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	03/31/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **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 protect the residents' right to dignity and privacy for two of two observed sampled residents (16 and 74) with soiled clothing and unclean hands and faces, and one of one observed sampled resident (3) not provided privacy while receiving personal care in his shared room by two of two observed certified nursing assistants (CNA) (N and Q). Findings include: 1.Review of the provider's 3/17/26 SD DOH FRI regarding resident 16 revealed resident 16's family member reported concerns related to the quality of care being provided for resident 16. Resident 16's family member reported that she did not feel resident 16 was being changed regularly or was assisted out of her bed and taken to the dining room for meals. 2. Observation on 3/24/26 at 2:23 p.m. of resident 16 in her room revealed she was sitting in her wheelchair with a dried green substance on her nose and, had a urinary catheter (flexible tubing placed in the bladder to drain urine). 3. Observation on 3/24/26 at 3:47 p.m. of resident 16 in her room revealed she was lying in her bed and the dried green substance remained on her nose. 4. Review of resident 16's electronic medical record (EMR) revealed she admitted to the facility on [DATE]. Her 3/6/26 Brief Interview of Mental Status (BIMS) assessment score was 4, which indicated her cognition was severely impaired. Her diagnoses included depression and senile degeneration of the brain (a progressive age-related cognitive decline caused by brain cell death). Her 3/25/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated she had difficulty with communication and was to be asked yes or no questions. The staff were to provide resident 16 with clear, careful explanations to facilitate her understanding. Resident 16 required the assistance of one staff member with getting dressed, was dependent upon the staff for her personal hygiene needs, and was to be transferred between surfaces with the assistance of two staff members with the use of a full body lift (a mechanical lift and sling used to lift (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a person's full body). 5. Interview on 3/25/26 at 2:50 p.m. with CNA/CMA R revealed director of nursing (DON) B and administrator A spoke with her about resident 16's family member's concern about resident 16 being left in her bed with her nightgown on until 2:30 p.m. CNA/CMA R stated she was not assigned to assist resident 16 with her cares prior to 3/17/26 when resident 16's family member expressed her concerns related to the care her mother had received by the staff. CNA/CMA R stated she had checked on resident 16 on 3/16/26 and asked her if she needed anything but resident 16 did not answer her so CNA/CMA R left her in her bed with her night gown on. 6. Interview on 3/30/26 at 2:08 p.m. with resident 16's family member on the phone revealed she had spoken with administrator A about her concerns related to the quality-of-care resident 16 received from the staff. Resident 16's family member stated that the resident was unable to use her call light to ask for assistance by the staff and was dependent on the staff for assistance with all of her personal care needs. About one week after resident 16 admitted to the facility, resident 16 was lying in her bed and spilled her juice on her stomach and her bed sheets. Resident 16's family member visited later that day and saw she had spilled juice on herself. The next day resident 16's family member arrived at the facility to visit the resident and noticed the resident's bed sheets were not changed because the dried juice stain was still on them. She came to visit resident 16 one day around 2:30 p.m. and found her lying in her bed, in her pajamas with food on her face and clothing. She was unable to remember the date of that observation but stated it was close to the day that she expressed her concerns to the administrator (3/17/26). On 3/17/26 resident 16's family member told administrator A that she wanted the resident to be out of bed to eat lunch and supper in the dining room and not be left uncared for in her room. 7. Interview on 3/31/26 at 1:41 p.m. with administrator A revealed she had completed the 3/17/26 DOH FRI. Resident 16's family member expressed her concerns about the quality-of-care resident 16 received from the staff to administrator A. Resident 16 refused some cares the staff offered her and at times refused to get out of bed for meals. Administrator A reviewed resident 16's EMR during her investigation of resident 16's family member's concerns and determined that the CNAs documented resident 16's clothing and incontinence (involuntary urine or bowel leakage) products were changed. 8. Observation on 3/24/26 at 9:06 a.m. of resident 74 revealed he was lying in his bed. He had a white shirt on that had multiple brown discolorations on the chest and arms of that shirt. 9. Observation and interview on 3/24/26 at 11:33 a.m. with resident 74 in the dining room revealed he was wearing a white shirt with the brown discolorations on the chest and sleeves. He was drinking out of a handled mug. When he brought the mug towards his mouth, the brown liquid from the mug (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	spilled out onto his clothing protector and shirt before he could bring the mug to his mouth. Resident 74 stated he was drinking coffee. During the lunch dining observation resident 74 continued to spill the coffee onto his clothing protector and shirt as he attempted to drink. The staff in the dining room did not offer assistance or interventions to avoid resident 74's drink spilling onto his clothing protector and shirt. 10. Observation and interview on 3/24/26 at 2:44 p.m. with resident 74 in his room revealed he was lying in his bed, wearing the same white shirt with the brown discolorations on the chest and arms, and pieces of food were in his beard around his mouth. He stated he would have liked the staff to change his shirt because it was dirty, he had trouble with spilling food and drinks on his shirt at times and would like more assistance with eating and drinking. 11. Observation on 3/30/26 at 1:03 p.m. of resident 74 sitting in his wheelchair in the hallway beside the nurses' stations revealed he had food in his beard and a thick orange substance on his fingers surrounding his fingernails. 12. Observation on 3/30/26 at 3:27 p.m. of resident 74 sitting in his wheelchair in the hallway beside the nurses' station revealed he had thick orange substance on his fingers surrounding his fingernails, orange and white substances in his beard, and red and orange pieces of food on his shirt. 13. Review of resident 74's EMR revealed he admitted to the facility on [DATE]. His 2/9/26 BIMS assessment score was 00, which indicated his cognition was severely impaired. His 3/25/26 care plan indicated that his speech was unclear at times but usually understood others and was usually able to be understood. He was dependent upon the staff for his personal hygiene, oral hygiene, and dressing. Resident 74's CNA task documentation and nurse progress notes did not indicate on 3/24/26 or 3/30/26 that he refused having his clothing changed or his face and hands washed. 14. Interview on 3/31/26 at 8:32 a.m. with registered nurse (RN) T revealed she expected the staff to offer to change a resident's clothing if it became soiled, but that the resident could refuse. If a resident refused to have their clothing changed, she expected the refusal to be documented in that residents EMR. She expected a resident's hands and face to be washed when they became soiled. Resident 74 required assistance from the staff to wash his face and hands and change his clothing. Resident 74 had refused his clothing being changed at times but had allowed them to be changed other times. 15. Interview on 3/31/26 at 8:56 a.m. with restorative aid (RA) PP revealed residents' clothing was to be changed when it was dirty. A resident's face and hands should be washed after meals and any time they were soiled. Resident 74 allowed staff to change his clothes and wash his hands and face if they asked him. She felt it was undignified treatment when residents did not get their clothing changed or their hands and face washed when they were soiled. She thought that resident 74 often was not assisted by the staff to change his clothing or wash his face and hands when they were soiled and stated that happened to other residents as well. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	16. Interview on 3/31/26 at 10:45 a.m. with director of nursing (DON) B revealed she expected the staff to change a resident's clothing and wash their hands and face when they were soiled. If the resident refused to have their clothing changed or their face and hands washed, she expected the CNA to document the resident's refusal and notify the resident's nurse so she could document the resident's refusal. 17. Observation on 3/24/26 at 2:55 p.m. of CNAs N and Q in resident 3's room revealed they each put on a pair of gloves and then placed a gait belt (a waist strap gripped as support for safe mobility and transfers) around resident 3's waist. They assisted him to stand at the sink, lowered his pants, removed his incontinence brief, cleaned his private areas with a wet wipe, and put a new incontinence brief on the resident. Resident 3's roommate was lying in his bed at that time. The privacy curtain was not pulled far enough to prevent the roommate from seeing resident 3 during the observed personal care above, and the window blinds were open. 18. Interview on 3/25/26 at 10:59 a.m. with CNA/staffing coordinator AA revealed that resident 3 should have been changed while lying in his bed or standing by his bed, with the privacy curtain pulled, and out of view of the window. 19. Interview on 3/31/26 at 1:05 p.m. with DON B revealed that she expected resident 3 to be changed in bed or in an area where he could not be seen by others. She acknowledged that the above observation did not provide him with dignity or privacy. 20. Review of resident 3's EMR revealed his 3/12/26 BIMS assessment score was 2, which indicated his cognition was severely impaired. He had diagnoses of depression (persistent sadness, low energy, and loss of interest in activities) and anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). His 2/18/26 care plan indicated he had a severe mental illness with a risk for abuse and neglect. 21. Review of the provider's 11/18/25 Resident Dignity and Privacy policy revealed that the facility was to protect and promote resident rights and treat each resident with respect and dignity, as well as, care for each resident in a manner and in an environment, that maintains resident privacy. Groom and dress residents according to resident preference. Clothing should be changed when soiled. Document any resident refusals. Privacy was to be provided to residents when assisting them with their personal care. And the doors, window blinds, and divider curtains were to be closed to provide privacy.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, and policy review, the provider failed to support the residents' right to choose and receive the frequency of bathing consistent with their preferences for four of thirty-four sampled residents (16, 36, 61, and 77) who preferred to receive bathing at least twice a week. Findings include:1. Review of the provider's 3/17/26 SD DOH FRI regarding resident 16 revealed resident 16's family member reported concerns related to the staff not providing resident 16 routine bathing.Administrator A indicated in the 3/17/26 FRI that resident 16 received a bath on 3/9/26 and 3/16/26 and was provided an additional bath on 3/17/26 at the request of resident 16's family member. 2. Review of resident 16's electronic medical record (EMR) revealed she admitted to the facility on [DATE]. Her Brief Interview of Mental Status (BIMS) assessment score was 4, which indicated her cognition was severely impaired.Her 3/25/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated she preferred to have a shower or bath two times a week.The 1/28/26 through 3/25/26 bathing documentation for resident 16 indicated she received a bath on 3/9/26, refused her bath on 3/13/26, received a bath on 3/16/26 and was not available for a bath on 3/20/26. There was no documentation that she received or was offered bathing on 3/23/26.Resident 16's 3/20/26 progress note indicated there was no documentation that resident 16 was out of the facility or any other reason she was unavailable for her bath that day. 3. Interview on 3/30/26 at 2:08 p.m. with resident 16's family member revealed that staff provided her mother one shower since she admitted to the facility on [DATE] and when she expressed her concerns about the care her mother received on 3/17/26. 4. Interview on 3/24/26 at 1:51 p.m. with resident 36 revealed there were times when he did not receive a bath for a week. He stated he had to repeatedly remind the staff that he needed a bath before he would get his bath. The days of the week which he was given his bath were not consistent. At times he would wait a week between his baths and other times his baths were every other day. 5. Review of resident 36's EMR revealed he admitted to the facility on [DATE]. His 2/25/26 BIMS assessment score was 12, which indicated his cognition was moderately impaired. His 3/25/26 care plan indicated he preferred to receive a shower or a bath two times per week.The bathing documentation from 1/28/26 through 3/25/26 for resident 36 indicated he was to be provided baths or showers two times a week on Wednesdays and Saturdays. He was scheduled to receive a bath or shower on January 28 and January 31; February 4, 7, 11, 14, 18, 21, 25, and 28; and March 4, 7, 11, 14, 18, and 21. There was no documentation that he refused to bathe or shower.Before his shower on 2/21/26, it was seven days since he had received a bath or shower and before his shower on 3/13/26, it was six days since he had received a bath or shower. 6. Interview on 3/24/26 at 2:00 p.m. with resident 61 revealed he did not receive the showers that he was supposed to. He was scheduled for a shower on 3/24/26 but he stated he did not know if he was going to receive a shower that day. 7. Review of resident 61's EMR revealed he admitted to the facility on [DATE] and his 2/25/26 BIMS assessment score was 15, which indicated his cognition was intact. His 3/25/26 care plan indicated he preferred to receive a shower or a bath two times per week.The bathing documentation from 1/28/26 through 3/25/26 for resident 61 indicated he was to be provided baths or showers two times a week on Tuesdays and Fridays. He did not receive a bath or shower on 2/13/26, 3/3/26, 3/6/26, and 3/17/26. There was no documentation that he refused to bathe or shower. Between 2/10/26 and 2/17/26 resident 61 was not bathed or showered for seven days, between 2/27/26 and 3/10/26 he was not bathed or showered for ten days, and between 3/13/26 and 3/20/26 he was not bathed or showered for seven days. 8. Observation and interview on 3/24/26 at 2:48 p.m. with resident 77 revealed he had long jagged fingernails and smelled like urine. He wanted his showers on Sundays and Thursdays but there were times he did not receive his shower on his (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scheduled day, or the day was changed. He stated there were times when the staff told him he was not going to get a shower because the shower was being repaired. 9. Review of resident 77's EMR revealed he was admitted to the facility on [DATE]. His 2/20/26 BIMS assessment score was 10, which indicated his cognition was moderately impaired, and his 3/24/26 care plan indicated he preferred to shower two to three times a week.Resident 77's shower documentation from 1/28/26 through 3/25/26 indicated he was to be provided a shower twice weekly on Sundays and Thursdays. He did not receive a shower on 1/29/26, 2/26/26, 3/5/26, and 3/19/26. There was no documentation that he refused to bathe or shower.Between 1/25/26 and 2/1/26 resident 77 did not bathe for six days, between 2/22/26 and 3/1/26 he did not bathe for six days, between 3/1/26 and 3/8/26, he did not bathe for six days, and between 3/15/26 and 3/22/25 he did not bathe for six days. 10. Review of the provider's undated Center Hall Bath Schedule revealed that resident 77 was scheduled to receive bathing on Sundays and Thursdays, resident 16 was scheduled to receive bathing on Mondays and Fridays, resident 61 was scheduled to receive bathing on Tuesdays and Fridays, and resident 36 was scheduled to receive bathing on Wednesdays and Saturdays. 11. Review of the provider's grievance log from November 2025 through March 2026 revealed on 11/19/25 four residents brought forward a concern of not having received their baths or showers. On 1/21/26 during a resident council meeting the residents expressed their concern about not having received their baths.On 3/6/26 residents 28 and 92 filed grievances because they were not receiving their baths. On 3/18/26 during a resident council meeting the residents indicated they wanted a designated bath aide to give them their baths and showers. The resolution indicated, Educated [the] residents in [the] resident council [meeting] on why [a] bath aide hasn't worked in the past, reviewed [the] resident's baths and they are receiving [their] baths, refusals [were] documented. 12. Interview on 3/25/26 at 10:00 a.m. with the resident council revealed there were eleven residents present during the interview and seven residents expressed concerns related to bathing.They said that the baths were not completed as scheduled. They were told by the CNA that was supposed to given them their bath that they were being skipped because there were other residents who had waited longer for their bath. They were told in resident council a bath aide was hired to give them their baths, but that did not last. They were told that they were short-staffed and the staff could not give the residents their baths.One resident said she had waited eight days to get a bath, another resident thought she previously waited two weeks between her baths, a third resident stated it was two weeks since his last bath because the chair he needed broke and was not fixed or replaced, and another resident stated he had one bath in three weeks and his preference was two baths per week.The residents stated they felt the provider worked on the issues they brought to the resident council meetings but then the issues returned after they were provided a resolution during resident council. 13. Interview on 3/31/26 at 8:32 a.m. with registered nurse (RN) T revealed she had received residents' complaints related to not receiving their baths as they were scheduled. There were times when leadership asked staff to come in to work an extra shift to attempt to get the residents bathed.If a resident refused a bath, she expected the CNA to reapproach that resident for their bath later. If that resident continued to refuse their bath, the CNA should document that resident's refusal in their EMR.She acknowledged that the residents not receiving their baths as scheduled could potentially contribute to odors, dignity concerns, and skin breakdown.RN T did not know how to determine what the residents' scheduled baths were or what each resident's bathing frequency preference was. She stated the residents' bathing schedule used to be on the pocket care plan (a document that identifies residents' care needs and interventions) but it was no longer there. 14. Interview on 3/31/26 at 8:56 a.m. with restorative aide (RA) PP revealed she gave residents' their baths when she worked as a CNA. She stated residents had complained to her about not receiving their baths as often as they preferred. The residents' baths were not completed as they were scheduled. There were times a resident may not be provided with a bath for more than one week. She acknowledged that the residents not receiving their scheduled baths had the potential to contribute to odors, skin conditions, and could impact that resident's dignity.The identified bathing (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	preferences were in each resident's care plan, and the baths were scheduled on a bath schedule form.The CNAs working with the residents who were scheduled for a bath on that day were responsible for assisting those residents with their bathing. There were two bathing rooms on the long-term care side of the facility and one bathing room for the short-term rehabilitation residents. 15. Interview on 3/31/26 at 10:45 a.m. with director of nursing (DON) B revealed she expected the residents to be bathed according to the residents' identified preferences in their care plans. The provider did not have a designated bath aid, the CNA responsible for the resident who was scheduled to have a bath that day would give that resident their bath.If a resident refused their bath, she expected that refusal to be documented in the resident's EMR.She was aware there were grievances brought forward during the resident council meeting several months ago related to residents not receiving their preferred bathing frequency. She felt the issue related to residents receiving their baths according to their identified preferences had improved.Each morning the facility's leadership staff reviewed any EMR triggered alerts related to bathing, which included if a bath was not given as scheduled. 16. Interview on 3/31/26 at 1:41 p.m. with administrator A revealed she had spoken with resident 16's family member about her concerns related to resident 16's bathing and felt she was not receptive to the explanation of the cares that were provided to resident 16.She expected the staff to follow the residents' care plans while they attended to each resident's care needs.Administrator A did not know why resident 16 was documented to be unavailable for her bath on 3/20/26. There was no additional information documented in the EMR about that. 17. Review of the provider's 5/14/25 Bathing policy revealed The purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. The resident has the right to choose timing and frequency of bathing activity. Document bathing activity or refusal of the bathing activity. If [the] resident refuses bathing, reapproach [the] resident at a later time or offer another day to bathe the resident.

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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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) Facility Reported Event (FRI) report, interview, record review, observation, and policy review, the provider failed to protect the resident's right to be free from neglect for one of one sampled resident (15) who was left in the dining room for approximately 10 hours by one of one certified nursing assistant (CNA) (RR) and one of one licensed practical nurse (LPN) (SS) without receiving identified interventions to meet his care needs. Findings include:1. Review of the 11/8/25 SD DOH FRI report revealed that on 11/8/25 at around 10:00 p.m., CNA AA notified director of nursing (DON) B that resident 15 was left in the dining room without being changed. Upon camera review, resident 15 was brought out to the dining room around 8:30 a.m. and was not taken back to his room until 6:31 p.m. The report indicated that resident 15 had a urinary catheter (flexible tubing placed in the bladder to drain urine), was able to move around in his wheelchair, readjust himself in his wheelchair, was forgetful and needed the staff to assist him with using the bathroom. His skin was assessed, and he did not have skin breakdown related to the incident. He was not incontinent of his bowels. When interviewed, resident 15 indicated he felt safe at the facility. CNA RR and LPN SS were responsible for providing his care needs that day (11/8/25). CNA RR's employment with the facility was terminated, and LPN SS was educated and returned to work after the investigation was completed. To prevent similar incidents from occurring, the facility reminded all staff to ensure that residents were taken out of the dining room between meals to have their cares completed, audits to ensure residents were not left in the dining room between cleans to receive cares were to be completed every four weeks and then monthly for two months, and all staff were educated about the provider's abuse and neglect policy. 2. Interview on 3/25/25 at 8:45 a.m. with resident 15 revealed that he did not answer questions appropriately and smiled. 3. Review of resident 15's electronic medical record (EMR) revealed he admitted to the facility on [DATE]. His 12/31/25 Brief Interview for Mental Status (BIMS) assessment score was 1, which indicated his cognition was severely impaired. He had diagnoses of metabolic encephalopathy (a decline in brain function related to a chemical imbalance in the body) and dementia (a group of symptoms affecting memory, thinking, and social abilities). He had a 4/3/25 physician's order to receive Donepezil 10 milligrams (mg) daily (a medication for dementia). Resident 15's 1/5/26 care plan indicated he was at risk for skin impairment related to his Braden score (a tool used to assess the risk of developing pressure ulcers) and a history of having a stage II (open wound or blister with partial-thickness skin loss) pressure ulcer to his right buttock and left foot. He was to be repositioned by staff every two hours and as needed, to prevent skin damage. He had a urinary catheter and was at risk for urinary infections. His urine output was to be documented every shift, typically after each emptying. He required substantial assistance from staff with completing his toileting hygiene care every two to three hours, transferring, and with his wheelchair mobility. He had a risk for falling, he required extensive care, and his care needs would be provided during his stay at the facility. Resident 15 would be treated with respect, dignity, and reside in the facility free of mistreatment. 4. Observations of resident 15 and other residents during the survey process from 3/24/26 through 3/26/26 and 3/30/26 through 3/31/26 revealed that residents were not left in the same area for prolonged periods of time. 5. Interviews completed with direct care staff during the survey process indicated that they received education to not leave the residents in an area for a prolonged period of time without care being provided. 6. Interview on 3/31/26 at 12:24 p.m. with registered nurse (RN) T revealed she monitored the resident's care provided by the staff, and she would document in the resident's EMR that scheduled repositioning was completed for the residents who needed to be repositioned. 7. Interview on 3/31/26 at 12:27 p.m. with CNA TT revealed that if he saw a resident sitting in the same area for a prolonged period without care he would notify the nurse. 8. Interview on 3/31/26 at 12:29 (continued on next page)

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	435039	A. Building B. Wing	03/31/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m. with dietary aide GG revealed that she would notify the nurse to assist residents who needed help if they were left in the dining room for a prolonged period. 9. Interview on 3/30/26 at 4:00 p.m. with DON B revealed the provided list of staff who were educated about the abuse and neglect policy did not include all of the facility staff. 10. Interview on 3/31/26 at 9:25 a.m. and 1:05 p.m. with DON B revealed that the facility's investigation of the above incident determined that resident 15 was neglected by the staff because CNA RR did not follow his care plan and did not provide him care for approximately ten hours. CNA RR's employment with the facility was terminated. She could not find documentation that all staff were educated on the abuse and neglect policy after the 11/8/25 incident, as was indicated in the provider's final investigation report to the SD DOH. 11. Review of the provider's 5/14/25 Abuse and Neglect policy revealed It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse,.neglect, or mistreatment. It defined neglect as the failure to provide necessary and adequate (medical, personal or psychological) care. Neglect is the failure to care for a person in a manner, which would avoid harm and pain, or the failure to react to a situation which may be harmful. Staff may be aware or should have been aware of the service the resident requires but fails to provide that service. Employees were to be trained on abuse and neglect during orientation and to have annual continuing education.

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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) report, interview, record review, and policy review, the provider failed to follow professional nursing standards regarding following physicians orders timely for one of one sampled resident (112) who was not administered antibiotic medications as ordered and notifying the physician about one of one sampled resident (88), who complained of feeling dizzy after receiving dialysis (a treatment that removes waste products and excess fluid from blood when the kidneys are unable to) that the resident was not consistently administered his blood pressure medication as ordered or of his low blood pressures. Findings include:1. Review of the SD DOH FRI report revealed that the provider received orders for resident 112 for cefuroxime (antibiotic) for a urinary tract infection (UTI) on Friday, 7/11/25. The order was left on a fax machine in the front reception area over the weekend, so it was not implemented. The provider found those orders on Tuesday, 7/15/25, and that same day received physicians' orders for a different antibiotic, nitrofurantoin, after the urine culture results were completed. On 7/15/25, resident 112 and her family requested to go to the emergency room. To prevent further instances from occurring, the provider educated all on-call managers and weekend managers to check the fax machine behind the reception desk for faxed orders and to give those orders to the respective nurses. The nurses were educated to check the main fax machine for orders throughout their shift. The physicians' offices were given updated fax machine numbers to which they should send orders to. 2. Phone interview on 3/30/26 with resident 112's son revealed that a few days after admission to the facility, resident 112 became more confused, had back pain, and he was concerned the resident had another UTI. He requested that she have urine collected for urinary analysis (urine testing for health issues such as infections, also known as UA) collected on a Monday. He called the facility that Tuesday to see if her urine sample was collected, and was told it would be collected that afternoon. He was told by staff that on Wednesday, they had collected the sample, but it had sat in the refrigerator for too long, and it had to be recollected. The person he talked to at the nursing home said he was going to deliver it to the laboratory himself. He said the facility did not start the antibiotic that was ordered while the urine culture (UC) was pending. He was told that the resident was given a dose of a newly prescribed antibiotic on 7/15/25, before she went to the emergency room. In the emergency room, the papers that were sent by the facility indicated that the antibiotic was not given to the resident. Resident 112 was admitted to the hospital on [DATE] and did not go back to the nursing home, per his request. He reported he was upset about the situation, and talked to the nursing home administration about his frustrations regarding his mother's delayed care. 3. Review of resident 112's electronic medical record revealed she admitted on [DATE]. Her 7/3/25 Brief Interview for Mental Status (BIMS) assessment score was 11, which indicated she had moderate cognitive impairment. Her diagnoses included respiratory failure (a condition making it hard to breathe) and pneumonia (lung infection). Her 7/2/25 care plan indicated she had the potential for infection. Staff were to monitor for signs and symptoms of infection. She was at risk for altered thought process, and staff were to notify the physician if she displayed any changes in her cognitive function or behavior. She had a urinary catheter that was to be changed per the physician's orders. A 7/8/25 at 4:24 a.m. progress note by registered nurse (RN) S stated that resident 112's son called with concerns that his mother was more confused, and he requested a urine sample to be collected. RN S notified the resident's physician. A 7/8/25 physician visit report indicated that resident 112 had increased confusion, and the physician ordered a UA. On 7/8/25, physician orders were received to change her urinary catheter and collect a urine sample for UA/UC. That order was noted as reviewed on 7/8/25 by licensed practical nurse (LPN) KK. On 7/8/25 at 11:19 a.m., a progress note by LPN KK included the resident 112's physician ordered a UA/UC. On 7/8/25 at 3:37 p.m., a progress note by LPN KK stated that resident 112 had been confused all day. She was supposed to wear her oxygen at (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	a flow rate of four liters (L) per minute, but the resident refused to wear the oxygen tubing because she thought there was urine in the tubing. LPN KK educated her, and reapplied her oxygen. On 7/8/25 at 4:37 p.m., a progress note by LPN KK indicated that resident 112 continued to be confused. The resident was on her phone talking to a friend, and she told her friend she was going to be kicked out of the facility. Resident 112's treatment administration record (TAR) indicated that her catheter was to be changed prior to the UA being collected, and the catheter was scheduled to be done on 7/8/25 at 6:00 p.m. It was documented as completed on 7/9/25 at 5:23 a.m. by RN S. A 7/10/25 at 3:13 p.m. lab report indicated the urine sample was collected on 7/10/25 at 1:30 p.m. and received on 7/10/25 at 2:53 p.m. The report was sent to the physician, and orders were received on 7/11/25 for Cefuroxime antibiotic 500 mg to be given to the resident twice a day for five days. This order was not noted as reviewed by staff. On 7/10/25 at 4:20 p.m., a progress note by RN F indicated that lab results were received and faxed to the physician. A 7/11/25 lab report indicated that resident 112's urine sample was collected on 7/9/25 at 1:07 a.m. and was received on 7/10/25 at 7:39 a.m. That lab result indicated there was Enterobacter cloacae complex (type of bacteria) in more than 100,000 (Colony Forming Units per milliliter) CFU/mL (indicates the number of bacterial cells found in the test), and susceptibility (a lab report that indicates what antibiotic could be used to treat the specific infection) was to follow. This urine lab result report was noted as reviewed by LPN KK on 7/11/25. On 7/11/25 at 11:20 p.m. progress note by LPN KK indicated that she had notified the physician of the above lab results. A 7/12/25 preliminary (an early report from the lab while the sample is still being tested) UC lab report indicated that the resident's urine sample was collected on 7/10/25 at 1:30 p.m. and received on 7/10/25 at 2:53 p.m. The result indicated the urine sample had Enterobacter cloacae and contained greater than 100,000 CFU/mL. The susceptibility was to follow. This report was not noted as reviewed. A 7/13/25 at 12:13 pm final UC result lab report indicated the urine sample was collected on 7/9/25 at 1:07 a.m. and received on 7/10/25 at 7:39 a.m. The result indicated growth of more than 100,000 Enterobacter cloacae complex, and to see the previous culture for susceptibility report. The physician responded to this result on Monday, 7/14/25, and ordered to stop cefuroxime and to start Nitrofurantoin 100 mg (antibiotic) twice a day for five days. This order was noted as reviewed on Tuesday, 7/15/25, by an unidentified staff member. A 7/13/25 at 12:13 p.m., a final UC result with susceptibility lab report indicated the sample was collected on 7/10/25 at 1:30 p.m. and received on 7/10/25 at 2:53 p.m. It indicated the Enterobacter cloacae complex bacteria was not susceptible to cefuroxime, but it was susceptible to Nitrofurantoin. This report was noted as reviewed by two unidentified staff members on an unknown date. On 7/15/25 at 10:45 a.m., a progress note by LPN H indicated that the physician originally ordered cefuroxime 500 milligrams (mg) twice a day for five days, but after the UC results, he discontinued that antibiotic order and ordered Nitrofurantoin 100 mg twice a day for five days. On 7/15/25 at 11:36 a.m., a progress note by LPN H indicated that the resident had severe flank pain and Nitrofurantoin antibiotic was to be started that day at 5:00 p.m. Resident 112's son was in the resident's room and was updated on the lab results and treatment plan. Since resident 112's pain was not controlled he wanted her sent to the emergency room. On 7/15/25 at 11:40 a.m., a progress note by director of nursing (DON) B indicated that she completed an investigation on why the 7/11/25 physician's order for cefuroxime was not started. It was found at the same time as the 7/15/25 order was found to stop the cefuroxime and to start nitrofurantoin. She updated the resident's family and physician regarding the incident. On 7/15/25 at 3:45 p.m., a progress note by social service designee (SSD) E indicated that resident 112's son discussed his concerns about the situation about his mother with her, and told SSD E that the resident had an infection in her spine. SSD E offered to him to hold the resident's bed at the facility for when she discharged from the hospital, but he declined. On 7/15/25 at 5:34 p.m., a progress note by LPN LL indicated that resident 112 was admitted to the hospital related to a UTI. 4. Interview on 3/26/26 at 1:04 p.m. with LPN O revealed that physician orders were to be processed within the first few hours after being received and completed by the end of their shift. Physician orders were faxed (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	by the physician's office to the facility's fax machine, which was specific to the unit where the resident resided. Sometimes the faxes were received at the front reception area fax machine, and the managers would check that fax machine. Sometimes they did not receive those orders until the next morning, and they processed them as soon as they could. 5. Interview on 3/26/26 at 1:20 p.m. with LPN W revealed the facility received physician orders by fax or by paper if the physician was at the facility. Faxed orders were supposed to go to the unit where the resident resided, and sometimes the orders went to the front reception area fax machine, which was to be checked by the managers, including on weekends. During non-business hours, on-call physicians were available if a resident needed physician services. The nursing staff could contact them if a resident had a change in their medical condition. If abnormal lab results were received during non-business hours, and a resident's current ordered antibiotic was not susceptible to treat the resident's infection, the nursing staff were to notify the on-call provider. If UA was ordered, they had 24 hours to collect it, put it in the refrigerator after it was collected, and it would be taken to the lab in the morning. To process physician orders, two nurses needed to note them as reviewed to ensure they were completed correctly. She was unsure how quickly the orders needed to be processed after being received, but they needed to be completed by the end of their shift. 6. Interview on 3/30/26 at 2:05 p.m., 4:00 p.m., and 4:35 p.m. with DON B revealed she was unsure why resident 112's 7/9/25 UA was recollected. If physician orders were received for a UA, it needed to be collected that same day. If the sample was not collected that same day, the physician needed to be notified. She expected that physician orders would be processed the same day they were received. She expected physician orders to be noted as reviewed and to include the date, not the time, and by whom. She expected the resident's physician to be notified of lab results. If the physician was out of the office or if it was after hours, she expected the nurse to notify the on-call physician. After the incident regarding 112, she stated that only nurse managers and unit managers received education regarding checking the fax machine at the front reception area for physician orders. Her investigation did not include information regarding resident 112's UA not being collected promptly, or that the on-call physician was not notified of the preliminary lab results. The incident investigation did not include steps to determine if other residents were affected. She did not educate nurses to check the main fax machine for orders throughout their shift, as indicated on the provider's report sent to the SD DOH. 7. Interview on 3/30/26 at 3:52 p.m. with SSD E revealed she did not remember what the frustrations resident 112's son talked to her about on 7/15/25 at 3:45 p.m. She documented in the EMR if residents or their families reported concerns to her. 8. Interview on 3/31/26 at 1:20 p.m. with administrator A revealed she did not recall if she spoke with resident 112's son. If she had, she would have documented it in the EMR. 9. Interview on 3/24/26 at 3:24 p.m. with resident 88 revealed that after he received dialysis treatments, he was dizzy and felt better the next day. When asked if staff were aware of his dizziness, he stated he was not sure. 10. Review of resident 88's EMR revealed he admitted to the facility on [DATE]. His 2/17/26 BIMS assessment score was 15, which indicated his cognition was intact. He had diagnoses of end-stage renal disease (the kidneys no longer work well enough to sustain life), dependence on renal dialysis, hypotension (low blood pressure), hypertension (high blood pressure), and heart failure (where the heart becomes too weak or stiff to pump blood efficiently). He had 2/2/26 physician's orders for dialysis treatments on Monday, Wednesday, and Friday, and the order commented that his ride came at 5:00 a.m. A 2/25/26 progress note indicated he had his dialysis fistula (a surgical connection between an artery and a vein on the arm created to make an access point for cleaning the blood) placed. He had 2/2/26 physician's orders to receive Midodrine 10 mg three times a day for hypotension, and it was to be held if his systolic blood pressure (SBP) (top number of the blood pressure) was 120 or greater. He had 2/3/26 physician's orders to receive Metoprolol Succinate ER (extended release) 25 mg daily for hypertension. This medication order did not have parameters when it needed to be held. Resident 88's March 2026 medication administration record (MAR) indicated he did not receive Midodrine on Monday, Wednesday, and Friday mornings, the days of his dialysis (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	treatments. From 3/9/26 through 3/30/26, he received Metoprolol Succinate ER on e time, on 3/20/26, on the day of his dialysis treatments. There was no documentation that his physician was notified that he did not receive those medications consistently as ordered on those days. Resident 88's dialysis records from 3/9/26 through 3/25/26 indicated that his blood pressure before dialysis was 112/62 on 3/9/26, his 3/11/26 records were not provided, his blood pressure on 3/13/26 was 122/24, on 3/16/26 it was 118/62, on 3/18/26 it was 115/62, on 3/20/26 it was 98/56, on 3/23/26 it was 117/62, and on 3/25/26 it was 118/62. Resident 88 March 2026 MAR indicated that his blood pressure was 79/44 on 3/20/26 before his 5:30 p.m. scheduled dose of Midodrine was given. His blood pressure was not checked again until the next morning, 3/21/26 at 7:30 a.m., was 81/43. There was no documentation that his provider was notified of those low blood pressures. He received his metoprolol (a medication that can lower blood pressure) on these days. Resident 88's treatment record (TAR) indicated that staff were to monitor him for post-dialysis complications, including low blood pressure symptoms, twice daily on Mondays, Wednesdays, and Fridays. His treatment record indicated the only day he had symptoms was on 3/6/26, and the other days he did not. 11. Interview on 3/26/26 at 1:04 p.m. with LPN O revealed that the physician was to be notified when a resident vital sign (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were not within the specific parameters, included in the resident's physician's orders. 12. Interview on 3/31/26 with DON B at 1:05 p.m. and 2:15 p.m. revealed she expected resident 88 to be given Midodrine before he went to dialysis if his blood pressure was within his ordered parameters. She verified that his physician was not notified that it was not given consistently before dialysis when his blood pressure was outside those parameters. If his blood pressure was low and he was not symptomatic, she did not expect his blood pressure to be rechecked or his physician to be notified. The physician would be notified based on the nurse's assessment. She stated there was no hard and fast rule when the physician needed to be notified. The facility did not have a policy regarding vital sign parameters. The parameters to notify the physician were not in the resident 88's orders. 13. Review of the provider's 11/18/25 Following Physician Orders policy revealed that all physician orders should be followed as ordered. If orders are not followed, the physician is to be made aware, including omission, medication not in stock, repeated resident refusals for medications/treatments, etc. 14. Review of the provider's 11/18/25 Notification of Change of Condition policy revealed that the facility will notify the physician of a resident's change in status. The facility must promptly notify the physician when there is a significant change in the resident's physical status. The physician was to be notified if a resident refused treatments or procedures at least three consecutive times. ˆ

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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) facility reported incident (FRI) review, SD DOH complaint intake report, record review, observation, interview, and policy review, the provider failed to implement pressure ulcer (skin and/or underlying tissue injury due to prolonged pressure) prevention interventions for one of one sampled resident (16) identified with risk for developing pressure ulcers who developed a stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer on her left buttock and one of one sampled resident (9) with a history of pressure ulcer and identified with risk for developing pressure ulcer who developed a stage III (3; open wound with full thickness skin loss, fatty tissue may be visible) pressure ulcer to his right gluteal fold (the horizontal skin crease separating the buttock from the posterior upper thigh) and his coccyx (tailbone), a left lateral heel deep tissue injury (DTI), left lateral lower leg stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to his left lateral (outer) lower leg. Findings include: 1. Review of the provider's 3/17/26 FRI submitted to the SD DOH regarding resident 16 revealed: *Resident 16's daughter reported concerns related to the quality of care being provided for resident 16 related to her not being provided with routine bathing, not being changed regularly and not consistently being assisted out of bed for meals. *After receiving resident 16's daughter's concerns the provider completed a skin assessment and found resident 16 had a two centimeter (cm) in length by 0.6 cm in width stage II pressure ulcer to her left buttock and Scabs that appear to be from being in bed. -The location of the scabs was not identified on the 3/17/26 FRI. *The provider's standing orders for skin concerns were initiated on 3/17/26. *The provider initiated a nursing order for resident 16 to be assisted into her chair for lunch and supper meals per the daughter's request and the management staff was to be notified if resident 16 refused to get up into her chair. 2. Review of resident 16's electronic medical record (EMR) revealed: *She admitted to the facility on [DATE]. *Her 3/6/26 Brief Interview of Mental Status (BIMS) assessment score was 4, which indicated her cognition was severely impaired. *Her diagnoses included diabetes (a condition involving disruptions in how the body regulates blood sugar), depression, and senile degeneration of the brain (progressive loss of cognitive function and brain tissue associated with aging). *Her 3/2/26 Braden Scale (a tool used to assess the risk of developing pressure ulcers) assessment indicated she had a high risk for the development of a pressure ulcer. *Her 3/3/26 care plan (personalized plan that addresses a resident's care needs, goals, and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	interventions) indicated resident 16 had difficulty with communication, required the assistance of one staff member for repositioning in bed, required a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position)with the assistance of one staff member for transfers, and was dependent upon staff for her personal hygiene needs. *She had a 3/3/26 focus area on her care plan for the potential for impairment to skin integrity [related to] weakness [and] decreased mobility with intervention of Apply wound treatment as ordered by the physician, Assess for pain and administer pain medication as ordered, observe feedback and notify MD [medical doctor] as necessary, Encourage good nutrition and hydration in order to promote healthier skin. *A 3/11/26 skin assessment indicated resident 16 had blanchable redness (reddened skin turned white when pressure was applied to that area) to her buttocks and barrier cream (a cream to provide a moisture barrier) to the skin on her buttocks. *On 3/16/26 licensed practical nurse (LPN) X documented a facility acquired 2 centimeter (cm) in length by 0.6 cm in width abrasion to resident 16's left buttocks and coccyx (tailbone) with redness surrounding the area, a facility acquired 4 cm in length by 0.3 cm in width undescribed area to the back of resident 16's right thigh, and a facility acquired 1.5 cm in length by 0.2 cm in width undescribed area to the back of resident 16's left thigh. *On 3/17/26 LPN Y documented resident 16's pressure ulcer on her left buttock as a stage II that measured 3.5 cm in length by 0.8 cm in width by 0.1 cm in depth with redness surrounding the pressure ulcer. *On 3/17/26 the focus area related to skin integrity was revised to indicate that, resident 16 has actual impairment to skin integrity. Left Buttock Pressure, Stage 2. Bilateral [both sides] Posterior [towards the backside] Upper thighs, Scabs with added interventions of Consult RD [registered dietician] as needed for nutritional recommendations for optimal wound healing, Monitor/document location, size, and treatment of skin ulcer. Report abnormalities, failure to heal, signs and symptoms of infection, maceration [moisture related skin damage] etc. to MD and Weekly monitoring of wounds by wound nurse or designee: Assessments, recommendations, measurements. *On 3/23/26 LPN Y documented resident 16's pressure ulcer on her left buttocks as a stage II that measured 3 cm in length by 2 cm in width by 0.1cm in depth. -That pressure ulcer was larger in area than the assessment on 3/17/26. *On 3/23/26 the skin integrity focus area had added interventions of, Encourage/Assist to turn and reposition at least every 2 hours and as needed, Keep skin clean and dry. Use lotion on dry skin, Pressure redistributing cushion to wheelchair, and Pressure redistributing mattress to bed. 3. Observation and interview on 3/25/26 at 2:15 p.m. of wound care certified/regional nurse consultant (RNC) L and licensed practical nurse (LPN) X changing the wound dressing on resident 16's left buttock pressure ulcer revealed: *Resident 16 was lying on her back in bed. The head of resident 16's bed was elevated, and resident 16 had slid down in bed and was bending at her chest. (continued on next page)

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	435039	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	*LPN X and wound nurse certified/RNC L lowered the head of the bed, rolled resident 16 from side to side to cleanse her pressure ulcer, applied a new dressing on the wound, and replaced her incontinence brief. *LPN X and wound nurse certified/RNC L then rolled resident 16 onto her back again and raised the head of resident 16's bed. 4. Interview on 3/25/26 at 2:50 p.m. with certified nursing assistant (CNA)/ certified medication aid (CMA) R revealed: *Director of nursing (DON) B and administrator A told her resident 16's daughter was concerned when she came to visit her mother, that she was still in her bed with her night gown on, CNA/CMA R had transferred resident 16 by pivot-transfer (when assisted to a standing position, the resident then turns their body to move to another surface) instead of the care planned sit-to-stand, and she had developed sores on her bottom. *CNA/CMA R stated she was assigned to care for resident 16 that day and that was the first time she had cared for resident 16. *She looked in resident 16's room and asked if she needed anything several times that day, but the resident did not reply to her, so she left her in bed. 5. Interview on 3/26/26 at 10:15 a.m. with CNA/CMA V revealed: *She was responsible for providing resident 16's cares on 3/26/26. *She used the Kardex (a report of the resident's care needs and interventions) or the pocket care plan (a document that identifies residents' care needs and interventions) to determine each resident's care needs. *She did not know what pressure prevention interventions were used before resident 16 developed her pressure ulcer or what was currently being provided for pressure reduction. 6. Observation on 3/30/26 at 1:52 p.m. of resident 16 in her room revealed: *She was lying in bed on her back. *The head of her bed was elevated and she was in a position that she bent at her chest. 7. Phone interview on 3/30/36 at 2:08 p.m. with resident 16's daughter revealed: *She spoke with the facility's administration about concerns she had related to the quality of care her mother had received. *She had come in to visit her mother one day around 2:30 p.m. (near the date she reported her concerns) and she found her mother lying in bed with her pajamas on and food on her face and clothing. *Her mother had been bathed one time between her admission date (3/2/26) and 3/16/26. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*She was told by the wound nurse that her mother had developed a pressure ulcer on her buttocks. *The wound nurse said the pressure ulcer was because the staff were pulling her mother up in bed by her arms instead of using a lift sheet. *Resident 16's daughter stated she had turned on her mother's call light one day, because she needed to be boosted up in bed. No one answered the call light for 30 minutes, so she went out into the hallway and could not locate a staff member. She went into another hallway and found a staff member to assist her mother. *She stated resident 16 was not able to use her call light to get assistance with her needs and could not get out of bed or reposition herself in bed without the staff's assistance. 8. Observation on 3/30/26 at 3:30 p.m. of resident 16 in her room revealed: *She was lying on her back. *The head of her bed was elevated, and she was bending at her chest. 9. Interview on 3/31/26 at 8:56 a.m. with restorative aide (RA) PP revealed she: *Used the Kardex to determine each resident's care needs. *Did not know what pressure prevention measures had been in place for resident 16 before she developed the pressure ulcer on her left buttocks or what was currently being used for pressure reduction interventions. *Acknowledged that residents who were not repositioned were at increased risk for the development of a pressure ulcer. *Acknowledged that residents who did not receive routine bathing were at risk for the development of skin impairments. 10. Interview on 3/31/26 at 10:02 a.m. with LPN Y, wound care certified, RNC L, and DON B revealed: *LPN Y started her role as the provider's wound nurse in the beginning of March 2026. *She was supervised by DON B and wound care certified, RNC L. *She had received wound education from online resources, wound care certified RNC L, and a consultant from their wound dressing supply company. *LPN Y stated the nurse who was caring for resident 16 identified the pressure ulcer on resident 16's buttock and reported that ulcer to LPN Y. *LPN Y assessed the newly identified pressure ulcer on resident 16's left buttock the day after it was found. *LPN Y stated the scabs on resident 16's upper back of her thighs were identified on the same day (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	she assessed resident 16's left buttock pressure ulcer. *She stated the scabbed areas on the upper back of resident 16's thighs were determined as being caused by shearing (a mechanical force occurring when skin sticks to a surface such as sheets while the underlying tissue and bone slide causing tissue layers to tear, stretch and damage blood vessels). *LPN Y stated she notified resident 16's daughter and physician of the newly identified pressure ulcer and added resident 16 to her wound rounds for the assessment and documentation of the wound weekly. *Certified wound nurse/RNC L acknowledged that resident 16's head of her bed being elevated increased the risk of shearing and the development of a pressure ulcer when she slid down in her bed. *DON B verified resident 16 could not turn herself in bed without staff assistance was able to adjust her hips by herself. She was unable to raise her hips up off the bed to reposition herself to prevent shearing of her skin. *DON B expected the staff to assist resident 16 with turning while she was in bed *Upon admission to the facility each resident's skin was to be assessed for alterations in their skin, and a Braden scale assessment was completed to assess for that resident's risk for developing a pressure ulcer. *Resident 16 did not have alterations in her skin upon her admission to the facility on 3/2/26, but she was identified as being at risk for the development of a pressure ulcer. 11. Interview on 3/31/26 at 10:45 a.m. with DON B revealed: *All residents were placed on a pressure reduction mattress upon admission and received a dietary consultation. Barrier cream was to be applied with each incontinence product change or if the resident was assisted to the toilet, if that resident had episodes of incontinence. *DON B was unable to find documentation in resident 16's EMR to support barrier cream was applied to the resident's skin or that she had refused the application of barrier cream. *DON B expected residents who could not reposition themselves to be assisted with repositioning by the staff every two hours, according to standard practice. *That repositioning was not documented by the staff when it was completed. If a resident refused repositioning DON B expected the nurse to be notified of the refusal so it could be documented in that resident's EMR. *DON B could not find documentation that supported that resident 16 refused repositioning in her EMR. *She expected the nurse managers to round (monitor) in their hallways to be sure each resident's care needs were attended to, which included repositioning. *Air mattresses were generally not used for pressure ulcer prevention, but were typically used if a (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	resident had a stage III pressure ulcer and on a case-by-case basis when a resident was receiving hospice services. *DON B verified resident 16 did not have an air mattress prior to or after the development of her pressure ulcer. *The pressure ulcer preventions put into place before resident 16 developed a pressure ulcer were standard for all admissions and not individualized related to her identified risk for being at risk for the development of a pressure ulcer. *She expected the staff to document in the resident's EMR if they refused any cares that were offered to them such as assisting a resident out of bed, bathing, repositioning, or skin cares. 12. Interview on 3/31/26 at 1:41 p.m. with administrator A revealed: *She had received concerns from resident 16's daughter on 3/17/26 related to care that resident 16 was receiving. *After she received those concerns LPN Y assessed resident 16's skin and identified the pressure ulcer on resident 16's buttock. *She thought resident 16's scabbed areas were caused by CNA/CMA R having used a split leg sling (a piece of the sling goes behind each leg and crosses over through the legs of the resident to attach to the lift) for the full body lift, so they changed resident 16 to be transferred with a full body sling (a one pieced complete rectangular sling). -Resident 16 was care planned to be a sit-to-stand lift at the time she developed the pressure ulcer on her left buttocks and the scabbed areas on the upper back of her thighs were found. *Administrator A stated resident 16 was receiving hospice services and refused care at times so she expected the resident to develop some skin breakdown. *She expected the staff to follow the residents' care plan while attending to each resident's care needs. 13. Review of the SD DOH complaint intake report for resident 9 revealed: *He was seen in an emergency department on 3/23/26 and was dehydrated despite being provided nutrition products and water through a feeding tube (a tube surgically placed through the abdomen into the stomach to administer liquid nutrition, fluids and medications). *He returned to facility on 3/23/26. *He discharged to an inpatient hospice facility on 3/25/26. *Upon admission to the hospice care facility he presented with the following wounds gluteal cleft wound, left buttocks wound, right upper thigh posterior wound, left heel wound left lateral calf, right lateral calf, right upper thigh anterior, penile wound, mouth and tongue red and irritated with skin peeling off, which made speech difficult for him. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	centimeters (cm) x 2 cm x 0.1 cm stage II. *His 3/16/26 skin evaluation identified a coccyx wound treatment was in place for wound prevention, and he had a feeding tube to his left abdomen with no signs or symptoms of infection noted. *A 2/12/26 skin/wound progress note regarding wound rounds were completed for pressure ulcerations to resident 9's coccyx, left gluteal fold, left lower back, and right outer heel, right upper thigh at gluteal fold, a mid-back surgical wound. Those areas were healed, and the provider and resident were updated. *On 3/10/26 a skin/wound progress note indicated an open area under resident 9's right buttock that measured 2 cm x 2.5 cm x 0.1cm that was freely bleeding. The resident complained of pain with cleaning of the area, and collagen and border gauze were applied. The provider and family were notified. *On 3/13/26 a skin/wound progress note indicated that his right gluteal fold was reclassified from moisture associated skin damage (MASD) to a pressure ulcer after reassessment. His physician was notified. *On 3/14/26 a physician's order for Wound right gluteal fold cleanse apply collagen cover with border gauze, every day shift for pressure was received and entered into his treatment administration record (TAR). *On 3/19/26, a skin /wound progress note indicated a pressure area to his coccyx, measuring 9 cm x 6.5 cm x 0.20 cm and that an air mattress would be placed in the resident's room to assist with pressure offloading. *On 3/19/26 a skin/wound progress note stated pressure area to left lateral heel with non-blanchable (area does not turn white when pressed with a finger) discoloration consistent with a deep tissue injury (DTI), measurements 6.6 cm x 5.4 cm depth not measurable due to intact skin. PCP notified, added to weekly rounds, heel boots were applied, and air mattress will be placed in the resident room to assist with pressure offloading. *On 3/19/26 a skin/wound progress note stated pressure noted to left lateral lower leg with blister present consistent with stage 2 pressure injury measurements 13 cm x 3.5 cm depth unable to be measured due to intact skin provider notified, placed on weekly rounds and air mattress added to resident room to assist with pressure offloading. *On 3/19/26 a skin/wound progress note stated right gluteal fold pressure injury measured 6 cm x 5.5 cm x .10 cm and Urethral meatus surgical incision [measure] 1.2 cm x 0.9 cm, Right heel redness noted but blanchable (indicates blood flow is present to the area). Care plan had been reviewed and updated. *He had physician's orders on 3/19/26 for: -Wound care urethral meatus cleanse with wound cleanser, pat dry and apply bacitracin (antibiotic ointment) every day and night shift. -Wound care left lateral lower leg pressure/blister cleanse with normal saline, pat dry, cover with no (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	sting skin prep to intact skin, apply border foam dressing every day shift every other day. -Wound care coccyx pressure cleanse with normal saline, pat dry, cover with no sting skin prep to intact skin (peri wound) and cover with bordered foam dressing every day shift every other day. *He had a physician's order on 3/24/26 for staff to encourage resident 9 to wear heel boots (specialized footwear designed to eliminate pressure on the heel and foot to prevent pressure injury) when in bed or float heels (elevating heels off mattress to prevent pressure ulcers) every shift. *His March 2026 treatment administration record (TAR) revealed the above ordered wound care treatments were documented completed on 3/20/26 and 3/22/26. They were not documented as completed on 3/24/26. *His current care plan indicated: -He had actual impairment to skin integrity of right gluteal fold stage III pressure injury, Urethral meatus surgical incision, left lateral heel pressure DTI, left lateral lower leg pressure blister stage II, coccyx pressure ulceration stage III, blanchable redness to groin, coccyx and sacrum initiated on 1/9/26 and revised on 3/19/26. -He had a history of scattered scabs and bruising to bilateral upper arms, right inner thigh, red raised rash, right inner heel blanchable redness, closed left gluteal fold, pressure stage II, closed left lower back pressure stage II, closed right outer heel pressure stage II, right upper thigh at gluteal fold pressure stage III and a history of mid back surgical incision initiated on 1/9/26 and revised on 3/19/26. -He had interventions: --An air mattress to his bed, that was initiated on 3/19/26. --Apply a pressure redistributing cushion to the wheelchair, initiated on 1/20/26 and revised on 1/30/26. --Apply wound treatment as ordered by physician initiated on 1/9/26. --Assess for pain and administer pain medication as ordered, observe for feedback and notify MD as necessary initiated on 1/9/26. --Consult RD [registered dietitian] as needed for nutritional recommendations for optimal wound healing initiated on 1/9/26. --Encourage good nutrition and hydration to promote healthier skin initiated on 1/9/26. --Keep skin clean and dry. Use lotion on dry skin initiated on 1/9/26. --Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, macerations, etc. to MD initiated on 1/9/26 and revised on 3/19/26. --Weekly monitoring of wounds by wound nurse or designee assessments, recommendations, and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	measurements initiated on 1/20/26 and revised on 3/19/26. --He required assistance with ADL's (bed mobility, transfers, dressing, locomotion, personal hygiene, eating and toileting) initiated on 1/9/26 and revised on 2/1/26. --He had interventions of two-person staff assistance with mechanical full body lift for transfers, he was dependent for bed mobility, dressing, personal hygiene, toileting, and bathing initiated on 1/9/26 and revised on 1/9/26. --He would use two mobility bars as an assistive device to help him to turn, reposition and/or transfer, initiated on 3/4/26 and revised on 3/4/26. 15. Interview on 3/31/26 with Physician Assistant Certified (PA-C) QQ revealed: *Resident 9 had developed sores in his mouth the evening of 3/24/26. She was notified by the hospice staff who requested an order for Lidocaine (a prescription anesthetic used to temporarily relieve pain) solution which she ordered on 3/25/26 when she saw him. *Resident 9 often refused cares. She was notified by the facility that he had refused to get up in his wheelchair twice daily, to be weighted and was refusing to participate in physical therapy. *She felt he was bedfast (confined to bed) and he refused to wear the heel lift boots on his heels. *She would expect the facility to have preventative measures in place to prevent re-occurrence of developing pressure ulcers such as an air mattress. 16. Interview on 3/31/26 at 8:49 a.m. with registered nurse (RN) unit manager J revealed: *Resident 9's air mattress was ordered on 3/19/26. *He refused to get up twice a day and they notified the MD of those refusals around 2/13/26. *The facility-initiated bed mobility bars to aid with repositioning on his bed. *She was unsure if he was on a turning or positioning schedule. *He had heel lift boots that he refused to wear. *She felt the facility did the best they could with residents to prevent them from redeveloping pressure ulcers. 17. Interview on 3/31/26 at 10:25 a.m. with licensed practical nurse (LPN) Y and director of nursing (DON) B revealed: *Staff encouraged resident 9 daily to get up in his wheelchair twice daily. On admission he had a pressure reducing mattress on his bed, InterDry (a cloth that [NAME] moisture away from skin) in his abdominal folds, and Triad wound dressing paste to his coccyx. *On 3/19/26 his pressure injuries were documented, an air mattress was ordered, new treatment (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	orders were received, his provider was notified of the pressure ulcers and weekly skin evaluations were started. *The floor nurses complete the weekly skin evaluations. *He received orders for heel lift boots for his heels. He would allow them to be placed and then would ask the certified nursing assistants (CNA's) to remove them shortly after applying them. *The facility's standard practice was to reposition all residents every two hours. *His doctor or provider was notified of his refusals to wear his heel lift boots and to get up into his wheelchair. *He had a pressure redistributing mattress; and air mattresses were usually implemented after a resident had a stage III pressure ulcer. *He had orders to be up in his wheelchair twice daily (BID), which he refused to do. *He had wound care orders for his pressure ulcers. *He could move in his bed but required assistance from staff for that. *He was not on a repositioning schedule. *His heels were offloaded and repositioned as needed. *The pressure ulcer that resident 9 had on admission had healed on 2/11/26 and then redeveloped. 18. Interview on 3/31/26 at 10:45 a.m. with DON B revealed: *She expected wound orders to be completed by the nursing staff as ordered. *She agreed that if wound orders had not been signed as completed in the TAR on 3/24/26 they were not completed. *She stated that his wound areas would become worse if his treatments were not completed. *She felt that pressure redistribution mattresses were effective pressure ulcer prevention interventions. *Resident 9 admitted to hospice services on 3/21/26. *She was unsure if an air mattress would have prevented his re-occurrence of his 3/19/26 developed pressure ulcers. *She expected all refusals to be documented or the CNAs to tell the nurse what approaches were successful, so they could be documented. 19. Review of the provider's revised March 23, 2023 Skin and Pressure Injury Prevention Program (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	policy revealed: *To ensure a resident who enters the facility without pressure injuries does not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable. To provide care and services to prevent pressure injury development and to promote the healing of pressure injuries/wounds that are present. *3. Risk Factor- Bed-fast Resident: -a. Offer repositioning at least every two hours and more frequently as needed if resident unable to move self. -b. Consider off-loading pressure hourly if the head of the bed is greater than 30 degrees (i.e., for residents with tube feeding or respiratory issues). -c. Use a special mattress that contains foam, air, gel, or water, as indicated. -d. Raise the head of the bed as little and for as short a time as possible, and only as necessary for meals, treatments, medical necessity, and resident comfort. e. Unless resident has both sacral and ischial pressure ulcers, avoid placing directly on the greater trochanter for more than momentary placement.

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	435039	A. Building B. Wing	03/31/2026

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure an ongoing restorative nursing program was completed according to the residents' care planned needs for two of two sampled residents (40 and 43) at risk for a decline in range of motion. Findings include:1. Observation and interview on 3/25/26 at 9:10 a.m. with resident 40 in her room revealed that she was frustrated that the fingers on her right hand were stiff and she could not make a fist. She felt she was not receiving the exercises she needed to maintain her strength and was getting weaker. She stated that there used to be exercises, but no one came to get her for her exercises anymore. She stated that she complained to the therapy department about not getting her exercises and was told those exercises were to be completed by the restorative nursing aides now. 2. Review of resident 40's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. Her diagnoses included Type 2 Diabetes Mellitus (a condition involving disruptions in how the body regulates blood sugar)with diabetic neuropathy (nerve damage that leads to weakness, numbness or tingling in one or more parts of the body), acquired absence of left leg above the knee (amputation), adjustment disorder with depressed mood, and stage 4 (severe) chronic kidney disease (a progressive kidney disease that reduces the kidneys ability to remove waste and keep the blood pressure normal), for which she required dialysis treatments three times per week.A 2/3/26 health status note indicated that the physician had ordered the staff to encourage participation in restorative activities.A 3/25/26 physician's order indicated staff were to Encourage patient to participate in restorative activity 3x [three times] weekly- Complete progress note when completed every day shift.Her 4/31/25 revised care plan included a focus area that resident 40 will participate in restorative therapy, with a goal that she would maintain her current functional ability. Interventions were per therapy and nursing recommendation of AROM [active range of motion].Her 2/25/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated she was cognitively intact.Her most recent quarterly 2/25/26 Minimum Data Set (MDS) assessment indicated she had a functional limitation in range of motion in one lower extremity (hip, knee, ankle, foot) and one upper extremity (shoulder, elbow, wrist, hand), and had received two days of active range of motion Restorative Nursing Programs during the seven day look back period (the time period over which the resident's condition or status is captured by the MDS assessment). 3. Review of resident 40's 12/15/25 through 3/28/26 restorative nursing program, lower extremity exercise task documentation revealed it was documented on nine days that resident 40 was not available, and on four days, resident 40 had refused. Eight days were documented as Not Applicable. Resident 40 received restorative lower extremity exercises on 2 days between 12/15/25 and 3/28/26.Review of resident 40's 1/1/26 through 3/31/26 restorative nursing program, kinetic bike exercise documentation revealed it was documented on nine days that resident 40 was not available, and on five days, resident 40 had refused. Six days were documented as Not Applicable. Resident 40 received restorative kinetic bike exercises on four days between 1/1/26 and 3/31/26. 4. Observation and interview on 3/30/26 at 2:15 p.m. with resident 43 in her room revealed that she used an iPad that translated conversations from her native language to English. She used a power wheelchair and had limited use of her upper and lower extremities. She participated in physical therapy when she admitted to the facility and was discharged from physical therapy services to a restorative program. She was upset that she had not been receiving her exercise program and had complained about that to director of rehab (DOR) MM. She was well informed about the exercise program that had been set up for her. She stated that no one came to get her for the exercises and felt that she was losing her strength and her ability to stand and transfer. 5. Review of resident 43's EMR revealed she was admitted to the facility on [DATE]. Her diagnoses included Rheumatoid Arthritis (a chronic disease that causes pain, swelling, and (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stiffness in joints in both the upper and lower extremities), polyneuropathy (nerve damage to many nerves throughout the body), and she had sustained fractures to her right lower leg and foot.Her 1/8/26 BIMS assessment score was 15, which indicated she was cognitively intactHer most recent modification of the quarterly 1/8/26 MDS assessment indicated she had a functional limitation in range of motion in one lower extremity (hip, knee, ankle, foot and she had received no restorative nursing exercise programs.Her 1/30/26 care plan included a focus area that resident 43 will participate in a restorative therapy program, with a goal that she would maintain her current functional abilities. Interventions were per therapy and nursing recommendation, Active ROM [range of motion], sitting exercises 3# [pound] green t-band [TheraBand], trunk exercises x 15 reps [repetitions], and Transfers: standing with walker up to 10 min [minutes]. 6. Review of resident 43's 1/26/26 through 3/30/26 restorative nursing program lower extremity exercise task documentation revealed that on ten days, resident 43 had refused. Four days were documented as Not Applicable. There was no documentation that resident 43 had received lower extremity exercises or had stood with her walker for ten minutes between 1/26/26 and 3/30/26. 7. Interview and review of residents 40 and 43's Restorative Nursing Program Transfer Forms with on 3/30/26 at 3:03 p.m. with DOR MM and physical therapy assistant (PTA) NN revealed that the therapy department made written recommendations to the restorative nursing program on those forms and that director of nursing (DON) B would set up those programs. They expected that restorative aide (RA) OO and RA PP would complete those restorative exercise programs with the residents.Resident 40 was to receive upper and lower extremity exercise programs three to six times per week using an arm bike, a lower extremity kinetic recumbent bike, five-pound weights, and green exercise bands.Resident 43 was discharged from physical therapy around 1/26/26. She was to begin a restorative nursing lower extremity exercise program three to six times per week that included standing for ten minutes with her walker, exercises with a three-pound weight, and green exercise bands. It was noted that she did not like to use the exercise bikes. 8. Interview and review of residents 40 and 43's restorative documentation on 3/31/26 at 9:01 a.m. with restorative aide (RA) OO revealed that she and RA PP provided restorative exercise programs to approximately 44 residents who resided at the facility. Each resident was scheduled to receive restorative exercises for 15 minutes seven days a week. Some days, she and RA PP worked together, but they were scheduled to work alternating weekends and had different days off, so there were several days when one RA was scheduled. It was impossible to see all 44 residents when one RA was working, but they did the best they could.Some residents could get to and from the restorative therapy room independently, and others required assistance to get to the restorative exercise room. They could not leave the residents alone in that room, and getting residents to and from the exercise room was challenging. She felt that there were residents who participated in restorative exercise programs more than others because they were ready for their exercises at their scheduled times, could get to the room independently, and enjoyed exercising. Some residents were known to refuse, and when they were busy, they had to prioritize the residents who were known to participate.She felt that resident 40 preferred to complete her restorative exercises with RA PP, was known to refuse, and was often unavailable because she attended her dialysis treatments three times a week. She was unsure of the last time she had completed resident 40's restorative exercises with her.RA OO stated that resident 43 was scheduled to receive restorative exercises daily, but that she had not completed restorative exercises with resident 43 in over a month. She thought that RA PP may have been assisting resident 43 with her restorative exercise program. 9. Interview by phone on 3/31/26 at 10:44 a.m. with RA PP revealed that she and RA OO provided restorative exercises seven days a week to residents who were listed as participating in restorative nursing exercise programs. There were more residents than could be seen each day, but they tried to accommodate all of the residents' schedules and preferences. Some residents participated regularly, others would refuse, would be unavailable due to medical appointments, or were more difficult to get to the exercise room.She was not allowed to be alone with (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident 40, and resident 40 had to complete her exercise program in the main therapy room. It was difficult to get resident 40 to the main exercise room when the exercise bike was available, another staff member was present, and resident 40 was not at her dialysis appointments. She did not recall when she had last seen resident 40 for her restorative exercises program.Resident 43 had refused to complete her restorative exercise program with RA PP once or twice. RA PP thought that RA OO was assisting resident 43 with her restorative program. She was unsure of the last time resident 43 had been offered restorative exercises. 10. Interview on 3/31/26 at 12:17 p.m. with DON B and regional nurse consultant M regarding the provider's restorative nursing program revealed that RA PP was recently hired, and the nurse who was previously in charge of that program was on a medical leave from the facility. DON B had been overseeing the restorative nursing program and expected that restorative exercises be offered and provided to all residents who currently had a written program for at least 15 minutes per day. She was aware that RA OO and RA PP had been having some difficulty providing the program to all of the residents as scheduled. They confirmed that resident 40 had received a total of seven days of restorative exercises since 12/15/25, and that it did not appear that resident 43 had received any restorative exercises since 1/26/26. They were unaware that residents 40 and 43 had concerns about not receiving their restorative exercise programs. 11. Review of the provider's revised 11/18/25 Restorative Nursing policy revealed Restorative Nursing Program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental and psychosocial functioning. A decision to implement a Restorative nursing program can be made.at any time the services are indicated. For a specialty program, restorative staff will be trained in the techniques that promote resident participation in the activity.

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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) review, record review, interview, and policy review, the provider failed to ensure resident safety and accident prevention when:*A staff member safely transferred one of one sampled resident (53), who needed to be transferred with the use of a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) according to that resident's care plan by one of one certified nursing assistant (CNA) VV, who attempted to transfer the resident without using the stand lift. That failure resulted in the resident sustaining a skin tear on his left forearm and a bump on his head, requiring him to be sent to the emergency department (ED), where a CT scan (a series of x-ray images taken from different angles used to produce three dimensional images of bones, organs, or soft tissues) revealed a subdural hematoma (a life-threatening collection of blood between the brain's surface and outer covering).*One of one sampled resident (16) was not safely transferred with the use of a sit-to-stand lift according to that resident's care plan, which placed her at risk for harm or injury.*Chemicals were not securely stored away from resident access in one of three bathtub rooms, and one of one housekeeping carts was left unattended in the main dining area with residents present by housekeeper CC.Findings include: 1. Review of the 3/4/26 SD DOH FRI revealed that on 3/4/26 at around 3:15 p.m., CNA VV was transferring resident 53 from the toilet to his wheelchair. Resident 53's legs gave out and resident 53 was lowered to the floor, hitting the back of his head against the fall. Resident 53's care plan stated that resident 53 should have been transferred using a sit-to-stand lift [a mobility device that assist patients to transition from sitting to standing]. CNA VV's employment was suspended during the investigation of the fall. Resident 53 was assessed by nursing staff, and a skin tear was found on resident 53's left forearm. There was a bump on the back of resident 53's head. Resident 53's blood pressure and pulse were elevated. Due to resident 53's history of using blood thinning medications and elevated blood pressure, he was sent to the ED for further evaluation. Resident 54 had a CT scan of his head and cervical spine [neck] in the ED. Results of the head CT revealed a subdural hematoma. CNA VV's employment was terminated for not following resident care plans after being educated multiple time. 2. Review of resident 53's electronic medical record (EMR) revealed that he was admitted to the facility on [DATE]. He had medical diagnoses that included hemiplegia [paralysis of one side caused by brain damage] following cerebral infarction [stroke] of the left side. On 3/10/26, his Brief Interview for Mental Status (BIMS) score was 9 (indicating severe cognitive impairment). His care plan stated that he was to transfer with 1 person using a stand-lift. 3. Interview on 3/31/26 at 12:30 with director of nursing (DON) B and regional nurse consultant (RNC) M revealed that both were in the facility on the day of the incident. DON B revealed that CNA VV had received education on the morning of 3/4/26 regarding the importance of following resident care plans. DON B reported that when she interviewed CNA VV after the incident, CNA VV acknowledged being educated that morning on the importance of following resident care plans. DON B stated that when she asked CNA VV why the care plan was not followed, CNA V told DON B that she could complete the transfer faster without using the stand-lift. DON B expected CNAs to follow each resident's care plans to help prevent falls and injuries. 4. Review of the provider's 3/17/26 FRI regarding resident 16 revealed resident 16's family member reported concerns related to the quality-of-care including reports that resident 16 may have been (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	injured during a transfer involving a mechanical lift operated by CNA/CMA R. Resident 16 used a sit-to-stand lift since she was admitted to the facility on [DATE] and was changed to a full body lift (a mechanical lift and sling used to lift a person's full body) due to a decline in her health on 3/18/26. 5. Review of resident 16's EMR revealed she admitted to the facility on [DATE]. Her diagnoses included senile degeneration of the brain (progressive loss of cognitive function and brain tissue associated with aging) and her 3/6/26 BIMS assessment score was 4, which indicated her cognition was severely impaired. Resident 16's 3/3/26 care plan indicated she was to be transferred with the use of a sit-to-stand lift, which was revised on 3/18/26 to indicate she transferred with the use of a full body mechanical lift. Her 3/4/26 lift assessment completed by RN CCC indicated she could not bear at least 50 percent of her weight on one leg, was unable to sit upright without physical assistance, and was not able to follow simple instructions. That assessment stated that if a resident could not do one of the criteria listed, they were not a candidate to transfer with the use of a sit-to-stand lift. Resident 16 was documented as not being able to do three of the criteria but RN CCC indicated within the summary and plan portion of the lift assessment that resident 16 was to use a sit-to-stand lift for bed to chair transfers. Review of resident 16's skin assessments revealed there was no documentation of bruising or purple discolorations on resident 16's arms or legs on those assessments. 6. Interview on 3/25/26 at 2:50 p.m. with CNA/CMA R revealed administrator A and DON B told her that resident 16's family member had expressed some concerns related to resident 16 being left in her night gown in bed until 2:30 p.m., transfers, and sores on her buttock. CNA/CMA R stated she was not assigned to assist resident 16 with her cares prior to 3/17/26 when resident 16's family member expressed her concerns related to the care her mother had received by the staff. On 3/17/26 resident 16's family member asked her to get resident 16 out of bed. The pocket care plan indicated resident 16 was a pivot transfer (when assisted to a standing position, the resident then turns their body to move to another surface) with the assistance of one staff member. Resident 16's family member told her resident 16 was a pivot transfer with the assistance of two staff members. CNA/CMA R transferred resident 16 with resident 16's family member by putting their arms under resident 16's arms and pivot transferring her from her bed to the bath chair. While they were transferring resident 16 from the bed to the bath chair resident 16 would not follow directions or move her feet. CNA/CMA R stated she held resident 16 up while she quickly pulled the bath chair under resident 16 and sat her down. Resident 16's family member had not expressed any concerns to her but had spoken with LPN Y that day. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	7. Interview on 3/26/26 at 10:15 a.m. with CNA/CMA V revealed she used the resident's Kardex (a report of the resident's care needs and interventions) or the pocket care plan (a document that identifies residents' care needs and interventions) to determine how a resident transfers. She asked the unit managers to update the pocket care plans at times because it was not kept up to date with each resident's care needs. 8. Review of the blue hallway's undated pocket care plan indicated resident 16 was to be transferred with a full body mechanical lift with a full body sling. 9. Interview on 3/30/26 at 2:08 p.m. with resident 16's family member on the phone revealed she spoke with administrator A about her concerns related to the quality-of-care resident 16 received from the staff. She came to visit resident 16 one day around 2:30 p.m. and found her lying in her bed, in her pajamas with food on her face and clothing. She stated the staff did not know how to lift her mother. They had not used a gait belt (a waist strap gripped as support for safe mobility and transfers) when they transferred her. Resident 16's daughter stated she had assisted staff members with pivot transferring resident 16 at times. At times the staff were using the sit-to-stand lift to assist her mother with transfers, but she recently had been changed to a full body lift. One time she had witnessed a CNA place the sit-to-stand sling behind resident 16 while she was seated at the side of the bed and then the CNA left her mother to go out into the hallway to get the sit-to-stand mechanical lift and her mother fell backwards into the bed. Resident 16's daughter felt the bruises on her mother's arms and legs were related to the sit-to-stand lift. Resident 16's daughter stated she was not aware of resident 16 having any falls since her admission to the facility. When resident 16 admitted to the facility on [DATE] a staff member had told her that resident 16 was a pivot transfer with the assistance of one staff member. Resident 16's daughter told that staff member that resident 16 would require at least two staff members to assist her with a pivot transfer because she used a mechanical lift in the facility she previously lived in. Resident 16 was designated to be transferred with a sit-to-stand lift after that conversation, but some staff continued to transfer resident 16 by pivot transfer with the assistance of two staff members and did not use a gait belt. 10. Observation on 3/30/26 at 3:30 p.m. of resident 16 in her room revealed she was lying in bed covered with blankets with her right arm outside the blankets. On her right arm were round purple discolorations of various sizes. 11. Interview on 3/31/26 at 8:56 a.m. with RA PP revealed she referred to the resident's Kardex or the pocket care plan to determine how to care for each resident. The pocket care plan and the residents' Kardex would include how that resident transfers. She stated the pocket care plans are not always kept up to date. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	12. Interview on 3/31/26 at 10:02 a.m. with LPN Y revealed she had notified resident 16's daughter of resident 16's pressure ulcer (skin and/or underlying tissue injury from prolonged pressure) on her left buttock but did not speak with her about any of her other concerns. 13. Review of resident 16's EMR and interview on 3/31/26 at 10:45 a.m. with DON B revealed resident 16 used a sit-to-stand lift to transfer since she admitted to the facility on [DATE]. She was changed to a full body mechanical lift after her daughter brought forward the concern she had possibly been injured during a transfer with a mechanical lift and a 3/17/26 lift evaluation was completed and indicated she was not a candidate for a sit-to-stand lift. Resident 16's daughter had told DON B that family members had been pivot transferring resident 16 but she was not aware the staff had been transferring resident 16 that way. DON B stated she was not aware of any bruises on resident 16 and stated there was no documentation of bruises on resident 16's skin assessments. She was not aware there were bruises on resident 16's arms and stated that if they were there they would be of an unknown origin. DON B verified resident 16's initial lift assessment completed by RN CCC indicated she was not a candidate for a sit-to-stand lift for transfers by the established criteria in the assessment, but RN CCC documented in the summary at the end of the assessment that resident 16 was to use a sit-to-stand lift for transfers. 14. Interview and review of resident 16's EMR and the facility's investigations related to resident 16's family member's concerns on 3/31/26 at 1:41 p.m. with administrator A revealed resident 16's family member reported her concerns related to the care resident 16 was receiving on 3/17/26. One of the concerns that was expressed by resident 16's family member was bruising related to an injury sustained by a mechanical lift, but she was unable to expand on that information. A skin assessment was completed by LPN Y after resident 16's family member brought forward her concerns. Administrator A did not recall resident 16's family member talking to her about the staff members using a stand pivot method for transferring her mother. She was not aware resident 16's 3/4/26 lift assessment completed by RN CCC indicated resident 16 was not a candidate for a sit-to-stand lift but was care planned to use a sit-to-stand lift despite the assessment results. Administrator A expected the staff to follow residents' care plans when they assisted each resident with their care needs. 15. 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 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 supervisors with specific information and observations of the Guest's needs, preferences and report (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	any behavioral changes. 16. Review of the provider's 5/14/2025 care plans policy revealed Policy: Individual, 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 consistently 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'. 17. Observation on 3/25/26 of the blue hallway bathtub room revealed the tub room door was open and there were no staff members in the bathtub room. On top of the bathtub was a pink crate that contained two spray bottles. One spray bottle was labeled Multi-Surface Peroxide (a multi-surface cleaner). The label on that bottle indicated it, Causes skin irritation and Causes serious eye damage. The second spray bottle was not labeled with what was in the bottle and it was two-thirds full of an unidentified liquid 18. Observation on 3/30/26 at 1:00 p.m. of the blue hallway bathtub room revealed the bathtub room door was open and there were no staff members in the bathtub room or near the entrance of the bathtub room. The two spray bottles were in the pink crate on top of the bathtub. 19. Observation and interview on 3/30/26 at 1:54 p.m. of the main dining room revealed there was an unsupervised housekeeping cart in the dining room. There were two residents sitting at a table in the dining room and no staff members were present. A bottle of toilet bowl cleaner was on the housekeeping cart with the spout open. The door on the housekeeping cart where the cleaning chemicals were stored was unlocked. In the lockable compartment was a bottle of Multi-Surface Peroxide cleanser and Micro Kill foaming disinfectant cleaner. The keys to unlock the cart were on the top of the cart. At 2:04 p.m. administrator A entered the main dining room and verified the chemicals were not secured away from residents' access. She called on her walkie-talkie and housekeeper CC entered the main dining area. Housekeeper CC acknowledged the housekeeping cart was hers and she had left it unlocked and unattended, and the toilet bowl cleaner was stored on her cart in a location that could not be locked. 20. Observation on 3/30/26 at 3:34 p.m. of the blue hallway bathtub room revealed the door was open; there were no staff members in the bathtub room or near the entrance to the bathtub room. The two spray bottles were in the pink crate on top of the bathtub. 21. Observation on 3/31/26 at 8:09 a.m. of the blue hallway bathtub room revealed the door to the bathtub room was open with no staff members in the room. The two spray bottles in the pink crate were on top of the bathtub. 22. Observation and interview on 3/31/26 at 8:18 a.m. with CNA WW revealed she had given residents' baths in the blue hallway bathtub room. She verified there were two spray bottles on top of the bathtub but stated she did not know what they were used for and she acknowledged the door on the (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	03/31/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	blue hallway bathtub room was to remain closed to prevent residents from accessing the room unsupervised. 23. Interview on 3/31/26 at 8:32 a.m. with RN T revealed the door to the bathtub rooms were to be closed and locked to prevent residents from entering the room and tripping as well as to prevent them from being exposed to unsecured chemicals. 24. Interview on 3/31/26 at 10:45 a.m. with DON B revealed she did not know what the chemical spray bottles in the blue hallway bathtub room were used for. She expected the door to the bathtub room to be closed to prevent residents from entering when eh room was unattended and chemicals were present. She acknowledged the chemicals in the blue hallway bathtub room were unsecured with the door open and posed a potential risk for a resident to be exposed or have access to those chemicals. She expected all chemicals to be labeled with what was in the bottle. 25. Observation and interview on 3/31/26 at 11:25 a.m. with regional nurse consultant (RNC) M revealed in the blue hallway bathtub room revealed she verified there were two spray bottles in the pink basket on top of the bathtub. One of the bottles was Multi-Surface Peroxide cleanser and the other bottle was unlabeled. RNC M smelled the liquid in the unlabeled spray bottle and verified the bottle did not contain water, but she was unsure what the liquid was. 26. Interview on 3/31/26 at 1:41 p.m. with administrator A revealed she did not know the bathtub door in the blue hallway was left open. She stated the bathtub room was to be closed, locked, and accessible only by staff through a code pad on the door. She expected all chemicals to be stored in their original labeled container in a secure location to prevent a resident's access to the chemical.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure the staff followed the care planned interventions for one of one sampled resident (72) identified as requiring all of her care to be provided by two caregivers who expressed distress and reported that one of one certified nursing assistant (CNA) (JJ) was rough with the resident when that CNA did not provide the resident's care with another staff member present. 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 11/16/25 SD DOH FRI revealed that on 11/16/25 at 11:30 a.m., resident 72 reported to licensed practical nurse (LPN) UU that CNA JJ was rough with her. CNA JJ was suspended pending the results of an investigation.LPN UU completed a skin assessment of that resident, and no new areas of concern or evidence of significant harm or injury were noted.Interviews conducted with staff on duty identified that resident 72 was screaming after [CNA JJ] went into the room and started helping her [resident 72], then left to get a second person to assist. CNA JJ confirmed that she went into the resident's room alone and assisted [resident 72] with care.Resident 72 had a history of allegations of staff being rough and is care planned to be cared for in pairs [two people] by staff.CNA JJ was not following the resident's care plan. and [her employment] was terminated effective 11/18/25. Staff education was initiated on cares in pairs [care provided by two staff members]. Audits [were] implemented to ensure care in pairs are being followed weekly x4 [for four] weeks. The resident's physician, the police department, and the family were notified. 2. Review of resident 72's electronic medical record (EMR) revealed she admitted to the facility on [DATE]. Her 10/28/22 care plan indicated a focus area of MANIPULATIVE BEHAVIOR (ALLEGED MISTREATMENT) [Resident 72] may voice allegations of mistreatment or exploitation by caregivers. This behavior appears to be related to feeling [a] loss of independence. Will also exhibit [the] behavior of abusive language.Interventions for that behavior included Assure [resident 72] that she is safe and secure. prefers caregivers without accents in her room. [resident 72] continues to make accusations against staff of African decent [descent]. Implement special care strategies as she will have two (2) caregivers address [her] needs and to observe the entire session. Have supervisory personnel observe care delivery, as [much as] possible and in accordance with privacy and dignity considerations. Offer staff of Caucasian descent when able.Her 11/16/25 skin evaluation indicated there were no new skin issues observed. 3. Observation and interview on 3/24/26 at 3:22 p.m. with resident 72 in her room revealed she did not recall the specific incident on 11/16/25, but indicated that she felt like the staff Do everything wrong. She stated that every time the staff touched her, they hurt her. She felt like they were trying to break her bones. She stated that they always bonked her on the head when they transferred her. And they never positioned her correctly in the bed or in the wheelchair. She did not like her custom wheelchair, her bed, or her door open. She stated she waited hours to be put to bed and that she wanted to be put back to bed. At 3:24 p.m., resident 72's call light was turned on, and at 3:26 p.m., an unidentified staff member entered the room and stated that she would get another staff member to assist her with putting resident 72 back to bed. At 3:28 p.m., CNA U and regional nurse consultant (RNC) L assisted resident 72 back to bed and with her care.This surveyor exited the room while those staff members provided the resident's personal care to maintain the resident's right to privacy. There were no episodes of the resident calling out observed.After that care was provided, the surveyor entered the resident's room and continued the interview. Resident 72 reported that she liked that one girl, but the other staff member tried to hurt her, went too fast, she felt like her fingers were broken, and she had not been positioned comfortably in bed. She declined the offer to inform the staff that she was uncomfortable and to request staff assistance to be (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	repositioned. 4. Interview on 3/24/26 at 3:44 p.m. with CNA U regarding resident 72's report of the care she received when assisted to bed during the above observation and interview revealed that resident 72 was to always receive care with two staff present because of the accusations she at times made after receiving care. Resident 72 told inconsistent stories, was manipulative, did not like new staff members, and was known to scream even before some staff members touched her. Resident 72 was very particular about who she allowed to help her. RNC L was not a familiar care provider to resident 72CNA U stated she felt she had a good relationship with resident 72 because the resident liked her, but it was very hard to make the resident happy. She felt that resident 72's reports of events were often not believable, and that resident 72 had not reported a concern with the care provided when she and RNC L assisted her to bed and had stated that she was comfortably positioned when they left her room. 5. Interview on 3/30/26 at 2:42 p.m. with administrator A and DON B regarding resident 72's 11/16/25 report that CNA JJ was rough with her during her care revealed that LPN UU had notified them of the incident on 11/16/25 and administrator A confirmed they immediately suspended CNA JJ, reported the incident to the SD DOH, resident 72's physician, and the resident's power of attorney, and conducted an investigation. They identified that the incident occurred because CNA JJ did not provide resident 72's care with two staff members present, as indicated in her care plan. They provided immediate education to all nursing staff working at that time and initiated ongoing education with all caregiver staff members. They interviewed residents identified as requiring their care to be provided in pairs to ensure that two staff members were present when care was provided and implemented weekly audits beginning on 11/21/25. They reviewed those audits in their QAPI program and continue to monitor that nursing staff members are following the residents' care plans related to providing cares in pairs for the residents with that intervention identified on their care plan. 6. Review of the provider's Abuse and Neglect, Cares in Pairs, and Care Plan, policy staff education initiated on 11/17/25 revealed that all nursing staff were educated about the information in those policies. 7. Review of the provider's QAPI notes from 12/10/25 revealed that resident 72's 11/16/25 allegations of abuse were reviewed, and a care plan performance improvement project (PIP) meeting had been scheduled. 8. Review of the provider's audits after resident 72's 11/16/25 report revealed the provider completed five audits a week for four weeks to observe if the resident's care plans were followed by the staff members providing the resident's care to ensure care was provided to the residents in accordance with the provider's cares in pairs expectations and no further issues were observed. No additional staff education was needed as a result of the audits. 9. The provider's implemented actions to ensure the deficient practice does not recur were confirmed on 3/31/26 after record review revealed the facility had followed their quality assurance process, education was provided to all nursing staff regarding expectations for following resident care plans and the resident's identified as requiring cares in pairs, the provider's care plan policy was reviewed, and audits were completed. Interviews with nursing staff revealed they understood the education provided regarding the resident care plans, and were able to identify residents who required cares in pairs both in the resident care plan and with signage posted on the residents' doors. Observations of resident care were conducted on residents requiring cares in pairs and confirmed that staff followed the resident care plan, and two staff members were present when indicated in the resident care plan. A QAPI meeting was held on 12/10/25, and the incident regarding resident 72 and the completed audits were reviewed to implement a corrective plan. The audit results will continue to be a part of their QAPI process for review and recommendations as needed. 10. Based on the above information, non-compliance at F684 occurred on 11/16/25, and based on the provider's 1210/25 implemented corrective actions for the deficient practice confirmed on 3/31/26, the non-compliance is considered past non-compliance.