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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	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 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 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	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)

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

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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)

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

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the provider failed to assess and manage pain for one of one sampled resident (78) who showed signs of having pain.Findings include:1. Observation on 3/25/26 at 9:15 a.m. in the hallway by resident 78's room revealed he was being wheeled to his room by (name of hospice agency) certified nursing assistant (CNA) YY after receiving a shower. Resident 78 could be heard moaning and his face was grimacing suggesting he was in pain. CNA WW wheeled resident 78 into his room and then closed the door to provide cares to resident 78. Over the following several minutes, resident 78 could be heard screaming outside his closed bedroom door.2. Review of resident 78's electronic medical record (EMR) revealed that he was admitted to the facility on [DATE]. Resident 78's medical diagnoses included Alzheimer's Dementia, Displaced fracture of right femur, and Polyneuropathy (neurological condition resulting from widespread damage of peripheral nerves, often causing numbness, tingling, pain, and muscle weakness). Resident 78's 1/5/26 Brief Interview for Mental Status (BIMS) assessment score was not completed. Question one of the assessment was Should Brief Interview for Mental Status be assessed? Answer was 0. No (resident is rarely/never understood). (meaning the resident does not have the cognitive ability to complete the assessment).Resident 78 was admitted to Hospice (a specialized comfort-focused form of care for individuals with a terminal illness. This care prioritizes quality of life, pain management, and emotional/spiritual support the patient and family) on 12/23/25.Resident 78's medication orders revealed that he received scheduled acetaminophen (mild pain reliever) and Tramadol (opioid for moderate to moderate/severe pain). There was an order for PRN (as needed) Morphine (a narcotic pain medication) 5 mg (milligrams) every two hours as needed for pain or dyspnea (shortness of breath).Resident 78's electronic medical record revealed that on 3/25/26, a medical diagnosis of Pseudobulbar Affect (a neurological condition characterized by sudden, uncontrollable, and inappropriate episode of laughing or crying that do not match a person's actual inner emotions) was added to his list of diagnoses.3. Interview on 3/25/26 at 9:24 a.m. with CNA YY revealed It's tough to determine if he [resident 78] is actually in pain because he has a lot of anxiety. He has a lot of lower body rigidity [involuntary, sustained stiffness or tension of muscles, causing discomfort and reduced range of motion].4. Observation on 3/25/26 at 11:10 a.m. outside of resident 78's room revealed that resident 78 could be heard outside of his room with the door closed moaning and yelling. CNA XX was observed walking with licensed practical nurse (LPN) H to resident 78's room and gave him PRN Morphine.5. Interview on 3/25/26 at 3:50 p.m. with LPN H revealed that she felt resident 78 was often feeling pain when he was moved and transferred. She did not feel that [name of hospice agency] was managing resident 78's pain appropriately. She reported that she had made her unit manager aware of her concerns about resident 78's pain.6. Interview on 3/26/26 at 10:09 a.m. with CNA/CMA BB revealed that she had provided cares for resident 78 for over a year. She felt that resident 78's behaviors were tough to interpret at times. He does have different noises. Some are happy, neutral, and crying. She reported that resident 78 will sometimes answer yes or no if he was in pain, but does not answer on a 10 point pain scale (used to determine someone's pain on a scale of 1 through 10). She stated, he is very rigid, and there probably is some pain when he is moved. She also felt it would be a good idea to medicate resident 78 before frequent movement.7. Observation on 3/26/26 at 10:21 a.m. outside of resident 78's room with the door closed revealed that he could be heard making moaning and yelling sounds while the staff were in the room providing cares for him.8. Interview on 3/26/26 at 10:29 a.m. with CNA ZZ after exiting resident 78's room revealed that when asked if she felt resident 78 was experiencing pain when cares were being provided, she responded I just started last week. I'm not sure if he is in pain. She did not feel she was able to judge his emotions yet.9. Interview on 3/26/26 at 11:07 a.m. with registered nurse (RN) unit manager J regarding resident 78's diagnosis of Pseudobulbar Affect revealed that there was conversation between the staff about (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	resident 78's behaviors that led to the review of his EMR that revealed he had a previous diagnosis of Pseudobulbar Affect and it must have dropped off of his list of diagnoses. The resident's primary care provider was faxed to ask if it was appropriate to add the diagnosis of Pseudobulbar Affect to his list of diagnoses. She reported that she was not made aware by staff that resident 87 was experiencing increased pain.10. Interview on 3/26/26 at 11:33 a.m. with CNA AAA revealed that she had provided cares for resident 78 for about a year and a half. She felt that resident 78 cries out when he expresses pain. She reported that resident 78 does not always cry when he is being transferred. She stated that earlier in the morning, resident 78 was crying when she took him to the dining room for breakfast and she felt he was experiencing pain, and she reported that to the nurse, LPN O.11. Interview on 3/26/26 at 12:41 with LPN O revealed that she felt resident 78 was tough to read. Sometimes his laugh sounds like a cry. Usually if he is in pain, I try the morphine. If that doesn't help, I try the Ativan [anxiety medication]. He seems really anxious when being transferred. I don't know that he is in pain.12. Review of resident 78's medication administration record (MAR) revealed that LPN O did not administer morphine that day or during March 2026.13. Observation on 3/30/26 at 3:26 p.m. with CNA/Staff coordinator AA and CNA/CMA BB changing resident 78's incontinence (involuntary urine or bowel leakage) brief revealed resident 78 appeared calm before the staff moved him. When resident 78 was turned onto his right side, he was constantly grimacing. He began to moan ga ga ga ga ga ga ga ga. His face was red with a grimace and he appeared to be in pain. The resident responded similarly when he was rolled onto his left side. CNA/Staff coordinator AA and CNA/CMA BB attempted to hold resident 78's hand and talk to him while changing his incontinence brief, but that did not seem to help.14. Interview on 3/30/26 at 4:28 p.m. with LPN H and RN P revealed that it was their opinion that resident 78's pain was not being managed appropriately. LPN H was told by DON B that LPN H should only be administering resident 78's PRN morphine when he had extreme pain. LPN H reported that she felt resident 78 was sometimes in extreme pain, so she treated it with the ordered morphine.LPH H reported that resident 78 was not cognitively intact and his pain could not be appropriately assessed using the 10 point pain scale. She used the PAINAD [Pain Assessment in Advanced Dementia. An observational tool that assesses 5 behaviors; breathing, negative vocalizations, facial expressions, body language, and consoloability] assessment to assess resident 78's pain and treated his pain according to that assessment.15. Observation and Interview on 3/31/26 at 9:25 a.m. with resident 78 near the nurse's station revealed he was well dressed and groomed. When asked if he was experiencing pain, he did not reply. When asked if he could describe his pain on a scale of 0-10, with 0 being no pain at all, and 10 being the worst pain he had ever experienced, he did not respond.16. A review of resident 78's documented pain rating assessments revealed that between 3/20/26 and 3/31/26, there were 51 pain assessments documented. 27 assessments were documented using the 10 point pain scale, and 24 assessments were documented using the PAINAD scale.17. Interview on 3/31/26 at 10:06 a.m. with DON B revealed that she was aware of resident 78's recent diagnosis of Pseudobulbar Affect. She stated that after surveyors had started to question if resident 78 was experiencing pain, it caused the staff to look to see if there may be other reasons for resident 78's behaviors. She reported that after a review of resident 78 VA (Veterans Administration) records, the staff found that the resident was diagnosed with Pseudobulbar Affect before being admitted to the facility.18. Review of resident 78's VA discharge documentation from 1/25/22, before admission to the facility, revealed there was no diagnosis of Pseudobulbar Affect listed in his medical diagnoses.19. Interview on 3/31/26 at 2:25 p.m. with RNC M revealed that after requesting documentation of resident 78's original documentation of Pseudobulbar Affect, RNC M stated The Pseudobulbar Affect diagnosis came from me. She reported that resident 78 was admitted initially under an inappropriate dementia diagnosis. She admitted that resident 78 was never diagnosed with Pseudobulbar Affect before 3/25/26. She did not feel that the 10 point pain scale was appropriate for a resident whose cognition was not intact and typically did not provide more than one word responses.20. Review of the providers 4/28/25 pain management policy revealed 1. The pain (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	management program is based on a facility wide commitment to resident comfort. 2. Pain Management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical conditions and established treatment goals. Recognizing Pain: 1. Observe the resident (during rest and movement) for physiologic and behavioral (non-verbal) signs of pain. Possible Behavioral Signs Of pain: A. Verbal expression such as groaning, crying, screaming. B. Facial expressions such as grimacing, frowning, clenching of the jaw, etc.; C. Changes in gait, skin color and vital signs; D. Behavior such as resisting care, irritability, depression, decreased participation in usual activities

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, observation, and policy review, the provider failed to ensure one of one registered nurse (RN) (F) administered a medication according to the physician's order for one of one sampled resident (44) with a history of heart disease who required the use of the medication to prevent chest pain. Findings include: 1. Interview on 3/24/26 at 9:22 a.m. with resident 44 revealed that he was admitted to the facility about three weeks ago. He was very upset about not receiving his nitroglycerin patch heart medication (a medication patch used to prevent chest pain caused by heart disease) as ordered the previous morning. He stated that he spent the entire day and night worrying that something terrible would happen to him.He asked the day nurse yesterday three or four times for that medication and was told he was not the only resident to whom the nurse had to provide medication, that he would receive his medication when the nurse brought it to him, and not to worry about it.Resident 44 stated that he had a heart attack in the past, had numerous stents (small mesh tubes used to hold open blood vessels) placed, and not receiving his nitroglycerin patch was causing him a lot of anxiety.He told the evening nurse, when she came to remove the patch on the evening of 3/23/26, that he did not receive that medication at all that day. He stated, I hope she documented that.He stated that he was at the facility once before last year and felt that the facility was aware of his healthcare needs and should have known that his nitroglycerine patch medication was important not to skip. 2. Review of resident 44's EMR revealed he was admitted to the facility on [DATE].He previously resided at the facility from 7/9/25 through 7/15/25, was discharged to the hospital due to chest pain, and then went home for several months before being admitted to the facility again this month.His 3/11/26 Brief Interview for Mental Status (BIM) assessment score was 15, indicating that his cognition was intact.A 3/5/26 focus area indicated that resident 44 has a diagnosis of anxiety. A goal that resident 44 will not be affected with signs/symptoms of psychosocial stressors, and that his episodes of anxiety will be relieved in a short period of time with staff intervention.His 7/9/25 care plan indicated a focus area that resident 44 was at risk for altered cardiovascular function related to atherosclerosis (a disease of the arteries where fatty material deposits on their inner walls), HTN [hypertension (high bloop pressure)], PVD [peripheral vascular disease (a progressive narrowing or blockage of blood vessels)], iron deficiency, anemia (not having enough red blood cells to carry oxygen to the body's tissues), unstable angina (a condition in which the heart does not get enough blood flow and oxygen), obesity (overweight), CKD [chronic kidney disease (kidney damage)], and TIA [transient ischemic attack (a brief blockage of blood flow to the brain)]. The 3/5/26 goal indicated that resident 44 will be free from signs and symptoms of complications of cardiac problems. Interventions included Administer medications as ordered.There was a 3/6/26 physician's order for Nitroglycerin Transdermal Patch 0.4 milligrams/hour (mg/hr), apply two patches transdermally (to the skin) one time a day and remove per schedule. This was scheduled to be applied each day at 8:00 a.m. and removed each day at 7:59 p.m.Resident 44's March 2026 medication administration record (MAR) indicated that on 3/23/26 at 8:00 a.m., registered nurse (RN) F, administered the Nitroglycerine Transdermal Patches. On 3/23/26 at 7:59 p.m., licensed practical nurse (LPN) G documented, Per resident patches were not applied this AM [morning]. 3. Interview on 3/25/26 at 3:15 p.m. with LPN/unit manager C regarding resident 44's report that he did not receive his physician-ordered nitroglycerin patches on the morning of 3/23/26 revealed that resident 44 told her about that incident today (3/25/26) after he mentioned it to the surveyor. She reported that information to director of nursing (DON) B and administrator A to conduct an investigation. 4. Interview on 3/25/26 at 3:18 p.m. with DON B and administrator A revealed LPN/unit manager C reported to them today that resident 44 stated that he did not receive his nitroglycerin patches on the morning of 3/23/26. They identified the nurses who worked that day, and were in the process of interviewing resident 44, RN F, and LPN G. 5. Observation and interview on 3/25/26 at 3:21 p.m. with DON B and LPN/unit manager C revealed that (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	LPN C and DON B completed a count of resident 44's Nitroglycerin Transdermal Patches 0.4 mg/hr. There were 22 patches remaining in the box.DON B planned to contact the pharmacy to confirm how many patches had been dispensed. The investigation was ongoing at that point, and she was unsure if resident 44 received all of the ordered doses of his patches at that time. 6. Review of resident 44's March 2026 MAR indicated that it was documented that resident 44 received 20 doses (40 patches) of his Nitroglycerin Transdermal Patches 0.4 mg/hr. 7. Review of RN F's 3/25/26 written statement revealed, I tried to give him [resident 44] his nitro patch in the dining room but he said later in my room and I gave them to him later when he came back to his room. 8. Interview on 3/26/26 at 9:07 a.m. with DON B revealed that she contacted the pharmacy regarding resident 44's Nitroglycerin Transdermal Patches. The pharmacy dispensed 60 patches; 20 doses of that medication (40 patches) were documented as administered, and 22 patches remained in the box. She expected there to be 20 patches remaining in the box.There was one dose (two patches) more than she expected. She felt that resident 44 had not received his 3/23/26 morning dose of that medication.RN F was suspended. DON B submitted a report to the South Dakota Department of Health and contacted resident 44's physician. On 3/25/26 at 4:48 p.m., she implemented monitoring of resident 44's pulse, blood pressure, and reports of chest pain or dizziness to occur for three days. Resident 44 was his own responsible person.DON B conducted interviews with resident 44, RN F, and LPN G.DON B reported that resident 44 told her that he felt anxious about not receiving his medication, but that resident 44 had not reported any dizziness or chest pain. 9. Interview on 3/30/26 at 4:00 p.m. with pharmacist II revealed she was notified of a possible medication error involving resident 44 not receiving a dose of his Nitroglycerin Transdermal Patches.She felt that DON B put in place appropriate monitoring of resident 44 once she became aware of the possible medication error, and pharmacist II was told that resident 44 did not experience any adverse effects, and because of that, she would not have considered this medication being missed a significant medication error.She declined to list the potential adverse effects of resident 44 missing a dose of his physician-ordered Nitroglycerin Transdermal Patches. She stated that the facility identified what monitoring was needed and that monitoring had been put in place. 10. Interview on 3/31/26 at 8:04 a.m. with LPN G revealed that on the evening of 3/23/26, when she went to remove resident 44's Nitroglycerin Transdermal Patches, there were no patches on his chest to remove, and she documented that.She did not inquire why those patches had not been put on or report that there were no patches to remove from resident 44's chest to her supervisor because she thought there must have been a valid reason resident 44 had not had them put on. Resident 44 stated that the morning nurse did not put his patches on, but she was unsure if resident 44 said why the patches were not put on.She stated that she was very busy that night, and after she documented that there were no patches to remove, she did not think about it again. Her only interactions that night with resident 44 were when she provided him with his medications. She did not recall if resident 44 was upset about not receiving his medication as ordered. 11. Review of the provider's undated Medication Administration - General Guidelines policy revealed Medications are administered as prescribed in accordance with good nursing principles and practices. Review of the provider's reviewed 5/14/25 Medication Errors policy revealed Errors will be documented, investigated, reported, and reviewed for need of intervention and to prevent recurrence.

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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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026
NAME OF PROVIDER OR SUPPLIER Avantara Norton		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 South Norton Avenue Sioux Falls, SD 57105	

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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 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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 review, the provider failed to ensure five of six sampled residents' (2, 8, 36, 41, and 49) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessments were accurately coded for the areas of Pre-admission Screening and Resident Review (a mandatory federal process that ensures people with mental illness or intellectual disabilities are not inappropriately placed in nursing homes)(PASRR), insulin administration, and prescribed psychotropic medications (drugs that affect brain activities associated with mental processes and behavior). Findings include:1. Review of resident 8's electronic medical record (EMR) revealed he admitted to the facility on [DATE] and had an approved PASRR Level II on 12/6/24. His 9/3/25 comprehensive MDS assessment indicated he did not have a PASRR Level II, and his PASRR Level II was added to his care plan on 2/2/26. His 3/6/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. He had diagnoses of depression (persistent sadness, low energy, and loss of interest in activities), bipolar disorder with psychotic features (extreme mood swings, mania or depression, accompanied by a temporary break from reality), and anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). He did not have a physician's order to take any medications for those diagnoses. 2. Review of resident 49's EMR revealed she admitted to the facility on [DATE] and had an approved PASRR Level II on 8/28/25. Her 9/26/25 comprehensive MDS assessment indicated she did not have a PASRR Level II, and her PASRR Level II was added to her care plan on 2/1/26. Her 3/5/26 BIMS assessment score was 15, which indicated her cognition was intact. She had diagnoses of major depressive disorder and generalized anxiety disorder, a 1/9/26 physician's order for Sertraline (a depression medication). 3. Interview on 3/26/26 at 12:45 p.m. with social services designee (SSD) E revealed that she entered resident information regarding PASRRs on the MDS assessments, and she should have entered that resident 8 and resident 49 had a PASRR Level II (an in-depth evaluation required by federal law for anyone applying to a Medicaid-certified nursing home who is suspected of having a serious mental illness or an intellectual/developmental disability). 4. Interview on 3/30/26 at 2:05 p.m. with director of nursing (DON) B revealed she expected the MDS to indicate a resident had a PASRR Level II if they had one. 5. Interview on 3/24/26 at 1:51 p.m. with resident 36 revealed he was being administered a long-acting insulin one time per day and a short-acting insulin with each meal. 6. Review of resident 36's EMR revealed he admitted on [DATE]. His 2/25/26 BIMS assessment score was 12, which indicated his cognition was moderately impaired. (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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He had a 2/5/26 physician's order for Aspart insulin (a short acting insulin) three times a day with meals and Glargine insulin (a long-acting insulin) one time a day for diabetes (a condition involving disruptions in how the body regulates blood sugar). Item N0350 of his 3/6/26 quarterly MDS assessment was coded as he had not received insulin injections during the seven-day look-back period (the time period over which the resident's condition or status is captured by the MDS assessment) of that MDS assessment. 7. Review of resident 2's EMR revealed she admitted to the facility on [DATE]. She had a physician's order for trazadone (an antidepressant medication) to be given at bedtime for depression and escitalopram (an antidepressant medication) to be given one time a day for anxiety. She did not have a physician's order for an anti-anxiety medication. Item N0415 of her 1/16/26 and 3/6/26 quarterly MDS assessments were coded as she had received an anti-anxiety medication during the seven-day look back period of those MDS assessments. 8. Review of resident 41's EMR revealed she admitted to the facility on [DATE]. She had a 9/25/24 physician's order for Rexulti (an antipsychotic medication) once daily for behaviors related to Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions). Item N0415 of her 8/26/25 and 12/1/25 quarterly MDS assessments were coded as she did not receive an antipsychotic medication during the seven-day look back period of those MDS assessments. 9. Interview and EMR review on 3/31/26 at 9:42 a.m. with minimum data set (MDS)/registered nurse (RN) D revealed she was responsible for the accurate submission of the residents' MDS assessments. She verified resident 2 was not prescribed an antianxiety medication but her 1/16/26 and 3/6/26 MDS assessment was coded as she had received antianxiety medications. She verified resident 36 was administered insulin four times a day since 2/5/26, but his 3/6/26 MDS assessment indicated he did not receive insulin which was inaccurate. She verified resident 41 took an antipsychotic medication since 9/25/24, but her 8/26/25 and 12/1/25 MDS assessment did not indicate she had taken an antipsychotic medication, which was inaccurate. 10. Interview on 3/31/26 at 10:45 a.m. with director of nursing (DON) B revealed she supervised the MDS nurses and she expected the residents' MDS assessments to be coded accurately. 11. Review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 revealed that when answering the N0350 question related to a resident's use of insulin the number of days during the seven day look back period that the resident received an insulin injection was to be entered for N0350A. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When coding medications within N0415 they are to be coded according to the medication's therapeutic category and/or pharmacological classification, not how it is used. Any medication that has a pharmacological classification or therapeutic category of antipsychotic medication must be recorded in this section, regardless of why the medication is being used. Residents suspected of having MI may require certain care and services provided by the nursing home or the state. When answering the PASRR question on the MDS assessment, question A1500 should be coded as a yes if the resident had a PASRR Level II, which would then require question A1510 to be answered to indicate the reason for PASRR Level II, Serious mental illness, Intellectual Disability, or Other related conditions. 12. Review of the provider's 5/14/25 PASRR policy revealed the Preadmission Screening and Resident Review (PASRR) is a federal requirement to ensure the Nursing Facility (NF) residents with Serious Mental Illness (SMI) or Intellectual and Developmental Disability (ID/DD) are identified and evaluated, placed in the most appropriate and least restrictive setting available, transitioned to an appropriate community setting when they no longer meet criteria for NF placement, and to provide with the MI/ID/DD services they need, including specialized services.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the provider failed to ensure the resident's baseline care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was completed within 48 hours of the resident's admission to the facility for three of nine sampled residents (2, 6, and 98), and was reviewed with, and a copy was offered to the resident or the resident's representative within 48 hours of the resident's admission to the facility for seven of nine newly admitted sampled residents (2, 6, 30, 36, 44, 61, and 98). Findings include:1. Interview on 3/24/26 at 9:22 a.m. with resident 44 revealed that he admitted to the facility about three weeks ago. He was upset about not receiving his nitroglycerin patch heart medication, which was ordered the previous morning. He stated that he spent the entire day and night worrying that something terrible would happen to him because he was not given that medication. There was a meeting the second week he was at the facility, where the staff members had discussed his care, and he was provided with a copy of his care plan. He pointed to the whiteboard in his room that indicated Care Conference 3/9/26. 2. Review of resident 44's electronic medical record (EMR) revealed he was admitted to the facility on [DATE], and his 3/11/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. There was an uploaded signed paper copy of his baseline care plan. It was signed by resident 44 on 3/9/26 to indicate that he had received a copy and that it was reviewed with him. 3. Interview on 3/24/26 at 2:00 p.m. with resident 30 revealed once she reviewed her baseline care plan she was not aware it included behavior issues. She disputed the statement in her care plan that she had a history of substance abuse and was a member of Al-Anon (a program of recovery for families and friends of alcoholics). She denied being a drug abuser, but it was in her care plan. She was not offered a copy of her care plan or her baseline care plan to review after her admission to the facility. 4. Review of resident 30's EMR revealed she admitted to the facility on [DATE]. Her baseline care plan was completed on 7/30/25. There was no documentation that a copy of the baseline care plan was offered to or reviewed with resident 30. 5. Interview on 3/25/26 at 3:54 p.m. with licensed practical nurse (LPN)/unit manager C revealed that she expected all residents' baseline care plans to be initiated during their nursing admission assessment on the day of their admission to the facility. She expected each resident to receive a copy of that baseline care plan when it was reviewed with them at their 48-hour care conference. Social services designee (SSD) E was responsible for printing the care plan, providing it to the resident, and scheduling the care conference. She stated that resident 44 admitted to the facility on a Thursday (3/5/26), and his care conference was held on the following Monday (3/9/26). The team reviewed his care plan with him during his care conference, and she thought that resident 44 had received a copy of his care plan that day. She confirmed resident 44 did not receive his baseline care plan, and it was not reviewed with him within 48 hours of his admission to the facility. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Interview on 3/26/26 at 9:52 a.m. with resident 36 revealed he did not recall anyone reviewing his baseline care plan with him or having been offered a copy of his baseline care plan after he admitted to the facility. He stated the physical therapy department was the only staff members who spoke with him about their plans and talked to him about his goals. 7. Review of resident 36's EMR revealed he admitted to the facility on [DATE], and his 2/25/26 BIMS assessment score was 12, which indicated his cognition was moderately impaired. His baseline care plan was documented by SSD E as having been reviewed with the resident or the resident's representative on 11/21/25. There was no documentation that resident 36 or his representative was offered a copy of his baseline care plan. 8. Review of resident 6's EMR revealed she admitted to the facility on [DATE], and her baseline care plan was documented by SSD K as having been reviewed with the resident or the resident's representative on 10/13/25, five days after she was admitted to the facility. There was no documentation that resident 6 or her representative was offered a copy of her baseline care plan. 9. Review of resident 61's EMR revealed he admitted to the facility on [DATE], and his baseline care plan was documented by SSD E as having been reviewed with the resident or the resident's representative on 11/21/25. There was no documentation that resident 61 or his representative was offered a copy of his baseline care plan. 10. Review of resident 2's EMR revealed she admitted to the facility on [DATE], and her baseline care plan was not locked to indicate it was completed until 1/6/26, seven days after she was admitted to the facility. There was no documentation that resident 2 or her representative was offered a copy of her baseline care plan. 11. Review of resident 98's EMR revealed she admitted to the facility on [DATE], and her baseline care plan was documented by SSD E as having been reviewed with the resident or the resident's representative on 3/16/26, five days after she admitted to the facility. There was no documentation that resident 98 or her representative was offered a copy of her baseline care plan. 12. Interview on 3/26/26 at 12:48 p.m. and again with SSD K regarding resident 30's baseline care plan revealed resident 30 did not agree with some items in her care plan and refused to sign it until SSD K clarified it. SSD K attempted to revise the resident's care plan wording without omitting needed information for the resident's approval and signature, but the resident did not agree to the care plan's content and did not sign it. SSD K confirmed there was no documentation resident 30 was offered a copy of the baseline care plan. 13. Interview and record review on 3/31/26 at 8:46 a.m. with SSD E regarding resident 44's baseline care plan revealed that the nurse who admitted him to the facility initiated his baseline care plan on 3/5/26. SSD E added information to that care plan and scheduled his care conference to be held on 3/9/26. She printed resident 44's baseline care plan and provided him a copy at the 3/9/26 care conference when they reviewed it with him. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She stated that when a resident would admit to the facility on a Thursday or a Friday, she would schedule the resident's conference for Monday or Tuesday of the following week. That meeting was considered the 48-hour care conference, where the care team would review the resident's care plan with the resident. She did not consider whether the weekend days should have been included when she calculated the 48 hours. She confirmed that resident 44 received his baseline care plan four days after he was admitted to the facility, and not within the 48 hours as required. 14. Interview on 3/31/26 at 12:13 p.m. with director of nursing (DON) B revealed she expected that all the residents would be provided a copy of their baseline care plans and that those baseline care plans would be reviewed with the resident or their representative within 48 hours of their admission to the facility. Resident 44 did not receive his baseline care plan, nor had it been reviewed with him or his representative within 48 hours of his admission to the facility. 15. Interview on 3/31/26 at 1:35 p.m. with administrator A revealed she knew residents were to be offered a copy of their initial care plan within 48 hours of their admission to the facility. She expected the interdisciplinary team to offer residents or their representative a copy of their initial care plan during the initial care conference. 16. Review of the provider's 5/14/25 revised Care Plans policy revealed 2. A Baseline Care Plan is started by nursing staff on the first day of admission to provide guidance to direct care givers as soon as possible after admission and completed no later than 48 hours after admission. 5. During the care conference the care plan is reviewed with the resident and/or resident's representative. A care conference sign in sheet may be utilized or the facility may list those in attendance on the LGHC Multidisciplinary Care Conference UDA. The care plan may be printed (select print with signature page) and signed by the resident or resident representative.

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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 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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026
NAME OF PROVIDER OR SUPPLIER Avantara Norton		STREET ADDRESS, CITY, STATE, ZIP CODE 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	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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NAME OF PROVIDER OR SUPPLIER: Avantara Norton		STREET ADDRESS, CITY, STATE, ZIP CODE: 3600 South Norton Avenue Sioux Falls, SD 57105	

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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 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 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure the code status (emergent treatment a person wishes to receive if their heart or breathing would stop) for two of two sampled residents (2 and 25) was currently and accurately documented in the residents' electronic medical records (EMR). Findings include:1. Review of resident 25's EMR revealed she admitted to the facility on [DATE]. A banner located at the top of her EMR indicated her code status was Full code [to start life-sustaining measures if one's heart or breathing stopped]-cardiac resuscitation [chest compressions and/or rescue breathing, also known as CPR] but no intubation [the insertion of a tube into the windpipe to maintain an open airway].There was a [DATE] physician's order for Full code-cardiac resuscitation but no intubation.Resident 25's [DATE] signed code status form was signed by resident 25 on [DATE] and the physician on [DATE]. That form indicated her wishes were Do Not Resuscitate [no life-sustaining measures if one's heart or breathing stops, also known as DNR]. There were no other signed code status forms in resident 25's EMR.The provider's undated pocket care plan (a paper reference used by staff to identify a resident's basic care needs) for resident 25 indicated she was a Full Code. 2. Review of resident 2's EMR revealed she admitted to the facility on [DATE] and admitted again on [DATE] after a hospitalization from [DATE] through [DATE]. A banner located at the top of her EMR indicated her code status was DNR: OK to intubate. There was a [DATE] physician's order that stated DNR: OK to intubate.On [DATE] resident 2 and a medical provider signed a Resuscitation Designation Order that indicated resident 2 wanted to be a DNR. There was no documentation on that form that indicated she wished to be intubated.The provider's undated pocket care plan for resident 2 indicated she was a Full Code. 3. Interview on [DATE] at 10:15 a.m. with certified nursing assistant (CNA)/certified medication aide (CMA) V revealed she referenced the Kardex (a report of the resident's care needs and interventions) within the resident's EMR or their pocket care plan.The nurse managers were responsible for updating the pocket care plan for their code status. The pocket care plans were not always up to date. If she noticed a pocket care plan was not up to date, she would notify the nurse manager that it needed to be updated.CNA/CMA V referenced resident 2 and 25's pocket care plans and stated they indicated both residents' code status was listed as full code. 4. Interview and EMR review on [DATE] at 3:46 p.m. with licensed practical nurse (LPN) O revealed a resident's code status was found on their EMR banner. If the identified code status displayed on the EMR screen was clicked on it would access that resident's written code status form.LPN O stated she would reference the resident's code status on the EMR banner or the resident's pocket care plan. She reviewed resident 2's and 25's EMR banners, signed code status forms, and their pocket care plans and verified that both residents' code statuses were not the same within those three areas.LPN O acknowledged that the differences between the residents' EMR banners, signed code status form, and their pocket care plans posed a risk that those residents' wishes may not be followed if they had a medical emergency and were unresponsive. 5. Interview on [DATE] at 10:45 a.m. with director of nursing (DON) B revealed the nurse managers and the social services staff were responsible for documenting the residents' code statuses on the written code status form and in that resident's EMR. 6. Interview on [DATE] at 1:41 p.m. with administrator A revealed the nurse manager reviewed the residents' wishes related to their code status when they admitted to the facility.The nurse manager would document the resident's desired code status on the written code status form, the resident or the resident's representative would sign the code status form, and then the form would be sent to the physician to be signed. The nurse manager entered the resident's desired code status into that resident's EMR banner.The resident's code status was to be reviewed with the resident or the resident's representative quarterly and updated as needed.Administrator A acknowledged that resident 2's and resident 25's code statuses (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were not consistent between their signed code status forms, the EMR banners, and the pocket care plans, which had the potential for the residents' wishes to not be followed if their heart or breathing stopped. 7. Review of the provider's [DATE] Advanced Directive policy revealed it was the policy of the facility for each resident to choose their Advanced Directives upon admission and such may be changed by the resident at any time during their stay. An Advanced Directive for (as provided by the healthcare facility) shall be completed with [the] resident and/or legal representative to verify treatment options as well as code status. The resident's Advanced Directive choices/options shall be reviewed with [the] resident/resident representative during quarterly and significant change assessment and care planning.

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
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the provider failed to follow standard food safety practices to ensure one of one observed dietary aide (DA) (EE) washed her hands after touching her face, hair, and pants, washed her hands for the required amount of time, wore gloves before handling resident's food, and replaced a milk jug lid after it fell on the floor in one of three dining rooms (Central). Findings include:1. Observation on 3/24/26 in the Central dining room revealed that at 11:34 a.m., DA EE touched her face, did not wash her hands, and placed covers on plates for the room trays. She touched her face again, did not wash her hands, and put the trays on the room tray cart. At 11:48 a.m., DA EE touched a resident's shoulder, took that resident's coffee cup into the kitchen, came out of the kitchen, and gave it back to her. She touched her face, did not wash her hands, obtained a plate of food for another resident, and served that to a resident. She touched her hair, obtained a plate of food, and served it to another resident. At 11:53 a.m., DA EE went into the kitchen and obtained butter. She did not wash her hands and used her bare hands to touch a resident's bread to apply the butter. At 11:59 a.m., DA EE dropped a chocolate milk lid on the floor in the dining room, picked it up off the floor, and put it back on the chocolate milk container. At 12:06 p.m., DA EE washed her hands in the sink for approximately four seconds, wiped her hands on paper towels, then wiped her left hand on the back of her pants, obtained a plate of food, and served it to a resident. 2. Interview on 3/24/26 at 1:42 p.m. with DA EE revealed she was to sanitize her hands after every three resident plates were served and before putting the room trays on the cart. She was supposed to sanitize her hands after touching a resident, her face, her hair, and her pants before serving resident plates. She was supposed to wash her hands and put on gloves before she touched the resident's food. When washing her hands in the sink, she was supposed to wash them for approximately 20 seconds. She did not recall dropping the chocolate milk lid on the floor and putting it back on the chocolate milk container. The milk lid should have been thrown away if it had been dropped on the floor. 3. Interview on 3/30/26 at 4:07 p.m. with dietary manager (DM) FF revealed that DAs are to sanitize their hands after every three resident plates are served, before putting room trays on the room tray cart, after touching their face or pants, and after touching residents. If the milk lid fell on the floor, it was to be thrown away.4. Review of the provider's 5/15/25 Hand Hygiene policy revealed that the facility considers hand hygiene the primary means to prevent the spread of infections.When washing their hands with soap and water, staff are to wash their hands for at least twenty (20) seconds. They are to wash their hands before and after handling food, and before and after direct contact with residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the provider failed to ensure the staff followed standard infection control practices regarding:*Hand hygiene (handwashing or hand sanitizer use) and glove use by two of two housekeepers (DD and HH) while cleaning residents' rooms.*Manufacturer's recommended chemical contact time (the duration a disinfectant must remain visibly wet on a surface to effectively kill pathogens) was followed by two of two housekeepers (DD and HH) while cleaning residents' rooms. Findings include:1. Observation on 3/24/26 at 2:29 p.m. of housekeeper HH cleaning room [ROOM NUMBER]revealed she put on a pair of gloves without performing hand hygiene. She entered room [ROOM NUMBER] and removed the garbage bags from the garbage cans on both sides of the room. The garbage bags were brought into the hallway and put in the garbage container on her housekeeping cart. Without removing her gloves or performing hand hygiene housekeeper HH took two clean garbage bags off a roll on her housekeeping cart, returned into room [ROOM NUMBER] and replaced the garbage bags on both sides of the room.Housekeeper HH exited room [ROOM NUMBER] with the same gloves on, did not remove the gloves or perform hand hygiene, and removed a bottle of Multi-Surface Peroxide cleaner and a cloth from her cart and brought them into room [ROOM NUMBER]. She sprayed the countertop beside the sink and immediately wiped it off with the cloth. She then exited the room, entered the hallway, and placed the cloth and Multi-Surface Peroxide cleaner in her housekeeping cart. She did not remove her gloves or perform hand hygiene.Housekeeper HH then entered room [ROOM NUMBER] with another cleanser and cloth and washed dried mud off the floor beside the resident's bed that was closest to the door. She exited the room and returned to her housekeeping cart in the hallway with the same gloves on, did not remove her gloves, or perform hand hygiene.She took the broom into room [ROOM NUMBER], swept the floor of the entire room and used the dustpan to pick up the dirt. She exited the room with her gloves on, with the broom and dustpan, and dumped the dirt in the garbage on her housekeeping cart. She did not remove her gloves or perform hand hygiene.Housekeeper HH then removed the mop pad from cleaning solution on her cart with the same gloves on, took it into room [ROOM NUMBER] and mopped the room. Once she had completed mopping, she exited the room with her gloves on. At her housekeeping cart she removed her gloves and used alcohol-based hand sanitizer to perform hand hygiene and applied a new pair of gloves. 2. Observation and interview on 3/30/26 at 1:08 p.m. of housekeeper DD while she cleaned resident room [ROOM NUMBER] revealed she put on a pair of gloves without performing hand hygiene, sprayed the Multi-Surface Peroxide cleaner on the recliner and wiped it off with a cloth. She then sprayed the cabinet with the Multi-Surface Peroxide cleaner and wiped it off with a cloth.Housekeeper DD sprayed the bed with the Multi-Surface Peroxide cleaner and wiped it off with a cloth. Housekeeper DD then exited the resident room, removed her gloves and performed hand hygiene.Housekeeper DD stated she used the Multi-Surface Peroxide cleaner when she cleaned hard surfaces in residents' rooms. She stated she would let the Multi-Surface Peroxide cleaner remain on a surface if it was visibly soiled before she wiped it off. If the area was not visibly soiled, she sprayed the cleaner on and wiped it off immediatelyThe label on the Mult-Surface Peroxide cleaner stated, 1. Spray on hard surfaces to be cleaned. 2. Wait: 1-2 [one to two] minutes. 3. Agitate (if necessary). 4. Wipe Dry. 3. Interview on 3/31/26 at 12:22 p.m. with housekeeper EEE revealed she used the Multi-Surface Peroxide cleaner on surfaces in the residents' room such as their over-the-bed table and countertop beside the sink.She did not know if the Multi-Surface Peroxide cleaner had a contact time for disinfection. She stated she would have to read up on that. 4. Director of housekeeping DDD was not in the facility or available for interview during the second week of the survey. 5. Interview on 3/31/26 at 12:40 p.m. with licensed practical nurse (LPN)/unit manager/infection preventionist C and wound care certified, regional nurse consultant (RNC) L revealed LPN/unit manager/infection preventionist C expected staff to perform hand hygiene before they applied gloves and after they (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed their gloves, before entering a resident's room, and after leaving a resident's room.Gloves were to be changed between residents, when a dirty task was completed and before a clean task was started.LPN/unit manager/infection preventionist C stated she would expect staff to follow the identified contact time needed for each chemical to disinfect the surface it was applied to.Wound care certified, regional nurse consultant L advised LPN/unit manager/infection preventionist to answer no further questions related to housekeeping glove use and hand hygiene or chemical contact times because she could not speak for housekeeping's infection control practices. 6. Interview on 3/31/26 at 1:41 p.m. with administrator A revealed hand hygiene and glove use was standard between all departments within the facility unless there was something specific identified in the policy.She expected all staff to follow the recommended contact time for each chemical they used to clean resident care items and surfaces. 7. Review of the provider's 5/15/26 Hand Hygiene policy revealed All personnel shall follow the hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. If hands are not visibly soiled, use an ABHR [alcohol based hand rub] .for all the following situations:Before and after direct contract with residentsWhen entering and leaving a Resident care area/roomBefore donning [putting on] and after removing gloves. The use of gloves does not replace hand hygiene. Hand hygiene must be completed prior to and after [the] removal of gloves.