24. -More than 100 hypodermic needles (a small, hollow, sharp tube used with a syringe to inject fluids into the body) expired on 1/3/22. -More than 60 22-gauge needles expired between 12/1/23 and 9/1/24. -More than 150 individually wrapped packages of hydrocortisone cream expired in July 2024. -Six Covid-19 home tests expired on 4/3/24.	S 603		

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S 603	Continued From page 31 2. Observation and interview on 1/14/26 at 12:35 p.m. with RN/DON C and administrator in training B in the third-floor medication room revealed: *Seven Covid-19 home tests expired on 4/3/24. *A catheter urine collection leg bag expired on 11/30/25, ordered for resident 12, who discharged from the facility on 1/5/25. *Thirty Mediplex Border Dressings (a foam wound dressing with an adhesive border), expired on 12/28/24, and a bag of NovoFine Autocovers (a disposable insulin pen needle with an automatic safety shield), ordered for resident 16, who discharged from the facility on 10/3/22. *Approximately 50 Accu-Chek lancets (a sterile needle used for blood glucose testing) expired on 9/30/25. *More than 25 22-gauge needles expired on 2/24/25. *Six boxes of alcohol prep pads expired in January 2025 *RN/DON C stated that the nurses and unlicensed medication aides were responsible to check the medication rooms for outdated medications and supplies and it was not assigned to a specific person. She expected that the nursing staff members would check that items were not expired before using them and would discard them if they were expired. 3. Review of the provider's undated policy packet revealed: *"Medications are managed under the direction of the DON. The DON is responsible for the following tasks in regard to the administration and control of medications: Overseeing the destruction of medications ..., Ensuring medications are not expired, and that any expired medications are not given and properly destroyed."	S 603		

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S 603	Continued From page 32 *" Permanently discontinued medications will not be retained in the community." *"When a resident moves out of the facility, all medications, including over-the-counter meds, should go with the resident when possible, or be returned to the pharmacy." *The policy did not address the monitoring and disposal of residents' expired medical supplies.	S 603	654 QA Team shall review the P&P for the removal of medications awaiting destruction. Administrator and/or DON shall educate all staff on the procedure for the removal of medications awaiting destruction. DON shall review and document Med cart audits no less than monthly to ensure medications awaiting destruction are not being stored in Med carts. QA Team shall review this documentation monthly for six months.	3/1/26
S 654	44:70:07:06 Drug Disposal 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.	S 654		
	This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, observation, interview, and policy review, the provider failed to ensure a system to reconcile, audit, and monitor medications to be destroyed regarding: *One of three medication carts had medications held for disposal separated from medications currently being used. *One of two medication rooms had a secure system for accounting for and auditing medications that were awaiting destruction. Findings include: 1. Review of resident 2's paper medical record and electronic medical record (EMR) revealed: *He was admitted on 2/29/24. *A 2/10/25 physician's order for "GG/Codeine SOL [an opioid cough syrup] 100-10/5, Give 5 ML			

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S 654	Continued From page 33 [milliliters] by mouth every 6 hours as needed" was discontinued on 5/15/25. *His paper medical record contained Controlled Drug Record Receipts for the GG/Codeine SOL 100-10/5 beginning on 3/29/25 through 8/23/25 and 11/25/25 through 12/31/25. *Resident 2's medication administration sheet documented that he received four doses of that medication between 2/12/25 and 2/15/25, accounting for the medication that was administered. 2. Review of the provider's narcotic count book located on the medication administration cart revealed it contained the 12/31/25 through 1/14/26 Controlled Drug Record Receipt for the GG/Codeine SOL 100-10/5. The provider was unable to locate the Controlled Drug Record Receipt for the GG/Codeine SOL 100-10/5 for the dates 2/10/25 through 3/29/25 or 8/24/25 through 11/25/25. 3. Review of the 3/29/25 through 8/23/25 and 11/25/25 through 1/14/26 Controlled Drug Record Receipts for the GG/Codeine SOL 100-10/5" revealed: *There was no Controlled Drug Record Receipt that indicated when the medication was received, which nurse received the medication, or the quantity of the medication received. *There was no documentation on the Controlled Drug Record Receipts of any doses provided to resident 2. *On 5/6/25, the documented "Amount Left" of that medication decreased from 100ml to 95ml with no documented "Amount Given" and was documented "reconciled" by registered nurse (RN) F. *There were 27 instances where a second staff person's signature was missing when a count of	S 654		

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S 654	Continued From page 34 that medication was documented as having been completed. *The Controlled Drug Record Receipt sheets were inconsistently completed. There was no documentation of: -"Date Dispensed" on 11 out of 13 sheets. -"Prescriber" on 12 out of 13 sheets. -"Drug/Name/Strength" on 6 out of 13 sheets. -"Directions" on 8 out of 13 sheets. -"Pharmacy" on 9 out of 13 sheets. -"Quantity Dispensed" on 13 out of 13 sheets. 4. Review of the pharmacy-provided Packing Slip for the GG/Codeine SOL 100-10/5 revealed that 120 ML of that medication was received from the pharmacy on 2/10/25. 5. Observation, interview, and review of the medication administration cart and resident 2's Controlled Drug Record Receipts for the GG/Codeine SOL 100-10/5 on 1/13/26 at 4:42 p.m. with registered nurse/director of nursing (RN/DON) C revealed: *The bottle of GG/Codeine cough syrup was in the locked narcotic drawer of the medication administration cart and contained approximately 95 MLs. *RN/DON C stated that the GG/Codeine cough syrup prescription was discontinued, and that the GG/Codeine cough syrup should have been removed from the medication cart and stored in the locked medication cabinet in the medication room to be destroyed by her and the pharmacist. *RN/DON C stated that she was unsure where the 2/10/25 through 3/29/25 or 8/24/25 through 11/25/25 Controlled Drug Record Receipts for that medication were located. There was a recent change in administration and nursing staff, and some documentation could not be located when those changes occurred.	S 654		

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S 654	Continued From page 35 *RN/DON C expected Controlled Drug Record Receipts to be completed and to be stored in the resident's paper medical record when removed from the narcotic count book on the medication administration cart. *She confirmed resident 2's Controlled Drug Record Receipts were incomplete. *RN/DON C stated that a previous nurse, RN F, completed a reconciliation of the GG/Codeine cough syrup medication on 5/6/25. She recalled that RN F poured the contents of the bottle into individual medication cups to measure the amount of medication that remained in the bottle. She was unsure why RN F had done that, and RN F was no longer employed at the facility or available for an interview. 6. Observation and interview on 1/14/26 at 12:35 p.m. with RN/DON C and administrator in training B in the third-floor medication room revealed: *RN/DON C stated that on 1/13/26, she moved all the medication that was to be destroyed from the locked cabinet in the second-floor medication room to the locked cabinet in the third-floor medication room. She moved those medications as a precaution after it was discovered that a spare set of medication cart keys was missing. She was also concerned that the lock on the cabinet in the second-floor medication room might have been tampered with. *The locked medication cabinet contained: -Approximately 90 1/2 tablets of resident 7's Lorazepam 0.5 milligram (mg) medication. RN/DON C stated that resident 7 had brought that medication with her when she was admitted to the facility on 12/15/25. There was no count sheet for that medication. -One tablet of resident 3's Zolpidem tablet (TAB) 5mg medication and two tablets of resident 3's Tramadol HCL 50 mg medication. There was no	S 654		

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S 654	Continued From page 36 count sheet for those medications. -Two tablets of resident 10's Tramadol HCL 50mg medication. RN/DON C stated that those scheduled medications were not given on 12/16/25 and 12/17/25 because resident 10 refused them. There was no count sheet for that medication -Approximately 64 tablets of resident 11's Divalproex 500mg medication. There was no count sheet for that medication. *RN/DON C expected that a count sheet would have been started for each medication in the cabinet. She expected those count sheets to be attached to the medication when they were placed in the locked cabinet until the medications were destroyed by her and the pharmacist. *RN/DON C stated that the medications listed above were not counted when they were placed in the locked cabinet on the second floor or when they were moved to the locked cabinet on the third floor. *RN/DON C had completed a medication storage audit on 1/13/26 after the medications were moved from the second floor to the third floor. She stated that all medications were accounted for at that time. 7. Review of the Medication Storage Audit completed on 1/13/26 by DN/DON C revealed: *An audit of the three medication carts was completed on 1/12/26 after new locks were placed. *The medication rooms were also 'checked.' The second-floor keyhole for the narcotic cabinet appeared 'altered,' and all medications in that cabinet were moved to the third floor. *No discrepancies were noted *"Controlled medications stored per policy" was marked yes.	S 654		

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S 654	Continued From page 37 8. Review of the provider's undated policy packet revealed: *"When a resident arrives at the community with new medication, steps will be taken to ensure proper storage, handling, and that there is an accurate count of the medication." *"Discontinued Narcotics, Narcotic Patches and Hazardous Drugs: ...If [the] medication is still in the med roll ...[the] nurse shall remove [the] medication and collect it in a plastic baggie properly labeled with the resident name, date, description of [the] medication and count. This medication shall be held in the med room in the narcotics drawer."	S 654	S685 All nebulizers and inhalers have been collected from residents listed in this PoC. DON is in the process of obtaining physician orders for residents capable of self-administration and that have passed the self-administration assessment. All staff shall be educated on the P&P regarding residents' abilities to self-administer medications. DON shall conduct quarterly assessments on residents self-administering medications in perpetuity. QA Team shall review physician records and DON assessments monthly for six months to ensure compliance.	3/1/26
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician, physician assistant, or nurse practitioner shall determine and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration. This Administrative Rule of South Dakota is not	S 685		

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S 685	Continued From page 38 met as evidenced by: Based on observation, interview, care record review, and policy review, the provider failed to ensure three of four sampled residents (4, 5, and 9) were supervised, assessed, and had a physician's order for the ability to safely self-administer their medications. Findings include: 1. Observation and interview on 1/14/26 at 11:32 a.m. with unlicensed medication aide (UMA) D during review of the medication cart revealed: *An empty Fluticasone AER (aerosol) 250 MCG (micrograms) inhaler (a portable device for administering inhaled medication) box for resident 5 was in the medication cart, marked "@ [At] BEDSIDE." *UMA D stated that three or four residents had inhalers or nebulizers (a device that converts liquid medication into an inhalable mist) treatments that they self-administered. -Resident 5 kept his inhaler with him or in his room, and he self-administered that medication as needed. -Resident 4 kept his inhaler in his room that he used as needed, and self-administered nebulizer treatments three times daily. The liquid nebulizer medication vials were stored in the medication cart, and she would provide them to him each day. Resident 4 was able to set them up and complete those treatments in his room independently. -Resident 9 had an inhaler in his room that he used as needed. 2. Observation and interview on 1/14/26 at 2:55 p.m. with resident 4 in his room revealed: *He had a nebulizer machine and an inhaler on his nightstand.	S 685		

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	71778	A. BUILDING: _____ B. WING _____	C 01/15/2026

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 685	Continued From page 39 *He stated staff members provided him with the vial of liquid nebulizer medication in the dining room when he requested it, and he set up his nebulizer treatments and completed those nebulizer treatments independently. He kept his inhaler in his room for when he needed it. 3. Review of resident 4's electronic medical record (EMR) revealed: *He was admitted on 5/15/23. *His 12/2/25 Brief Interview for Mental Status (BIMS) assessment score was 8, which indicated his cognition was moderately impaired. *His 5/26/25 Evaluation for Self-Administration of Medications indicated he was unable to: -State the name of the medication or the common side effects of each medication. -Correctly say the proper dosage of the medication. -Demonstrate secure storage for medications. -Correctly measure medication from the container. -"Medications given by designated staff at appropriate times. Resident needs occasional reminding." *There was no documentation that a physician's order was obtained for resident 4 to self-administer his nebulizer or inhaler medications. 4. Observation and interview on 1/14/26 at 3:01 p.m. with resident 9 in his room revealed: *An Airspura inhaler marked "12/30/25" was on the nightstand. Resident 9 stated he used that inhaler approximately three to four times a day. *There were 3 vials of liquid nebulizer medication on his nightstand. Resident 9 stated that he self-administered the nebulizer treatments about once a week.	S 685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 685	Continued From page 40 5. Review of resident 9's EMR revealed: *He was admitted on 7/9/21. *His 4/29/25 BIMS assessment score was 15, which indicated his cognition was intact. *His 12/10/25 Evaluation for Self-Administration of Medications indicated he was unable to: -State the name of the medication or the common side effects of each medication. -Correctly say what each medication was for. -The common side effects of each medication. -Correctly say what time the medication was to be taken. -Correctly say the proper dosage of the medication. -Demonstrate secure storage for medications. -Correctly measure medication from the container. -Correctly provide each medication by the proper route. -"Unable to self administer medications. Medications [are] kept under lock & [and] key with designated personal [personnel] to pass out." *There was no documentation that a physician's order was obtained for resident 9 to self-administer his nebulizer or inhaler medications. 6. Observation and interview on 1/14/26 at 3:03 p.m. with resident 5 and UMA D regarding administration of his inhaler medications revealed that resident 5 had his inhaler in his jacket pocket. He removed the inhaler and put it back in his pocket. He stated that he kept it with him at all times and only used it when he needed it. 7. Review of resident 5's EMR revealed: *He was admitted on 11/25/25. *His 12/22/25 BIMS assessment score was 12, which indicated his cognition was moderately impaired.	S 685		

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S 685	Continued From page 41 *His 11/25/25 Evaluation for Self-Administration of Medications indicated he was unable to: -State the name of the medication or the common side effects of each medication. -Correctly say what each medication was for. -The common side effects of each medication. -Correctly say what time the medication was to be taken. -Correctly say the proper dosage of the medication. -Demonstrate secure storage for medications. -Correctly measure medication from the container. -Correctly provide each medication by the proper route. *There was no documentation that a physician's order was obtained for resident 5 to self-administer his inhaler medication. 8. Interview on 1/14/26 at 3:27 p.m. with registered nurse/director of nursing (RN/DON) C revealed: *The UMAs provided resident 4 with the vial of liquid nebulizer medication in the dining room when it was due, and he completed his nebulizer treatments in his room. She was unaware that resident 4 setting up and completing his nebulizer treatments in his room was considered self-administration of that medication. *She expected resident 4's inhaler to be stored in the medication cart and administered by the UMAs when it was scheduled. *RN/DON C was unaware that resident 5 was self-administering his inhaler. *RN/DON C was unaware that resident 9 was self-administering his inhaler. She expected his inhaler to be kept in the medication cart and administered by the UMAs when it was scheduled. *Resident 9 did not have an order for nebulizer	S 685		

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S 685	Continued From page 42 treatments, and thought that his family provided him with the vials of liquid nebulizer medication. *RN/DON C expected that the Evaluation for Self-Administration of Medications would be completed quarterly for each resident. The Evaluation for Self-Administration of Medications would indicate if a resident was able to self-administer their medications. *A physician's order was required when a resident self-administered any of their medications. 9. Review of the provider's undated policy packet revealed: *"Each Resident has a right to self-administer drugs unless the facility interdisciplinary team has determined for a particular Resident that this practice is unsafe." *"Medications for all residents in [provider's name] shall be administered by licensed or certified staff." *"Due to resident safety, it is our policy to hold all medication in a secure room." *"General practice is to store all medications in the Medication Room. If it is deemed, at the discretion of the DON, that a resident is capable of self-administration, that resident may keep his or her medication in his or her room in a locked container." *"If the physician and DON agree that the resident is capable of self-storage and self-administration of medication, the resident's medications are stored in a locked compartment in his/her room."	S 685		