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	02/04/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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, observation, and policy review, the provider failed to ensure residents received quality care when one of one certified nurse aide (CNA) N applied Nair (chemical hair removal cream) cream to one of one sampled resident's (2) peri area (perineum, the skin between the genitals and anus) who did not have a physician's order for use of that cream and subsequently sustained a chemical skin burn. 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 1/19/26 SD DOH FRI revealed:*On 1/16/26 CNA N had applied Nair cream to resident 2's peri area when she gave the resident her shower.*CNA N reported the Nair cream was in resident 2's room, and the resident wanted the cream applied.*On 1/17/26, during a regular wound treatment on resident 2, licensed practical nurse (LPN) G noticed resident 2's peri area was red, and the resident indicated the area was sore.*LPN G verified with CNA N, who had given resident 2 her shower on 1/16/26, that resident 2's peri area was not shaved with a razor, but did have Nair cream applied to it.*LPN G notified resident 2's family of the incident and informed them that the Nair cream needed to have a physician's order for it to be used in the facility.*The Nair cream was discarded in the garbage per the family's request.*Resident 2's physician and the local police department were notified of the incident.*Resident 2 had a weekly scheduled skin assessment on 1/18/26. The peri area was documented as pink and appears healed. The area was treated with Aquaphor (skin protectant ointment).*On 1/20/26 at 1:45 p.m., resident 2 had a scheduled Urology appointment and was taken to that appointment by her sister in a private car.*At the Urology appointment, resident 2 did not verbalize responses appropriately and was more confused than at her baseline cognitive level.*Resident 2's mother, who was her legal guardian, requested that resident 2 be sent to the emergency department (ED) for further evaluation.*Resident 2 was admitted to the local hospital on 1/20/26 for acute encephalopathy (diffuse disease of the brain that alters its structure or function) with an unknown cause of the disease.*The wound care team at the hospital assessed resident 2's peri area to be moist, pink, and red and 100 percent epithelial tissue [skin].*On 1/21/26, the hospital reported to SD DOH that resident 2 came to the hospital with chemical burns on her bilateral thighs/labia due to the Nair cream being left on the resident for too long. Resident 2 had progressive multiple sclerosis and was dependent on staff at the facility for all of her care, and was unable to wipe the Nair cream off of herself.*The hospital indicated that the mother of resident 2 was aware of the incident that occurred at the nursing home facility, and the facility investigated and addressed the incident.*Resident 2 returned to the facility on 1/23/26.*CNA N was initially suspended pending the investigation and then CNA N's employment at the facility was terminated because of the incident. 2. Review of resident 2's electronic medical record (EMR) revealed:*She was admitted to the facility on [DATE].*Her diagnoses were multiple sclerosis (MS) (a chronic (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: 435039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
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F 0684 Level of Harm - Actual harm Residents Affected - Few	autoimmune disease of the central nervous system), cerebral vascular disease (CVA) (a stroke), hemiplegia (total paralysis of one side of the body), hemiparesis (weakness or partial loss of strength), deep vein thrombosis (DVT) (a blood clot), and Epilepsy (a seizure disorder).*Her 1/12/26 Brief Interview of Mental Status (BIMS) assessment score was 5, which indicated her cognition was severely impaired.*She had a 1/20/26 physician order for Triamcinolone cream 0.1% (a cream to decrease redness and irritation to the skin) to be applied to the pubic area topically twice daily.*Her 1/20/26 hospital admission papers indicated she was assessed as having acute encephalopathy; etiology [cause] is unclear; however, a possible reason could be cellulitis (bacterial infection affecting the skin's deep layers and underlying tissue) from the chemical burn from the waxing cream [Nair].*She had prescriptions from her physician for her chronic pain that she had received before the chemical burn, and no additional pain medications were needed.*Resident 2's 6/15/22 revised care plan indicated her stay at the facility was identified as long-term, and she required extensive care (assistance from the staff in the long-term care setting). 3. Interview on 2/3/26 at 2:03 p.m. with LPN J revealed a request from a resident to use a hygiene product, such as Nair cream, would require a physician's order. 4. Interview on 2/3/26 at 2:12 p.m. with LPN K revealed:* She was not aware of any resident who used Nair cream and resided at the facility.*A physician's order would be required for a resident to be allowed to use Nair cream.*The Nair cream would need to be locked in a medication cart or in the medication room for safe storage. 5. Interview on 2/3/26 at 2:20 p.m. with LPN/Unit manager C revealed:*All over-the-counter (OTC) medications, such as Nair cream, would require a physician's order and would need to be stored in the locked medication cart.*A medication self-administration assessment needed to be completed to determine if a resident was able to safely administer the Nair cream by themselves. 6. Interview and observation on 2/3/26 at 2:30 p.m. with CNA L in the shower room revealed:*There were no hygiene products in the shower room that required a physician's order.*She indicated that a cognitively impaired resident would not be a reliable source if they requested a chemical hygiene product, such as Nair cream, to be applied to their skin without a physician's order to do so.*A chemical hygiene product would be required to be applied by a nurse, as that is not part of her work delegated tasks and responsibilities as a CNA. 7. Interview on 2/3/26 at 2:40 p.m. with resident 2 revealed:*She was not aware of what the Nair cream was.*She did not know who applied the Nair cream to her peri area, but indicated that the staff member did not provide additional care for her that day.*She was not concerned about her safety at the facility. 8. Interview on 2/3/26 at 3:03 p.m. with CNA D revealed:*On 1/16/26, she gave resident 2 her shower.*She did not apply the Nair cream to resident 2's peri area.*She indicated that the Nair cream was applied by CNA N in resident 2's room and then taken off the resident's skin before she was brought to the shower room.*She indicated resident 2 was happy that the Nair cream was applied to her peri area and thought it would alleviate the discomfort she experienced when staff used the sling to assist with her transfers.*She did not see any redness to resident 2's skin on her peri area when she showered her. 9. Interview on 2/3/26 at 3:34 p.m. with resident 2's mother revealed:*She purchased the Nair cream for resident 2 when she was admitted to the facility.*She indicated that resident 2's family applied the Nair cream to resident 2's legs.*LPN G called resident 2's mother on 1/17/26 and informed her of the chemical burn resident 2 acquired from the use of the Nair cream and indicated it was applied to the resident's peri area.*She requested that LPN G discard the Nair cream in the garbage.*She stated LPN G instructed her that all over-the-counter medications brought into the facility by the family for a resident must be discussed with the nurse, an order must be received from the physician to use that medication, and it must be kept locked up.*She had no safety concerns for resident 2 and stated that she received (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	good care from the staff at the facility. 10. Interview on 2/4/26 at 10:15 a.m. with the director of nursing (DON), B revealed:*She was not aware that resident 2 had the Nair cream in her room.*She interviewed CNA N, and she indicated that she used it as a personal hygiene product for resident 2 and followed the directions on the bottle.*CNA N should not have applied the Nair cream to resident 2's peri area on 1/16/26.*The hospital indicated that the Nair cream had caused a chemical burn to resident 2's skin, and as a result, she developed cellulitis from the burn.*She started weekly audits of 5 resident rooms to ensure there were no ointments, creams, or treatments at their bedside without a physician's order.*She started weekly audits with 5 staff to ensure they understood that an order is needed for all treatments applied to residents and that it is not appropriate for a CNA to apply medicated treatments.*Provider's next QAPI (Quality Assurance and Performance Improvement) meeting was scheduled for 2/21/26, and they planned to review the audits and the additional education that was provided for all staff to ensure they are effective in preventing the reoccurrence of this type of injury. 11. Interview on 2/4/26 at 11:20 a.m. with LPN G revealed:*On 1/17/26, during a regular wound treatment for resident 2, she noticed the resident's peri area was red, and resident 2 indicated the area was sore.*She stated the skin looked like it had razor burn from being shaved with a razor.*She verified with CNA N, who worked on 1/16/26, that resident 2's peri area was not shaved with a razor, but indicated she applied the Nair cream when resident 2 requested it.*She notified resident 2's family of the incident and informed them that the Nair cream must have a physician's order for it to be used in the facility, and it must be locked up for resident safety.*The Nair cream was discarded in the garbage per the family's request. 12. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 2/4/26 after a record review revealed:*The provider followed their quality assurance process, and education was provided to all staff.-All staff were educated on items brought in by family members and that a physician's order is needed for those items. Competencies were conducted, and weekly audits were conducted of 5 resident rooms by the administrator or designee.*These will be reviewed during the QAPI meeting on 2/21/26 and thereafter for compliance.*A letter was sent out to families to ensure that any treatment they would like for the residents to have while in the facility must have a physician's order. The items needed to be brought to the nursing staff, and a physician's order must be obtained.*The letter was added as part of the admission paperwork for all residents and their families. *The social worker will do monthly check-ins with resident 2 for the next 3 months to ensure she feels safe at the facility.*Observations and staff interviews revealed that the staff understood the education provided and the revised processes 13. Review of the provider's 5/20/22 Certified Nursing Assistant job description revealed: In keeping with our organization's goal of improving the lives of the Guests we serve, the Certified Nursing Assistant (C.N.A.) plays a critical role in providing superior customer service and nursing care to all Guests. The C.N.A. safeguards the health, safety, and welfare of all Guests under their care by following applicable laws, regulations, and established nursing policies and procedures.The Essential Functions are included: 1. Provides quality nursing care to Guests in an environment that promotes their rights, dignity, and freedom of choice. 2. Provides individualized attention, which encourages each Guest's ability to maintain or attain the highest practical physical, mental, and psychosocial well-being. 3. Carry out assignments required for the Guest's activities of daily living (ADL's) which include but not limited to bathing, dressing, grooming, toileting, and feeding. 4. Attends to individual needs of all Guests in regards to incontinent care, transferring, ambulation, range of motion, communication and other needs. 5. Provides care that maintains each Guest's skin integrity to prevent pressure ulcers, skin tears and other damage by changing incontinent Guests, turning, (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	repositioning immobile Guests, and by applying moisturizers to fragile skin and other areas. 6. Performs various tasks assigned by the floor nurse, including checking vital signs, weighing Guests and by applying creams/ointments and collecting specimens. 14. Review of the provider's January 2018 Medication Storage in the Facility policy revealed: Medications and biologicals are stored safely, securely, and properly, following the manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. Based on the above information, non-compliance at F684 occurred on 1/16/26, and based on the provider's implemented corrective action for the deficient practice confirmed on 2/4/26, the non-compliance is considered past non-compliance.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) complaint report review, record review, observation, interview, and policy review, the provider failed to monitor and implement pressure ulcer (skin and/or underlying tissue injury due to prolonged pressure) healing and prevention interventions for one of one sampled resident (1) who admitted to the facility with a stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to her coccyx (tailbone) that worsened and who developed a pressure ulcer to her right ankle. Findings include:1. Review of the 1/23/26 SD DOH complaint report revealed:*Resident 1 had an infected open wound on her buttocks when she was admitted to the hospital 12/16/25.*Resident 1 was admitted to the facility from the hospital on [DATE].*When a family member asked a nurse about what treatments were being done to resident 1's bed sores the nurse stated she was not aware resident 1 had bed sores.*The family member was told at that time that the wound nurse was on vacation.*The nurse placed some dressings on resident 1's buttocks.*The family member dated those dressings and reported they remained on her buttock for nearly two weeks without being changed.*The family member stated, at the time of the report, there were no dressings on resident 1's buttocks.*Resident 1 was reported to be having increased confusion and continued weight loss since she admitted to the facility on [DATE].*She was reported to be weak, wanted to sleep all of the time, and was unable to adjust herself in bed or transfer from her bed to her chair.2. Review of resident 1's electronic medical record (EMR) revealed:*She was admitted to the facility from the hospital on [DATE].*Her 1/28/26 BIMS assessment score was 7, which indicated her cognition was severely impaired.*Resident 1's 12/31/25 hospital transfer orders indicated:- Miscellaneous Discharge OrderComments: Skin Breakdown Risk:1) Assess Bony prominences2. Turn/reposition every 2 hours3) Heels up/off bed.4) Protect skin- keep clean and dry.5) Moisture barrier for incontinence [involuntary urine or bowel leakage].6) Use lift pad [a pad used to lift or transfer a resident designed to prevent the dragging of a resident on the surface that they were being transferred to or from].7) Specialty bed if indicated (or air mattress overlay per facility protocol).* Coccyx pressure point Open with red wound bed.* Bedside RN [registered nurse] made aware of assessment and recommendations. Make sure patient is being repositioned at least every 2 hours to more frequently, heel lift boots are in place when in bed, and patient is sitting in the chair and/or ambulating [walking] as able.*A 12/31/25 progress note written by licensed practical nurse (LPN) J in resident 1's admission summary stated, open wound on coccyx (triad [a zinc-based paste to manage draining wounds such as a pressure ulcer] & [and] Mepilex daily).*Resident 1's 12/31/25 skin assessment upon her admission stated, the pressure ulcer was on her coccyx and measured 1 centimeter (cm) in length, 0.6 cm in width, and 0.1cm in depth. Resident 1's pressure ulcer was staged as a II.-There was no documentation of redness to her ankles, elbows, or hips.*Her 12/31/25 Braden Scale assessment (a tool used to assess the risk of developing pressure ulcers) indicated she had high risk for the development of a pressure ulcer due to her pressure ulcer that was present on admission.*On 12/31/25 there was a physician's order for Heel boots while in bed every shift for promotion of skin integrity but the order was not scheduled to start until 1/8/26.*On 1/4/26 there was a physician's order for Please offer recliner to resident BID [two times daily] for 1-2 hours two times a day for promotion of skin integrity.*A 1/6/26 progress note written by LPN K stated, The [redacted identification] approached writer and requested the resident's skin/wounds be checked. Writer assessed residents [resident 1's] skin per request. No current treatments noted on the treatment list at this time of assessment. Skin assessment revealed redness to the right outer ankle; existing mepilex dressing was removed and replaced. Sacral [done directly above the tailbone] area noted to have bony (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	prominence with a partially healed area consistent with a previous pressure injury; Mepilex dressing was removed and triad paste was applied to the area. Bilateral hips noted to have bony prominence; mepilex dressings present for cushion only, no open areas or skin breakdown underneath. Redness noted to bilateral elbows; Mepilex dressings were replaced. The resident tolerated assessment and care without distress. Findings were reported to PCP [primary care provider] and requested to have dressing changes completed every other day. Awaiting response at this time.*Resident 1's skin assessments indicated:-On 1/7/26 a skin evaluation was completed and stated there was a pressure ulcer on her coccyx, but it did not include the measurements, description of the wound bed or the surrounding tissue, or if there was any drainage from the wound.--The Mepliex dressings that were in place on that evaluation were on resident 1's bilateral hips, not on her elbows or ankles.-LPN/wound nurse O's first documentation of the pressure ulcer on resident 1's coccyx was on 1/8/26. It stated resident 1 had a stage III (3; open wound with full-thickness skin loss. Fatty tissue may be visible) pressure ulcer to her coccyx that measured, 0.4 cm in length, 0.5cm in width, and 0.1 cm in depth. The wound base was 50 percent covered in slough (yellowish, soft, stringy, and moist layer of dead tissue that acts as a barrier to healing) with redness and maceration (the softening and whitening of skin caused by prolonged exposure to moisture) to the surrounding tissues.*A 1/8/26 physician's order stated. Check areas covered by mepilex daily & [and] notify [resident 1's doctor] if wound develops; right outer ankle, bilateral hips and bilateral elbows,*A 1/9/26 physician's order for Arginaid [a supplement used to help with wound healing} two times per day.-The 1/9/26 physician's order for Arginaid was not charted as being attempted to be administered until 1/12/26.*On 1/14/26 LPN K documented the measurements of resident 1's stage III pressure ulcer to her coccyx as 0.4 cm by 0.5cm by 0.1cm. She also documented that resident 1's right outer ankle wound was a pressure ulcer but did not document measurements or a description of the wound.-The 1/14/25 wound evaluation completed by LPN/wound nurse O did not include an assessment of resident 1's right outer ankle.*Resident 1's medication administration record (MAR) and treatment administration record (TAR) indicated the physician's order for santyl [a cream to remove dead tissue] dressing was to be applied to resident 1's coccyx wound bed daily and as needed from 1/14/26 through 1/19/26.-It was not documented that the santyl dressing change was completed on 1/19/26.*A 1/19/26 physician's order stated, wound: coccyx- pressure: cleanse, collagen to wound bed, cover [with] silicone foam, change every other day and as needed.*On 1/21/26 LPN/wound nurse O documented resident 1's pressure ulcer to be no longer present.*On 1/23/26 an air mattress was ordered to promote skin integrity.3. Observation and interview on 2/3/26 at 11:15 a.m. with resident 1 in her room revealed:*Resident 1 was lying in her bed and was positioned on her right side with a pillow underneath her back.*The head of the bed and the foot of the bed were in a raised position.*She appeared thin and frail.*There was an air mattress on her bed.*There were two Prevalon boots (a cushioned boot that lifts the heel off the surface of the mattress, to help reduce pressure) on top of a cushion in her wheelchair.*Resident 1's heels were resting on the air mattress.*She had Mepilex dressings (a foam dressing used to treat wounds such as a pressure ulcer) on both of her elbows.*Certified nursing assistant (CNA) H entered resident 1's room. She woke up resident 1 and asked her if she could get her up for lunch, resident 1 stated no after multiple attempts and encouragement to get her out of her bed for lunch.*CNA H stated she had taken the Prevlon boots off resident 1 earlier that morning because she had had them on all night.*CAN H left the room and resident 1 stated the staff helped her when she needed help, but she did not want to get up or eat, she wanted to sleep.4. Observation on 2/3/26 at 12:00 p.m. of resident 1 in her room revealed:*She is lying in bed with the head of the bed and the foot of the bed elevated.*Her Prevalon boots were on both of her (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	feet.*The pillow remained behind her back, positioning her onto her right side.5. Interview on 2/3/26 at 1:56 p.m. with LPN K revealed:*On 1/6/26 resident 1's family member had asked her what the treatments were for her resident 1's wounds.*LPN K stated she did not know resident 1 had wounds, but she would look at resident 1's EMR.*LPN K stated there were no wound treatment orders in resident 1's EMR.*Resident 1 did not have a skin evaluation scheduled for that day, and she was unable to talk to the wound nurse.*LPN K looked at resident 1's skin and stated there were Mepilex dressings on both sides of her hips, right ankle, and coccyx.*Resident 1's hips and ankle did not have any wounds on them.*Her coccyx area had an open area on it.*LPN K stated she had measured the size of the open area on resident 1's coccyx but she was unable to find the measurements when she reviewed resident 1's EMR.*LPN K stated she had notified LPN/wound nurse O of resident 1's wounds at that time.*LPN K stated the Mepilex dressings she had removed were dated 12/31/25.*LPN K stated that on 1/6/26 resident 1 did not have an air mattress on her bed, a cushion in her wheelchair, or Prevalon boots for pressure ulcer treatment and prevention.6. Interview on 2/3/26 at 2:05 p.m. with LPN J revealed:*She had admitted resident 1 on 12/31/25 with director of nursing (DON) B.*She stated resident 1 was malnourished (an imbalance or deficiency of nutrients leading to poor physical health).*She had reddened areas on her both sides of her hips, both elbows, both ankles, and an open wound to her coccyx.*The wound on resident 1's coccyx was open, and there was a large area of redness.*LPN J and DON B measured resident 1's wound on her coccyx and documented the skin evaluation information in resident 1's admission assessment within her.*LPN J replaced the Mepilex dressings that covered those areas and notified LPN/ wound nurse O of the coccyx wound and the reddened areas.*LPN J stated that the interventions and treatments that the staff followed when a resident was admitted to the facility were the physician's orders from the hospital.*She did not know what those interventions were but stated they would be documented in resident 1's MAR or TAR.7. Observation on 2/3/26 at 2:45 p.m. of resident 1 in her room.*She was seated in her recliner which did not have a seat cushion.*She was not wearing her Prevalon boots and her heels were resting on the foot rest of the recliner.8. Interview on 2/4/26 at 8:30 a.m. with LPN M revealed:*On 1/7/26 resident 1's family member told LPN M that no one had looked at resident 1's skin.*LPN M completed a skin assessment on resident 1 and documented it in resident 1's EMR.*She stated resident 1 had an open area on her coccyx with slough in the wound.*She verified that she had not measured the open area on resident 1's coccyx because the wound nurse would do weekly rounds on the residents with wounds and document the appearance and measurements of those wounds.*LPN M notified LPN/wound nurse O of the open wound on resident 1's coccyx and the red areas on her hips, ankles, and elbows.* After review of resident 1's EMR LPN M verified the order for the Mepilex dressing changes every three days did not begin until 1/8/26, eight days after she was admitted .9. Interview on 2/4/26 at 9:28 a.m. with LPN/unit manager C and DON B revealed:*LPN/unit manager C stated the provider's process for wound identification and treatment upon admission to the facility was the nurse who completed the admission assessment would document any skin issues or wounds on the resident's admission assessment.-That nurse would then notify the wound nurse of any wounds or areas of concern and then the wound nurse was expected to follow up by the next business day.-The wound nurse would complete a detailed assessment of the wound, write a progress note in the resident's EMR, and update the resident's care plan (personalized plan that addresses a resident's care needs, goal, and interventions) with any preventative interventions or treatments that the resident was to have.*DON B expected that the wound nurse would assess a resident's wounds or skin concerns within 48 hours of admission to the facility and update that resident's care plan.*DON B stated that LPN/wound nurse O was the wound nurse at the time of resident 1's admission but had resigned from that (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	position at the facility recently.*LPN/unit manager C stated she had removed resident 1's Mepilex dressing to her left heel on 1/5/26, replaced it with a new Mepilex dressing, and applied Prevalon boots on resident 1's feet.*After reviewing resident 1's EMR she verified that the Prevalon boots were not documented as having been applied routinely by the nursing staff until 1/8/25 and resident 1 did not have an air mattress until 1/23/26.*LPN/unit manager C did not know why the 12/31/25 physician's order for Prevalon boots did not start until 1/8/26.10. Interview on 2/4/26 at 10:00 a.m. with DON B revealed:*She reviewed resident 1's EMR and verified the initial wound nurse visit was completed on 1/8/26, which was eight days after resident 1 was admitted to the facility.*DON B verified resident 1's care plan was not updated by the LPN/wound nurse O with interventions or treatments when she was admitted to the facility on [DATE].*DON B staged resident 1's pressure ulcer when she was admitted to the facility on [DATE].*DON B did not know why resident 1's 1/9/26 Arginade supplement order was not started until 1/12/26.Continued interview on 2/4/26 at 12:00 p.m. with DON B revealed:*The provider did not have a skin assessment or evaluation policy.*She was unable to locate any documentation that LPN/wound nurse O had evaluated resident 1 between her admission on [DATE] and 1/8/26.*DON B verified LPN/wound nurse O did not evaluate or provide preventative interventions or treatments for resident 1's wounds to prevent the worsening of the pressure ulcer on resident 1's coccyx and to prevent the reddened areas on both her ankles, both sides of her hips, and both elbows from developing into a pressure ulcer until 1/8/26.*DON B acknowledged the delay in providing pressure reduction interventions and treatment for resident 1's pressure ulcer on her coccyx could have delayed the time it took for the pressure ulcer to heal.11. Review of the provider's 5/14/25 Skin and Pressure Injury Prevention Program policy revealed:* To provide care and services to prevent pressure injury development and to promote the healing of pressure injuries/wounds that are present.* A baseline assessment of the resident's skin status will be completed upon admission/readmission by completing the Nursing Admission/readmission UDA [User Defined Assessment].* A plan of care (POC) will be put into place for residents that are identified with actual skin breakdown or at-risk for skin breakdown.* Nursing personnel will utilize the results of the physical exam and the Pressure Injury Assessment tools to determine an individualized pressure injury prevention program for each at-risk resident. This will include interventions to:a. Protect skin against the effects of pressure, friction, and shear.b. Protect skin from moisture.c. Encourage optimal nutrition and fluid intake.d. Educate staff, residents and families.e. Train front-line caregivers.f. Immediate prevention plan instituted when potential areas are identified.* A wound assessment will be completed:A) When a pressure injury is identified: This assessment will include,a) Site, stage, size, appearance of wound bed, (use %) undermining, depth, drainage, (amount, color, type, consistency and odor) and status of peri-wound tissue;b) Treatment of the pressure injury (cleansing, debridement, dressings);c) A review of the resident's current POC and medical status- any other possible risk factors, impaired healing due to diagnosis.* Reassess the wound at least weekly (if the wound has not improved within 2-3 weeks, contact MD [medical doctor]/Provider for a change in treatment.* Nursing personnel will develop a plan of care (POC) with interventions consistent with resident and family preferences, goals and abilities, to create and environment to the resident's adherence to the pressure injury prevention/treatment plan. POC to include: Impaired mobility, including turning and repositioning at least every two hours or more if indicated by assessment. Pressure relief, Nutritional status and interventions, Incontinence, Skin condition checks, Treatment, Pain, Infection, Education of resident and family, Possible causes for pressure injury and what interventions have been put into place to prevent.* If the assessment is completed by a LPN, there should be collaboration with a RN (may be the DON or other designated RN) to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026

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.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	ensure wound status, treatments and interventions are reviewed. This may be accomplished through the facility's at risk meeting or other documented means to show LPN to RN collaboration is occurring at least weekly.

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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 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. Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review, the provider failed to ensure the staff safely transferred a resident according to the resident's care plan for one of one sampled resident (4) who needed to be transferred with the assistance of two staff members by one of one certified nursing assistant (CNA)(P) who attempted to transfer the resident without the assistance of another staff member. That failure resulted in the resident having pain in her left knee and sustaining two skin tears to her left leg.Findings include:1. Review of the 1/20/26 SD DOH FRI revealed that on 1/15/26 at around 4:00 p.m., resident 4 sustained two skin tears when her left leg hit her wheelchair during a transfer. According to resident 4's care plan, she was to be transferred with the assistance of two staff members. CNA P attempted to transfer resident 4 by herself. During the transfer, resident 4's left leg hit her wheelchair causing the skin tears. After the incident, resident 4 did have increased pain in her left knee and received an x-ray of that knee on 1/19/26.2. Review of resident 4's electronic medical record (EMR) revealed that her 11/21/25 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated that her cognition was intact. She had diagnoses of muscular dystrophy [a genetic disease that causes irreversible weakness and degeneration of skeletal muscles], unsteadiness on her feet, and decreased mobility. Her 11/24/25 care plan had a Focus area of requires assistance with ADLs [activities of daily living] r/t [related to] muscular dystrophy and an intervention of Transfers: Extensive assist of 2 [2 staff members].3. Interview on 2/3/26 at 3:55 p.m. with CNA P revealed that she was aware that resident 4 was supposed to be transferred with two staff members. She recalled that she had transferred resident 4 by herself before without any problems. She said that she had grabbed resident 4 under her armpits and lifted her up from the wheelchair, then turned to place her on the bed. CNA P then realized that she did not put resident 4's bed in a low position and was unable to lift her high enough to get her onto the bed. She turned back to place resident 4 back in her wheelchair. When she set resident 4 down, resident 4 started to slide down out of her wheelchair and was lowered to the ground. CNA P admitted that she should have had a second staff member to assist with the transfer.4. Interviews were conducted on 2/4/26 in the afternoon with CNAs E, F, and H. They were aware of where to find resident information regarding resident cares and transfers.5. Interview on 2/4/26 at 12:40 p.m. with director of nursing (DON) B revealed she was notified of the incident by the staff after it happened. She reported that CNA P was immediately interviewed about the event and was educated on the use of resident care plans. She expected CNAs to follow the resident's care plans to help prevent falls and injuries.6. Review of the provider's 5/20/2022 CNA job description revealed In keeping with our organization's goal of improving the lives of the Guests we serve, the Certified Nursing Assistant (C.N.A.) plays a critical role in providing superior customer service and nursing care to all Guests. The C.N.A. safeguards the health, safety, and welfare of all Guests under their care by following applicable laws, regulations, and established nursing policies and procedures. Essential functions of the CNA included 4. Attends to individual needs of all Guests in regards to incontinent care, transferring, ambulation, range of motion, communication and other needs. 5. Provides care that maintains each Guest's skin integrity to prevent pressure ulcers, skin tears and other damage by changing incontinent Guests, turning, repositioning immobile Guests and by applying moisturizers to fragile skin and other areas. 7. Must be knowledgeable of individual care plans and support the care planning process by providing supervisor's with specific information and observations of the Guest's needs, preferences and report any behavioral changes.7. Review of the provider's 5/14/25 care plans policy revealed Policy: Individual, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. 3. Care planning is constantly in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death. 5. The physician's orders (including medications, treatments, labs, and diagnostics) in conjunction with the resident's care plan constitute the total ‘plan of care.’