

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2026
NAME OF PROVIDER OR SUPPLIER Avantara Mountain View		STREET ADDRESS, CITY, STATE, ZIP CODE 916 Mountain View Road Rapid City, SD 57702	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI), interview, record review, and policy review, the provider failed to ensure residents received quality of care for: One of one sampled resident (18) who was not repositioned and provided continence care for approximately nine hours by two of two certified nursing assistants (CNA) (U and V) between 7/18/25 and 7/19/25. One of one sampled resident (64) whose care plan was not followed by one of one CNA (S) on 12/7/25. One of one sampled resident (23) who was not provided timely continence care by one of one CNA (P) on 1/1/26. This citation is considered past non-compliance after review of the corrective actions the provider implemented following those incidents. Findings include: 1. Review of the provider's 7/22/25 FRI revealed that resident 18 was not repositioned or provided continence care for approximately nine hours between 8:30 p.m. on 7/18/25 and 5:41 a.m. on 7/19/25. This was confirmed after the provider reviewed their 7/18/25 and 7/19/25 camera footage. The root cause of the incident, per the provider's investigation, was that staff assignment sheets had not been updated by the nurse to reflect that CNA U and CNA V had split the 7/18/25 overnight shift. There was also no hand-off communication between those two CNAs when one CNA was finished working the split shift and the second CNA started working the split shift. Interview on 1/4/26 at 3:15 p.m. with CNA W, CNA X, and CNA Y revealed that staff assignment sheets were kept on a clipboard at the nurses' station for CNAs to know their shift assignments. If there was a shift split between two CNAs, that was reflected on the assignment sheet. Huddles [meetings to update staff about residents' care needs or changes] occurred between the CNAs and the nursing staff at the start of shift and as needed throughout the shift to keep the CNAs informed of changing resident needs. Outgoing and incoming CNAs also completed walking rounds [resident status updates that occurred while walking door to door by residents' rooms]. At the start of the shift, the outgoing (going off duty) CNA shared a brief report with the incoming (coming on duty) CNA regarding each resident they had cared for during the shift. Review of the 1/4/26 assignment sheet with CNA X revealed there were separate assignment sheets for the first and second floors. The sheets identified the nursing, CNA, and qualified medication aides assigned to work the day, evening, and night shifts that day. Each scheduled CNA was assigned specific resident room numbers that they were responsible for during their shift. Interview on 1/4/26 at 3:30 p.m. with licensed practical nurse (LPN) I revealed that the assignment sheets were made up by a nurse manager at least one day in advance. It was the responsibility of the floor nurse to notify the on-call nurse of any staffing changes. The on-call nurse had a copy of the current assignment sheet and worked with the floor nurse to make any necessary changes to the assignment sheet. It was the floor nurses' responsibility to update the assignment sheet with any staffing changes and communicate those changes to the floor staff. Review of the provider's 7/22/25 SD DOH FRI report regarding resident 18 and interview on 1/6/26 at 2:45 p.m. with director of nursing (DON) C and administrator A revealed the following post-incident follow-up was completed and verified while on-site: CNA U and CNA V were suspended from work</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>pending the outcome of the incident investigation. Both CNAs received disciplinary action related to the 7/22/25 incident. Education was provided for CNA U, CNA V, and all other staff regarding the provider's Abuse/Neglect policy. Nurses were educated regarding their responsibility to update staff assignment sheets when CNA work assignments are changed. CNAs were educated regarding the expectation that hand-off communication occurs between the outgoing and oncoming CNAs. Staff were interviewed following the incident regarding their knowledge of abuse/neglect reporting, and the expectation that routine resident checks occurred. Residents were interviewed to determine if they were regularly checked on by staff, as well as their feelings of safety inside the building. Audits were initiated to confirm that routine rounding on residents was occurring and that assignment sheets had been updated when it was indicated. Resident 18's care plan was updated to reflect her and her family's request that she have every four-hour checks related to the resident's preference not to be disturbed during the overnight hours. CNA U returned to work after the completion of the investigation. CNA V is no longer employed by the facility. 2. Review of the provider's 12/15/25 FRI revealed that during the investigation of an unrelated incident, it was identified that CNA S had not followed resident 64's care plan, which indicated that the resident was to receive Cares in Pairs, meaning the presence of two staff was expected when the resident's care was provided. CNA S assisted resident 64 with toileting without another staff person present. There were no adverse consequences that occurred as a result of this failure. The incident occurred on 12/7/25 at 8:30 p.m. Interview on 1/4/26 at 12:10 p.m. with CNA T regarding Cares In Pairs revealed that the term meant the presence of two staff persons was expected when resident care was provided due to reasons such as resident behavioral concerns, staff, or resident safety. There were several places a CNA could look to identify if a resident required Cares in Pairs including their care plan or their electronic medical record (EMR). Observation and interview on 1/6/26 at 10:40 a.m. with resident 64 revealed that two unidentified CNAs assisted her out of bed, into and out of the bathroom. After exiting the bathroom, resident 64 asked, How did they [the CNAs] do? That same question was redirected back to the resident for her response, and she stated the CNAs did well. She indicated she was satisfied with her caregivers. She was treated with dignity and respect by them. Resident 64 had no concerns. She had been directing her own care for two years. Review of resident 64's care plan revealed on 9/13/24, an intervention for Cares in Pairs was initiated related to the resident's history of manipulative behavior, verbal abuse towards staff, recording staff without their knowledge or permission, and making false accusations/statements about staff. Review of the provider's 12/15/25 submitted SD DOH FRI report and interview on 1/6/26 at 2:45 p.m. with director of nursing (DON) C and administrator A revealed the following post-incident follow-up was completed and verified while on-site: CNA S was suspended from work pending an investigation of the 12/7/25 event. She received written discipline and education regarding the expectation that residents' care plans were followed. She returned to work after the investigation was completed. Law enforcement, the resident's power of attorney, and her medical provider were notified of the incident. All staff were educated regarding the expectations for residents who require Cares in Pairs. 3. Review of the provider's 1/2/26 submitted SD DOH FRI report regarding resident 23 and interview on 1/5/26 at 3:45 p.m. with DON C and administrator A revealed: On 1/1/26, certified nursing assistant (CNA) P was assigned to provide resident 23's care. At 6:19 p.m., resident 23 activated her call light. At that same time, CNA P was seen exiting another resident's room. She entered resident 23's room, turned off resident 23's call light, then returned to the room she had just exited. At 6:47 p.m., CNA P exited that room and was approached by an unidentified resident's family member. It appeared that the resident's family member had requested assistance from CNA P for a resident (their relation). At</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7:40 p.m. on 1/1/26, resident 23 was heard hollering out from inside her room. CNA Q informed CNA P that resident 23 was hollering. CNA P responded: [Resident 23] always does that, [the resident] just wants her [dinner] tray removed [from her room]. CNA R then asked CNA Q to check on resident 23. CNA Q entered resident 23's room and then exited that room at 8:15 p.m. after she had changed resident 23's brief. The resident had a bowel movement that was coming out of her brief. Fecal matter was observed on the resident's bedding that looked like it had been there awhile. Review of CNA P's personnel file revealed her date of hire was 9/22/25. She had completed training related to resident rights, mandatory incident reporting, and abuse/neglect shortly after her hire date. Her background check was reviewed. No significant findings were noted. Interview on 1/5/26 at 2:30 p.m. with resident 23 regarding the 1/1/26 incident revealed that she confirmed having soiled her brief that evening and turning on her call light to have it changed. The resident stated it was one and a half to two hours before a CNA came into her room to change her brief. The resident was not able to recall the names of the staff members she had interacted with on the evening of 1/1/26. Resident 23 stated her incontinence care was usually promptly provided by staff. She felt the 1/1/26 incident was an isolated event. It was resident 23's experience that the staff had treated her with dignity and respect. Interview on 1/6/26 at 2:45 p.m. with DON C and administrator A revealed the following post-incident follow-up was completed and verified while on-site: An assessment of resident 23's skin was completed, and no new skin concerns were identified. CNA P was suspended from work pending the outcome of the provider's investigation into the incident on 1/1/26. On 1/4/26, CNA P text messaged her resignation to the provider. Both CNA Q and CNA R were educated regarding the provider's Abuse/Neglect policy, including the expectation that the on-call nurse be contacted immediately regarding any resident abuse/neglect allegation. Education for all other staff was initiated regarding that same information. A sample of staff persons was interviewed and confirmed their knowledge and understanding of the facility's abuse/neglect policy and the expectations for reporting such allegations. A sample of residents was interviewed regarding how staff interacted with them, how staff had cared for them, and their feelings of safety. There were no negative findings. The social services director was meeting with resident 23 to monitor the resident for potential negative outcomes as a result of the incident. Interview and record review on 1/6/26 at 3:45 p.m. with DON C and administrator A revealed the interviews, education, and audits referenced in the provider's 7/22/25, 12/15/25, and 1/2/26 submitted SD DOH FRIs were completed and documented. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 1/6/26 after record review revealed the facility had followed their quality assurance process, education was initiated for all direct care staff regarding resident abuse and neglect, FRI-related audits were initiated, and observations and interviews confirmed staff understood the expectations for updating and following the staff assignment sheets, implementing Cares in Pairs, and how to identify and report alleged resident abuse and neglect. Based on the above information, non-compliance at F684 occurred on 7/18/25, 12/7/25, and 1/1/26, and based on the provider's implemented corrective actions for the deficient practice confirmed on 1/6/26, the non-compliance is considered past non-compliance.</p>		