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
	10733	A. BUILDING: ______ B. WING ______	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELHAUS YANKTON	300 E 6TH ST YANKTON, SD 57078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 12/3/24 through 12/4/24. Angelhaus Yankton was found not in compliance with the following requirements: S085, S150, S201, S202, S295, and S443.	S 000		
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, interview, and policy review, the provider failed to ensure one of one whirlpool tub (main floor) had been cleaned and disinfected appropriately by one of one observed certified medication aide (CMA) (E). Findings include: 1. Observation and interview on 12/4/24 at 10:40 a.m. in the main floor tub room with CMA E revealed: *She confirmed she had cleaned the tub after residents' baths. *A lot of the residents preferred to take a bath. *She demonstrated how she cleaned the tub. *She: -Picked up a bottle labeled Sani T-10 disinfectant and handed it to the surveyor.	S 085	S 085 Angelhaus modified cleaning procedure policy as state recommended. The policy was revised to state the name of the chemical to be used. A step in the policy was added to ensure the chemical is left on tub surface for 5 minutes before rinsing. Staff meeting was conducted for the purpose of retraining on topic. Staff member CMA E was present at the meeting. PoC Verification Steps: (1) Administrator will establish a daily checklist for tub cleaning and sanitation to be used daily by floor staff. (2) Administrator shall review checklist monthly for nine months. (3) QA Team shall review documentation for no less than nine months or until compliance has been achieved.	12/24/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: CFO/Admin (X6) DATE: 1-15-24

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S 085	Continued From page 1 -Stated she would spray the disinfectant in the tub. *When asked by the surveyor how long she would let the disinfectant stay on the tub walls she responded "As long as it took her to get a washcloth." *She continued to state she would then wipe the tub down. *She did not disinfect the tub jets. *The residents were mostly independent with taking a tub bath. *Some of the residents required a staff member to close the door to the tub. *She had worked at the facility for five months. *Another staff member who was not employed anymore had taught her how to clean the tub. Interview and policy review on 12/4/24 at 11:35 a.m. with chief finance officer (CFO)/administrator A regarding the cleaning and disinfecting of the whirlpool tub revealed she confirmed: *CMA E had not disinfected the tub according to their policy. *The Tub Cleaning policy had not included the name of the cleaner and the jets had not been listed to be cleaned after each use. Review of the provider's undated Tub Cleaning policy revealed: *"Tub Cleaning: -2. Thoroughly wet all surfaces with Disinfecting Bathroom Cleaner using sprayer. -3. Leave chemical on surface for 5 minutes. -4. Wipe surfaces with damp cloth or sponge. -5. Wipe down door seal/jamb after each use to maintain the integrity of the water seal." *"Flushing Procedure: Twice per month: -1. Fill tub with hot water. -2. Add 2 tablespoons of low-foaming dishwasher detergent.	S 085		

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S 085	Continued From page 2 -3. run the whirlpool/air for a minimum of 15 minutes. -4. Drain bath. -5. Refill with cold water and operate the whirlpool for 15 minutes. -6. Drain bath." *The policy had not included: -How to disinfect the whirlpool tub between each resident use. -To use a disinfectant between each resident use.	S 085		
S 150	44:70:02:13 Lighting Any space occupied by people, machinery, and equipment within buildings and their approaches and parking lots shall have artificial lighting at a level for general safety. Each resident bedroom shall have general lighting and night lighting. A reading light shall be provided for each resident who can benefit from one. Each required exit shall be equipped with continuous emergency lighting. Emergency power shall be provided if the main source of power fails. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, interview, and record review the provider failed to maintain operational battery pack emergency lighting for two randomly observed locations (north stair tower and south stair tower). Findings include: 1. Observation on 12/4/24 at 11:41 a.m. revealed the battery pack emergency light for the center landing of the stairway was hanging from its cord. That battery pack emergency light could not be tested as it would have fallen. Interview with director of resident finances B and	S 150	S 150 Emergency lights have been repaired or replaced with new models if necessary. PoC Verification Steps: (1) Maintenance Manager shall monitor batteries monthly. Monthly emergency light checks will be added to maintenance checklist. (2) Administrator shall review documentation monthly for four months. (3) QA Team shall review documentation for no less than four months or until compliance has been achieved.	12/24/24

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S 150	Continued From page 3 maintenance director D at the time of the observation confirmed that finding. When asked about the required monthly and annual testing for that life safety-equipment director of resident finances B stated he was aware of the requirements for testing but had recently taken over that position. Further interview with maintenance director D at that same time revealed he was unaware that light was in that location. Record review that same day confirmed no records of testing battery pack emergency lights could be produced. The deficiency had the potential to affect any occupant in the north corridor. 2. Observation on 12/4/24 at 12:18 p.m. revealed the battery pack emergency light for the south stair tower at the ground floor was not functioning when tested using the built-in testing button. Interview with Maintenance Director D at the time of the observation confirmed that finding. He stated he was not aware that light was not properly operating. Record review that same day confirmed no records of testing battery pack emergency lights could be produced. The deficiency had the potential to affect any occupant in the south corridor.	S 150		
S 201	44:70:03:02 General Fire Safety Each facility must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for	S 201		

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S 201	Continued From page 4 escape from the structure in case of fire or other emergency. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, the facility must conduct monthly drills to provide training for all personnel. This Administrative Rule of South Dakota is not met as evidenced by: Based on document review and interview, the provider failed to conduct monthly fire drills for three months in 2024 (January, February, and March). Findings include: 1. Document review on 12/4/24 at 2:27 p.m. revealed fire drill log sheets were not available for January, February, and March of 2024. Interview on 12/4/24 at 2:48 p.m. with chief financial officer (CFO) A and administrator B confirmed that finding. CFO A stated she was aware they were missing a few fire drills.	S 201	S 201 Angelhaus shall complete monthly fire drills in accordance with Life Safety Code. Fire drill reminders have been added to the monthly Admin and Maintenance calendars. PoC Verification Steps: (1) Fire alarms shall be conducted by the Administrator and/or Head of Maintenance. (2) Monthly alarms shall be documented by the Administrator and/or Head of Maintenance. (3) QA Team shall review documentation at monthly meetings for no less than four months or until compliance has been achieved.	12/24/24
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 observation, interview, resident identification roster review, license review, and policy review, the provider failed to maintain staffing on each resident floor of the building at all times. Findings include:	S 202	S 202 Schedule was modified designating each staff member to a specific floor. Staff was educated and floor assignments are now indicated on the schedule. PoC Verification Steps: (1) Floor assignment schedule will be monitored weekly by the Nurse for nine months. (2) Schedule will be assessed monthly by administrator for nine months. (3) QA Team shall review documentation at monthly meetings for no less than four months or until compliance has been achieved.	12/24/24

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S 202	Continued From page 5	S 202		

1. Review of the provider's 7/1/24 Assisted Living Center license revealed they had been approved for additional services for physically impaired residents.

Review of the resident roster provided by the facility revealed 22 residents resided on the main floor and 9 residents resided on the second floor.

Interview on 12/3/24 at 9:30 a.m. with director of resident finance B regarding staffing revealed:
*There were always two certified medication aides scheduled at all times.
*He confirmed there would be times when a staff member would not be present on the second floor when residents were present.
*The staff would go between the two floors to check on the residents.
*They had a call system the residents could use if they needed assistance.
*There was always a nurse on call twenty-four hours/day.

Observation on 12/3/24 at 10:15 a.m. on the second floor revealed there were six residents and no staff member present.

Interview on 12/3/24 at 10:25 a.m. with resident 1 in the day room revealed:
*There were "plenty of times" no staff were on the second floor.
*There was not a staff member on the floor at that time.

Interview on 12/4/24 at 10:00 a.m. with chief finance officer (CFO)/administrator A regarding staffing on the main floor and on the second floor revealed she thought they had to have two staff in the building at all times, not a staff member on each floor where residents resided at all times.

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S 202	Continued From page 6 Review of the provider's undated Schedule and Assignments policy revealed: *"The building must be occupied by no less than two staff members at all times. -It is optimal to have at least two aides on the floor at all times."	S 202		
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 employee file review and interview, the provider failed to ensure ongoing annual education was provided on required subjects for one of five sampled employee (F) who had completed none of the eleven personnel training topics. Findings include: 1. Review of employee F's personnel file revealed: *A hire date of 7/14/23. *She had been hired as director of resident care. *There was no documentation that she received annual training on: -Fire prevention and response. -Emergency procedures and preparedness. -Infection control and prevention. -Accident prevention and safety procedures. -Resident rights. -Confidentiality. -Incidents and diseases subject to mandatory	S 295	S 295 Administrator will ensure each employee is achieving the proper level of employee training. Checklists shall be created to ensure proper documentation for each staff member. Employee F has completed all required training and will attend all required staff meetings. PoC Verification Steps: (1) Administrator will check documentation monthly to ensure proper training is being completed for nine months. (2) Nurse will review documentation quarterly for 12 months. (3) QA Team shall review documentation at monthly meetings for no less than four months or until compliance has been achieved.	12/24/24

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S 295	Continued From page 7 reporting and the facility's reporting mechanism. -Nutrition risks and hydration. -Abuse, neglect, and misappropriation of resident property and funds. -Problem solving and communication techniques related to residents with cognitive impairment or challenging behaviors. -Education based on resident needs (oxygen, CPR). *The education for the above topics had last been completed by employee F upon hire. Interview on 12/4/24 at 9:45 a.m. with director of resident finance B and on 12/4/24 at 10:16 a.m. with chief finance officer (CFO) A regarding employee F revealed education had not been completed annually. Review of the provider's undated Personnel Training policy revealed: *They would have a formal orientation program and an on-going education program for all personnel. *The training would be "within 30 days of new employment and annually thereafter."	S 295		
S 443	44:70:05:07 Care Of A Resident With Cognitive Impairment Each facility shall use a validated screening tool for evaluation of a resident's cognitive status upon admission, yearly, and after a significant change in condition. This Administrative Rule of South Dakota is not met as evidenced by: Based on care record review, interview, and policy review, the provider failed to ensure three of three sampled residents (3, 4, and 5) had an	S 443	S 443 Angelhaus nursing staff will be implementing a checklist to ensure annual, quarterly, and monthly assessments will be completed. Resident 3, 4 and 5 have completed the Mini mental screening as required. Nursing staff were educated on the screening regulations and a checklist has been put in place. PoC Verification Steps: (1) Nurse will establish checklist and assess documentation monthly. (2) Administrator shall review documentation quarterly for nine months. (3) QA Team shall review documentation at monthly meetings for no less than four months or until compliance has been achieved.	12/24/24

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S 443	Continued From page 8 annual cognitive screening completed. Findings include: 1. Review of resident 3's care record revealed: *She was admitted on 8/27/13. *Her last cognitive screening had been completed on 3/27/23. *There was no documentation to support annual cognitive screenings were completed. 2. Review of resident 4's care record revealed: *She was admitted on 1/10/19. *Her last cognitive screening had been completed on 3/27/23. *There was no documentation to support annual cognitive screenings were completed. 3. Review of resident 5's care record revealed: *She was admitted on 5/6/20. *Her last cognitive screening had been completed on 3/25/23. *There was no documentation to support annual cognitive screenings were completed. 4. Interview on 12/4/24 at 9:23 a.m. with licensed practical nurse C regarding cognitive screening expectations revealed the residents' annual cognitive screenings should have been completed. 5. Review of the provider's undated Resident Care Plan policy revealed: *They would "provide safe and effective care from the day of admission through the ongoing development and implementation of written care plans for each resident." *"2. The Resident's condition and required care will be updated 30 days after admission and then on an annual basis, or sooner as condition indicates"	S 443		

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S 443	Continued From page 9 *"3. The Care Plan will address the resident's medical, physical, mental and emotional needs as well as the assessment and management of symptoms, including pain."	S 443		