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	06/24/2026

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 0689 Level of Harm - Minimal harm or potential for 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, record review, interview, and policy review, the provider failed to ensure resident safety and supervision for one of one cognitively impaired sampled resident (1) identified at risk for elopement (leaving the facility without staff knowledge), was to be monitored and redirected when near exits and was seen outside the facility, walking down the street by a community member, who notified the facility. The resident was located over two blocks away from the facility, walking on the sidewalk, by licensed practical nurse (LPN) D. Failure to adequately supervise and redirect the resident may have contributed to the resident's elopement placing the resident at risk for an accident and/or injury while she was out of the building and unsupervised. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include:1. Review of the provider's 6/11/26 SD DOH FRI revealed on 6/11/26 the staff was alerted by a visitor that resident 1 was seen walking down the street. The staff exited the building to look for resident 1. At approximately 3:21 p.m. resident 1 was found by a staff member walking on the sidewalk.Resident 1's husband passed away in May 2025, and since his death, resident 1 talked about going to visit her mother and father. On 6/11/26, before she eloped, resident 1 told receptionist G that her mother and father were going to pick her up soon.The provider's review of the video camera footage during their investigation revealed that at 3:15 p.m. resident 1 was seated on a bench near the front door. Receptionist G pushed a remote button to allow a visitor to enter the building. Once that visitor entered the building receptionist G looked away from the door. Resident 1 caught the door before it closed and exited the building without the staff being aware she exited the facility. 2. Observation of the facility's entrance on 6/23/26 at 12:30 p.m. revealed that the outer door was not locked, and opened to a small entrance room, that had a locked inner door. There were instructions beside the door to ring a doorbell for entrance into the facility. A receptionist was seated at a desk within view of the locked door. The receptionist unlocked the door. The door automatically began to close slowly and paused approximately three inches from being fully closed. After the brief pause, the door fully closed and latched. That door opened into an open commons area, and along the wall near the door was a wooden bench. 3. Review of resident 1's electronic medical record (EMR) revealed she admitted to the facility on [DATE]. She had a Brief Interview of Mental Status (BIMS) assessment score of 7, which indicated her cognition was significantly impaired. Her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) with behavioral disturbance, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and delusional disorder (a mental illness where a person holds strong, false beliefs despite evidence to the contrary).Her 6/23/26 care plan indicated she was at risk for elopement due to increased confusion since the death of her husband. The interventions for her elopement risk included, Exit and stairwell alarms, If resident looks for family and/or significant other, reassure [her] that others know where to find them, Redirect [her] away from exits as needed and Photo in high risk for elopement to alert staff. The Photo in high risk for (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elopement to alert staff was revised on 6/11/26 from Maintain Elopement Binder, which was initiated on 6/1/26.The certified nursing assistants' (CNA) behavior documentation from 5/25/26 through 6/23/26 revealed that resident 1 was wandering on 5/28/26, 5/30/26, 5/31/26, 6/3/26, 6/5/26, 6/7/26, and 6/10/26.Resident 1's 5/28/26 Elopement Risk Evaluation indicated that The resident verbalized a strong desire to leave the facility and has the ability to do so and she was to be monitored by the staff for elopement.Resident 1's 6/2/26 Minimum Data Set (MDS) significant change assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) indicated she wandered four to six days during the seven day look-back period (the time period over which the resident's condition or status is captured by the MDS assessment), and yes was marked for the section this places the resident at significant risk of getting into potentially dangerous place.A 6/10/26 progress note written by social service designee (SSD) C indicated, When I was in [the] room speaking with [the] resident [resident 1] and [the resident's] daughter, [the] resident was very upset with [her] daughter and myself saying ?why are you doing this to me?' What do you think your [you're] doing with [resident 1's husband's] stuff. I tried to get [the] resident to go on a walk with me so [her] daughter could clean out [the] room. Resident was very upset about moving someone else in her husbands space.A 6/11/26 at 3:15 p.m. progress note written by licensed practical nurse (LPN) D indicated, Resident [resident 1] left through the front door after a visitor entered the facility. Staff [were] notified of [a] potential elopement. At 3:21 p.m. staff seen [saw] resident [resident 1] on the side walk in front of them. Staff [LPN D] ran to residents [resident 1's] side where she [resident 1] stated she was walking to her parents house. Resident [resident 1] was wearing socks, shoes, capri pants, a shirt with a sweater over the top, and was using her walker. The temperature was 69 [degrees Fahrenheit] and it is sunny outside. Resident was redirected to DON [director of nursing] car where she was driven back to the facility with no issues. Vitals were taken and are 138/66 [blood pressure], temp [temperature] 98.1 [degrees Fahrenheit], pulse 82, resp [respirations] 18, and O2 [blood oxygen saturation] 96 [percent]. A skin assessment was done and there are no skin issues found from elopement. 4. Interview on 6/23/26 at 3:10 p.m. with LPN D revealed she worked at the facility on 6/11/26, when resident 1 eloped from the facility. She stated resident 1 had dementia and since her husband passed away on 5/1/26 she had increased confusion and wandering. On the day she eloped (6/11/26), she received a new roommate which upset her. That same day she wandered around the facility with a bag stating she was going to her parents' house. LPN D saw resident 1 in the common area near the entrance to the building visiting with another resident before she eloped.When the staff were notified that resident 1 eloped, LPN D ran outside to look for her. LPN D found resident 1 approximately two and one-half blocks away from the facility. Resident 1 had crossed two streets but was walking on the sidewalk when LPN D found her. LPN D stated that resident 1 was laughing and stated she was going to her mother's and father's home. LPN D was able to get resident 1 into DON B's car, and they brought her back into the building.LPN D stated that after resident 1's husband passed away resident 1 began wandering and exit seeking. She did not attempt to elope from the facility before 6/11/26. Her picture was placed in the elopement binder (a reference binder for staff that contained the names and pictures of residents who were identified by the provider as being at risk for elopement from the facility) after her husband passed away because of her increased wandering and exit seeking.When resident 1 would wander and exit seek LPN D would remind resident 1 that her parents had passed away in the 1970s and her husband had passed away in May 2026 and then redirect her away from the building's exits. LPN D stated that she could usually redirect resident 1, but other staff members, at times, could not redirect her. 5. Interview and review of the elopement risk sheet at the reception desk on 6/23/26 at 3:46 p.m. regarding elopements with receptionist G revealed she was working as the receptionist on 6/11/26, when resident 1 eloped from the facility. On 6/11/26 receptionist G unlocked the door for a visitor to enter. Resident 1 was seated on the bench near the facility entrance. Resident 1 snuck between two visitors and exited the building. Receptionist (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G did not see resident 1 leave the building. Receptionist G thought resident 1 was seated on the bench near the door for about 15 minutes before she eloped.On 6/11/26 resident 1 told receptionist G that she wanted to leave multiple times and that she was very fast and she would get out. Resident 1 often came to the reception desk and told the receptionists that she wanted to go home. Resident 1 did not attempt to leave the building before that incident, but receptionist G said she was not surprised that resident 1 eloped because the resident often sat on the bench by the entrance and stated she wanted to go home. Receptionist G stated she told SSD C about resident 1's restlessness and that she stated she wanted to go home on 6/11/26 because SSD C often talked with resident 1 when she was upset. Receptionist G stated that the receptionists had a laminated elopement risk sheet that indicated the residents' names and their photographs if they were an elopement risk. The form was dated 5/21/26 and had resident 1's name and picture on it. 6. Interview on 6/24/26 at 10:20 a.m. with SSD C revealed she worked on 6/11/26 when resident 1 eloped from the building. She was told by a visitor that resident 1 was about two blocks from the facility. SSD C called a code walk (the provider's code to announce an elopement) and began looking for resident 1. SSD C was aware that resident 1's wandering increased after her husband's death, and that she was upset she had a new roommate. SSD C was not aware that resident 1 stated she was going to leave on 6/11/26. Resident 1 told SSD C that when she was upset, she would go for walks, but she never attempted to elope from the building before 6/11/26. 7. Review of the video camera footage from resident 1's 6/11/26 elopement revealed resident 1 was seated on the bench near the entrance. She was bent over doing something with her shoe. Receptionist G opened the door with the remote button on the receptionist's desk for a visitor at the door. The visitor entered the building. Receptionist G then looked down at the papers and her computer on the receptionist's desk. Resident 1 stood up, caught the door before it closed, and exited the building at 3:15 p.m. without receptionist G seeing her leave. 8. Interview on 6/24/26 at 11:23 a.m. with DON B revealed she was working on 6/11/26, when resident 1 eloped from the building. After the code walk was called DON B got in her car to look for resident 1. She found resident 1 and LPN D about two and one-half blocks away from the facility. She had crossed two streets but was walking on the sidewalk when they found her. Resident 1 was laughing and stated she got out of there really fast and that she was going to her parent's home. Resident 1 was redirected into DON B's car and brought back into the facility.Resident 1 became more confused shortly before her husband's death in May 2026. She began wandering and exit seeking after his death. After she began wandering and exit seeking, she was identified as having a high risk for elopement, her care plan was updated, and the receptionist elopement risk sheets were updated. After her elopement her picture was placed in the elopement binder (a binder that identified the residents who were at high risk for elopement to alert the staff they needed to redirect those residents away from exits) that resident 1 had been identified as being at risk for elopement and the staff needed to redirect her away from exits when she was exit seeking.On 6/11/26 DON B initiated education for all staff to be sure they were not looking away from the entrance door until it closed and latched to prevent a resident from exiting the building without staff being aware. She was auditing five staff members weekly to be sure the staff watched the building front entrance door until the door closed and latched. The elopement incident was scheduled to be reviewed at the provider's next Quality Assurance and Performance Improvement (QAPI) meeting.DON B was aware that resident 1 liked to sit on the bench near the building's front entrance and expected staff to redirect her away from that bench if she was exit seeking. 9. Review of the provider's 5/14/26 Elopement policy revealed, The facility must take steps to keep the resident safe and assess residents who identify those who are risk for elopement. Upon return of the resident to the facility, the Director of Nursing or charge nurse should: .Make appropriate notations in the resident's medical record and update the care plan. 10. Based on the above information, non-compliance at F689 occurred on 6/11/26, and based on the provider's corrective action plans that were initiated on 6/11/26 and implemented for the deficient practice confirmed on 6/23/26, the non-compliance is considered past non-compliance.