STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Huron	1345 Michigan Avenue SW Huron, SD 57350

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the South Dakota Department of Health (SD DOH) complaint report, interview, document review, record review, and policy review, the provider failed to protect the resident's right to be free from sexual abuse by one of one certified nursing assistant (CNA) (D) for one of two sampled resident (57) who reported she was touched in a private area without her consent. And by one of one unidentified staff member for one of two sampled resident (78) who reported she was touched in a private area without her consent. Immediate Jeopardy (IJ) at F600, severity J., began on 3/11/26 at 11:40 a.m. when resident 57 revealed in an interview that she had a concern about being touched by a staff member on 1/23/26 during the night rounds. Resident 57 reported that certified nursing assistant (CNA) D had pulled back the blankets and checked her incontinence (involuntary urine or bowel leakage) brief by touching her. She was unsure whether it was on the inside or outside of her brief, which startled her. Resident 57 reported this concern to registered nurse (RN) H on 1/23/26. The facility failed to recognize the resident's concern as a potential abuse situation and failed to implement immediate measures to protect all residents within the facility following resident 57's allegation of abuse. The facility failed to report and thoroughly investigate the allegation of abuse to other entities, provide education to all staff, interview any further residents and staff regarding the allegation, and provide safety to resident 57 and all the residents to prevent similar situations from occurring. Review of a SD DOH complaint report revealed that resident 78 had reported an allegation of inappropriate touching to her perineal area by an unidentified female staff member that occurred between 11/6/25 and 12/8/25 during the night shift. Resident 78 no longer resided at the facility. While she resided there the resident reported her allegation to certified occupational therapy assistant (COTA) E. Interview on 3/11/26 at 1:20 p.m. with COTA E confirmed the resident had reported the allegation to her and COTA E transported resident 78 to report it to social service designee (SSD) F. Interview on 3/11/26 at 1:45 p.m. with SSD F revealed she denied knowledge of the resident's allegation of being touched inappropriately by a staff member. Further interviews on 3/11/26 at 3:10 p.m. with administrator A and director of nursing (DON) B confirmed there was no documentation to support any other allegations had been reported or investigated as a potential abuse situation. Administrator A was notified of the IJ on 3/11/26 at 6:52 p.m. and a removal plan as requested. The removal plan was received on 3/12/26 at 12:58 a.m. by email. The edited removal plan was received on 3/12/26 at 7:31 a.m., and it was accepted on 3/12/26 at 8:35 a.m. The IJ was removed on 3/12/26 at 9:35 a.m. as confirmed by onsite verification by the survey team. After the IJ removal, the severity of the non-compliance remained at a G. The current census was 71. Findings include:1. Review of the complaint report submitted to the SD DOH on 2/6/26 revealed that either a student or an aide had stuck their hands down her [resident 78's] pants to check if she was dry, without her permission. She stated her mind is good, and she had told the person that she didn't need to go to the toilet, and that she was dry. The aide or student proceeded to ?check' her without asking. She felt very embarrassed by this. She stated she spoke with facility management the next day, and they verified the person should not have done that. There was no further follow-up with the resident. She could not (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	recall the name of the person who had done it, and the incident bothered her. 2. Interview on 3/10/26 at 12:21 p.m. with DON B revealed that an internal investigation was completed after resident 57 complained to RN H that a staff member checked her incontinence brief to see if it was wet, which startled her since she was independent with using the bathroom. RN H reported that to DON B. DON B explained that CNA D did not mean it in a sexually inappropriate way so she did not report the incident to the SD DOH. The incident happened on 1/23/26 during the night shift rounds. She stated CNA D currently worked at the facility and she disciplined and educated CNA D after the incident. She stated that resident 57's pocket care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) was updated, and the staff who cared for her reviewed that. She thought the CNAs that read that were educated on the changes to her care plan. She did not have a signature sheet to verify that staff education regarding resident 57's abuse allegation was completed. She acknowledged that touching a resident's incontinence brief was not an acceptable way to see if they were incontinent. She said the investigation report she completed indicated that resident 57's brief was not checked by touching her. If CNA D had touched the brief to see if it was wet, DON B would have reported it to the SD DOH, and CNA D would have been suspended until the investigation was completed, and possibly had his employment at the facility terminated. No audits were completed after the incident occurred to ensure it would not occur again. DON B told resident 57's daughter about the incident and asked her daughter to notify them if resident 57 brought it up. The investigation documentation stated SSD F had followed up with resident 57 a few days after the incident. 3. Review of the provider's internal investigation form revealed that resident 57's abuse allegation was reported on 1/23/26 to RN H by resident 57 and stated the night aide came in her room and pulled back her blanket and checked her brief which had startled her. [RN H] reported that [resident 57] did not feel that this was completed inappropriately towards her, but more of a lack of education. RN H reported this to DON B, and DON B had SSD F conduct a social service visit to discuss the incident with [resident 57]. Review of SSD F interview documents that were attached to the internal investigation form revealed it stated, I spoke with [resident 57] about what happened and checked on how she was feeling about the situation. [Resident 57] reported that staff entered her room during the overnight rounds while she was sleeping and she was not expecting someone to come in at that time. The CNA pulled down her blanket to check her brief which startled her. [Resident 57] and I talked about how the CNA was completing routine rounds and may not have known her usual nighttime routine. [Resident 57] stated she understood and said she does not believe the CNA meant anything inappropriate towards her. She also stated she is not upset with the CNA and felt he likely did not know her routine. I stayed with [resident 57] for a while and we continued to talk about the situation. During the visit she appeared calm and comfortable with discussing what happened. She did not express ongoing concerns. I asked if she would like me to notify family and she declined. Social Services will continue to monitor and remain available if she has any concerns. [Resident 57] reports that she feels safe at the facility. On 1/26/26 SSD F interviewed resident 57 regarding the incident, and it stated [Resident 57] reported that she has had no further issues. She remains to feel safe at the facility. On 1/27/26 SSD F interviewed resident 57 regarding the incident, and it indicated that resident 57 had no further issues, felt safe, and she would notify SSD if she had further issues. The outcome of the investigation summary section described the incident that had occurred. It stated that administrator A and DON B called resident 57's daughter to notify her of the incident, and her daughter said she would call them if resident 57 said anything about it. It stated that DON B interviewed CNA D on 1/23/26, and he reported that he said the resident's name before pulling the resident's blankets back. He thought she knew what he was doing, and he apologized that he startled her. DON B gave him a written warning. DON B told resident 57 that her care plan was changed, and the investigation summary indicated that resident 57 was happy with that. It stated, In review of South Dakota's reporting guidelines this did not rise to the level of abuse/neglect due to [resident 57's] denial of inappropriate action towards her and [CNA D's] lack of touching her and therefore was not reported (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to the Department of Health. 4. Interview on 3/11/26 at 11:15 a.m. with SSD F revealed that CNA D touched the resident's incontinence brief to see if she was wet. SSD was unsure if resident 57's incontinence brief or private area was touched when CNA D checked her for incontinence. She verified that it was not an appropriate way to see if a resident was incontinent. 5. Interview on 3/11/26 at 11:40 a.m. with resident 57 revealed that the CNA touched her on the inside of her incontinence brief. She became tearful, and by the end of the interview she was not sure if she was touched on the inside or the outside of her incontinence brief, and she just wanted to forget about it. 6. Interview on 3/11/26 at 9:08 a.m. with RN H revealed that during a night shift, a CNA was confused about which residents needed to be checked for incontinence, and that the residents down the D wing were startled by this. The CNA still worked here, and she was not aware whether he continued to do that, and no residents had complained about that. 7. Interview on 3/11/26 at 12:50 p.m. with independent living specialist QQ regarding resident 78's complaint about a female staff member who put her hands down resident 78's pants to feel if she was wet, revealed resident 78 was no longer at the facility. Resident 78 was just there for rehab and at the time of the incident, she was independent with toileting. The incident made resident 78 feel uncomfortable and she reported to independent living specialist QQ that she had nightmares about it and recalled resident 78 saying got an eerie gross feeling about it. Independent living specialist QQ continued to stay in contact with her. She was not sure who resident 78 reported the incident to at the facility, but said resident 78 made a formal complaint, and she did not hear back from anyone about it. Independent living specialist QQ was unsure when the incident occurred. 8. Phone interview on 3/11/26 at 12:58 p.m. with resident 78 revealed she was unsure when the incident occurred, but she was able to recall that it happened during a night shift. The female staff member asked her if she needed to use the bathroom, and when resident 78 said no, the female staff member put her hand down resident 78's pants and said, Nope, you're dry. Resident 78 reported that she had resided in the D wing, she wore her own underwear, and that a female staff member put her hand on the inside of her underwear when she checked her. She said she did not do anything about it that night, but the next day, she told COTA E about it. Resident 78 reported that COTA E brought her to SSD F's office for her to report the incident to SSD F. She said she reported the incident to the two women in that office, and said they had looked surprised. When she was telling them what happened, she thought it appeared that SSD F was looking at the staffing schedule to see who was working that night. Resident 78 was told that they had students from a vocational school there at the facility. Resident 78 stated that she had made a formal complaint with SSD F and the other lady that was in the office, and when she read her discharge paperwork from the facility, she did not see anything about the incident, so she made a complaint report with the SD DOH so it would not happen to other residents. She said no one from the facility followed up with her after she made the formal complaint. 9. Interview on 3/11/26 at 1:20 p.m. with COTA E revealed that resident 78 told her about the incident that occurred during the night shift, where a staff member put their hands in resident 78's pants to see if she was incontinent. COTA E reported that resident 78 was upset and that she was sleeping when that staff member came into her room. She said she took resident 78 directly to the social services office, and SSD F was there, but she was unsure if anyone else was in there. COTA E stated that was not the first time residents had reported this concern to her. She was not sure how many residents had, but thought five or less, in the last six months. Residents reported to her that the staff ripped off their blankets and would feel around to see if they were incontinent. It happened to the residents who were both continent and incontinent. She listed two other residents who were still in the facility, who she recalled having that happen to. 10. Interview on 3/11/26 at 1:45 p.m. with SSD F revealed that she did not recall COTA E bringing resident 78 to her office or that resident 78 made a formal complaint to her. She reported that the therapy department brought the residents to her office frequently about this or that. She stated that their process for filing resident grievances was to listen to them, document the grievance, investigate them, and report them to the SD DOH if needed. SSD F said that she did not recall any (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	other residents, besides resident 57, reporting that staff put their hands in their pants to check if they were incontinent and stated, it's a pretty serious thing. She said that and incident like that would be reported to administrator A and DON B for them to investigate it. Regarding resident 57, she stated she wrote her follow-up notes in a notebook, which she no longer had, and did not document about it in the electronic medical record (EMR). She said she did not talk to other staff or residents to see if a similar incident occurred with them. She said she visited with resident 57, but no other counseling was offered to her. When she talked to resident 57 about the incident, she told SSD F that she was embarrassed about it. 11. Interview on 3/11/26 at 2:27 p.m. with SSD G revealed that she did not recall any complaints regarding staff putting their hands down residents' pants to check to see if they were incontinent, and she did not recall COTA E bringing resident 78 to her office. If she were to receive a resident grievance, she was to document it on a form and turn it in to administrator A. 12. Interview on 3/11/26 at 3:10 p.m. with DON B revealed she only received a complaint from resident 57 regarding staff putting their hands in her pants to check to see she was incontinent. If a resident had a complaint concerning abuse allegations, she would investigate it. If the investigation determined that the staff were inappropriate, then she would report it to the SD DOH. She stated that their grievance process depended on the situation. They had grievance forms to fill out, but if she completed an internal investigation, she did not need to fill out the grievance form. Regarding the incident that involved resident 57, she interviewed RN H and the other night nurses about CNA D, but she did not document those interviews. She did not interview other residents to see if there was a similar incident that had happened to them. Mental health services were not offered to resident 57. 13. Interview on 3/11/26 at 5:00 p.m. with administrator A and DON B revealed that they were not aware that resident 57 had was touched to check to see if she was incontinent. DON B had SSD F visit with resident 57 regarding the incident, and she thought resident 57 told SSD F that CNA D did not touch her. She explained how she updated the pocket care plan and that she talked with CNA D, provided him with education, and wrote him up. She stated that no other residents were interviewed. Administrator A stated that allegations of sexual abuse were to be reported to the SD DOH within two hours, reported to law enforcement, and Dakota at Home. She expected staff not to put their hands in the residents' incontinence briefs or touch the brief to check if the resident was incontinent. The incontinence brief had lines on it that turned color when it was wet, and the staff were to let the residents know what they were going to do and get their permission before they did anything. If a resident did not want to be checked, the staff were to report it to the charge nurse. 14. On 3/11/26 at 6:52 p.m., administrator A was notified of the IJ. On 3/12/26 at 12:58 a.m., the removal plan was received by email. On 3/12/26 at 7:31 a.m., the edited removal plan was received, and on 3/12/26 at 8:35 a.m., it was accepted. REMOVAL PLAN: 1. Resident 57's allegation of sexual abuse was reported to the South Dakota Department of Health (DOH), [NAME] County Sheriff's Department, Dakota at Home, her power of attorney (POA), and provider on 3/11/26. Resident 57 refused skin assessment on 3/11/26. Her previous skin assessment was completed by registered nurse (RN) on 3/5/26 with no skin alterations or other injuries noted. Resident 57 will be offered counseling services. Certified Nursing Assistant (CNA) D was immediately suspended upon notification of allegation on 3/11/26. Resident 78's allegation of sexual abuse was reported to the DOH, [NAME] County Sheriff's Department, Dakota at Home, and the facility Medical Director on 3/11/26. Resident 78 was discharged from the facility on 12/8/25. No immediate corrective action could be taken to ensure no injury occurred. Certified Occupational Therapy Assistant (COTA) and Social Service Designee (SSD) were immediately suspended on 3/11/26 for failure to report an allegation of sexual abuse. 2. On 3/11/26, Nurse Managers completed interviews with all cognitive residents that have a Brief Interview for Mental Status (BIMS) score of 12 or greater, this included 32 residents, to determine if they had concerns regarding inappropriate touch by a staff member or whether they had witnessed another resident being touched inappropriately by a staff member. Nurse Managers completed interviews with all staff working evening and night shift on 3/11/26 to determine if a resident has (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ever reported that they had been touched inappropriately, whether they have ever witnessed a staff member touching a resident inappropriately, and if they know who to report abuse concerns to. Director of Nursing (DON) or designee will complete interviews with all remaining staff prior to their next shift worked to determine if a resident has ever reported that they have been touched inappropriately, whether they have witnessed a staff member touch a resident inappropriately, and if they know who to report abuse concerns to. 3. Senior Regional Nurse Consultant educated the Administrator and DON on the Abuse and Neglect policy, including immediate reporting and investigating, to ensure interventions are implemented to safeguard all residents from abuse that continues to put all residents at risk on 3/11/26. Regional Nurse Consultant educated all Nurse Managers on the Abuse and Neglect policy, including immediate reporting requirements, to ensure all residents remain free from abuse and/or neglect on 3/11/26. Nurse Managers educated all staff working the evening/night shift on 3/11/26 on the Abuse and Neglect policy, including immediate reporting and investigating, to ensure all residents remain free from abuse and/or neglect. Admin [administrator], DON, or designee will educate all other facility and contract staff on the Abuse and Neglect policy, including immediate reporting and investigating, to ensure all residents remain free from abuse and/or neglect prior to their next shift worked. DON or designee will ensure new staff, including contract staff, receive education on the Abuse and Neglect policy, including immediate reporting requirements, prior to their first shift worked. DON or designee will interview 5 random residents each week to ensure they remain free from abuse and/or neglect and feel safe in the facility. Additionally, the DON or designee will observe 5 CNAs each week on random shifts to ensure residents are approached and touched appropriately when assisting them with incontinent care. These interviews and audits will continue for four weeks and then monthly for three months. Results of audits will be reviewed by the Administrator, DON or designee with IDT and Medical Director at monthly Quality Assurance Performance Improvement (QAPI) for analysis and recommendation for continuation/discontinuation/revision of audits based on findings. 15. Interviews were completed by the survey team on 3/12/26 between 9:12 a.m. and 9:29 a.m. with residents 3, 35, and 65 and staff members LPN I, CNA T, medical records director OO, activity aide PP, housekeeper RR, and activity aide SS to ensure the provider followed through with their removal plan. 16. The survey team verified onsite, through interviews, and document review that the provider followed their IJ removal plan and the immediacy was removed. The scope and severity level of the noncompliance remained at a G. 17. On 3/12/26 at 9:54 a.m., administrator A was notified that the IJ was removed. 18. Review of resident 57's EMR revealed she was admitted to the facility on [DATE]. Her 2/6/26 Brief Assessment for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had diagnoses of Generalized Anxiety Disorder (GAD) (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), other manic episodes (a period of abnormally high energy, extreme happiness, or severe irritability), Agoraphobia (a fear of being in situations where escape might be difficult or help unavailable if a panic attack occurs), Major Depressive Disorder (MDD) (a persistent feeling of hopelessness, emptiness, or low mood). Review of resident 57's 2/22/26 care plan revealed that social services would visit with her to assess her psychosocial needs and would follow up as needed. She had a hearing deficit, and she was independent with toileting. Review of resident 57's medication record revealed she took Lexapro 20 milligrams (mg) (an antidepressant) daily and Seroquel 50 mg every night for MDD, and Depakote 250 mg twice daily for MDD and other manic episodes. 19. Review of resident 78's EMR revealed she was admitted to the facility on [DATE] and discharged to home on [DATE]. Her 12/8/25 BIMS assessment score was 15, which indicated her cognition was intact. She had diagnoses of anxiety disorder and depression. Resident 78's 11/17/25 care plan did not indicate what assistance she required for personal hygiene care, ambulating (walking), or using the bathroom. Resident 78 had physician orders to take Mirtazapine 15 mg (a depression medication) daily. 20. Review of the provider's 5/14/25 Abuse and Neglect policy revealed that the facility would provide care services in (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	an environment that was free from any type of abuse. And to follow federal guidelines to prevent abuse and investigate allegations of abuse. The abuse coordinator was the administrator, and she was responsible for developing and implementing the abuse prevention training curriculum and conducting the investigation in situations of alleged abuse/neglect. Sexual abuse included implied or actual contact between a caregiver and resident of sexual nature. If an allegation of sexual abuse towards a resident is reported., the facility will send resident to the emergency room to be evaluated if ordered by the resident's physician. A report will be made to the local police department the same day the allegation is made. If abuse was suspected the facility would immediately protect the residents, notify appropriate authorities that an investigation would be conducted, conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses, notify law enforcement if needed (example- Sexual abuse), and report the investigation findings to all necessary state and/or local agencies and other identified persons as required by law. The steps indicated to prevent abuse were screening, training, prevention, identification, investigation, protection, and reporting/responding. The provider was to inform residents, residents' families, and staff how to report grievances or concerns and to whom they could report it to. The provider was to respond to the residents, families, or staff concerns that reported grievances or concerns. The administrator or designee was to investigate all abuse allegations of abuse immediately. The provider was to interview all people who might know information about the allegation to determine if abuse had occurred. The investigation was to be documented thoroughly. The provider was to protect residents from physical and psychosocial harm during the investigation, assess the resident for injury, notify the physician, and suspend the accused employee during the investigation. The provider was to report to the administrator immediately any allegations or suspicions of abuse. The allegation of abuse needed to be reported to the SD DOH within two hours of the allegation. A final investigation report was to be submitted to the state agency within five working days.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the South Dakota Department of Health (SD DOH) complaint report review, interview, document review, record review, and policy review, the provider failed to implement policies and procedures to report to the SD DOH and law enforcement, allegations of sexual abuse for two of two sampled residents (57 and 78) who reported sexual abuse allegations to social service designee (SSD) (F) that they were touched in their private area by one of one certified nursing assistant (CNA) (D) and an unidentified staff member. The provider's failure to report those allegations to law enforcement for review and investigation may have put those residents at continued risk for further abuse and all residents at risk for potential abuse. Findings include: 1. Review of the complaint report submitted to the SD DOH on 2/6/26 revealed that either a student or an aide had stuck their hands down her [resident 78's] pants to check if she was dry, without her permission. She stated her mind is good, and she had told the person that she didn't need to go to the toilet, and that she was dry. The aide or student proceeded to ?check' her without asking. She felt very embarrassed by this. She stated she spoke with facility management the next day, and they verified the person should not have done that. There was no further follow-up with the resident. She could not recall the name of the person who had done it, and the incident bothered her. 2. Interview on 3/10/26 at 12:21 p.m. with director of nursing (DON) B revealed that an internal investigation was completed after resident 57 complained to RN H that a staff member checked her incontinence brief to see if it was wet, which startled her since she was independent with using the bathroom. RN H reported that to DON B. DON B explained that CNA D did not mean it in a sexually inappropriate way so she did not report the incident to the SD DOH. The incident happened on 1/23/26 during the night shift rounds. She stated CNA D currently worked at the facility and she disciplined and educated CNA D after the incident. She acknowledged that touching a resident's incontinence brief was not an acceptable way to see if they were incontinent. She said the investigation report she completed indicated that resident 57's brief was not checked by touching her. If CNA D had touched the brief to see if it was wet, DON B would have reported it to the SD DOH, and CNA D would have been suspended until the investigation was completed, and possibly had his employment at the facility terminated. 3. Review of the provider's internal investigation form revealed that resident 57's abuse allegation was reported on 1/23/26 to RN H by resident 57 and stated the night aide came in her room and pulled back her blanket and checked her brief which had startled her. [RN H] reported that [resident 57] did not feel that this was completed inappropriately towards her, but more of a lack of education. RN H reported this to DON B, and DON B had SSD F conduct a social service visit to discuss the incident with [resident 57]. Review of SSD F interview documents that were attached to the internal investigation form revealed it stated, I spoke with [resident 57] about what happened and checked on how she was feeling about the situation. [Resident 57] reported that staff entered her room during the overnight rounds while she was sleeping and she was not expecting someone to come in at that time. The CNA pulled down her blanket to check her brief which startled her. [Resident 57] and I talked about how the CNA was completing routine rounds and may not have known her usual nighttime routine. [Resident 57] stated she understood and said she does not believe the CNA meant anything inappropriate towards her. She also stated she is not upset with the CNA and felt he likely did not know her routine. I stayed with [resident 57] for a while and we continued to talk about the situation. During the visit she appeared calm and comfortable with discussing what happened. She did not express ongoing concerns. I asked if she would like me to notify family and she declined. Social Services will continue to monitor and remain available if she has any concerns. [Resident 57] reports that she feels safe at the facility. The internal investigation form indicated that the physician, police, ombudsman, and the state agency were not notified of the incident. On 1/26/26 SSD F interviewed resident 57 regarding the incident, and it stated [Resident (continued on next page)

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	435020	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Huron	1345 Michigan Avenue SW Huron, SD 57350

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	57] reported that she has had no further issues. She remains to feel safe at the facility. On 1/27/26 SSD F interviewed resident 57 regarding the incident, and it indicated that resident 57 had no further issues, felt safe, and she would notify SSD if she had further issues. The outcome of the investigation summary section described the incident that had occurred. It stated that administrator A and DON B called resident 57's daughter to notify her of the incident, and her daughter said she would call them if resident 57 said anything about it. It stated that DON B interviewed CNA D on 1/23/26, and he reported that he said the resident's name before pulling the resident's blankets back. He thought she knew what he was doing, and he apologized that he startled her. DON B gave him a written warning. DON B told resident 57 that her care plan was changed, and the investigation summary indicated that resident 57 was happy with that. It stated, In review of South Dakota's reporting guidelines this did not rise to the level of abuse/neglect due to [resident 57's] denial of inappropriate action towards her and [CNA D's] lack of touching her and therefore was not reported to the Department of Health. 4. Interview on 3/11/26 at 11:15 a.m. with SSD F revealed that CNA D touched the resident's incontinence brief to see if she was wet. SSD was unsure if resident 57's incontinence brief or private area was touched when CNA D checked her for incontinence. She verified that it was not an appropriate way to see if a resident was incontinent. 5. Interview on 3/11/26 at 11:40 a.m. with resident 57 revealed that the CNA touched her on the inside of her incontinence brief. She became tearful, and by the end of the interview she was not sure if she was touched on the inside or the outside of her incontinence brief, and she just wanted to forget about it. 6. Interview on 3/11/26 at 9:08 a.m. with RN H revealed that during a night shift, a CNA was confused about which residents needed to be checked for incontinence, and that the residents down the D wing were startled by this. The CNA still worked here, and she was not aware whether he continued to do that, and no residents had complained about that. 7. Interview on 3/11/26 at 12:50 p.m. with independent living specialist QQ regarding resident 78's complaint about a female staff member who put her hands down resident 78's pants to feel if she was wet, revealed resident 78 was no longer at the facility. Resident 78 was just there for rehab and at the time of the incident, she was independent with toileting. The incident made resident 78 feel uncomfortable and she reported to independent living specialist QQ that she had nightmares about it and recalled resident 78 saying got an eerie gross feeling about it. Independent living specialist QQ continued to stay in contact with her. She was not sure who resident 78 reported the incident to at the facility, but said resident 78 made a formal complaint, and she did not hear back from anyone about it. Independent living specialist QQ was unsure when the incident occurred. 8. Phone interview on 3/11/26 at 12:58 p.m. with resident 78 revealed she was unsure when the incident occurred, but she was able to recall that it happened during a night shift. The female staff member asked her if she needed to use the bathroom, and when resident 78 said no, the female staff member put her hand down resident 78's pants and said, Nope, you're dry. Resident 78 reported that she had resided in the D wing, she wore her own underwear, and that a female staff member put her hand on the inside of her underwear when she checked her. She said she did not do anything about it that night, but the next day, she told COTA E about it. Resident 78 reported that COTA E brought her to SSD F's office for her to report the incident to SSD F. She said she reported the incident to the two women in that office, and said they had looked surprised. When she was telling them what happened, she thought it appeared that SSD F was looking at the staffing schedule to see who was working that night. Resident 78 was told that they had students from a vocational school there at the facility. Resident 78 stated that she had made a formal complaint with SSD F and the other lady that was in the office, and when she read her discharge paperwork from the facility, she did not see anything about the incident, so she made a complaint report with the SD DOH so it would not happen to other residents. She said no one from the facility followed up with her after she made the formal complaint. 9. Interview on 3/11/26 at 1:20 p.m. with COTA E revealed that resident 78 told her about the incident that occurred during the night shift, where a staff member put their hands in resident 78's pants to see if she was incontinent. COTA E (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	reported that resident 78 was upset and that she was sleeping when that staff member came into her room. She said she took resident 78 directly to the social services office, and SSD F was there, but she was unsure if anyone else was in there. COTA E stated that was not the first time residents had reported this concern to her. She was not sure how many residents had, but thought five or less, in the last six months. Residents reported to her that the staff ripped off their blankets and would feel around to see if they were incontinent. It happened to the residents who were both continent and incontinent. She listed two other residents who were still in the facility, who she recalled having that happen to. 10. Interview on 3/11/26 at 1:45 p.m. with SSD F revealed that she did not recall COTA E bringing resident 78 to her office or that resident 78 made a formal complaint to her. She reported that the therapy department brought the residents to her office frequently about this or that. She stated that their process for filing resident grievances was to listen to them, document the grievance, investigate them, and report them to the SD DOH if needed. SSD F said that she did not recall any other residents, besides resident 57, reporting that staff put their hands in their pants to check if they were incontinent and stated, it's a pretty serious thing. She said that and incident like that would be reported to administrator A and DON B for them to investigate it. 11. Interview on 3/11/26 at 3:10 p.m. with DON B revealed she only received a complaint from resident 57 regarding staff putting their hands in her pants to check to see she was incontinent. If a resident had a complaint concerning abuse allegations, she would investigate it. If the investigation determined that the staff were inappropriate, then she would report it to the SD DOH. 12. Interview on 3/11/26 at 5:00 p.m. with administrator A and DON B revealed that they were not aware that resident 57 had was touched to check to see if she was incontinent. DON B had SSD F visit with resident 57 regarding the incident, and she thought resident 57 told SSD F that CNA D did not touch her. She explained how she updated the pocket care plan and that she talked with CNA D, provided him with education, and wrote him up. She stated that no other residents were interviewed. Administrator A stated that allegations of sexual abuse were to be reported to the SD DOH within two hours, reported to law enforcement, and Dakota at Home. She expected staff not to put their hands in the residents' incontinence briefs or touch the brief to check if the resident was incontinent. The incontinence brief had lines on it that turned color when it was wet, and the staff were to let the residents know what they were going to do and get their permission before they did anything. If a resident did not want to be checked, the staff were to report it to the charge nurse. 13. Review of resident 57's EMR revealed she was admitted to the facility on [DATE]. Her 2/6/26 Brief Assessment for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had diagnoses of Generalized Anxiety Disorder (GAD) (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), other manic episodes (a period of abnormally high energy, extreme happiness, or severe irritability), Agoraphobia (a fear of being in situations where escape might be difficult or help unavailable if a panic attack occurs), Major Depressive Disorder (MDD) (a persistent feeling of hopelessness, emptiness, or low mood). Review of resident 57's 2/22/26 care plan revealed that social services would visit with her to assess her psychosocial needs and would follow up as needed. She had a hearing deficit, and she was independent with toileting. Review of resident 57's medication record revealed she took Lexapro 20 milligrams (mg) (an antidepressant) daily and Seroquel 50 mg every night for MDD, and Depakote 250 mg twice daily for MDD and other manic episodes. Resident 78's 11/17/25 care plan did not indicate what assistance she required for personal hygiene care, ambulating (walking), or using the bathroom. Resident 78 had physician orders to take Mirtazapine 15 mg (a depression medication) daily. 14. Review of resident 78's medical record revealed she was admitted to the facility on [DATE] and discharged home on [DATE]. Her 12/8/25 BIMS assessment score was 15, which indicated her cognition was intact. And she had diagnoses of Anxiety Disorder and Depression. Review of resident 78's 11/17/25 care plan revealed it did not indicate what assistance she required for hygiene care, ambulating, or using the bathroom.Review of resident 78's physician orders revealed she took Mirtazapine 15 mg (depression (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	medication) daily. 15. Review of the provider's 5/14/25 Abuse and Neglect policy revealed that the facility would provide care services in an environment that was free from any type of abuse. And to follow federal guidelines to prevent abuse and investigate allegations of abuse. The abuse coordinator was the administrator, and she was responsible for developing and implementing the abuse prevention training curriculum and conducting the investigation in situations of alleged abuse/neglect. Sexual abuse included implied or actual contact between a caregiver and resident of sexual nature. If an allegation of sexual abuse towards a resident is reported., the facility will send resident to the emergency room to be evaluated if ordered by the resident's physician. A report will be made to the local police department the same day the allegation is made. If abuse was suspected the facility would immediately protect the residents, notify appropriate authorities that an investigation would be conducted, conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses, notify law enforcement if needed (example- Sexual abuse), and report the investigation findings to all necessary state and/or local agencies and other identified persons as required by law. The steps indicated to prevent abuse were screening, training, prevention, identification, investigation, protection, and reporting/responding. The provider was to inform residents, residents' families, and staff how to report grievances or concerns and to whom they could report it to. The provider was to respond to the residents, families, or staff concerns that reported grievances or concerns. The administrator or designee was to investigate all abuse allegations of abuse immediately. The provider was to interview all people who might know information about the allegation to determine if abuse had occurred. The investigation was to be documented thoroughly. The provider was to protect residents from physical and psychosocial harm during the investigation, assess the resident for injury, notify the physician, and suspend the accused employee during the investigation. The provider was to report to the administrator immediately any allegations or suspicions of abuse. The allegation of abuse needed to be reported to the SD DOH within two hours of the allegation. A final investigation report was to be submitted to the state agency within five working days.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the South Dakota Department of Health (SD DOH) complaint report review, interview, document review, record review, and policy review, the provider failed to ensure two of two sampled residents' with expressed feelings of emotional distress (57 and 78) allegations of sexual abuse reported to social services designee (F) regarding having been touched in their private areas without the residents' consent by one of one certified nursing assistant (CNA) (D) and an unidentified staff member were thoroughly investigated to prevent further emotional distress, further staff-to-resident sexual abuse or to mitigate the risk of sexual abuse. Findings include:1. Review of the provider's complaint report submitted to the SD DOH on 2/6/26 revealed that either a student or an aide had stuck their hands down her [resident 78's] pants to check if she was dry, without her permission. She stated her mind is good, and she had told the person that she didn't need to go to the toilet, and that she was dry. The aide or student proceeded to ?check' her without asking. She felt very embarrassed by this. She stated she spoke with facility management the next day, and they verified the person should not have done that. There was no further follow-up with the resident. She could not recall the name of the person who had done it, and the incident bothered her. 2. Interview on 3/10/26 at 12:21 p.m. with director of nursing (DON) B revealed that an internal investigation was completed after resident 57 complained to RN H that a staff member checked her incontinence brief to see if it was wet, which startled her since she was independent with using the bathroom. RN H reported that to DON B. DON B explained that CNA D did not mean it in a sexually inappropriate way so she did not report the incident to the SD DOH. The incident happened on 1/23/26 during the night shift rounds. She stated CNA D currently worked at the facility and she disciplined and educated CNA D after the incident. She acknowledged that touching a resident's incontinence brief was not an acceptable way to see if they were incontinent. She said the investigation report she completed indicated that resident 57's brief was not checked by touching her. If CNA D had touched the brief to see if it was wet, DON B would have reported it to the SD DOH, and CNA D would have been suspended until the investigation was completed, and possibly had his employment at the facility terminated. No audits were completed after the incident occurred to ensure it would not occur again. DON B told resident 57's daughter about the incident and asked her daughter to notify them if resident 57 brought it up. The investigation documentation stated SSD F had followed up with resident 57 a few days after the incident. 3. Review of the provider's internal investigation form revealed that resident 57's abuse allegation was reported on 1/23/26 to RN H by resident 57 and stated the night aide came in her room and pulled back her blanket and checked her brief which had startled her. [RN H] reported that [resident 57] did not feel that this was completed inappropriately towards her, but more of a lack of education. RN H reported this to DON B, and DON B had SSD F conduct a social service visit to discuss the incident with [resident 57]. Review of SSD F interview documents that were attached to the internal investigation form revealed it stated, I spoke with [resident 57] about what happened and checked on how she was feeling about the situation. [Resident 57] reported that staff entered her room during the overnight rounds while she was sleeping and she was not expecting someone to come in at that time. The CNA pulled down her blanket to check her brief which startled her. [Resident 57] and I talked about how the CNA was completing routine rounds and may not have known her usual nighttime routine. [Resident 57] stated she understood and said she does not believe the CNA meant anything inappropriate towards her. She also stated she is not upset with the CNA and felt he likely did not know her routine. I stayed with [resident 57] for a while and we continued to talk about the situation. During the visit she appeared calm and comfortable with discussing what happened. She did not express ongoing concerns. I asked if she would like me to notify family and she declined. Social Services will continue to monitor and remain available if she has any concerns. [Resident 57] reports that she feels safe at the facility. The internal investigation (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	form indicated that the physician, police, ombudsman, and the state agency were not notified of the incident. On 1/26/26 SSD F interviewed resident 57 regarding the incident, and it stated [Resident 57] reported that she has had no further issues. She remains to feel safe at the facility. On 1/27/26 SSD F interviewed resident 57 regarding the incident, and it indicated that resident 57 had no further issues, felt safe, and she would notify SSD if she had further issues. The outcome of the investigation summary section described the incident that had occurred. It stated that administrator A and DON B called resident 57's daughter to notify her of the incident, and her daughter said she would call them if resident 57 said anything about it. It stated that DON B interviewed CNA D on 1/23/26, and he reported that he said the resident's name before pulling the resident's blankets back. He thought she knew what he was doing, and he apologized that he startled her. DON B gave him a written warning. DON B told resident 57 that her care plan was changed, and the investigation summary indicated that resident 57 was happy with that. It stated, In review of South Dakota's reporting guidelines this did not rise to the level of abuse/neglect due to [resident 57's] denial of inappropriate action towards her and [CNA D's] lack of touching her and therefore was not reported to the Department of Health. 4. Interview on 3/11/26 at 11:15 a.m. with SSD F revealed that CNA D touched the resident's incontinence brief to see if she was wet. SSD was unsure if resident 57's incontinence brief or private area was touched when CNA D checked her for incontinence. She verified that it was not an appropriate way to see if a resident was incontinent. 5. Interview on 3/11/26 at 11:40 a.m. with resident 57 revealed that the CNA touched her on the inside of her incontinence brief. She became tearful, and by the end of the interview she was not sure if she was touched on the inside or the outside of her incontinence brief, and she just wanted to forget about it. 6. Interview on 3/11/26 at 9:08 a.m. with RN H revealed that one night, a CNA was confused about which residents needed to be checked for incontinence, and that the residents down the D wing were alerted by this. He still worked here, and she was not aware whether he continued to do that. She had not had a resident come to her to complain about that. 7. Interview on 3/11/26 at 12:50 p.m. with independent living specialist QQ regarding resident 78's complaint about a female staff member who put her hands down resident 78's pants to feel if she was wet, revealed resident 78 was no longer at the facility. Resident 78 was just there for rehab and at the time of the incident, she was independent with toileting. The incident made resident 78 feel uncomfortable and she reported to independent living specialist QQ that she had nightmares about it and recalled resident 78 saying got an eerie gross feeling about it. Independent living specialist QQ continued to stay in contact with her. She was not sure who resident 78 reported the incident to at the facility, but said resident 78 made a formal complaint, and she did not hear back from anyone about it. Independent living specialist QQ was unsure when the incident occurred. 8. Phone interview on 3/11/26 at 12:58 p.m. with resident 78 revealed she was unsure when the incident occurred, but she was able to recall that it happened during a night shift. The female staff member asked her if she needed to use the bathroom, and when resident 78 said no, the female staff member put her hand down resident 78's pants and said, Nope, you're dry. Resident 78 reported that she had resided in the D wing, she wore her own underwear, and that a female staff member put her hand on the inside of her underwear when she checked her. She said she did not do anything about it that night, but the next day, she told COTA E about it. Resident 78 reported that COTA E brought her to SSD F's office for her to report the incident to SSD F. She said she reported the incident to the two women in that office, and said they had looked surprised. When she was telling them what happened, she thought it appeared that SSD F was looking at the staffing schedule to see who was working that night. Resident 78 was told that they had students from a vocational school there at the facility. Resident 78 stated that she had made a formal complaint with SSD F and the other lady that was in the office, and when she read her discharge paperwork from the facility, she did not see anything about the incident, so she made a complaint report with the SD DOH so it would not happen to other residents. She said no one from the facility followed up with her after she made the formal complaint. 9. Interview on 3/11/26 at 1:20 p.m. with (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	COTA E revealed that resident 78 told her about the incident that occurred during the night shift, where a staff member put their hands in resident 78's pants to see if she was incontinent. COTA E reported that resident 78 was upset and that she was sleeping when that staff member came into her room. She said she took resident 78 directly to the social services office, and SSD F was there, but she was unsure if anyone else was in there. COTA E stated that was not the first time residents had reported this concern to her. She was not sure how many residents had, but thought five or less, in the last six months. Residents reported to her that the staff ripped off their blankets and would feel around to see if they were incontinent. It happened to the residents who were both continent and incontinent. She listed two other residents who were still in the facility, who she recalled having that happen to. 10. Interview on 3/11/26 at 1:45 p.m. with SSD F revealed that she did not recall COTA E bringing resident 78 to her office or that resident 78 made a formal complaint to her. She reported that the therapy department brought the residents to her office frequently about this or that. She stated that their process for filing resident grievances was to listen to them, document the grievance, investigate them, and report them to the SD DOH if needed. SSD F said that she did not recall any other residents, besides resident 57, reporting that staff put their hands in their pants to check if they were incontinent and stated, it's a pretty serious thing. She said that and incident like that would be reported to administrator A and DON B for them to investigate it. Regarding resident 57, she stated she wrote her follow-up notes in a notebook, which she no longer had, and did not document about it in the electronic medical record (EMR). She said she did not talk to other staff or residents to see if a similar incident occurred with them. She said she visited with resident 57, but no other counseling was offered to her. When she talked to resident 57 about the incident, she told SSD F that she was embarrassed about it. 11. Interview on 3/11/26 at 2:27 p.m. with SSD G revealed that she did not recall any complaints regarding staff putting their hands down residents' pants to check to see if they were incontinent, and she did not recall COTA E bringing resident 78 to her office. If she were to receive a resident grievance, she was to document it on a form and turn it in to administrator A. 12. Interview on 3/11/26 at 3:10 p.m. with DON B revealed she only received a complaint from resident 57 regarding staff putting their hands in her pants to check to see she was incontinent. If a resident had a complaint concerning abuse allegations, she would investigate it. If the investigation determined that the staff were inappropriate, then she would report it to the SD DOH. Regarding the incident that involved resident 57, she interviewed RN H and the other night nurses about CNA D, but she did not document those interviews. She did not interview other residents to see if there was a similar incident that had happened to them. Mental health services were not offered to resident 57. 13. Interview on 3/11/26 at 5:00 p.m. with administrator A and DON B revealed that they were not aware that resident 57 had was touched to check to see if she was incontinent. DON B had SSD F visit with resident 57 regarding the incident, and she thought resident 57 told SSD F that CNA D did not touch her. She explained how she updated the pocket care plan and that she talked with CNA D, provided him with education, and wrote him up. She stated that no other residents were interviewed. She expected staff not to put their hands in the residents' incontinence briefs or touch the brief to check if the resident was incontinent. The incontinence brief had lines on it that turned color when it was wet, and the staff were to let the residents know what they were going to do and get their permission before they did anything. If a resident did not want to be checked, the staff were to report it to the charge nurse. 14. Review of resident 57's EMR revealed she was admitted to the facility on [DATE]. Her 2/6/26 Brief Assessment for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had diagnoses of Generalized Anxiety Disorder (GAD) (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), other manic episodes (a period of abnormally high energy, extreme happiness, or severe irritability), Agoraphobia (a fear of being in situations where escape might be difficult or help unavailable if a panic attack occurs), Major Depressive Disorder (MDD) (a persistent feeling of hopelessness, emptiness, or low mood). Review of resident 57's 2/22/26 care plan revealed (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	that social services would visit with her to assess her psychosocial needs and would follow up as needed. She had a hearing deficit, and she was independent with toileting. Review of resident 57's medication record revealed she took Lexapro 20 milligrams (mg) (an antidepressant) daily and Seroquel 50 mg every night for MDD, and Depakote 250 mg twice daily for MDD and other manic episodes. Resident 78's 11/17/25 care plan did not indicate what assistance she required for personal hygiene care, ambulating (walking), or using the bathroom. Resident 78 had physician orders to take Mirtazapine 15 mg (a depression medication) daily. 15. Review of resident 78's medical record revealed she was admitted to the facility on [DATE] and discharged home on [DATE]. Her 12/8/25 BIMS assessment score was 15, which indicated her cognition was intact. And she had diagnoses of Anxiety Disorder and Depression. Review of resident 78's 11/17/25 care plan revealed it did not indicate what assistance she required for hygiene care, ambulating, or using the bathroom.Review of resident 78's physician orders revealed she took Mirtazapine 15 mg (depression medication) daily. 16. Review of the provider's 5/14/25 Abuse and Neglect policy revealed that the facility would provide care services in an environment that was free from any type of abuse. And to follow federal guidelines to prevent abuse and investigate allegations of abuse. The abuse coordinator was the administrator, and she was responsible for developing and implementing the abuse prevention training curriculum and conducting the investigation in situations of alleged abuse/neglect. Sexual abuse included implied or actual contact between a caregiver and resident of sexual nature. If an allegation of sexual abuse towards a resident is reported., the facility will send resident to the emergency room to be evaluated if ordered by the resident's physician. A report will be made to the local police department the same day the allegation is made. If abuse was suspected the facility would immediately protect the residents, notify appropriate authorities that an investigation would be conducted, conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses, notify law enforcement if needed (example- Sexual abuse), and report the investigation findings to all necessary state and/or local agencies and other identified persons as required by law. The steps indicated to prevent abuse were screening, training, prevention, identification, investigation, protection, and reporting/responding. The provider was to inform residents, residents' families, and staff how to report grievances or concerns and to whom they could report it to. The provider was to respond to the residents, families, or staff concerns that reported grievances or concerns. The administrator or designee was to investigate all abuse allegations of abuse immediately. The provider was to interview all people who might know information about the allegation to determine if abuse had occurred. The investigation was to be documented thoroughly. The provider was to protect residents from physical and psychosocial harm during the investigation, assess the resident for injury, notify the physician, and suspend the accused employee during the investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Huron	1345 Michigan Avenue SW Huron, SD 57350

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure the safety of one of one sampled resident (7) who eloped (left the facility without staff knowledge) from the front door of the facility on 9/2/25, and one of one sampled resident (77) who fell while being transferred by certified nursing assistant (CNA) V, who did not transfer the resident as directed in the resident's care plan (personalized plan that addresses a resident's care needs, goals, and interventions). This citation is considered past non-compliance based on a review of the provider's corrective actions immediately following the incidents.Findings Include:1. Review of the provider's 9/3/2025 SD DOH FRI revealed on 9/2/25 at 2:48 p.m. resident 7 exited the building following a staff member leaving the property. Resident 7 was seen outside in the parking lot by the front door at 2:50 p.m. and escorted back into the facility. A skin assessment, blood pressure, pulse, temperature, and respirations were taken by registered nurse (RN) K on 9/2/25 upon resident 7 entering the facility. The staff education on the elopement policy and where the elopement photographs (photographs taken and displayed of residents who are a high risk for leaving the facility) were located was initiated. Elopement audits were started on 9/9/25 and reviewed in Quality Assurance and Performance Improvement (QAPI) meeting. Staff were aware of which residents were at risk of elopement. Resident 7's care plan and elopement risk assessments were reviewed. Her primary care provider (PCP) and family were notified of the incident. 2. Review of resident 7's electronic medical record (EMR) revealed that her Brief Interview for Mental Status (BIMS) score on 8/6/25 was three and on 1/26/26/26 was zero, which both indicated her cognition was severely impaired. Resident 7's 7/3/25 and 9/2/25 elopement risk assessments' scores were 5, which indicated she had a high risk for elopement. 3. Resident 7's care plan in use prior to the elopement revealed non-pharmaceutical (no medications) interventions for when resident was wandering. Interventions initiated on 8/28/24 were to cue, reorient and supervise resident 7. Interventions added to her care plan on 3/5/25 were the use of animatronic dog, conversation, walking with resident, inviting her to activities, encouraging rest and providing less stimulation when exhibiting anxious behaviors, delusions or wandering. Interventions added to her care plan on 9/2/25 identified resident 7 as an elopement risk due to diagnosis of dementia and delusional disorders with additional interventions that include exit and stairwell alarms, follow a familiar routine, keep photographs of resident on the unit and at the front desk, redirect the resident with familiar pictures and items, and maintain a calm environment. Interventions added on 1/19/26 resident 7's visitors would notify staff when they leave her room so staff will know resident 7's whereabouts within the facility. 4. Resident 7's progress notes revealed at the time of the elopement on 9/2/25, she was ambulating with a walker throughout the facility. 5. Observation on 3/8/26 at 6:35 p.m. of resident 7 revealed she was maneuvering around the dining (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	room in a wheelchair. 6. Observation on 3/10/26 at 8:57 a.m. with receptionist BB revealed that anytime a new resident showed signs of possible elopement risk, staff posted a picture at the front desk and in the time clock room where staff clock in and out for the day. 7. Observation on 3/10/26 at 9:00 a.m. revealed that residents who are at risk for elopement had photos laminated on a sheet of paper in the time clock room and at the front desk. 8. Interviews on 3/11/26 at 8:45 a.m. to 9:30 a.m. with certified nursing assistants (CNA) (Y, M, V) and RN H revealed they identified elopement-risk residents by using the pictures in the time clock room, and the pocket care plans (a document that identifies residents' care needs and interventions) that say if they were an elopement risk. 9. Interview on 3/11/26 at 3:00 p.m. with director of nursing (DON) B revealed she did not consider resident 7's elopement a lack of staff supervision. She stated, the residents are mobile and deemed an elopement risk, but if they were to get outside that it is an elopement based on our policy. She expected staff to know the photos of the residents and which residents were high elopement risks. She expected staff to respond to door alarms immediately and if there was an elopement she expected the staff to call her immediately. DON B stated that during resident 7's elopement, the staff member let in five family members into the front door, which crowded the direct sight of receptionist at the front desk from seeing resident 7 use her walker to leave the facility. 10. Review of the provider's staff education provided on 9/2/25 revealed that all staff received education on the elopement policy, including the expectation that staff know which residents were in the area of the exit door when they were leaving the facility for any reason, and that they ensure the door closes behind them once they exited the building. 11. Review of the provider's quality assurance and performance improvement (QAPI) notes from October 2025 revealed the elopement for resident 7 was being monitored. 12. Review of the provider's audits after resident 7's elopement revealed weekly audits of four staff members or visitors that were exiting the building were visually checked to ensure no resident followed them from the building. Audits were completed over the course of four weeks from 9/9/25-9/30/25. All 28 audits were documented to show the doors were being monitored by staff and visitors when they were exiting. 13. Review of the provider's February 2024 Elopement policy revealed The facility must take steps to keep the resident safe and assess residents to identify those who are risk for elopement. 14. The provider implemented actions to ensure the deficient practice did not reoccur. On 3/12/26, observation, interviews, and record review confirmed the facility had followed its quality assurance process. The facility provided education to all nursing staff regarding the elopement policy, and the elopement photographs were placed at the front reception desk and the time clock room. Staff interviews showed they understood the education provided. The facility completed audits demonstrating staff knowledge of expectations when exiting the facility and awareness of residents at risk for elopement and their surroundings. The QAPI committee was monitoring the progress of the audits as noted in their meeting documentation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	15. Based on the information above, non-compliance at F689 occurred on 9/2/25. Because the provider implemented corrective actions from 9/2/25 through 9/30/25, and those actions were confirmed on 3/12/26, the non-compliance is considered past non-compliance. 16. Review of the provider's 11/25/25 SD DOH FRI for resident 77 revealed that on 11/11/25 at 8:00 a.m., licensed practical nurse (LPN) I was called to resident 77's room by CNA V. Resident 77 was lying on her right side on the floor at the foot of her bed. CNA V reported he had been assisting resident 77 from the bathchair to her wheelchair when she was unable to stand any longer and he eased her to the floor. LPN I immediately assessed resident 77 and found a one-centimeter skin tear to her right eyebrow that was closed with a steri-strip [an adhesive strip used to close small, shallow wounds], and a light blue bruise that measured ten centimeters by three centimeters on her right upper arm. Resident 77's range of motion was at baseline, and her neurological assessments (an assessment of nerve function, reflexes, coordination, motor skills, sensation, and mental status) and vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were within normal limits. Resident 77 complained of pain at 3 on a scale from 0 (no pain) to 10 (worst imaginable pain). Pain medication was provided, and an icepack was applied to resident 77's arm. Resident 77's care plan indicated she was to be transferred by one-person assist with a gait belt (a waist strap gripped as support for safe mobility and transfers). CNA V did not use a gait belt when he transferred resident 77 and was suspended immediately. The provider's interdisciplinary team (IDT) met following resident 77's fall and reviewed her care plan, which remained appropriate. Education regarding gait belts and the provider's Transfer Gait Belt Use policy was initiated with all staff members on 11/25/25. Audits will be conducted on [CNA V] weekly x [for] 4 weeks and 3 random residents weekly x 4 weeks. Residents 77's primary care physician and power of attorney were notified. 17. Review of resident 77's EMR revealed she was admitted to the facility on [DATE]. Her 8/13/25 care plan indicated she transferred with one person's assistance using a walker and a gait belt. Her 8/13/25 Fall Risk Evaluation indicated she was at a high risk for falling. 18. Interview on 3/10/26 at 1:10 p.m. with CNA V revealed that he recalled the events of resident 77's 11/25/25 fall and confirmed the information reported in the FRI was accurate. He knew that he needed to use a gait belt when he transferred resident 77 from the bath chair to the wheelchair, and was unsure why he had not used one that day. He received education on resident care plans, the use of gait belts, and safe transfers with residents. 19. Interview on 3/10/26 at 1:10 p.m. with DON B revealed resident 77's fall occurred because CNA V did not follow the resident's care plan, which included that she needed to be transferred with a gait belt. Education was provided to all caregiver staff on following the resident care plans, the use of gait belts, and safe transfers with residents. Audits were started and completed weekly on CNA V and other staff members when transferring residents to ensure that resident care plans were followed, and gait belts were used when required. A QAPI meeting was held on 12/3/25 and included resident falls, including resident 77's 11/11/25 fall, safe resident transfers, and ensuring transfer status and equipment were included in the resident (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	care plans. 20. Interview on 3/11/26 at 4:19 p.m. with administrator A regarding resident 77's 11/25/25 fall revealed that she confirmed they immediately suspended CNA V, reported the incident to the SD DOH, resident 77's physician, and the resident's power of attorney, and conducted an investigation. They identified that CNA V had not used a gait belt, as indicated in her care plan, when he transferred resident 77 that day, and she fell. They provided immediate education to CNA V and initiated education with all caregiver staff members on 11/25/25. They completed weekly audits of CNA V and other staff members completing transfers. They included those audits in their QAPI program and are continuing to monitor falls throughout the facility. 21. Review of the provider's Transfer and [NAME] Belt Use, Care Plan, and Falls Management policy staff education initiated on 11/25/25 revealed that all staff were educated. 22. Review of the provider's QAPI notes from 12/3/25 revealed that resident falls, including resident 77's 11/25/25 fall, were reviewed, and a gait belt performance improvement project (PIP) had been initiated. 23. Review of the provider's audits after resident 77's 11/25/25 fall revealed the provider completed three audits a week for four weeks, and no further issues were observed. Care plans were followed, including the use of the gait belt, and further education was provided to staff members when needed. 24. The provider's implemented actions to ensure the deficient practice does not recur were confirmed on 3/12/26 after record review revealed the facility had followed their quality assurance process, education was provided to all nursing staff regarding care plans, the use of gait belts, and the provider's fall management policy, and audits were completed. Interviews with nursing staff revealed they understood the education provided regarding the resident safety with transfers, the use of gait belts, and following the resident care plan. Observations of transfers in residents' rooms were conducted, and confirmed that staff understood how to use gait belts, followed the resident care plan, and transferred residents safely. A QAPI meeting was held on 12/5/25 to implement a plan, and will continue to be a part of their QAPI process for review and further advise staff as needed. 25. Based on the above information, non-compliance at F689 occurred on 11/25/25, and based on the provider's 12/5/25 implemented corrective actions for the deficient practice confirmed on 3/12/26, the non-compliance is considered past non-compliance.