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	11/14/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (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
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and policy review, the provider failed to ensure staff members followed infection prevention practices for:*Personal protective equipment (PPE) use by one of one observed certified nursing assistant (CNA) D when providing care for five of five sampled residents (1, 2, 3, 4, and 5) on enhanced barrier precautions (use of gown and gloves while providing contact care)(EBP).*Cleaning shared-use equipment, specifically lift devices, after each resident's use by one of one CNA D.*Maintaining a clean environment in one of one sampled resident (6) room who reported spilled urine that remained on the floor for about two hours. Findings include: 1. Observation on 11/13/25 at 7:08 a.m. of certified nursing assistant (CNA) D revealed she brought a resident lift (a mechanical device used to transfer residents) out of resident 7's room, did not clean the lift, and placed it in the hallway after use. 2. Observation on 11/23/25 at 7:42 a.m. of CNA D revealed:*She entered resident 1's room with the same lift and transferred the resident from his bed to his wheelchair without wearing a gown.*A sign was on the outside of his door that indicated the resident was on enhanced barrier precautions (glove and gown use when providing contact care)(EBP). -The sign indicated that staff should wear a gown and gloves when providing high contact resident care.*A supply of PPE was hanging on the outside of the door and available for use.*When she brought the lift out of resident 1's room, she did not clean.Interview on 11/13/25 at 3:18 p.m. with CNA D regarding resident 1 and infection control processes revealed:*She would usually put on a gown and gloves when providing care for a resident on EBP, but she thought that EBP had been discontinued for resident 1.*She acknowledged that the EBP sign was on resident 1's door and PPE was available for use.-She stated she did not wear a gown when she provided care for resident 1, but should have.*She stated that lifts should be cleaned after each resident use and acknowledged that she did not clean the lift after she used it while providing care for resident 1. 3. Interview on 11/13/25 at 7:45 a.m. with licensed practical nurse (LPN) E revealed that resident lifts should be cleaned after each resident use. 4. Interview on 11/13/25 at 7:48 a.m. with CNA F revealed:*Resident lifts should be cleaned after each resident use.*Staff should wear gown and gloves when providing direct care to residents on EBP.*He explained that he did not wear a gown when transferring resident 1 because he was controlling the lift and not touching the resident. 5. Interview on 11/13/25 at 7:50 a.m. with resident 1 in his room revealed:*He required staff assistance to transfer him from his bed to his wheelchair. 6. A review of 1's medical record revealed:*His most recent brief interview for mental status (BIMS) score was 15, which indicated he had no cognitive deficits.*He reported that staff did not wear gowns when assisting him to transfer, but they did wear gloves. 7. A review of resident 2's medical record revealed:*His latest BIMS assessment score was 15.*He was on EBP due to a multi-drug resistant organism (MDRO) [an antibiotic resistant bacteria] in his urine. 8. Observation and Interview on 11/13/25 at 10:00 a.m. with resident 2 in his room revealed:*There was a sign on the outside of his door that indicated he was on EBP.*He required staff assistance to transfer him from his bed to his wheelchair.*He reported that staff had tried to give him a urinal (a hand-held container that holds urine) without a lid on it.-He was concerned that he would spill his urine if he used it.-His current urinal had a lid attached to it. 9. Review of resident 3's medical record revealed:*Her latest BIMS assessment score was 15.*She was on EBP because she had a feeding tube [a medical device inserted into the stomach to provide nutrition]. 10. Observation and interview on 11/13/25 at 1:10 p.m. with resident 3 in her room revealed:*There was a sign on the outside of her door that indicated she was on EBP.*A supply of PPE was hanging on the outside of her door and available for use.*She received tube feedings due to weight loss.*She reported that staff did not wear a gown when providing care for her, only gloves.*She was not sure why the EBP sign was on her door. 11. Review of resident 4's medical record revealed:*He was on EBP because he had wounds on his heels.*His BIMS assessment score was 13, which indicated he was cognition was intact. 12. Observation and interview on 11/13/25 at 2:05 p.m. with resident 4 in his room revealed:*There was a sign on the outside of his door that indicated he was on EBP.*There was PPE available hanging on the outside of the door.*Regarding the EBP sign on his door, he stated That sign means nothing. They only use gloves. The one [staff member] came in this morning with a gown on, but that's the only one. 13. Review of resident 5's medical record revealed:*His latest BIMS assessment score was 14, which indicated his cognition was intact.*He was on EBP due to wounds on his buttocks. 14. Observation and interview on 11/13/25 at 2:45 p.m. with resident 5 in his room revealed:*Four urinals were hanging from his trash bin.*He reported that staff did not regularly wear a gown when providing his cares or when transferring him, and stated They have worn gowns in the past, but don't