STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435040	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Mountain View	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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, record review, and policy review, the provider failed to protect the residents' right ro be free of misappropriation of property by one of one certified nurse aide (CNA)/qualified medication aide (QMA) (D) who agreed to cash one of one sampled resident's (2) scratch tickets in exchange for half of the winning money amount and who took one of one sampled discharged resident's (1) medication for her personal use. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include:1. Review of the provider's 5/21/26 SD DOH FRI revealed that assistant administrator C was notified by human resources director I that on 5/21/26 CNA/QMA D had possibly taken a discharged resident's Mounjaro (an injectable medication for type 2 diabetes that frequently leads to significant weight loss), after registered nurse (RN) G reported the incident to human resources. CNA/QMA D was immediately interviewed and admitted that she took resident 1's Mounjaro medication. She stated that she asked RN E to administer the injection for her. CNA/QMA D and RN E were suspended on 5/21/26 pending investigation. CNA/QMA D's employment with the facility was terminated on 5/22/26 and RN E returned to work after completing education on medication disposal and abuse and neglect on 5/23/26. 2. Review of the provider's 6/19/26 SD DOH FRI revealed that on 6/19/26 resident 2 had told licensed social worker (LSW) H that she had offered CNA/QMA D half of her lottery scratch ticket winnings if CNA/QMA D would go cash them out at a gas station. Resident 2 had won $50 and offered CNA/QMA D $25. Resident 2 could not remember the exact date of the incident. CNA/QMA D's employment with the facility was terminated on 5/22/26, so no disciplinary action could be taken. All residents with a BIMS of 10 or higher were interviewed to determine if there had been any other misappropriation of property, and all of those sampled residents stated no. 3. Observation and interview on 7/1/26 at 4:07 p.m. with resident 2 in her room revealed that she liked to purchase lottery scratch tickets. She had made an arrangement with CNA/QMA D to turn in her scratch tickets when she won money, and in exchange, resident 2 would give CNA/QMA D half of her winnings for gas money and time. She remembered winning $50 and offered to give CNA/QMA D $25. Resident 2 was educated on the facility's policy that the staff were not allowed to accept money from the residents. There was a $25 voucher on her bedside table that indicated the facility had reimbursed her, along with a copy of the facility's gift policy. 4. Review of resident 2's electronic medical record (EMR) indicated that she admitted to the facility on [DATE]. She had a 4/3/26 Brief Interview of Mental Status (BIMS) assessment score of 15, which indicated that her cognition was intact. There were no notes in her EMR regarding the reported incident on 6/19/26. 5. Review of resident 1's EMR indicated that she admitted to the facility on [DATE] and was discharged on 5/12/26. She had a 4/17/26 physician's order for 10 milligrams of Mounjaro to be administered per injection every Friday. 6. Interview on 7/2/26 at 8:55 a.m. with licensed practical nurse (LPN) F revealed that unused medication was expected to be returned to the pharmacy or destroyed by two nurses. There was a list of medications in the medication room for the staff members to determine which medications were eligible to be sent back to the pharmacy. Only nurses and qualified medication aides had access (continued on next page)

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

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the medication room. She indicated that the staff members recently had to complete education on the facility's gift policy, destruction of medications, and the facility's abuse and neglect policy. When a resident discharged from the facility, all the resident's medications were expected to be collected, counted, and either returned to the pharmacy or destroyed. 7. Interview on 7/2/26 at 9:14 a.m. with RN E revealed that CNA/QMA D asked her to administer the Mounjaro injection to her. The Mounjaro injection syringe did not have a label on it that indicated who that syringe belonged to. RN E asked CNA/QMA D to confirm what dose of medication she was on, and the dose she stated matched the dose in the syringe. RN E did administer the Mounjaro injection to CNA/QMA D. She would not have administered the medication if she had known that CNA/QMA D took the syringe from a discharged resident's medication supply. 8. The provider's actions that were implemented to mitigate the likelihood of the deficient practice from reoccurring were verified on 7/2/26. Review of the investigation notes regarding CNA/QMA D taking resident 1's injectable medication revealed that all residents taking injectable medications were audited and no missing medication was found. The facility also performed medication disposition audits of five discharged residents and all of those medications were counted, and either returned to the pharmacy or destroyed. Those audits were completed weekly for four weeks, and no further missing medications found. The incident will be brought to the next Quality Assurance and Performance Improvement (QAPI) meeting for further review by the interdisciplinary team. In addition, a sample of ten staff members were interviewed by nursing management regarding if they had ever witnessed any misappropriation of discharged residents' medications and all reported that they did not. Those same ten staff members were then asked about the process for destroying or returning medications and all ten were able to state the facility's process correctly. All staff members with access to the resident's medications completed education on the return or disposal of discharged residents medications. 9. Review of the investigation notes regarding CNA/QMA D accepting money from resident 2 revealed that ten residents with a BIMS score of 10 or higher were interviewed by the facility's management team. All ten residents stated that they had no concerns about the safety of their money in the facility and that the staff did not ask for or receive any money from them. All staff members were required to complete education regarding the facility's gift policy and the employee handbook that they were not allowed to accept any cash or gifts from the residents. 10. Review of the provider's undated Disposal of Medications Policy revealed that medications left in the facility after a resident's discharge were to be determined by nursing staff if they qualified to be returned to the pharmacy. If the medication did not qualify to be returned to the pharmacy, that medication as to be removed from the current medication supply for prompt disposition. Regular medications (considered non-controlled medications), shall be destroyed by the nursing care center [authorized facility staff] in the presence of a pharmacist or nurse, and one other witness. 11. Review of the provider's May 2025 Abuse and Neglect Policy revealed that financial abuse included diversion of a resident's medication for personal use or gain. 12. Review of the provider's August 2024 Gift Policy revealed that the employees were not allowed to accept any cash, tips, gratuities, personal checks, gift cards, etc., that could not be shared with other staff members. 13. Review of the provider's March 2025 Employee Handbook revealed that it is strictly prohibited to accept any gifts, tips, or gratuities from any resident, resident family member, or vendor, and acceptance of gifts, tips, or gratuities will result in immediate termination of employment. Based on the above information, noncompliance at F602 occurred on 5/21/26, and based on the provider's corrective action plans that were initiated on 5/22/26 and implemented for the deficient practice confirmed on 7/2/26, the noncompliance is considered past noncompliance.