STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Norton	3600 South Norton Avenue Sioux Falls, SD 57105

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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Norton	3600 South Norton Avenue Sioux Falls, SD 57105

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 - Minimal harm or potential for actual harm Residents Affected - Few	Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, review of call light log, review of personnel file, interviews and policy review, the provider failed to protect the resident's right to be free from neglect for one of one sampled resident (2) who waited for staff assistance for more than an hour after turning on his call light. This citation is considered past non-compliance based on a review of the provider's corrective actions immediately following the incident.Findings include: 1. Review of the provider's 5/30/25 SD DOH FRI regarding resident 2 revealed:*Resident 2 filed a grievance with the provider on 5/30/25.*On the night of 5/28/25 resident 2 did not receive help from staff. -His call light (a device that alerts staff of a request for assistance) had been on for an extended period.-Certified nursing assistant (CNA) D came in to his room to assist him, was rude, and walked out.-CNA D was suspended pending investigation.-The resident's primary care provider (PCP) was notified of the grievance.-An investigation was initiated.*An assessment of the resident's skin was completed on 5/30/25 with no new identified skin areas. *Resident 2's call light response times for 5/28/25 were reviewed.-At 6:16 p.m. CNA Q delivered his dinner tray.-At 6:40 p.m. licensed practical nurse (LPN) R entered his room and completed his medication administration.--He had stated to LPN R that no one would answer his call light, LPN R told him that staff were doing the best they could.-At 8:22 p.m. CNA L entered his room and told him she would come back to assist him.-At 9:45 p.m. CNA D responded to his call light, he was upset, CNA D left room and asked for assistance from CNA L.-When CNA L arrived at resident 2's room resident 2 refused assistance with his cares and was getting himself ready for bed.*Following a review of the staff schedules for the evening of 5/28/25 education was provided to the nurse managers and staffing coordinator S for scheduling conflicts and how to address them.*Five residents who reside in the same hall on the same hall were interviewed and had no concerns with staff response to call lights.*Call light response audits and education on the call light policy, the abuse and neglect policy, and providing resident cares in pairs (two staff members assisting a resident together) was initiated.*Resident 2's care plan was reviewed, and it was determined he would remain to be assisted by staff using cares in pairs to ensure his safety.*CNA D was educated on the call light policy, the abuse and neglect policy, residents who needed care provided by using cares in pairs and was allowed to return to work.*The resident's PCP was notified of above interventions.*Resident 2 was responsible for himself and was pleased with those interventions. 2. Review of resident 2's electronic medical record (EMR) revealed:*His Brief Interview for Mental Status (BIMS) assessment score on 4/16/25 was 15 which indicated his cognition was intact.*He had diagnoses of:-Diabetes Mellitus type one (the body's immune system mistakenly attacks and destroys insulin-producing cells in the pancreas).-Legal blindness (significant vision impairment).-Anxiety disorder (intense, persistent worry or fear).*His care plan revealed:-He received behavioral counseling services.-He required cares in pairs.-He had skin wounds to his left and right heels.-He was resistant to cares, treatments and medications.-He required assistance with all activities of daily living (ADLs).*There were multiple documentations of refusal of wound treatments, bathing, and medication administration in his progress notes. 3. Review of the 5/28/25 call light log for resident 2 revealed:* He had activated his call light four times between 6:00 p.m. and 9:45 p.m.-At 6:12 p.m. his call light had been on for four minutes.-At 6:23 p.m. his call light was on for seventeen minutes.-At 8:28 p.m. his call light was on for six minutes.-At 8:37 p.m. his call light was on for one hour and eight minutes. 4. Review of personnel file on 7/9/25 at 11:40 a.m. for CNA D revealed:*A corrective action suspension on 5/30/25 for an allegation of neglect.*An employment termination corrective action dated 7/7/25 regarding an investigation related to the provider's harassment policy. 5. Interview on 7/9/25 at 11:00 a.m. with CNA Q revealed:*He brought resident 2's dinner tray to his room a little after 6:00 p.m. on 5/28/25.*He had not noticed if resident 2's light was on.*There had been four staff working in that wing on 5/28/25.*Resident 2 did not have behaviors.*Resident 2 did not refuse assistance with his cares.*Resident 2 would refuse to eat lunch sometimes.*Resident 2 was alert and oriented.*Resident 2 was legally blind.*Resident 2 transfers with two assistance of two staff members and a gait belt (a waist strap gripped as support for safe mobility and transfers).*Resident 2 call light was to always be in a specific spot, so he would know where it was.*Resident 2 was able to make his needs known. Interview on 7/9/25 at 1:20 p.m. with resident 2 revealed:*He felt CNA D seemed to have an attitude and was rude.*He could wait an hour or more for staff to respond to his call light at times.*On 5/28/25 he turned his call light on because he needed help with getting ready for bed and waited over an hour for staff to respond to it.*CNA D came in and shut his light off, she did not come back for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Norton	3600 South Norton Avenue Sioux Falls, SD 57105

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, and policy review, the provider failed to ensure professional nursing standards of practice regarding medication administration were followed by licensed practical nurse (LPN) (F) who administered one of one sampled resident'(4) another resident's medications. That failure resulted in medication errors.Findings include:1. Review of the 6/9/25 SD DOH FRI revealed:* On the evening of 6/9/25, LPN F mistakenly administered resident 5's medications to resident 4.*Medications administered to resident 4 included Zolpidem (medication to assist with sleeping) 10 milligrams (mg) and Eliquis (blood thinning medication) 5 mg.*Resident 4 had an allergy to Zolpidem and did not take blood thinning medications.*The on-call physician was notified of those medication errors.*The on-call physician ordered for the resident to be monitored by staff and for resident 4's normal medications to be resumed the next day.*No adverse reactions were noted to resident 4 due to the medication errors. 2. Interview on 7/9/25 at 2:15 p.m. with registered nurse (RN) G revealed:*She had been employed by the facility for about six months.*To identify a resident before administering their medications, there was a picture of the resident in their electronic medical record (EMR). The resident's name outside of their door should match the name in the EMR. If the resident had appropriate cognition, she would have the resident give their name and date of birth . 3. Interview on 7/9/25 at 2:25 p.m. with LPN E revealed:*She had been employed by the facility for about two months.*To identify the resident before administering medications, she would compare the room number to the number in the EMR. She would then use the picture of the resident in the EMR for further identification. If the resident had appropriate cognition, she would have the resident give their name and date of birth .*She recalled receiving recent education regarding the six rights of medication administration. 4. Interview on 7/9/25 at 4:55 p.m. with director of nursing (DON) B revealed:*She interviewed LPN F after the 6/9/25 medication error and LPN F admitted she did not follow the six rights to medication administration (Right Patient, Right Medication, Right Dose, Right Route, Right Time, and Right Documentation).*DON B acknowledged the facility policy stated five rights of medication administration, but staff were educated on the six rights of medication administration.*It was DON B's expectation that the six rights of medication administration would be followed by staff who were administering medications. 5. Interview on 7/10/25 at 8:50 a.m. with LPN F revealed:*She recalled working the evening of 6/9/25.*She recalled it had been a busy evening, and there was a resident in the hallway who was talking to her, and she felt that had become a distraction.*She recalled having administered the evening medications for both resident 4 and resident 5.*She had prepared and written the first name of the resident on each of the cups containing each of those residents' medication.*She stated that those residents' first names were similar, and their rooms were located next to each other.*She recalled stepping away from the medication cart to help with assisting the resident in the hallway.*When she came back to the medication cart, she grabbed resident 5's medications and administered them to resident 4.*She came back to the medication cart to get resident 5's medications to administer to him, she realized she had given resident 4 resident 5's medications in error. *She immediately contacted the DON and on-call physician to explain the medication error to them. 6. Review of the provider's undated medication administration policy revealed:*Medications are administered as prescribed in accordance with good nursing principles and practices and only by legally authorized to do so.*4. FIVE RIGHTS-Right resident, right drug, right dose right route, and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of medication for administration: (1)when the medication is selected, (2)when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication is put away.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Norton	3600 South Norton Avenue Sioux Falls, SD 57105

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Norton	3600 South Norton Avenue Sioux Falls, SD 57105

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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure one of one sampled resident (3) with a pressure ulcer received the necessary dressing changes as ordered and interventions according to the resident's care plan to prevent his ulcer and infection from worsening. This citation is considered past non-compliance based on a review of the provider's corrective actions immediately following the incident. Findings include:1. Review of resident 3's electronic medical record (EMR) revealed:*He was admitted on [DATE] for intensive (extreme in degree of care) wound cares with intravenous (administration of medications directly into a vein) (IV) antibiotics. *He had a Brief Interview for Mental Status (BIMS) assessment score of 11, which indicated he had moderate cognitive impairment.*His diagnoses included: an unstageable pressure ulcer (a full-thickness wound where the depth cannot be determined because the base of the ulcer is obscured by slough, which is (yellowish, tan, gray, green, or brown dead tissue,) or eschar, which is (black, brown, or tan dead tissue) to his left lower leg/heel, non-pressure chronic ulcer (a persistent skin wound caused by conditions other than pressure), type two diabetes mellitus (the body does not use insulin properly), diabetic polyneuropathy (nerve damage complication of diabetes that causes pain), peripheral vascular disease (narrowing of blood vessels that reduces blood flow to limbs and organs), and cellulitis (bacterial skin infection that causes redness, swelling, and pain) of his left lower leg. *His current care plan interventions included:*A physician order initiated on 4/15/25 for staff to offload (remove or reduce pressure to body areas) his heels.*A physician order initiated on 4/15/25 for staff to ensure he utilized a crow boot (a specialized boot that redistributes pressure and stabilizes the foot) to his left foot and a custom shoe to his right foot when he was out of bed.*A physician order initiated on 4/15/25 for staff to monitor and document the location, size, and treatment and to report abnormalities, failure to heal, and signs and symptoms of infection to the medical doctor. *A physician order initiated on 4/15/25 to change the dressing to left lower leg/heel twice daily and as needed with betadine (topical antiseptic used to prevent and treat infections), adaptic (non-adhering dressing), 4x4's gauze pads, ABD (gauze pads to absorb wound drainage), wrap with kerlix (woven gauze bandage roll) and an Ace wrap (elastic bandage wrap). *A physician order initiated on 4/15/25 for IV Zosyn (an antibiotic) 4-0.5 GM/100ML therapy was to be administered three times daily through his PICC line (long, thin, flexible tube inserted into a vein in the arm, and threaded into a large vein near the heart to administer fluids or to draw blood samples). *A physician order initiated on 4/17/25 his left lower leg/heel ulcer was to be monitored weekly by licensed practical nurse (LPN)/wound nurse C.*He had been seen by the physician on 4/29/25 with much improvement to the pressure ulcer and less swelling and signs of infection to lower left leg/heel.*On 5/1/25 at 9:19 PM revealed resident 3's left lower leg/heel ulcer measurements were 12.10 Length (L) x 11.00 width (W) x 0.10 diameter (D).*Treatment administration record (TAR) documentation for 5/1/25 through 5/5/25 had been signed off by registered nurse (RN) J, RN K, RN M, and RN N, indicating resident 3's dressing changes to left lower leg/foot/heel had been completed twice daily, as ordered by the physician.*On 5/6/25, a progress note revealed resident 3's Left medial ankle wound communicating to left lower leg, rear. Left lower leg, pressure unstageable: 16.00 L x 32.50 W x 0.10 D.-On 5/6/25, LPN/wound nurse C had completed the dressing change after identifying that it had not been changed on 5/1/25 at 9:00 PM, and 5/2/25, 5/3/25, and 5/4/25, at 8:00 AM, and 9:00 PM as ordered. There was heavy drainage, wound bed wetness, and an odor noted during the dressing change. -Resident 3 had increased fatigue and was afebrile. *Resident 3's primary care provider was notified that resident 3 had not received wound care to his left lower leg/heel on 5/1/25 at 9:00 PM, and 5/2/25, 5/3/25, and 5/4/25, at 8:00 AM, and 9:00 PM as ordered. -Orders were received for blood work and to notify the infectious disease (ID) doctor for further management. *An order was received on 5/5/25 by the ID doctor for resident 3 to be sent to the emergency room for further evaluation. -Resident 3's laboratory results showed an up-trending white blood count (WBC) which was 16.0 on 4/28/25 and on 5/5/25 it was 20.2 which indicated he had an infection and a mild increase in C-reactive protein (CRP) (measures the inflammation in the body) which was 137.1 and reference range is less than 5.0 milligrams per liter (mg/L). -Radiography (X-rays) of his left tibia and fibula (two bones of the lower leg) did not show osteomyelitis (infection in the bone). *Resident 3's primary care provider and his family had been notified regarding his care on his dressing changes to his left lower leg/heal had not been changed as ordered by the provider. *Resident 3 returned to the facility on 5/6/25 after his evaluation in the ED. *Orders received from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Norton	3600 South Norton Avenue Sioux Falls, SD 57105

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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Norton	3600 South Norton Avenue Sioux Falls, SD 57105

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview and policy review, the provider failed to protect the safety of one of one sampled resident (1) identified as at risk for elopement (leaving the facility without staff knowledge). Who was assisted out of the building by certified nursing assistant (CNA) H who left the facility property and resident 1 remained outside unsupervised. This citation is considered past non-compliance based on a review of the provider's corrective actions immediately following the incident.Findings include:1.Review of the provider's 6/7/25 SD DOH FRI involving resident 1 revealed:*On 6/7/25 at 6:31 p.m. resident 1 exited the building when certified nursing assistant (CNA) H held the door open for her at the end of her shift.*Resident 1 remained on the property in the front of the building unsupervised.*CNA P and licensed practical nurse (LPN) I recognized when leaving resident 1 should not have been outside alone at approximately 6:38 p.m.*CNA P and LPN I remained with resident 1 outside, until she agreed to return inside the building.*Director of nursing (DON) B called CNA H and re-educated her about the elopement binder and how to find out which residents were at risk for elopement. *A skin assessment was completed on resident 1 on 6/7/25, and no injuries were found.*CNA H's new hire orientation was reviewed, and elopement was a part of her completed of new hire orientation.*All staff education on the elopement policy and where the elopement binder was located was initiated.*Elopement drills were completed on all shifts following the above incident on what to do if a resident was missing. *Elopement audits were started 6/19/25 weekly and reviewed:-Staff were aware of which residents were at risk of elopement.-Reviewed new admissions, readmissions or change in condition of resident elopement risk.-Reviewed all residents at risk of elopement care plan's, elopement risk evaluations, and elopement binder.*Audits were to be reviewed at the next Quality Assurance and Performance Improvement (QAPI) meeting for the elopement policy and to review audits completed for needed changes.*Resident 1's care plan was reviewed.*An elopement risk assessment of resident 1 was completed on 6/7/25.*Her primary care provider (PCP) and family were notified of the incident and had no further concerns. 2. Review of resident 1's electronic medical record (EMR) revealed:*She admitted to the facility on [DATE].*Her care plan included a focus area that indicated she had the potential for elopement which was initiated on 8/7/2023 interventions included:-Exit and stairwell alarms.-Facility doors alarmed/secured to prevent elopement.-Follow a familiar routine.-If exit seeking, keep photographs of the resident on the unit and at the front desk.-Maintain elopement binder.-Provide care, activities and a daily schedule that resembles resident 1's prior lifestyle as able.*She was identified as having a low risk for elopement on her 10/11/24 elopement risk assessment.*Her Brief Interview for Mental Status (BIMS) assessment score on 4/21/25 was three, which indicated she had severely impaired cognition.*She was identified as having a high risk for elopement on her 6/7/25 and 6/9/25 elopement risk assessment. 3. Interview on 7/10/25 at 8:20 a.m. with administrator A revealed:*CNA H walked out of the building with resident 1.*Resident 1 was at risk for elopement.*Resident 1 was left by CNA H, unattended by staff, so the incident was considered an elopement. Interview on 7/10/25 at 9:46 a.m. with CNA H revealed:*She had started working at the facility a few months before the 6/7/25 incident involving resident 1.*She had completed her orientation training which included elopement prevention and how to locate a missing resident and managing elopement.*She had completed her shift on 6/7/25 at approximately 6:30 p.m.*She saw resident 1 standing at the front entry door and held the door open for her to exit the building.*After assisting resident 1 out of the building she left for the day.*She was unaware that resident 1 should not have been left outside by herself.*She was educated on the elopement binders by DON B on 6/7/25 and that they were located at the nurses' stations and the reception desk after the above incident occurred.*She was educated on their elopement policy following the above incident. Interview on 7/10/25 at 10:55 a.m. with DON B revealed:*All staff were to be educated upon hire about elopement and the facility's elopement binders.*CNA H had received that education before she started to work with residents in the facility.*CNA H had been re-educated on the elopement policy and where the elopement binders were located following the incident with resident 1 on 6/7/25.*She expected all facility policies to be followed by the staff.*Staff could ask members of the management team or the on-call staff if they had questions. 4. Review of the provider's revised 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. Facility personnel must investigate all reports of missing residents. Elopement drills should be conducted monthly.*2. It is the