South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71778	A. BUILDING: _____ B. WING _____	C 03/27/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 3/27/24. The area surveyed was resident neglect. Angelhaus Huron was found not in compliance with the following requirements: S296 and S415.	S 000		
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 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	S 296	Management team has reviewed the new hire checklist to ensure all manadatory training shall be completed no later than 30 days after the date of hire of new employees, as well as for ongoing inservice training. Mandatory CPR training courses have been scheduled for all staff on June 1st and June 9th. Management Team shall educate all staff on how to check for a resident's code status and next steps. Compliance Coordinator shall track and document all above training for three months. QA Team shall review documentation in monthly meeting for six months or until compliance is deemed achieved. Addendum to PoC: The Management Team consists of Owner/Administrator, Owner/RN, DON, Compliance Coordinator, and Administrator in Training. CPR training had to be scheduled after 5/11/24 due to instructor scheduling. A memo was distributed to staff on how to check for a resident's code status and next steps. Compliance Coordinator shall track training documentation no less than bi-weekly for no less than three months or until compliance is achieved per the QA Team's monthly meetings.	5/11/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Owner/Administrator | (X6) DATE: 5/21/24

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S 296	Continued From page 1 the training required by subdivision (8). This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, facility incident report review, interview, and policy review, the provider failed to ensure the cardiopulmonary resuscitation (CPR) training was completed based on the individual care needs of the residents accepted and retained by the provider for one of two sampled employees (unlicensed medication aide (UMA) K and resident assistant (RA) R). Findings include: 1. Review of the 3/27/24 resident list that included their advance directive status revealed: *There were twenty-nine residents. *Three of the residents had do-not-resuscitate orders. *The remaining twenty-six residents had a full code status (CPR would be initiated if their heart stopped). Review of the 3/27/24 staff list provided by registered nurse (RN)/owner B and indicating those that had completed CPR training revealed: *UMA K's hire date was 6/3/22. -She had completed CPR training. -The date of completion was not provided. *RA R's hire date was 9/19/23. -He had not completed CPR training. Review of the facility's incident report completed on 3/3/24 at 4:00 a.m. by UMA K revealed: *Resident 19 fell in the hallway outside of room	S 296		

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S 296	Continued From page 2 309 at approximately 6:20 p.m. on 3/2/24. *RA R was assigned to the third floor and communicated with CMA C on the second floor the resident had collapsed. *UMA K found the resident on her stomach with her oxygen tubing off. *Resident 19 was minimally responsive, and staff had difficulty obtaining vital signs. *UMA K called emergency services and RA R went down to the entrance to meet the emergency personnel. *The emergency personnel arrived on the scene, rolled the resident over, and initiated CPR. *The resident was sent to the local hospital by ambulance before being transferred to a larger hospital for additional services. Interview on 3/27/24 at 1:55 p.m. with RN/owner B and compliance coordinator P revealed: *RA R and UMA K had been working the evening that resident 19 collapsed. *Resident 19 passed away several days after at the hospital. *RN/owner B acknowledged that all but three of their current residents wished to have CPR initiated. -They acknowledged that there were many staff that had not completed the CPR training. -It was the expectation that staff would have been first aid and CPR trained. -They confirmed RA R had not completed CPR training. *RN/owner B acknowledged that the residents had unique needs that required the staff to be trained and able to assist in providing CPR. Review of the undated Medical Emergencies policy revealed no information related to the initiation of CPR if a resident was a full code.	S 296		

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S 296	Continued From page 3 Review of the undated Emergency Room process sheet located at the second and third floor nurses' stations revealed " Step 5: If unresponsive, begin CPR (only if code status magnet is green)."	S 296		
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 record review, interview, and job description review, the provider failed to ensure a change in condition for one of one closed record residents (19) was documented by registered nurse (RN) H. Findings include: 1. Review of resident 19's closed care record revealed: *She was admitted on 6/28/22. *Her diagnoses included schizophrenia, anxiety, seizure disorder, congestive heart failure, chronic obstructive lung disease, traumatic brain injury, and history of noncompliance with medication regimen. *On 3/2/24, she collapsed in the hallway on the third floor. -Staff called 911.	S 415	Administrator C shall train all nurses on implemented flow chart, and how to properly document on resident conditions on both the flow chart and in Point Click Care. Management Team shall audit flow charts no less than three times per week for six weeks or until compliance is achieved as deemed by the QA Team. QA Team will review flow chart and PCC documentation to ensure compliance at monthly meetings. Addendum to PoC: Administrator educated DON, Administrator in Training, and Compliance Coordinator on 5/8/24 as an inservice on using the flow tracker and PCC. Management Team shall continue to audit flow charts no less than three times per week for a minimum of six additonal weeks and until QA Teams feels compliance is achieved at its monthly meeting. There are currently seven flow charts active.	5/11/24

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S 415	Continued From page 4 -Cardiopulmonary resuscitation (CPR) was initiated by emergency medical services (EMS) personnel. -The resident was transferred to the hospital and passed away. Review of the 3/10/24 submitted online facility reported incident regarding resident 19 revealed: *She had been seen by a medical provider on the following dates: -During a hospital stay from 2/20/24 through 2/21/24. -Clinic visits on 2/24/24, 2/28/24, and 2/29/24. *She had a history of noncompliance with her plan of care. Review of resident 19's care record from 2/1/24 through 3/2/24 revealed the following documentation by a licensed nurse: *A progress note on 2/16/24 indicating her oxygen saturation was periodically in the 70's. Education was provided to her to use her oxygen and nebulizer treatments; however, the resident continued to be noncompliant and took off her oxygen and went outside to smoke. *There was no further documentation regarding her health condition that led to the emergency room and clinic visits in February 2024. Interview on 3/27/24 at 4:00 p.m. with RN H regarding documentation for resident 19 revealed: *She acknowledged that she had completed minimal documentation in the care record related to the resident's condition. *She stated she had technical issues with inputting documentation in the computer on 3/2/24, 3/3/24, and 3/4/24. *She stated she was behind on documentation and it had been completed on paper.	S 415		

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S 415	Continued From page 5 *She was unable to provide the paper documentation. Interview on 3/27/24 at 4:30 p.m. with RN/owner B revealed: *RN H was the main nurse working at the facility on a full-time basis. *She was aware that RN H was behind in her nursing documentation. *It was her expectation that if the documentation was not in the computer, then it should have been completed on paper. Review of the undated job description for the director of nursing revealed: *" The Director of Nursing is responsible for the efficient functioning and coordination of center operations to assure that residents receive the best quality care." *"Assures coordination of resident care within the facility." A policy for documentation was requested on 3/27/24 at 4:30 p.m. from owner/RN B but was not received by the conclusion of the survey. An email was received from owner/RN B on 3/27/24 at 7:56 p.m. with nursing documentation for resident 19 dated from 2/19/24 through 2/29/24. No information was provided regarding the reason this information was not provided at the time of the survey.	S 415		

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{S 000}	Compliance Statement An onsite revisit survey was conducted on 6/12/24 for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for all previous deficiencies cited on 3/27/24. Angelhaus Huron was found not in compliance with the following requirements: S296 and S415.	{S 000}	(S296) As of 7/3/24, it will be the standard of this agency to conduct the following training programs for all new employees, within the defined "30 day on-boarding period" which starts with orientation, training programs will be conducted by department managers and completion will be recorded on the designated "Employee Training & Verification Log" in employee file subsection "Training & Development", QAMT meetings conducted quarterly for verification: 1. Fire Prevention & Response: appropriate responses in the event of a fire & emergency. 2. Emergency Preparedness: Education on response to simulated emergency situations, resident emergencies, advanced directives, DNR/ FULL CODE status identification SOP 3. Infection Control & Prevention: Training on best practices for infection control to maintain a safe and hygienic environment 4. Accident Prevention and Safety Procedures: Instruction on accident prevention strategies and safety procedures to safeguard residents and staff. 5. Resident Rights: Education on the rights and privileges entitled to residents within the facility. 6. Confidentiality of Resident Information: Training on maintaining the privacy and confidentiality of resident information. 7. Incident and Disease Reporting: Understanding mandatory reporting requirements for incidents and diseases. 8. Nutritional Risks and Hydration Needs: Knowledge of assessing and addressing nutritional risks and hydration needs of residents. 9. Abuse, Neglect, and Exploitation: Training on identifying and addressing issues related to abuse, neglect, and exploitation. 1 10. Problem-Solving and Communication Techniques: Techniques for effective problem-solving and communication, especially with residents exhibiting cognitive impairment or challenging behaviors. 11. Data-driven Healthcare Personnel Continuing Education r/t identified unmet needs & role development. The Operations Manager tracks record keeping compliance monthly & reviews at designated QAMT meetings. Topics may be provided by DOH, SDBON, LTSS, DSS, JCC, CMS or other institutes that regulate best practice. 7/25/24 all current personnel training logs up to date from 1/1/24. "EmployeeTraining & Verification Log" By prioritizing ongoing training & education for healthcare personnel, Angelhaus Huron aims to enhance the quality of care provided to residents, promote a safe & supportive culture to uphold regulatory compliance standards within the facility, including record keeping.	7/3/24 7/25/24,
{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 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	{S 296}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Owner/ APRN — (X6) DATE: 8/1/24

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{S 296}	Continued From page 1 the training required by subdivision (8). This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and plan of correction (POC) review from the 3/27/24 survey with a completion date of 5/11/24, the provider failed to provide evidence that the POC was followed for the previously cited S296 for having failed to ensure the tracking of the education related to resident code status and cardiopulmonary resuscitation was completed. 1. Review of the provider's 5/11/24 POC revealed: "Compliance coordinator shall track training documentation no less than bi-weekly for no less than three months or until compliance is achieved per the QA [quality assurance] team's monthly meetings." Interview with administrator in training S on 6/12/24 at 9:30 a.m. revealed: *Compliance coordinator P's last day of employment at the facility was 6/4/24. *Compliance coordinator P had left a three-ring binder with survey and revisit information. -She was unable to locate evidence in the binder that there had been tracking of the training completed related to the education regarding code status and completion of cardiopulmonary resuscitation (CPR) training. *She identified herself as the individual responsible to complete the duties that had previously been assigned to Compliance Coordinator P.	{S 296}	(S 296) .Employee Training records (including continuing education topics, attendance rosters, completion logs, agency tools, training materials, presentation techniques, duration, methodology, dates and times) shall be retained and maintained by Angelhaus Operations Management or a designated Administrative Personnel. These records will be archived in the "Training & development" section of the Employee Personnel Files. All completed training will be tracked on the "Employee Training & Verification Log" attached to each Employee Personnel file for quick reference. Compliance met as of 7/25/24.of Bi-weekly auditing by Executive Director & designated QAMT manager. As of 7/25/24 Auditing of training records shall be conducted at a minimum of monthly each year, by Operations Manager with review at each QAMT meetings. A formal Document Management System (DMS) will be implemented by 7/25/24 for organizational framework that meets the following criteria: 1. Supports administrative needs for compliance and record keeping 2. Includes systematic categories and classifications organization 3. Promotes efficiency for use in admin record-keeping, training, SOP's, P&P's, resident care, auditing, compliance 4. Designates appropriate personnel to manage data 5. Identifies contingency plan protocol 6. Adheres to all applicable regulations including HIPAA and PHI standards 7. Accessible to all authorized, on-site personnel	7/25/24

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{S 296}	Continued From page 2 *She stated she was not aware the tracking of the education and CPR training needed to be completed.	{S 296}	(S 415) Effective 1/1/24 The Quality Assurance Management Team (QAMT) will ensure resident care needs are being appropriately identified & addressed by the care team using a blended system of metrics. This blended metrics approach will start by incorporating quality staff education, with a focus on UMA TRAINING and Continuing professional development,all AH staff will receive minimum of 6 hours of relevant continuing education annually. UMA Training will include at minimum the following: - formal UMA evaluation with metric scoring to be conducted quarterly by RN in a 1 on 1 clinical preceptor session. Nurse and UMA staff will conduct and record quarterly meetings to review policies, evaluate current procedures, and implement relevant, evidence-based practices for improved quality of care. A formal agenda will be determined and include: - Review of 6 rights of UMA -Continuing Education r/t resident safety and medication admin including UMA & Nurses r/t 44:70:0411 - Review of current practices, policies, regulation, and SOP's for UMA written summary of SOP for medication pass r/t safety -SDBON 20:48:04.01:02 r/t Nurse delegation UMA scope of practice -Evidence based, best practices r/t behavioral health care assisted living setting -Case study review of VA's Gentle Awakening approach for medication dispensing in r/t Person Centered Care model and improved behavioral outcomes. -Patient Rts reviewed including rt to privacy and refusal with proper doc -Nurse notification/delegation for UMA safe practice per SDBON -Required PCC doc for adjusted plan of care including altered med Admin times, with nurse delegation -Review of provided tools and resources to assist with resident compliance and UMA tasks: walkie-talkies, Davis Drug Guide app available for reference on all devices used EMAR & paper copy book at Med cart resource, UMA/Nurse Communication Channel use in	
{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 interview and plan of correction (POC) review from the 3/27/24 survey with a completion date of 5/11/24, the provider failed to provide evidence that the POC was followed for the previously cited S415 for having failed to ensure the auditing of flow charts was completed by the management team. 1. Review of the provider's 5/11/24 POC revealed "Administrator educated DON, Administrator in Training, and Compliance Coordinator on 5/8/24 as an inservice on using the flow tracker and PCC [Point Click Care]. Management team shall continue to audit flow charts no less than three times per week for a minimum of six additional weeks and until QA [quality assurance] team feels compliance is achieved at its monthly meeting..." Interview with administrator in training S on	{S 415}		7/23/24

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{S 415}	Continued From page 3 6/12/24 at 9:30 a.m. revealed: *Compliance coordinator P's last day of employment at the facility was 6/4/24. -The audits were not located in the three-ring binder she had left with the survey and revisit information. *Administrator in training S had provided additional education to RN H regarding the flow chart expectations. -She had consulted with administrator/owner C prior to completing the re-education. -She was unsure of the date the education was provided but estimated it to be in mid-May. *Acknowledged that an auditing tool had not been created to monitor the completion of the flow chart documentation as described in the POC.	{S 415}	scheduling app with 24 hour access to nurse/UMA network for direct messaging of non-emergent Communication, On call resource use, P&P book for reference, SOP for resident medication dispensing The blended metrics for ensuring quality resident care will also include, BUT NOT LIMITED TO, the following areas of focus: Standardizing documentation requirements with EBP, conducting random charting audits (EMR/paper), Resident surveys, unannounced supervisory visit with scorecard,care plan development by team, conduct group training sessions, person-centered care model practices. QAMT will measure outcomes by: 1. Point Click Care (PCC) Flowchart Auditing Reports: Effective 7/8/24 The Administrator is responsible for monitoring compliance of resident charting and care documentation, using the PCC reporting system for virtual access. The administrator will document and present report findings as reference material during designated QAMT meetings. The on-site QAMT will perform monthly audits of paper and electronic resident charting to using the PCC reporting system to provide results during designated QAMT meetings. 2. Paper Charting Review: Regular review of paper charts will be undertaken, with any necessary updates promptly documented in residents' charts within 30 days of intervention/service rendered. 3. Compilation and Monthly Entry: All paper documentation, notes, and records will be compiled monthly and entered into residents' charts with precision and organization to maintain a comprehensive record of care activities. 4. Incorporation of Activity Logs/ RA Tasks: Activity logs will be diligently maintained and integrated into residents' charts to provide a complete overview of daily activities and care provision. 5. Quality Assurance Meetings and Evaluations: The QAMT will convene quarterly Quality Assurance meetings to assess performance, discuss findings, and plan improvements. Evaluations will be conducted using designated auditing tools and forms to ensure comprehensive oversight of care practices. 6. Utilization of Established Documentation Processes:"By implementing these methodologies and processes, the QAMT aims to uphold high standards of care, ensure compliance with regulations, and continuously improve the quality of services" provided to residents. Regular monitoring, auditing, and collaboration within the team will facilitate effective oversight and maintenance of excellence in resident care.	

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{S 000}	Compliance Statement A second onsite revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 8/13/24 for deficiencies cited on 6/12/24. All deficiencies have been corrected, and no new noncompliance was found. Angelhaus Huron is in compliance with all regulation surveyed.	{S 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE