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 _____	R 02/26/2025

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 An onsite revisit survey was conducted on 2/25/25 through 2/26/25 for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for all previous deficiencies cited on 11/14/24. Angelhaus Huron was found not in compliance with the following requirements: S035, S085, S202, S275, S280, S295, S296, S305, S331, S337, S375, S450, S468, S478, S506, and S776.	{S 000}		
S 035	44:70:01:08 Plans Of Correction Within ten days of the receipt of the statement of deficiencies, each licensed facility shall submit to the department a written plan of correction for any citation of noncompliance with licensure requirements. The plan of correction shall be signed, dated, and on the original forms provided by the department. The department may reject the plan of correction if there is no evidence the plan will cause the facility to attain or maintain compliance with SDCL chapter 34-12 and this article. This Administrative Rule of South Dakota is not met as evidenced by: Based on previous survey report review, record review, and interview, the provider failed to ensure an acceptable plan of correction (POC) had been written, accepted, and implemented for the onsite revisit survey that identified continued non-compliance from the 11/14/24 licensure and complaint survey. Findings include: 1. Review of the provider's most recent survey report from the 11/14/24 licensure and complaint survey revealed twelve total deficiencies were identified.	S 035	S035 Both surveys completed and returned by Administrator on May 12th, 2025.	5/23/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/12/25

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S 035	Continued From page 1 Review of the South Dakota Department of Health (SD DOH) communication to the provider related to the 11/14/24 survey revealed: *On 12/2/24 the statement of deficiencies was sent to the provider for the POC. -The email had been sent to administrator/co-owner M and co-owner and registered nurse/chief operating officer (RN/COO) A. --RN/COO A had identified herself as the individual that would be handling the survey and POC. -A letter was sent with the statement of deficiencies that indicated the POC was due back to SD DOH on 12/12/24. -An additional attachment was sent that included the instructions for writing a POC. *The facility was granted extensions requested by RN/COO A on 12/12/24 and 12/16/24 with the POC due on 12/20/24. *On 12/27/24 an email was sent to the provider requesting the POC be turned in as soon as possible as it was overdue. *A POC was returned to SD DOH on 1/6/25. *On 1/22/25 SD DOH staff reviewed the POC and found it was not acceptable as written related to the following concerns: -There were no identified system changes to correct the deficient practices. -The staff education did not consistently identify items such as who had provided the education to staff, what education was completed, or which staff were educated. -There was no formal monitoring system in place. -It had not supported how ongoing compliance would be achieved or maintained. *The updated POC was due back to the DOH on 1/24/25. *RN/COO A provided no additional	S 035		

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S 035	Continued From page 2 communication to SD DOH after a voicemail was left on 1/23/25. *The RN/COO A and co-owner/administrator M were informed on 1/27/25 that they had been changed to a provisional license from an active status due to issues with ongoing and sustained compliance. *No POC had been returned to SD DOH prior to survey team entry to the facility on 2/25/25. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not submitted an acceptable plan of correction. The presence by telephone or in-person during the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A declined to participate in the survey.	S 035		
{S 085}	44:07:02:03 Cleaning Methods And Facilities The facility shall have supplies, equipment, work areas, and complete written procedures for cleaning, sanitizing, or disinfecting all work areas, equipment, utensils, and medical devices used for residents' care. Common-use equipment shall be disinfected after each use. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, review of the incomplete plan of correction from the 11/14/24 survey, and interview, the provider failed to provide evidence	{S 085}	S085 Admin Team shall review tub disinfection P&P. DON and/or Administrator to train all floor staff on tub infection control protocols. Review of tub infection control protocols and training documentation shall be reviewed in monthly QAPI meetings the first Wednesday of every month.	5/23/25

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{S 085}	Continued From page 3 that a process had been implemented to ensure one of one whirlpool tub (second floor) was being cleaned and disinfected appropriately. Findings include: 1. Observation on 2/25/25 at 1:37 p.m. of the whirlpool room on the second floor revealed a handwritten sign was posted with instructions on how to clean the whirlpool tub. Review of a document titled "Housekeeping and Chemical Training 4 hrs [hours] revealed there: *Were thirteen names listed on the sheet. *Was no date/time listed. *Was no information regarding what information was covered or who conducted the training. Review of the provider's incomplete plan of correction (POC) revealed it stated, "By 12/29/24 The chemical data binder will be reviewed in a training session for RA, housekeeping, and direct care staff. Printed references and hands-on training will be provided, team will have a competency assessment performed by the DON [director of nursing] before 12/29/24." *There was no evidence to support a chemical data binder was reviewed or competencies were completed with staff. Review of the provider's incomplete POC revealed the following information related to monitoring/audits: *"Add supply maintenance and daily checks to RA [resident aide] task list, QAMT [quality assurance management team] will conduct monthly audits to monitor compliance and identify barriers." *"Weekly observation of whirlpool tub cleaning procedures by QAMT. *"Monthly audit of cleaning supplies and PPE [personal protective equipment] by QAMT."	{S 085}		

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{S 085}	Continued From page 4 Review of the post-survey binder revealed there was no evidence to support ongoing monitoring or audits were being conducted to ensure the whirlpool tub was being cleaned or disinfected appropriately. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not submitted an acceptable plan of correction. The presence by telephone or in-person during the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A declined to participate in the survey.	{S 085}		
{S 202}	44:70:03:02 General Fire Safety At least two personnel must be on duty at all times, unless the department has approved a staffing exception requested by the facility. In a multilevel facility, at least one personnel must be on duty on each floor containing occupied beds. This Administrative Rule of South Dakota is not met as evidenced by: Based on review of the incomplete plan of correction (POC) from the 11/14/24 survey and interview, the provider failed to provide evidence that the POC was followed for the previously cited S202 for having failed to ensure there are staff available for each level where there are occupied beds. Findings include: 1. Review of the provider's incomplete plan of	{S 202}	S202 Administrator shall educate all staff on regulations requiring at least one staff on all occupied floors. Upon educating staff, Admin Team shall assign floor responsibilities to each staff member when building the schedule and listing the assigned floors in the digital scheduling App utilized (WhenIWork). Admin Team shall do random spot checks on scheduling App to ensure compliance no less than 1x per week during Admin Team meetings that will take place no less than 3x per week. Results and discussion of process shall take place during monthly QAPI meetings.	5/23/25

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{S 202}	Continued From page 5 correction revealed the following information related to policy and monitoring/audits: *"...by 1/15/25 a formal written policy ensuring at least one staff member is on duty on each occupied resident floor at all times will be added to P&P [policy and procedure]." *"Daily observation of staff presence on each floor by QAMT [quality assurance management team]. Regular review of staff schedules for compliance with the new policy by admin [administrator] and QAMT." Review of the post-survey binder revealed there was no documentation to support a policy had been established or that the presence of staff on each floor was being monitored. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not submitted an acceptable plan of correction. The presence by telephone or in-person during the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A declined to participate in the survey.	{S 202}		
S 275	44:70:04:01 Governing Board Each facility operated by a limited liability partnership, a corporation, or a political subdivision shall have an organized governing body legally responsible for the overall conduct of the facility. If the facility is operated by an individual or partnership, the individual or partnership shall carry out the functions in this	S 275		

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S 275	Continued From page 6 chapter pertaining to the governing body. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and review of the incomplete plan of correction (POC) from the 11/14/24 licensure and complaint survey, the governing board failed to ensure an acceptable POC had been written, accepted, and implemented and resident health and safety complied with the Administrative Rules of South Dakota 44:70 Assisted Living Regulations. Areas of concern included: *The appropriate cleaning and disinfection of a whirlpool tub between resident uses. *The facility had staff assigned to each level of a multi-level building. *Required training had not been completed within thirty days of hire and on an annual basis. *Employees had been evaluated upon hire to ensure they had been screened for tuberculosis and were free from communicable diseases. *The kitchen was operated in a safe and sanitary manner. *There was no process in place for ensuring a physician was contacted for order clarification and medication refusals. *Residents were provided meals that had been evaluated annually by a registered dietician and in accordance with their diet order and personal choice. Findings include: Review of the provider's most recent survey report from the 11/14/24 licensure and complaint survey revealed twelve deficiencies were identified. Review of the South Dakota Department of	S 275	S275 Administrator of record shall be granted authority to make all decisions pertaining to the facility's P&P's, operation, staffing, staff duties, and compliance objectives as per his years of experience in operating ALC's. The other member(s) of the Governing Body may assist in providing support to the operation and participate in monthly QAPI meetings, but shall not directly interfere with the Administrator's daily operation. All staff shall report to the Administrator, not the Governing Body. All staff shall be educated on the chain of command.	5/23/25

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S 275	Continued From page 7 Health (SD DOH) communication to the provider related to the 11/14/24 survey revealed: *On 12/2/24 the statement of deficiencies was sent to the provider for the POC. -The email had been sent to administrator/co-owner M and co-owner and registered nurse/chief operating officer (RN/COO) A. --RN/COO A had identified herself as the individual that would be handling the survey and POC. -A letter was sent with the statement of deficiencies that indicated the POC was due back to SD DOH on 12/12/24. -An additional attachment was sent that included the instructions for writing a POC. *The facility was granted extensions requested by RN/COO A on 12/12/24 and 12/16/24 with the POC due on 12/20/24. *On 12/27/24 an email was sent to the provider requesting the POC be turned in as soon as possible as it was overdue. *A POC was returned to SD DOH on 1/6/25. *On 1/22/25 SD DOH staff reviewed the POC and found it was not acceptable as written related to the following concerns: -There were no identified system changes to correct the deficient practices. -The staff education did not consistently identify items such as who had provided the education to staff, what education was completed, or which staff were educated. -There was no formal monitoring system in place. -It had not supported how ongoing compliance would be achieved or maintained. *The updated POC was due back to the DOH on 1/24/25. *RN/COO A provided no additional communication to SD DOH after a voicemail was left on 1/23/25.	S 275		

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S 275	Continued From page 8 *The RN/COO A and co-owner/administrator M were informed on 1/27/25 that they had been changed to a provisional license from an active status due to issues with ongoing and sustained compliance. *No POC had been returned to SD DOH prior to going onsite to the facility on 2/25/25. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *Co-owner/administrator M acknowledged that the governing board had consisted of him and RN/COO A. *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not submitted an acceptable plan of correction. The presence by telephone or in-person during the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A declined to participate in the survey. Refer to S085, S202, S295, S296, S305, S331, S337, S450, S468, S478, S506, and S776.	S 275		
S 280	44:70:04:02 Administrator The governing body shall designate a qualified administrator to represent the owner or governing body and to be responsible for the daily overall management of the facility. The administrator shall designate a qualified person to represent the administrator during the administrator's absence. The governing body shall notify the department in writing of any change of administrator.	S 280	S280 The Administrator has assigned the DON and the Director of Resident Services to serve as acting Administrator when the Administrator is not in the building. All staff shall be educated on the chain of command.	5/23/25

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S 280	Continued From page 9 This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, policy review, and review of the incomplete plan of correction (POC) from the 11/14/24 survey, the administrator failed to ensure the daily overall management of the facility was in compliance with the Administrative Rules of South Dakota 44:70 Assisted Living regulations related to the following: *An acceptable POC had not been completed and implemented following the November 2024 survey. *Twelve of twelve previous areas of deficient practice remained uncorrected at the time of the revisit. *Documentation did not support that staff had received education or that audits were being completed related to the deficiencies cited. Findings include: Review of the provider's most recent survey report from the 11/14/24 licensure and complaint survey revealed twelve total deficiencies were identified. Review of the South Dakota Department of Health (SD DOH) communication to the provider related to the 11/14/24 survey revealed: *On 12/2/24 the statement of deficiencies was sent to the provider for the POC. -The email had been sent to administrator/co-owner M and his co-owner and registered nurse/chief operating officer (RN/COO) A. --RN/COO A had identified herself as the individual that would be handling the survey and POC. -A letter was sent with the statement of deficiencies that indicated the POC was due back	S 280		

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S 280	Continued From page 10 to SD DOH on 12/12/24. -An additional attachment was sent that included the instructions for writing a POC. *The facility was granted extensions requested by RN/COO A on 12/12/24 and 12/16/24 with the POC due on 12/20/24. *On 12/27/24 an email was sent to the provider requesting the POC be turned in as soon as possible as it was overdue. *A POC was returned to SD DOH on 1/6/25. *On 1/22/25 SD DOH staff reviewed the POC and found it was not acceptable as written related to the following concerns: -There were no identified system changes to correct the deficient practices. -The staff education did not consistently identify items such as who had provided the education to staff, what education was completed, or which staff were educated. -There was no formal monitoring system in place. -It had not supported how ongoing compliance would be achieved or maintained. *The updated POC was due back to the DOH on 1/24/25. *RN/COO A provided no additional communication to SD DOH after a voicemail was left on 1/23/25. *The RN/COO A and co-owner/administrator M were informed on 1/27/25 that they had been changed to a provisional license from an active status due to issues with ongoing and sustained compliance. *No POC had been returned to SD DOH prior to going onsite to the facility on 2/25/25. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *Co-owner/administrator M acknowledged that he was the administrator of record for the facility and	S 280		

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S 280	Continued From page 11 he had stepped back to allow RN/COO A to handle the November 2024 licensure and complaint survey and its follow-up with the SD DOH. *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not submitted an acceptable plan of correction. The presence by telephone or in-person during the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A declined to participate in the survey. Refer to S085, S202, S295, S296, S305, S331, S337, S450, S468, S478, S506, and S776.	S 280		
{S 295}	44:70:04:04 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. Ongoing education programs must cover the required subjects annually. This Administrative Rule of South Dakota is not met as evidenced by: Based on the review of the incomplete plan of correction from the 11/14/24 survey, personnel record review, and interview, the provider failed to ensure: *Two of the three sampled employees identified on the 11/14/24 survey had completed the required ongoing annual education. *A system had been developed to ensure the education was completed by all staff. *There were ongoing audits/monitoring to ensure the education had been completed.	{S 295}	S295 Admin Team shall review and modify new hire training logs, annual inservice training logs, and P&P regarding new hires. New hire and annual training logs, and tracking protocols shall be implemented by the Admin Team. Admin Team shall review both training logs no less than 1x per week during Admin Team meetings that take place no less than 3x per week. All training logs shall be reviewed and discussed during monthly QAPI meetings.	5/23/25

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{S 295}	Continued From page 12 Findings include: 1. Review of the statement of deficiencies for the 11/14/24 survey revealed: *One of five sampled employees (J) had completed none of the eleven personnel training topics. *One of five sampled employees (I) had completed only one of the eleven personnel training topics. *One of five sampled employees (E) had completed only three of the eleven personnel topics. Review of the personnel records for employees J, I, and E revealed: *Employee J was no longer employed at the facility and his last day worked had been on 11/17/24. *There was no evidence that employee I had completed the ten remaining training topics that had been required. *There was no evidence that employee E had completed the eight remaining training topics that had been required. Review of the provider's incomplete plan of correction for S295 revealed the following statements: *"1. Conduct mandatory retraining for all staff on the eleven required training topics within 30 days of Plan of Correction submission. Documentation of completed training for each staff member will be maintained in employee files." *"2. Implement a system for tracking employee training completion dates and ensuring annual updates." *"Review of the employee records for all staff. Ongoing monitoring of training compliance through regular audits by QAMT [quality	{S 295}		

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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 295}	Continued From page 13 assurance management team." Review of the post-survey binder and personnel files revealed there was no evidence that: *All staff were educated on the required training topics within the time specified in their POC. *A tracking system was created for completion of the required topics. *Ongoing tracking or monitoring of the training had occurred. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not submitted an acceptable plan of correction. The presence by telephone or in-person during the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A declined to participate in the survey.	{S 295}		
{S 296}	44:70:04:04(1-11) Personnel Training These programs must be completed within thirty days of hire for all healthcare personnel and must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness, including responding to resident emergencies and information regarding advanced directives; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Resident rights; (6) Confidentiality of resident information; (7) Incidents and diseases subject to mandatory	{S 296}	S296 Admin Team shall review and modify new hire training logs, annual inservice training logs, and P&P regarding new hires. New hire and annual training logs, and tracking protocols shall be implemented by the Admin Team. Admin Team shall review both training logs no less than 1x per week during Admin Team meetings that take place no less than 3x per week. All training logs shall be reviewed and discussed during monthly QAPI meetings.	5/23/25

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{S 296}	Continued From page 14 reporting and the facility's reporting mechanisms; (8) Nutritional risks and hydration needs of residents; (9) Abuse and neglect; (10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility; and (11) Any additional healthcare personnel education necessary based on the individualized resident care needs provided by the healthcare personnel to the residents who are accepted and retained in the facility. Any personnel whom the facility determines will have no contact with residents are exempt from the training required by subdivision (8). This Administrative Rule of South Dakota is not met as evidenced by: Based on the review of the incomplete plan of correction from the 11/14/24 survey, personnel record review, and interview, the provider failed to ensure: *Two of the two newly hired employees identified on the 11/14/24 survey had completed the required education upon hire. *A system had been developed to ensure the education was completed by all staff. *There were ongoing audits/monitoring to ensure the education had been completed. 1. Review of the statement of deficiencies for the 11/14/24 survey revealed: *One of the two newly hired employees (C) had	{S 296}		

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{S 296}	Continued From page 15 completed none of her required training topics. *One of two newly hired employees (H) had completed only five of the eleven personnel training topics. Review of the personnel records for employees C, H, P, and Q revealed: *There was no evidence that employee C had completed the required eleven training topics. *Employee H had completed two additional personnel training topics since the last survey but four remained. She had not completed: -Fire prevention and response. -Emergency procedures and preparedness including responding to resident emergencies and information regarding advanced directives. -Resident rights. -Confidentiality. *Employee P had been hired as a resident aide on 10/24/24. -She completed training on the following topics on 10/23/24. --Fire prevention and response. --Emergency procedures and preparedness. -There was no evidence that she had completed the following nine topics within thirty days of hire: --Infection control and prevention. --Accident prevention and safety procedures. --Resident rights. --Confidentiality. --Incidents and diseases subject to mandatory reporting and the facility's reporting mechanism. --Nutrition risks and hydration. --Abuse, neglect, and misappropriation of resident property or funds. --Problem solving and communication techniques related to residents with cognitive impairment or challenging behaviors. --Education specific to resident needs. *Employee Q had been hired as a certified	{S 296}		

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{S 296}	Continued From page 16 medication aide (CMA) on 1/21/25. -There was no documentation that she had completed training on the eleven required personnel topics within thirty days of hire. Review of the provider's incomplete plan of correction for S296 revealed the following statements: *"1. Conduct mandatory retraining for all staff on the eleven required training topics within 30 days of Plan of Correction submission. Documentation of completed training for each staff member will be maintained in employee files." *"2. Implement a system for tracking employee training completion dates and ensuring annual updates." *"Review of the employee records for all staff. Ongoing monitoring of training compliance through regular audits by QAMT [quality assurance management team." Review of the post-survey binder and personnel files revealed there was no evidence that: *All staff were educated on the required training topics within the time specified in their POC. *A tracking system was created for completion of the required topics. *Ongoing tracking or monitoring of the training had occurred. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not submitted an acceptable plan of correction. The presence by telephone or in-person during the survey of RN/COO A was requested upon	{S 296}		

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{S 296}	Continued From page 17 entry on 2/25/25 at 10:00 a.m. but RN/COO A declined to participate in the survey.	{S 296}		
{S 305}	44:70:04:05 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. All personnel must be evaluated by a licensed health professional for a reportable communicable disease that poses a threat to others before assignment to duties or within fourteen days after employment including an assessment of previous vaccinations and tuberculin skin tests. This Administrative Rule of South Dakota is not met as evidenced by: Based on the review of the incomplete plan of correction (POC) from the 11/14/24 survey, personnel record review, and interview, the provider failed to ensure: *Four of five sampled employees health status for communicable disease was evaluated within fourteen days of hire. *A system had been developed to ensure that all new employees were evaluated by a licensed health professional within fourteen days of hire. *There were ongoing audits/monitoring to ensure the evaluations had been completed. 1. Review of the statement of deficiencies for the 11/14/24 survey revealed: *Employee C had been hired on 10/1/24. -Her health evaluation had been completed on 10/1/24 but it had not been evaluated and signed by a licensed health professional. *Employee H had been hired on 3/6/24. -There was no health evaluation located in her personnel file.	{S 305}	S305 Admin Team shall implement a form that combines TB testing and the declaration that an employee or resident is free from communicable diseases into one form to be signed by a nurse. This new form shall be included in the admission/staff onboarding process to be kept on file for compliance. Admin Team shall review new TB form for all new hires and new residents no less than 1x per week during Admin Team meetings that take place no less than 3x per week. All new TB forms shall be reviewed and discussed during monthly QAPI meetings.	5/23/25

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{S 305}	Continued From page 18 Review of the personnel records revealed: *Employee P had been hired on 10/24/24. -A health evaluation had been partially filled out by the employee. -The health evaluation had not been evaluated or signed by a licensed health professional. *Employee Q had been hired on 1/21/25. -There was no health evaluation in her personnel file. Review of the provider's incomplete POC for S305 revealed the following statements: *"Implement a system for tracking completion of these evaluations and maintaining records by 12/29/24." *"Review of employee health records for all staff." *"QAMT [quality assurance management team] will continue with ongoing monitoring of health evaluation compliance though regular audits." Review of the post-survey binder and personnel files revealed there was no evidence that: *A tracking system had been created for completion of the health evaluations of new or existing employees. *All employee health records had been reviewed. *Ongoing tracking or monitoring of the completion of the health screenings by a licensed health professional had occurred. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *A POC should have been returned to the SD DOH. *They were not aware that registered nurse/chief operating officer (RN/COO) A had not submitted an acceptable plan of correction. The presence by telephone or in-person during	{S 305}		

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{S 305}	Continued From page 19 the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A declined to participate in the survey.	{S 305}		
{S 331}	44:70:04:10(1) Tuberculin Screening... Requirements Tuberculin screening requirements for healthcare personnel and residents are as follows: (1) Each healthcare personnel or resident shall receive an initial individual TB risk assessment that is documented and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment are considered two-step. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin or blood assay TB testing having been completed within the prior twelve months. Skin testing or TB blood assay tests are not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any healthcare personnel or resident who has a newly recognized positive reaction to the skin or TB blood assay test must have a medical evaluation and a chest X-ray to determine the	{S 331}	S331 Admin Team shall implement a form that combines TB testing and the declaration that an employee or resident is free from communicable diseases into one form to be signed by a nurse. This new form shall be included in the admission/staff onboarding process to be kept on file for compliance. Admin Team shall review new TB form for all new hires and new residents no less than 1x per week during Admin Team meetings that take place no less than 3x per week. All new TB forms shall be reviewed and discussed during monthly QAPI meetings.	5/23/25

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{S 331}	Continued From page 20 presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on review of the incomplete plan of correction from the 11/14/24, personnel records, and interview, the provider failed to ensure: *Four of five sampled newly hired employees had a tuberculin (TB) screening completed within twenty-one days of hire. *A system had been developed to ensure that all new employees had a TB screening completed. *There were ongoing audits/monitoring to ensure the screenings were being completed for new employees. 1. Review of the statement of deficiencies for the 11/14/24 survey revealed: *Employee C had been hired on 10/1/24. -The first step TB skin test was administered on 10/2/24. -The second step TB skin test was administered on 11/2/24. *Employee H had been hired on 3/26/24. -The first step TB skin test was administered on 5/14/24. -The second step TB skin test was administered on 6/19/24. Review of the personnel records revealed: *Employee C had no information related to the delay in her second TB skin test. *Employee H had no information related to the delay in her first and second TB skin test. *Employee P was hired on 10/24/24. -Her twenty-first day of employment was 11/14/24. -The first step TB skin test was administered on	{S 331}		

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{S 331}	Continued From page 21 11/15/24. -The second step TB skin test was administered on 11/20/24. -There was no documentation to support the rationale for the delay in administration of the TB screening. *Employee Q was hired on 1/21/25. -She had been employed prior to January 2025 but left employment on 9/17/23. -Her last TB screenings had been completed on 7/31/23 and 8/23/23. -There was no documentation to support that she had been screened upon hire in January 2025 or evaluated for having a screening in the last twelve months. Review of the provider's incomplete plan of correction for S331 revealed the following statements: *"Implemented a system for tracking completion of these screenings and maintaining records." *"Review of TB screening records for all staff." *"Ongoing monitoring of TB screening compliance through regular audits." Review of the post-survey binder and personnel files revealed there was no evidence that: *A tracking system was created for completion of the TB screenings for new or existing employees. *All employee health records had been reviewed. *Ongoing tracking or monitoring of the completion of the TB screenings had occurred. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not submitted an acceptable plan of correction.	{S 331}		

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{S 331}	Continued From page 22 The presence by telephone or in-person during the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A declined to participate in the survey.	{S 331}		
{S 337}	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on review of the incomplete plan of correction from the 11/14/24 survey, South Dakota Board of Nursing (SD BON) verification website review, and interview, the provider failed to ensure a system was in place to monitor employee certificates and licenses to ensure they were not lapsed. Findings include: 1. Review of the statement of deficiencies for the 11/14/24 survey revealed medication aide (MA) G had been working in that role since 10/5/24 on a lapsed certificate. Review of the SD BON medication aide verification webpage revealed her certification had been renewed on 11/14/24. Review of the provider's incomplete plan of correction for S337 revealed the following statement, "Implement a system for monitoring the expiration dates of all staff certifications and licenses."	{S 337}	S337 Administrator shall create a spreadsheet that tracks expiration dates of all licenses and certifications for all staff to prevent lapses in accreditations. Admin Team shall review new spreadsheet no less than 1x per week during Admin Team meetings that take place no less than 3x per week. Spreadsheet shall be reviewed in monthly QAPI meetings. Admin Team shall review P&P's regarding residents' refusals to take medications and dealing with PCP's not responding to written or oral requests in care of our residents. Admin Team shall discuss and track residents' refusals to take medications and PCP's not responding in team meetings no less than 1x per week during Admin Team meetings that take place no less than 3x per week. With a team tracking approach we feel these incidents can be better documented and adapted to.	5/23/25

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{S 337}	Continued From page 23 Review of the post-survey binder revealed there was no evidence that a system was implemented to ensure staff remained current in certifications and licenses. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not submitted an acceptable plan of correction. The presence by telephone or in-person during the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A declined to participate in the survey. B. Based on review of the incomplete plan of correction from the 11/14/24 survey, care record review, and interview, the provider failed to ensure: *A process was in place to clarify physician orders. *A process was in place for notification of the physician due to repeated medication refusals by the resident. Findings include: 1. Review of the statement of deficiencies for the 11/14/24 survey revealed: *Resident 7's closed care record had orders on 6/10/24 from two different medical providers that contradicted each other related to the residents ability to take her medication while on therapeutic outings. *Resident 9 had routinely declined to take his oral medications and only allowed an eye drop to be administered.	{S 337}		

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{S 337}	Continued From page 24 *Resident 6 had routinely declined to take his nebulized medication. Review of the provider's incomplete plan of correction for S337 revealed the following statements: *"Develop a policy for notifying physicians of repeated medication refusals by residents." *"Establish a process for clarifying conflicting physician orders, including documentation of the resolution." *"Review of resident charts for documentation of physician notification and order clarification." Review of resident 9's care record revealed: *A 12/9/24 notification to the primary medical provider from the registered nurse (RN)/director of nursing C stating, "I am sending you copies of recent MARs [medication administration record]. Refuses oral meds [medications] regularly. VSS [Vital signs stable]. When asked why he is refusing [he] states, 'I'm not crazy.' Is often seen sitting alone at dining room table having verbal conversations with nobody present. Since he is refusing his oral medications can we d/c [discontinue] them?" -There was no documentation to that a response was received from the medical provider. -The review of the December 2024, January 2025, and February 2025 MAR reveal his oral medications were listed as refused. Interview on 2/26/25 at 1:55 p.m. with RN/DON C revealed: *No response had been received from the medical provider. -There had been no additional follow-up after no response was received. *Resident 9 continued to refuse his oral medications.	{S 337}		

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{S 337}	Continued From page 25 Review of resident 6's care record revealed: *A 12/9/24 notification to the primary medical provider from RN/DON C stating, "I am attaching the past three months TARs [treatment administration record]. As you can see resident frequently refuses his nebulizer. Do you think we could change that to BID prn [twice daily as needed]?" -There was no documentation that a response was received from the medical provider. -The review of the December 2024, January 2025, and February 2025 TAR reveal his nebulized medications were listed as refused. Interview on 2/26/25 at 1:55 p.m. with RN/DON C revealed: *No response had been received from the medical provider. -There had been no additional follow-up after no response was received. *Resident 6 continued to refuse his nebulized medications. Review of the post-survey binder revealed there was no evidence to support: *A policy had been established for the notification of the medical provider related to repeated medication refusals. *A process had been established for clarification of physician orders. *Resident charts had been reviewed for physician notification and order clarification. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not	{S 337}		

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{S 337}	Continued From page 26 submitted an acceptable plan of correction. The presence by telephone or in-person during the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A declined to participate in the survey.	{S 337}		
S 375	44:70:04:15 Quality Assessment Each facility shall provide for on-going evaluation of the quality of services provided to residents. Components of the quality assessment evaluation shall include establishment of facility standards; review of resident services to identify deviations from the standards and actions taken to correct deviations; resident satisfaction surveys; utilization of services provided; and documentation of the evaluation and report to the governing body. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and review of the incomplete plan of correction review from the 11/14/24 survey, the provider failed to identify concerns or areas of improvement with the facility's delivery of care and services and implement an effective quality assurance performance improvement (QAPI). Findings include. Review of the provider's most recent survey report from the 11/14/24 licensure and complaint survey revealed twelve total deficiencies were identified. *An acceptable plan of correction (POC) had not been attained. *These deficiencies remained uncorrected with the 2/25/25 through 2/26/25 revisit.	S 375	S375 Admin Team shall meet consistently no less than 3x per week with the intent to meet 5x per week. These meetings with standing agenda items addressed in this survey, along with consistent QAPI meetings the first Wednesday of every month, should pave the road for this facility's road to compliance.	5/23/25

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S 375	Continued From page 27 Interview on 2/25/25 at 3:30 p.m. with registered nurse (RN)/director of nursing C regarding a QAPI program: *There had been no formal QAPI program since she began her employment in October 2024. *She felt that the facility tried to incorporate QAPI into the daily huddle but was not able to identify a formal process. *She acknowledged that co-owner registered nurse (RN)/chief operating officer (COO) A should have been a part of the QAPI process. Interview on 2/25/25 at 5:10 p.m. with medication aide G regarding a QAPI program revealed there had not been a program in place since the previous administrator in training left her employment in October 2024. Review of the South Dakota Department of Health (SD DOH) communication to the provider related to the 11/14/24 survey revealed: *On 12/2/24 the statement of deficiencies was sent to the provider for the POC. -The email had been sent to administrator/co-owner M and co-owner RN/COO A. --RN/COO A had identified herself as the individual that would be handling the survey and POC. -A letter was sent with the statement of deficiencies that indicated the POC was due back to SD DOH on 12/12/24. -An additional attachment was sent that included the instructions for writing a POC. *The facility was granted extensions requested by RN/COO A on 12/12/24 and 12/16/24 with the POC due on 12/20/24. *On 12/27/24 an email was sent to the provider requesting the POC be turned in as soon as	S 375		

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S 375	Continued From page 28 possible as it was overdue. *A POC was returned to SD DOH on 1/6/25. *On 1/22/25 SD DOH staff reviewed the POC and found it was not acceptable as written related to the following concerns: -There were no identified system changes to correct the deficient practices. -The staff education did not consistently identify items such as who had provided the education to staff, what education was completed, or which staff were educated. -There was no formal monitoring system in place. -It had not supported how ongoing compliance would be achieved or maintained. *The updated POC was due back to the DOH on 1/24/25. *RN/COO A provided no additional communication to SD DOH after a voicemail was left on 1/23/25. *The RN/COO A and co-owner/administrator M were informed on 1/27/25 that they had been changed to a provisional license from an active status due to issues with ongoing and sustained compliance. *No POC had been returned to SD DOH prior to going onsite to the facility on 2/25/25. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *They had not been involved in a QAPI program at this facility. *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not submitted an acceptable plan of correction. The presence by telephone or in-person during the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A	S 375		

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S 375	Continued From page 29 declined to participate in the survey.	S 375		
{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 review of the incomplete plan of correction from the 11/14/24 survey, the provider failed to ensure a safe and sanitary food service environment in the kitchen had been maintained. Findings include: 1. Observations on 2/25/25 between 10:57 a.m. and 11:35 a.m. in the kitchen revealed: *At 11:00 a.m. the coffee cart: -On the top shelf of the portable cart was a coffee urn and packets of sugar, sugar substitute, and creamer. The top shelf surface had a moderate amount of white dust present resembling sugar crystals. -The second shelf contained a bowl containing a butter knife. The bowl was partially covered by an undated Ziploc bag. *At 11:10 a.m. two wall-mounted oscillating fans were in use: -The first fan had a build up of a gray and black particles on the blades and cover and was in use over the clean dishes. -The second fan near the dishwasher had a build up of gray and black particles on the blades and cover. *Between 11:17 a.m. and 11:30 a.m. with resident	{S 450}	S450 All fans in the dining/kitchen area shall be cleaned by Facility Engineer or dietary staff. All staff shall be educated on the safety, sanitation, and hygiene practices related to dietary service. All staff shall be educated on temperature documentation related to meds, fridge temps, and food service. Member of Admin Team shall spot check dietary staff no less than weekly to observe and reinforce proper infection control methods are being practiced by dietary staff.	5/23/25

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{S 450}	Continued From page 30 aide (RA)/cook R: -The lunch meal had arrived from the outside vendor. -RA/cook R had placed a pair of gloves on her hands and with those gloves handled a large can of pears, grabbed a can opener out of the cupboard, used a pen to record on the temperature log, opened the door to the walk-in cooler, obtained the milk and juice from the cooler, and used the scoop at the ice machine. --Her gloves were not changed and no hand hygiene was observed. *At 11:30 a.m. RA/Cook R was observed changing gloves with no hand hygiene between glove changes. Interview on 2/25/25 at 11:50 a.m. with RA/cook R in the kitchen revealed: *There had been some education completed after the survey regarding food temperatures and making sure the steam tables were turned on. *She did not identify who provided the education or when it was completed. Review of the food temperature log from 11/15/24 to 2/23/25 revealed food temperatures for the week of: *11/15/24 through 11/17/24 two meal services were missed out of nine opportunities. *11/18/24 through 11/24/24 two meal services were missed out of twenty-one opportunities. *11/25/24 through 12/1/24 three meal services were missed out of twenty-one opportunities. *12/2/24 through 12/8/24 five meal services were missed out of twenty-one opportunities. *12/9/24 through 12/15/24 seven meal services were missed out of twenty-one opportunities. *12/16/24 through 12/23/24 eight meal services were missed out of twenty-one opportunities. *12/23/24 through 12/29/24 twelve meal services	{S 450}		

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{S 450}	Continued From page 31 were missed out of twenty-one opportunities. *12/30/24 through 1/5/25 nine meal services were missed out of twenty-one opportunities. *1/6/25 through 1/12/25 six meal services were missed out of twenty-one opportunities. *1/13/25 through 1/19/25 five meal services were missed out of twenty-one opportunities. *1/20/25 through 1/26/25 one meal service were missed out of twenty-one opportunities. *1/27/25 through 2/2/25 four meal services were missed out of twenty-one opportunities. *2/3/25 through 2/9/25 four meal services were missed out of twenty-one opportunities. *2/10/25 through 2/16/25 eight meal services were missed out of twenty-one opportunities. *2/17/25 through 2/23/25 seven meal services were missed out of twenty-one opportunities. *There was no documentation provided to support the rationale for the missed food temperature opportunities on the temperature logs or any re-education that was provided. Review of the provider's incomplete plan of correction for S450 revealed the following statements: *"Review and revise the Food Services policy to include detailed procedures for handwashing, glove changing, and food handling." *"Conduct retraining for all kitchen staff on food safety, sanitation, and hygiene practices." *"Implement a system for regularly checking and documenting food temperatures." *"Establish a schedule for cleaning and sanitizing the kitchen and dining room." *"Daily observation of kitchen and dining room sanitation by QAMT [quality assurance management team]." *"Review of staff training records and food temperature logs."	{S 450}		

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{S 450}	Continued From page 32 Review of the post-survey binder and documentation available in the kitchen revealed there was no evidence that: *A Food Services policy had been reviewed or revised to include handwashing, glove changing, and food handling. *Training had been conducted with all kitchen staff on food safety, sanitation, and hygiene practices. *A system had been implemented and followed for regularly checking food temperatures. *A schedule had been established for cleaning and sanitizing of the kitchen and dining room. *There was daily observation of the kitchen and dining room sanitation by the QAMT. *There had been a review of staff training and food temperature logs. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not submitted an acceptable plan of correction. The presence by telephone or in-person during the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A declined to participate in the survey.	{S 450}		
{S 468}	44:70:06:06 Therapeutic Diets A facility that admits or retains any resident requiring a therapeutic diet, excluding low sodium diets, shall employ or contract with a dietitian. The dietitian shall approve written menus and diet extensions, assess the resident's nutritional status and dietary needs, plan individual diets,	{S 468}		

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{S 468}	Continued From page 33 and provide guidance to dietary personnel in areas of preparation, service, and monitoring the resident's acceptance of the diet. The frequency of dietitian consultations must be at least quarterly or sooner as determined by the resident's dietary need. This Administrative Rule of South Dakota is not met as evidenced by: Based on license review, record review, interview, and review of the incomplete plan of correction from the 11/14/24 survey, the provider failed to ensure the menus had extensions for individuals on a therapeutic diet. Findings include: 1. Review of the facility's 1/27/25 provisional assisted living licensure revealed they were licensed for therapeutic diets. Review of resident diets revealed: *Resident 2 was on a no added salt, limited sodium, and fluid restriction. *Resident 8 was on a no added salt diet. *Resident 10 was on a diabetic and mechanical soft diet. Interview on 2/25/25 at 12:10 p.m. with resident aide (RA)/cook R regarding resident 10's mechanical soft diet revealed: *He is served the same meal as the other residents. *She stated, "He doesn't ever ask for anything different." Review of the provider's incomplete plan of correction for S468 revealed the following statements: "Engage a registered dietician [RD] to review and approve menus annually, including addition of the	{S 468}	S468 Admin Team shall meet with Registered Dietician to review dietary P&P's, menus, and training protocols. Under the guidance of the RD, Admin Team shall establish P&P's for communicating resident dietary needs between the dietary department and the nursing department. Resident dietary needs shall be discussed in meetings that take place no less than 3x per week with the Admin Team. Dietary needs and processes shall be reviewed and discussed during monthly QAPI meetings.	5/23/25

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{S 468}	Continued From page 34 therapeutic diet extensions and portion sizes." "Review of the menus for dietician approval, extensions, and portion sizes." Review of the spring week 1 through 4 menus revealed they had been evaluated by the RD and signed on 8/31/23. Review of the post-survey binder and documentation available in the kitchen revealed there was no evidence that: *There had been an RD review of the menus since 8/31/23. *Menu extensions were available. *There had been any monitoring or audits to ensure that menus had RD approval and extensions. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not submitted an acceptable plan of correction. The presence by telephone or in-person during the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A declined to participate in the survey.	{S 468}		
{S 478}	44:70:06:09 Written Menus A dietician shall annually approve, sign, and date each planned menu for all facilities except a facility without therapeutic diet services.	{S 478}	S478 Admin Team shall meet with Registered Dietician to review menus. Administrator shall ensure menus are signed annually by the RD to ensure compliance. Menus will be reviewed during monthly QAPI meetings.	5/23/25

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{S 478}	Continued From page 35 This Administrative Rule of South Dakota is not met as evidenced by: Based on license review, record review, observation, interview, and review of the incomplete plan of correction from the 11/14/24 survey, the provider failed to ensure: *The registered dietician (RD) approved, signed, and dated the planned menus. *A substitution menu was available for residents to choose what they wanted at mealtime. 1. Review of the facility's 1/27/25 provisional assisted living license revealed they were licensed to provide therapeutic diets. Review of the spring weeks 1 through 4 menus revealed: *They had been evaluated and signed by the RD on 8/31/23. -There was no documentation to support they have been evaluated in 2024. *There were no substitutions listed for the therapeutic diets. Observation and interview on 2/25/25 at 11:30 a.m. with resident aide/cook R revealed: *There was not a substitution menu available. *If a resident did not want the food option that was on the menu the alternative would be a peanut butter sandwich. Review of the provider's incomplete plan of correction for S478 revealed the following statements: *"Develop a system for providing residents with menu substitutions or meal choices." *"Observation of resident meal choices." Review of the post-survey binder and documentation available in the kitchen revealed	{S 478}		

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{S 478}	Continued From page 36 there was no evidence that: *A system had been establish to provide menu substitutions or meal choices. *There had been any monitoring or audits to ensure the residents had been offered a choice or substitution. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not submitted an acceptable plan of correction. The presence by telephone or in-person during the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A declined to participate in the survey.	{S 478}		
{S 506}	44:70:06:17 Required Dietary Inservice Training The person in charge of dietary services or the dietitian shall provide ongoing inservice training for all healthcare personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for any dietary or food-handling personnel and must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and	{S 506}	S506 Admin Team shall review and modify new hire dietary training logs and annual dietary inservice logs. Dietary new hire and annual training logs shall be implemented by the Admin Team. Admin Team shall review both training logs no less than 1x per week during Admin Team meetings that take place no less than 3x per week. All training logs shall be reviewed and discussed during monthly QAPI meetings.	5/23/25

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{S 506}	Continued From page 37 (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on review of the incomplete plan of correction from the 11/14/24 survey, personnel record review, and interview, the provider failed to ensure the annual dietary training had been completed. Findings include: 1. Review of the statement of deficiencies for the 11/14/24 survey related to employee E revealed: *Her hire date was 6/14/23. *There was no documentation that she had completed the required annual dietary trainings. Review of the provider's incomplete place of correction for S506 revealed the following statements: *"Provide annual dietary training for all dietary and food handling personnel covering the nine required topics. Maintain records of training completion." "*Review of employee training records for all dietary staff." *Ongoing monitoring of training compliance through regular audits." Review of the post-survey binder and personnel files revealed there was no evidence that: *Employee E had completed the required training topics. *Education on the required dietary training topics had been provided to dietary staff. *Ongoing monitoring or audits were being completed to ensure compliance with the completion of the dietary training.	{S 506}		

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{S 506}	Continued From page 38 Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not submitted an acceptable plan of correction. The presence by telephone or in-person during the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A declined to participate in the survey.	{S 506}		
{S 776}	44:70:09:02(1) Facility To inform Resident Of Rights The information must contain: (1) The resident's right to exercise the resident's rights as a resident of the facility and as a citizen of the United States; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, record review, and review of the incomplete plan of correction from the 11/14/24 survey, the provider failed to ensure residents had additional choices of food at mealtime. Findings include: 1. Observation on 2/25/25 between 11:30 a.m. and 12:00 p.m. with resident aide/cook R revealed residents were provided with one meal option.	{S 776}	S776 Admin Team shall review and modify P&P for menu substitutes with guidance from RD. All staff shall be educated on P&P for providing residents food alternatives. Food substitutes shall be reviewed and discussed during monthly QAPI meetings.	5/23/25

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	71778	A. BUILDING: _____ B. WING _____	R 02/26/2025

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 776}	Continued From page 39 Observation on 2/25/25 at 12:00 p.m. of the posted menu in the dining room revealed: *It listed one planned meal. *There were no alternative food items listed for residents. Review of the provider's incomplete plan of correction for S776 revealed the following statements: *"Revise the resident menu to provide choices for each meal. Ensure residents are aware of their right to choose their meals." *"Review of menu for food choices." *"Observation of resident meal selections." *"Resident interviews regarding food choices." Review of the post-survey binder and documentation available in the kitchen revealed there was no evidence that: *The meals had been revised to provide choices with each meal. -They had been evaluated by the registered dietician since 8/31/23. *Residents were made aware of their food choices or had interviews conducted. *There had been any monitoring audits to ensure the residents had been offered a choice at mealtime. Interview on 2/26/25 at 10:10 a.m. with co-owner/administrator M, chief financial officer N, and director of resident finances O revealed: *A POC should have been returned to the SD DOH. *They were not aware that RN/COO A had not submitted an acceptable plan of correction. The presence by telephone or in-person during the survey of RN/COO A was requested upon entry on 2/25/25 at 10:00 a.m. but RN/COO A	{S 776}		

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{S 776}	Continued From page 40 declined to participate in the survey.	{S 776}		

South Dakota Department of Health

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S 000	Compliance Statement 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 2/25/25 through 2/26/25. The areas surveyed included quality of life, administration and personnel, resident neglect, admission, transfer, discharge, and resident abuse related to potential sexual abuse by a former staff member. Angelhaus Huron was found not in compliance with the following requirements: S030, S165, S285, S415, S701, and S838.	S 000		
S 030	44:70:01:07 Reports To The Department Each facility shall report the following events to the department through the department's online reporting system within twenty-four hours of the discovery of the event: (1) An attempted suicide; (2) Any cause to suspect abuse or neglect of a resident; (3) Any death resulting from other than natural causes that originated on facility property; (4) A missing resident; (5) A fire in the facility; (6) Any loss of utilities, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than twenty-four hours; or (7) Any unsafe drinking water samples, or samples from pools or spas. The facility shall conduct an internal investigation for the event and report the results to the department no later than five working days after the event.	S 030	S030 DON and Administrator have received guidance and education from the DOH Complaint Advisor and have successfully completed three approved incidents reported to the state. Admin Team shall review Policies and Procedures (P&P). Administrator and/or DON shall train all staff on the process for filling out an Incident Report and how to submit the report to the Admin Team for proper filing internally or with the DOH. Administrator shall meet with the Admin Team no less than 3x per week to discuss static agenda items including reviews of any incidents to ensure proper filing and follow-up action is completed. All Incident Reports shall be reviewed in monthly QAPI meetings held on the first Wednesday of each month.	5/23/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/12/25

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S 030	Continued From page 1 The department may request additional information from the facility and investigate any reported event. This Administrative Rule of South Dakota is not met as evidenced by: Based on a review of the South Dakota Department of Health (SD DOH) complaint intake form, record review, interview, and policy review, the provider failed to investigate and report to SD DOH: *An altercation between two of two sampled residents (6 and 11). *Inappropriate contact between one of one sampled resident (3) and a former staff member. Findings include: 1. Review of the 1/27/25 and 1/28/25 SD DOH complaint intake forms revealed: *Resident 11 had a traumatic brain injury (TBI) (a brain injury caused by an external force, such as a blow, bump, fall, or penetration) and staff were not trained to care for him. *Registered nurse/chief operating officer (RN/COO)/co-owner A had called the state and stated they terminated a staff member for having inappropriate contact with a resident. *RN/COO/co-owner A, was informed that an incident report and an investigation needed to be completed, and submitted to the SD DOH with the findings. Review of resident 11's closed electronic medical record (EMR) revealed: *He was admitted to the facility on 7/19/24. *His Brief Interview for Mental Status (BIMS) assessment was incomplete. *His diagnoses included: personality change due to known physiological condition, depression,	S 030		

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S 030	Continued From page 2 nicotine dependence, other symptoms and signs involving cognitive functions and awareness, and mental disorder. *On 1/15/25 he approached resident 6 and asked him for money, resident 6 refused, resident 11 hit resident 6 across the face with a cane, and resident 6 pushed him back to self-protect. *A petition was made to the local police department after that incident. *No further documentation was made in the resident EMR until two days later. *Resident 11 was discharged from the facility on 2/13/25 to a behavioral health center. Interview on 2/26/25 at 2:07 p.m. with registered nurse/director of nursing (RN/DON) C regarding the above incident revealed: *She was aware of the incident. *RN/COO/co-owner A was responsible for submitting reports to the SD DOH and was aware of the incident. *RN/DON C had submitted a petition to the local police department on 1/15/25 and again on 2/4/25 when the staff found a knife in resident 11's room. -A petition stated a resident was needing more assistance than the facility could provide. *An incident report form was not filled out on 1/15/25. *RN/DON C stated that RN/COO/co-owner A came to the facility and discussed with resident 11 that his behaviors were unacceptable. They had petitioned to find him a better suitable place, but she did not document that. *She agreed there was little documentation indicating how they kept other residents safe while resident 11 was still residing at the facility. 2. Review of the 1/27/25 SD DOH complaint intake revealed: *Inappropriate contact between a staff member	S 030		

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S 030	Continued From page 3 and a resident. -The staff member was terminated. *The local police department was notified. *RN/COO/co-owner A, was informed that an incident report and an investigation needed to be completed and submitted to the SD DOH with the findings. Review of resident 3's EMR revealed: *She was admitted to the facility on 6/14/21. *She had a BIMS assessment score of 9, which indicated she was moderately cognitively impaired. *Her diagnoses included: adjustment disorder with disturbance of conduct and long-term drug therapy. Interview on 2/26/25 at 10:12 a.m. with administrator/co-owner M regarding the above inappropriate contact incident revealed: *He was aware of the incident. *He confirmed it was sexual contact between resident 3 and a former staff member. *He agreed the incident should have been reported. Review of the provider's undated Incident Report policy revealed: *"The appropriate employee shall document any incident involving a resident on an Incident Report as per the instructions on the form." *"An accident report is to be completed for every accident, unexpected occurrence, act of abuse, or suspicion of abuse." *"If the incident involves a resident, the basic facts of the incident should be recorded in the resident's health record. Actions taken as a result of the incident and the follow-up should also be recorded in the resident's health record."	S 030		

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S 030	Continued From page 4 Refer to S838.	S 030		
S 165	44:70:02:17 Occupant Protection Each facility must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to any occupant. The extent and complexity of occupant protection precautions are determined by the services offered and the physical needs of any resident admitted to the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the facility was maintained and operated to avoid injury or danger to occupants related to: *One of one sampled resident (3) who had a four wheeled walker with brakes that were not functioning causing her to have a fear of falling. *Concerns of a leak in the boiler system that caused staff to add water every few hours to keep an appropriate temperature in the building during an unknown amount of time with extremely cold outside temperatures. Findings include: 1. Observation and interview on 2/25/25 at 11:38 a.m. with resident 3 in her room revealed: *She was sitting on the seat portion of her four-wheeled walker and using that to move around in her room. *Her friend, resident 4 was also in the room and was sitting in a chair. *Resident 3 voiced a concern that her walker brakes had not been working for about a month.	S 165	S165 Facility Engineer shall be reeducated on their responsibilities to maintain the health and safety of the building, residents, and staff by the Administrator. Facility Engineer shall sign their job description for our personnel file. Admin Team shall review P&P for handling maintenance requests and modify as needed. Administrator shall educate Facility Engineer on P&P for handling maintenance requests and how to track/document them. Administrator shall review status of all maintenance requests weekly as documented by the Facility Engineer. All Maintenance Requests shall be reviewed in monthly QAPI meetings.	5/23/25

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S 165	Continued From page 5 *She demonstrated that neither brake was functioning as it should have been and the walker continued to move easily. *She indicated she had told maintenance staff U about it and he had not fixed them yet. *She was frustrated and afraid she was going to fall and get hurt because of brakes not working. *Resident 4 confirmed resident 3's concern and that maintenance staff U was aware of the problem. *Resident 3 reminded the surveyor more than once to check into the situation because she felt it was unsafe for her to be using the walker but it was her main device for moving around. Interview on 2/25/25 at 5:10 p.m. with medication aide (MA) G regarding resident 3's walker brakes revealed: *She was not aware the resident's walker brakes were not working. *She confirmed the resident used the walker all the time and it was a safety concern if the brakes were not working correctly. *If staff were told of a maintenance concern there were work orders they were to fill out to let maintenance staff U know. Interview on 2/26/25 at 9:55 a.m. with registered nurse/director of nursing (RN/DON) C regarding resident 3's concern above revealed: *She had not been aware the resident's walker brakes were not working. *She confirmed it was a safety issue and put the resident at risk for potential falls. *If staff had been told they would have filled out a maintenance work order to fix the walker. *She was unsure if maintenance staff U was aware of the problem or not. Interview of 2/26/25 at 11:30 a.m. with	S 165		

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S 165	Continued From page 6 maintenance staff U regarding resident 3's walker revealed: *He was aware of her complaint about the walker brakes not working. -The resident had told him herself. *He had not looked at the walker yet and had not tried to fix them. *He was unsure when she had asked him about it and there was no work order or documentation regarding her request to have the walker brakes fixed. *He confirmed it was a safety issue if she was using the walker for mobility and the brakes were not functioning properly. Follow-up interview on 2/25/25 at 2:10 p.m. with maintenance staff U revealed he had just repaired the resident's walker brakes and they were working properly now. 2. Interviews on 2/25/25 at 2:00 p.m. and on 2/26/25 at 10:00 a.m. with RN/DON C regarding staffing, work orders, and maintenance concerns revealed: *There were several days at the beginning of January 2025 when the weather was extremely cold. *During that time frame the building was having issues with the boiler and a leak and maintaining heat in the building. *She was told to add water into the boiler system to keep the water at the appropriate level and to keep it heating the resident spaces appropriately. *She did not feel comfortable dealing with the boiler and did not feel adequately prepared to do so. *Because of the water leak the staff had to refill water into the boiler every one to two hours. -She had to set an alarm for that task, and when she was not working she had to come into the	S 165		

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S 165	Continued From page 7	S 165		

building at all different hours of the day and night to ensure it was being done.
*Those issues lasted several days and she was exhausted so she showed two other staff members where to add the water.
-She did not feel good about showing others how to fill the boiler system when she did not feel comfortable with it herself.
*When asked about maintenance in the building she indicated maintenance staff U was responsible for that area and she was in charge of nursing services.
*During the time frame of the boiler leak maintenance staff U was not available in the facility.
*She believed he was a full-time employee but was unsure of his schedule or regular hours worked as she did not oversee that area.
*When asked about contractors or service vendors coming in to look at the boiler she stated she believed someone called a repair business and eventually they got the leak fixed.
*She did not have documentation of that or when that would have occurred.
-Maintenance staff U should have had that information.

Interview on 2/25/25 at 5:10 p.m. with MA G regarding maintenance in the building revealed:
*It was an old building and there were issues sometimes.
*They had some heating problems when it was really cold outside a month or so ago.
*Maintenance staff U was responsible for the building maintenance.
*He did not work every day but the staff could have called him if there was a maintenance concern.

Interview on 2/26/25 at 11:30 a.m. with

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S 165	Continued From page 8 maintenance staff U revealed: *He confirmed he oversaw the maintenance areas of the building. *He was aware of the issues with the boiler system when it was extremely cold outside the month before. -He thought that happened over a span of about four days. *The boiler system had a leak but it was not a big one. *Staff were instructed to add water to the system during that time. *He felt the temperatures in the building were maintained in a normal range when the issues were occurring. *He had no invoices related to vendors coming to repair the leaks but thought it was two different companies. *The surveyor requested any documentation he had related to the boiler system concerns in January 2025. -No information was received by the survey exit time on 2/26/25 at 3:00 p.m. that day. 3. Review of the provider's undated policy manual revealed: *There was no job description for the maintenance staff person role. *"Building Maintenance On-call: All building and maintenance related issues are handled by the Facility Engineer, secondarily by the Administrator, and thirdly by the Nurse." -The person listed for the maintenance role was not maintenance staff U and was not a name listed as an active employee on the Employee List. *For Safety Equipment related to a walker, "...Notify your supervisor with concerns." *For Safety and Security: -"The facility is responsible to provide a safe and	S 165		

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S 165	Continued From page 9 secure environment for residents, family members and employees. Every employee needs to perform every duty correctly and safely and should report safety hazards to the Administrative Team." -"Records of repairs to safety and security systems are kept in the office, including any recommendations for replacement." -"Environmental safety is provided by keeping the facility clean and orderly and includes properly operating Administrators and things in the entire facility in good repair."	S 165		
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 interview, record review, and policy review, the provider failed to ensure there was sufficient and qualified staff to provide safe and effective care to the residents related to medication administration. *There were only three currently employed and qualified staff members to perform medication	S 285	S285 Administrator shall update BON approval for our internal UMA training program and establish DON as approved trainer for said program. Admin Team shall modify and implement staff onboarding checklist to ensure all new hire training and trainees are compliant. Admin Team shall modify and implement checklists for all staff to ensure compliance and proper tracking of annual staff training modules. Administrator shall train Admin staff on staff education tracking and procedures. Admin Team shall establish a P&P to vet and train any outside licensed or certified med passers to ensure the safety of residents, including obtaining training and credentials from other agencies. Admin Team is actively recruiting new staff members for the team. Utilization of outside credentialed individuals shall be discussed in monthly QAPI meetings to ensure efforts lead the organization to compliance.	5/23/25

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S 285	Continued From page 10 administration for all residents which caused concerns of uncovered shifts or unqualified staff performing medication administration. *There were two randomly identified medication aides (MA) (S and T) that had performed medication administration for residents but had no documentation to support they were qualified and safe to do so. Findings include: 1. An entrance conference was conducted with registered nurse/director of nursing (RN/DON) C on 2/25/25 at 10:00 a.m. to explain the purpose of the survey. During that time a list of all current employees with their hire dates and roles was requested. Surveyors also requested a list of staff that had left their employment with the facility from 11/15/24 through 2/25/25. Review of the provider's 2/25/25 Employee List and interview with RN/DON C on 2/25/25 at 2:00 p.m. revealed: *The first page contained 25 staff members' names. *RN/DON C indicated: -Five of the staff listed were no longer employed and had not been for a month or more. -Two of the staff were the co-owners. Neither of them were in the building on a regular basis. -Two other staff were chief financial officer (CFO) N and the representative payee/director of resident finances O. Neither of them worked in the building on a regular basis. *The 16 remaining staff members included: -RN/DON C, who was the only licensed nurse. -Two MAs, G and Q. -Two cooks. -Eight resident aides (RA). -One other MA who worked only as needed and had not worked there in over a month.	S 285		

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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 285	Continued From page 11 -One maintenance staff member. -One housekeeping staff member. *RN/DON C confirmed there were only two currently scheduled MAs for the facility who were qualified to perform medication administration for residents along with her as the licensed nurse. -With only two MAs it was difficult to cover all the shifts. *There were night shifts when no MA was scheduled or available for medication administration. *The night staff could have called her to come in if a resident needed a medication during the night. *She frequently worked in the MA role to ensure medications were administered. *When she worked in that MA role it was hard for her to keep up with her normal nursing duties and documentation. *She had talked to RN/chief operating officer(COO)/co-owner A about training another RA to be a MA, but that had not happened. *The facility did not have an approved MA training program with the South Dakota Board of Nursing. *She confirmed the facility was responsible for ensuring sufficient and qualified staff to provide safe and effective care to residents which included medication administration. Review of residents' 10 and 12's February 2025 Medication Administration Records (MAR) revealed: *Five total staff members had signed as completing the residents' medication administrations throughout the month. *Those staff included: -RN/DON C. -MAs G, Q, S, and T. Interview on 2/25/25 at 5:10 p.m. with MA G	S 285		

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S 285	Continued From page 12 revealed: *She had been working there for three years and had received her MA certification and training at the facility from a previously employed RN. *She normally worked full-time during the evening shift. *She confirmed there was no MA scheduled or on duty during the night shift at times. *If a resident requested a medication during the night shift when there was no MA on duty then the RA would have offered them an ice pack or hot pack until the day shift MA arrived in the morning. -If it was an emergency or the resident really wanted a medication then the RA could have called the RN. *She confirmed MAs S and T had administered residents' medications when they filled in for MA shifts recently. *MAs S and T were not employees of the facility. -Those MAs were employees of RN/COO/co-owner A's other business that provided in-home care services. *She was not sure what kind of training MAs S and T had received prior to working in the facility. Review of personnel files for MAs G, Q, S, and T revealed: *There was no documentation to support MAs S and T were trained and qualified to perform medication administration in the facility. *Their files had minimal documentation in them. Interview and record review on 2/25/25 at 10:00 a.m. with administrator/co-owner M, CFO N, and director of resident finances O regarding staffing, documentation, and medication administration revealed: *They confirmed the personnel files for MAs S and T had no documentation to support they were qualified to perform medication administration in	S 285		

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the facility.
-Those two MAs were not employees of the facility.
-They were employees of RN/COO/co-owner A's other business.
*They were not aware the Employee List had included five staff members who no longer worked for the facility.
*They confirmed the facility was responsible for ensuring sufficient and qualified staff to provide safe and effective care to residents which included medication administration.

Upon entry to the facility on 2/25/25 at 10:00 a.m. the surveyors requested the presence of RN/COO/co-owner A by telephone or in-person during the survey. RN/COO/co-owner A had not participated in the survey on 2/25/25 or on 2/26/25 prior to the survey exit.

Review of the provider's undated policy manual revealed:
*"Staff scheduling is handled primarily by the Administrator, secondarily by the DON, and thirdly by the Nurse."
-Three nurses' names and phone numbers were listed.
--One was RN/DON C, one was RN/COO/co-owner A, and the other was not listed on the active Employee List.
*"All staff will receive initial orientation and ongoing in-service training based on SD state regulations and the needs of the residents being served in the facility. Staff training is a team effort between the Administrator, DON, senior employees, and Nurse. The Administrator is primary to the new hire training process and is responsible for scheduling and documenting new employees in the training program."
*"Angelhaus offers its employees the ability to

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S 285	Continued From page 14 obtain the Unlicensed Medication Aide designation or UMA certification." -The policy had not mentioned if that training was done in the facility or who was responsible for it. *Schedule and Assignments: -"...Staff assignments are based on facility/resident needs, and the recommendations of the Administrator and DON..." *Medication Management: -"Medications for all residents in Angelhaus shall be administered by licensed or certified staff..." -"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 UMA's."	S 285		
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 a review of the South Dakota Department of Health (SD DOH) complaint intake form, observation, interview, record review, and policy review, the provider failed to follow their nail care policy for one of one sampled diabetic resident (2).	S 415	S415 Admin Team shall review and modify P&P regarding fingernail and toenail care to offer residents scheduled options for service. All staff shall be training on process for scheduling nail care. Review of process for nail care shall be conducted monthly in QAPI meetings.	5/23/25

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S 415	Continued From page 15 Findings included: 1. Review of the 1/28/25 SD DOH complaint intake form revealed residents were not getting proper care. Observation and interview on 2/25/25 at 11:30 a.m. with resident 2 revealed: *His fingernails were long. *He stated he had asked registered nurse/director of nursing (RN/DON) C to clip his fingernails a few days ago. *He stated he does not like his fingernails long. Review of resident 2's electronic medical records (EMR) revealed: *He has a Brief Interview for Mental Status (BIMS) assessment score of 14 which indicated he was cognitively intact. *His diagnoses included: major depressive disorder, blindness, hypertension, and diabetes. *He had no documentation on the treatment administration record (TAR) for nursing to clip his fingernails weekly. Interview on 2/26/25 at 2:02 p.m. with RN/DON C revealed: *She did not remember resident 2 had asked for his fingernails to be clipped. *Agreed his fingernails were long. *His fingernails were not being clipped weekly. *She was the only nurse who could clip his fingernails. Review of provider's undated Nail Care policy revealed: Nail Care *Fingernail care will be provided at least weekly. *Diabetic nail care can only be provided by a licensed nurse.	S 415		

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S 701	44:70:08:01(1-6) Record Service The resident care records shall include the following: (1) Admission and discharge data including disposition of unused medications; (2) Report of the physician's, physician assistant's, or nurse practitioner's admission physical evaluation for resident; (3) Physician, physician assistant, or nurse practitioner orders; (4) Medication entries; (5) Observations by personnel, resident physician, physician assistant, nurse practitioner, or other persons authorized to care for the resident; and (6) Documentation that assures the individual needs of residents are identified and addressed. 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 five sampled residents (10 and 12) included detailed and appropriate nursing assessments and documentation by nursing staff related to their unique medical conditions. Findings include: 1. Observation and interview on 2/25/25 at 2:45 p.m. with resident 12 in her room revealed: *She was independent with her activities of daily living (ADLs) and answered questions	S 701	S701 A Director of Resident Services (DRS) shall be hired to coordinate care services working directly with the DON and Administrator. The DRS will ensure physician orders are received by the nurses and help track follow-up documentation related to residents' cares and services. DRS, DON and Administrator shall meet no less than 3x weekly to discuss physician orders, progress notes, and care coordination. Care coordination processes between the DRS, DON and Administrator shall be discussed and reviewed during monthly QAPI meetings.	5/23/25

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appropriately.
*Staff assisted her with medications and other things as needed.
*She was concerned about needing to see a specialist in another town related to previous health conditions.
*She was unsure when she would see that doctor but hoped staff were following up on that for her.

Interview on 2/25/25 at 4:00 p.m. with registered nurse/director of nursing (RN/DON) C regarding resident 12 revealed:
*She confirmed the resident would be seeing a specialist in March 2025 and the staff would ensure she had transportation set up for that.
*She indicated the records related to that appointment and other visits and orders should have been in the resident's medical record.

Review of resident 12's electronic medical record (EMR) and paper medical record revealed:
*She was admitted 11/16/23.
*Her diagnoses included: Schizoaffective disorder, anxiety disorder, overactive bladder, major depressive disorder, and a history of breast cancer.
*On 2/10/25 a Visit to the Medical Doctor form indicated she had seen a local practitioner for an annual wellness check.
-The reason for the visit included a note by RN/DON C of "Please check for UTI [urinary tract infection]. C/O [complaint of] LBP [low back pain] [increased] temp [temperature], [increased] needs [with] ADLs back pain."
-The practitioner's comments included to obtain a urinalysis and that she had a planned appointment in another town for 3/29/25.
-That order was noted as reviewed by RN/DON C.
*A 2/11/25 Approved Prescription fax order from

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S 701	Continued From page 18 the pharmacy for the resident to start Bactrim DS one tablet every twelve hours for five days. -There was no indication for use or diagnosis specified and it was not noted as reviewed a nurse. *A 2/13/25 Approved Prescription fax order from the pharmacy for the resident to start Augmentin one tablet every twelve hours for seven days for a UTI. -There was no documentation to support the nurse had reviewed or acknowledged the order. *A 2/13/25 laboratory report indicated her urinalysis was cultured to identify a specific organism and had diagnoses and orders related to a UTI and to start Augmentin one tablet every twelve hours for seven days for a UTI and to discontinue the Bactrim. --There was no documentation to support the nurse had reviewed or acknowledged the orders. Review of resident 12's February 2025 Medication Administration Records (MAR) revealed: *She received an antibiotic, Bactrim DS one tablet every twelve hours for five days, starting 2/11/25 through 2/16/25, for a possible UTI. -The Bactrim had not been discontinued on 2/13/25 according to the above laboratory orders. *She received another antibiotic, Augmentin one tablet every twelve hours for seven days, starting 2/13/25 through 2/20/25, for a UTI. *She received as needed Tylenol twice on 2/7/25 and once on 2/8/25, 2/9/25, 2/12/25, 2/14/25, 2/15/25, 2/17/25, and 2/19/25 which was indicated for pain or elevated temperature. Review of resident 12's progress notes in the EMR from 1/1/25 through 2/25/25 revealed: *A 1/31/25 registered dietitian note for her annual nutrition assessment.	S 701		

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S 701	Continued From page 19 *A 2/7/25 at 6:56 a.m. a Health Status Note by RN/DON C stated the resident had a 99.6 degree temperature with notes of "Monitor Temp Q [every] shift. Immediate report to nurse if S&S [signs and symptoms] of influenza/COVID present. Encourage to stay in room & wear mask when out of room." -There was no indication a nursing assessment of her condition or what other symptoms she may have had relating to the increased temperature. *The next entry was a Behavior Note on 2/13/25 at 5:07 p.m. by RN/DON C that stated "Noted to need increased cueing to participate in ADLs ie [abbreviation for: that is] will ask staff to bring her tray or carry her tray for her or use the walker or walk with her. She is currently being treated for a UTI." *There were no further notes to support nursing assessments or documentation related to: -Her 2/10/25 Visit to the Medical Doctor appointment, symptoms, and orders from that appointment. -Her UTI or what symptoms she had prior to, during, or after treatment of the UTI. -The initial order for an antibiotic on 2/11/25 or the change in antibiotic on 2/13/25. Interview on 2/26/25 at 9:00 a.m. with RN/DON C regarding resident 12 revealed: *She confirmed the resident's record had not contained adequate documentation to support nursing assessments of the resident's health condition related to her UTI symptoms, appointment, laboratory tests and results, orders, and follow up. *She was the only licensed nurse and it was hard to keep up with the documentation due to staffing. *The normal process was for the nurse to document regarding the resident's health condition and note or acknowledge any new or	S 701		

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changes in orders.
*Unlicensed nursing staff also had the ability to put progress notes into resident's records but were not licensed nurses and were not able to perform assessments of residents' conditions.

2. During entrance conference with RN/DON C on 2/25/25 at 10:00 a.m. a list of all current residents with recent changes in their condition or frequent outside appointments was requested. The list received later that day identified resident 10 as having wound care and a practitioner related to changes.

Review of resident 10's EMR and paper record revealed:
*He was admitted on 5/15/23.
*His diagnoses included: Schizoaffective disorder, mild intellectual disabilities, anxiety disorder, Type 2 diabetes mellitus, history of a diabetic foot ulcer, history of a pulmonary embolism (blood clot in the lungs), and hypertension.
*His cognitive screenings in May 2023 and May 2024 indicated he had moderate cognitive impairment.
*His 11/30/24 Annual Assisted Living Evaluation indicated:
-He was alert and oriented to person, time, and place but had short term memory loss.
-He was independent and had a thin appearance.
-He smoked, had a history of respiratory problems and used oxygen.
-He had no skin breakdown or wounds.

Review of resident 10's January and February 2025 MARs revealed:
*He had multiple medication order changes during the month including the following:
-An antibiotic, Azithromycin, every Monday,

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S 701	Continued From page 21 Wednesday, and Friday starting on 1/27/25 with no stop date. -A respiratory nebulizer medication, Xopenex every evening and night shift from 2/2/25 through 2/3/25. --Another Xopenex order for three times daily as needed from 2/2/25 through 2/9/25. -An antianxiety medication, Ativan, every evening and bedtime, from 2/2/25 through 2/8/25 and another order for every eight hours as needed that started on 2/4/25. -An antibiotic, Doxycycline, twice daily from 2/2/25 through 2/12/25. -A liquid cough medication, diabetic tussin, every four hours as needed for five days from 2/2/25 through 2/7/25. -A pain/fever reducing medication, acetaminophen, every four hours from 2/3/25 through 2/5/25 then every six hours as needed starting on 2/9/25. -A steroid, Prednisone, daily from 2/3/25 through 2/7/25. -An anti-inflammatory/pain medication, ibuprofen, four times daily from 2/3/25 through 2/4/25 with a similar order of four times daily as needed from 2/3/25 through 2/6/25. -A congestion medication, Mucinex, twice daily from 2/3/25 through 2/8/25. -An antibiotic, Augmentin, twice daily from 2/3/25 through 2/10/25 and again from 2/13/25 through 2/20/25. -An antiviral medication, Tamiflu, from 2/3/25 through 2/7/25. -An opioid pain medication, Norco, daily as needed for seven days from 2/12/25 through 2/19/25. -An opioid pain medication, Percocet, every bedtime from 2/18/25 through 2/24/25 and then reordered for seven more days. *He was supposed to be having his vital signs	S 701		

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S 701	Continued From page 22 (VS) checked three times daily with no start date identified. -There were multiple areas left blank or that had an "X" in them indicating the vital signs had not been obtained during a shift. Interview and record review on 2/26/25 at 9:00 a.m. with RN/DON C regarding resident 10 revealed: *The resident had been experiencing changes in his condition over the last month or so. *He had told her one day that his left heel was hurting so she checked it out. -She noted a darkened area and described it as a diabetic ulcer to his heel. *She said the resident reported he had told someone else about his heel hurting prior to that day and that person just thought it was a bruise. *She had not been told about a skin concern prior to the resident bringing it to her attention. *As soon as she saw the wound she notified the resident's practitioner and requested an appointment and wound care for it. *Review of the progress notes indicated a 1/30/25 7:35 a.m. entry by RN/DON C stating: -"C/O left leg heel pain. Appointment was made resident seen in clinic on 1/27/25 'Left heel eschar [thick, dry, dead tissue]. Referred for MRI & wound care. Cough x 2 months with course breath sounds on exam...' Return appointment to wound care 1/31/25...Upon writers assessment of wound it is on heel with dark discoloration approx [approximately] 3 cm [centimeters] around and firm to touch around it no bogginess noted. Does have discomfort..." *She indicated that was the start of the wound care and he continued to see outpatient wound care for all his dressings and treatments twice weekly. -A dressing was in place to cover the wound and	S 701		

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S 701	Continued From page 23 the staff at the facility did not do any wound care on it. *Around that same time the resident got acutely ill with a respiratory illness. -She indicated he had a significantly high temperature, cough, congestion, weakness, and was not feeling well. *On 2/2/25 he was sent to the emergency room (ER), and returned to the facility with new orders for an antibiotic, steroid, and cough medicine. *On 2/3/25 she felt the resident was not doing well and she updated his physician again. The resident went back to the ER and later returned to the facility that day with a confirmed Influenza diagnosis. *She confirmed the notes from 1/30/25 through 2/3/25 had minimal details regarding his condition and assessments prior to or between those ER visits. *There were no condition notes from 2/5/25 through 2/8/25. *On 2/9/25 at 1:21 p.m. RN/DON C documented "States he is feeling better today. Spirts [Spirits] good has not been out of room today. VS WNL [within normal limits]. Neb [nebulizer] equipment switched out. Pleasant mood. Cooperative with all cares." -There was no indication a nursing assessment of his condition was done. *On 2/9/25 at 9:55 p.m. a medication aide (MA) documented the resident came downstairs, started gasping for air, stated he could not breathe, and wanted to go to the ER. The MA reported to the nurse and the resident was sent to the ER and returned to the facility about an hour later. *There were no follow-up notes by the licensed nurse until 2/13/25 which said "Was seen by PCP [primary care practitioner] new orders & appointment dates noted."	S 701		

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S 701	Continued From page 24 *The next licensed nursing note was on 2/24/25 regarding an appointment with a specialist and "Wound looks better - less pain - keep covered & dry elevate on pillows." *RN/DON C confirmed the progress notes lacked details and documentation to support nursing assessments related to his health status, changes in condition, and wound care. -She felt she was too busy taking care of the residents and sometimes the documentation had not gotten done. *She agreed the resident's record should have included documented details of his symptoms, his outpatient visits with wound care and other providers, his order changes, and his overall health status. 3. 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 ensure the individual needs of the residents were identified and addressed. Review of the provider's undated DON job description revealed their responsibilities included the following: *Assuring coordination of resident care. *Monitoring resident records and makes adjustments as necessary. Review of the provider's undated RN and LPN job descriptions revealed their responsibilities included the following:	S 701		

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S 701	Continued From page 25 *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 701		
S 838	44:70:09:09(4) Quality Of Life A facility shall provide care and an environment that contributes to the resident's quality of life, including: 4) Freedom from verbal, sexual, physical, and mental abuse and from involuntary seclusion, neglect, or exploitation imposed by anyone, and theft of personal property; This Administrative Rule of South Dakota is not met as evidenced by: Based on a review of the South Dakota Department of Health (SD DOH) complaint intake form, record review, interview, and policy review, the provider failed to ensure: *One of one sampled resident (6) was protected and kept safe from physical abuse by one of one sampled resident (11). *One of one sampled resident (3) was protected and kept safe from sexual abuse by a former staff member. Findings include: 1. Review of 1/27/25 and 1/28/25 SD DOH complaint intake forms revealed:	S 838	S838 Resident 11 is no longer under the facility's care. Staff member referenced is no longer employed by the facility. Admin Team shall review P&P regarding abuse & neglect. Administrator shall educate all staff on abuse/neglect pertaining to residents and to staff. Staff education will include process for filing out Incidents Reports and how to submit reports to the Admin Team.	5/23/25

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S 838	Continued From page 26 *Resident 11 had a traumatic brain injury (TBI) (a brain injury caused by an external force, such as a blow, bump, fall, or penetration) and staff were not trained to care for him. *Registered nurse/chief operating officer (RN/COO)/co-owner A had called the state and stated they terminated a staff member for having inappropriate contact with a resident. *RN/COO/co-owner A, was informed that an incident report and an investigation needed to be completed, and submitted to the SD DOH with the findings Review of resident 11's closed electronic medical record (EMR) revealed: *He was admitted to the facility on 7/19/24. *His Brief Interview for Mental Status (BIMS) assessment was incomplete. *His diagnoses included: personality change due to known physiological condition, depression, nicotine dependence, other symptoms and signs involving cognitive functions and awareness, and mental disorder. *On 1/15/25 he approached resident 6 and asked him for money, resident 6 refused, resident 11 hit resident 6 across the face with a cane, and resident 6 pushed him back to self-protect. *A petition was made to the local police department after that incident. *No further documentation was made in the resident's EMR until two days later. *Resident 11 was discharged on 2/13/25 to a behavioral health center. Interview on 2/26/25 at 2:07 p.m. with RN/director of nursing (DON) C regarding the above incident revealed: *She was aware of the incident. *The RN/COO/co-owner A was responsible for submitting reports to the SD DOH and was aware	S 838		

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S 838	Continued From page 27 of the incident. *RN/DON C had submitted a petition to the local police department on 1/15/25 and again on 2/4/25 when the staff found a knife in resident 11's room. -The petition stated a resident needed more assistance than the facility could provide. *An incident report form was not filled out on 1/15/25. *RN/DON C stated that the RN/COO/co-owner A came in to the facility and discussed with resident 11 that his behaviors were unacceptable. They had petitioned to find him a better suitable place, but she did not document that. *She agreed there was little documentation showing how they kept other residents safe while resident 11 was still residing at the facility. 2. Review of the 1/27/25 SD DOH complaint intake form revealed: *On 12/16/24, RN/COO/co-owner A called to report a former staff member had inappropriate contact with a resident. *She had notified the local police department. *RN/COO/co-owner A, was informed that an incident report and an investigation needed to be completed, and submitted to the SD DOH with the findings Review of resident 3's EMR revealed: *She was admitted to the facility on 6/14/21. *She has a BIMS assessment score of 9, which indicated she was moderately cognitively impaired. *Her diagnoses included: adjustment disorder with disturbance of conduct and long-term drug therapy. Interview on 2/26/25 at 10:12 a.m. with administrator/co-owner M regarding the above inappropriate contact incident revealed:	S 838		

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S 838	Continued From page 28 *He was aware of the incident. *He confirmed it was sexual contact between the resident and a former staff member. *He agreed the incident should have been reported. RN/DON C notified the RN/COO/co-owner A of the survey, but RN/COO/co-owner A declined to participate in the survey. Review of provider's undated Abuse, Fraud, and Wrongdoing policy revealed: *"The community takes all reasonable steps to prevent resident abuse and neglect." *"The Administrator will investigate any reports of abuse, fraud, or other wrongdoing." *Procedure -"All staff will receive training on elder abuse incidence, signs and symptoms, and reporting requirements." "Resident, their responsible parties, personnel, health professionals and all relevant stakeholders are encouraged to report any suspected incidence of abuse, fraud, or other wrongdoing." *"If a report of abuse, fraud, or other wrongdoing is received: -The Administrator is notified immediately. -Any urgent medical or safety issues are addressed immediately. -An Incident Report is filled out. -The Administrator or member of the Administrative Team initiates an investigation. -The resident's responsible party is notified." *"If the suspected abuse, fraud, or other wrongdoing is substantiated a written report is made to the SD Department of Health, the responsible party, the Ombudsman, and Adult Protective Services." *"All appropriate parties are notified of the outcome of the investigation."	S 838		

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S 838	Continued From page 29 *"Appropriate disciplinary actions will be made if community staff participated in substantiated abuse, fraud, or other wrongdoing."	S 838		