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	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Mountain View	916 Mountain View Road Rapid City, SD 57702

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the provider failed to ensure the staff followed professional standards of practice to ensure:*The resident's physician was notified that one of two sampled residents (31) with physician's orders for dialysis treatments refused four of those treatments from 12/5/25 through 12/31/25.*One of one observed certified medication aide (CMA) (L) administered medications according to the physician's order to ensure the full dose was given for one of one sampled resident (34) with orders for lactulose laxative medication.*One of one sampled resident's (57) insulin was administered according to the physician's order by one of one licensed practical nurse (LPN) (I).*Documentation supported that one of one sampled resident's (86) WanderGuard (a wearable door alarming device) was checked each shift to ensure it was on the resident's ankle and functioning, according to his physician's order and the provider's policy.*One of one sampled resident's (5) gastric tube was checked for placement according to the physician's order and the provider's policy for one of one sampled resident (5) with a tube for receiving nutritional formula, medication, and hydration. Findings include:1. Review of resident 31's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *Her diagnoses included: End-stage renal disease, chronic kidney disease stage 5, renal dialysis, type 2 diabetes, and edema. *Her physician's orders included a 6/4/25 order for dialysis treatments on Monday, Wednesday, and Friday. *Her 12/5/25, 12/12/25, 12/19/25, and 12/24/25 nurse progress notes indicated she had refused to go to those dialysis treatments. There was no indication that her physician had been notified of those refusals. *Her dialysis assessment forms for her dialysis treatment dates of 12/5/25, 12/12/25, 12/18/25, 12/23/25, and 12/31/25 were initiated but not completed. There was no indication that her physician had been notified of her refusal to attend her dialysis treatments on those assessment forms. 2. On 1/5/26, resident 31 was at dialysis and not available for an interview. 3. Interview and record review on 01/06/2026 at 11:09 a.m. with infection preventionist/LPN K regarding dialysis treatments revealed: *She was aware that resident 31 was to receive dialysis treatments. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*When a resident refuses dialysis the nurse should document that in a progress note, and notify the physician. *She was unable to find documentation that resident 31's physician was notified of her dialysis treatment refusals on the above dates. 4. Interview and review of resident 31's EMR on 1/6/26 at 2:24 p.m. with director of nursing (DON) C revealed: *When a resident refused to attend their dialysis treatment, she expected that the resident's physician would be notified and documented by the nurse. *Confirmed there was no documentation in resident 31's EMR that supported that resident 31's physician was notified of her dialysis treatment refusals on 12/5/25, 12/12/25, 12/19/25, and 12/24/25. 5. Review of the provider's 2/20/24 Dialysis Management policy revealed it did not include the process for when a resident refused their ordered dialysis treatments. 6. Interview on 1/6/26 at 2:14 p.m. with regional nurse consultant (RNC) B and DON C regarding dialysis revealed the provider did not have a dialysis refusal policy. 7. Review of the provider's 11/18/25 Notification of Change of Condition policy revealed: *The facility will provide care to residents and provide notification of resident change in status. *The facility must promptly inform the resident; consult with the resident's medical provider; and notify, consistent with his or her authority, the resident representative(s) when:: *A need to alter treatment significantly . *Continued resident refusal of ordered treatments or procedures (at least three consecutive refusals). 8. Observation and interview on 1/4/26 at 11:40 a.m. with certified medication aide (CMA) L in resident 34's room revealed CMA L administered the resident's eye drops. She then reminded the resident to drink the clear liquid inside the plastic cup that was on the resident's bedside table. CMA L stated there was lactulose (a laxative medication) in that cup. CMA L stated she left the lactulose on the resident's bedside table during a medication pass earlier that morning and planned to check back later to verify that the resident took the lactulose. 9. Review of resident 34's January 2026 medication administration record (MAR) revealed the resident's lactulose was documented as having been administered at 8:00 a.m. on 1/4/26. 10. Interview on 1/5/26 at 2:45 p.m. with CMA L regarding the above observation revealed she documented resident 34's lactulose was administered even though she knew the resident had not yet taken that medication. MAR documentation was not expected to occur until after she had confirmed a medication was taken by the resident. 11. Observation on 1/5/26 at 4:50 p.m. of CMA M preparing resident 66's medications for (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration revealed she mixed the resident's MiriLAX (a laxative medication) powder with water inside a drinking cup. She crushed the resident's pills and mixed them with apple sauce inside a medication cup. CMA M had resident 66 take sips of the MiriLAX in between swallowing spoonfuls of the crushed medications. The resident ingested all of the crushed medications, and CMA M returned the cup with remaining MiriLAX in it to the medication cart. She marked that cup with the resident's initials, then documented on the resident's MAR that both the MiriLAX and the crushed medications were administered. CMA M explained she would continue to periodically offer sips of the MiriLAX to the resident until the MiriLAX was gone. This was her usual practice for administering the resident's MiriLAX. CMA M stated that she was not expected to document a medication administration on the MAR without confirming a medication was taken by the resident. 12. Observation and interview on 1/6/26 at 8:35 a.m. with LPN I revealed she had checked resident 57's blood sugar level, and the amount of Humalog (insulin) she would then administer to the resident was contingent upon that blood sugar level. 13. Review of resident 57's 11/25/25 Humalog insulin order with LPN I revealed the resident was to be administered two units of Humalog based on the resident's 181 blood sugar reading. The order indicated that insulin was to be administered before meals and at bedtime. The resident also had an order to receive 18 units of scheduled [NAME] (insulin). That insulin was to be administered in the morning and at bedtime. 14. LPN I entered resident 57's room with insulin administration supplies and prepared to administer the resident's insulin. She inserted the needle on the Humalog insulin pen into the resident's left lower abdomen, and then pressed the injection button for less than two seconds before removing it from the resident's abdomen. She inserted the needle on the Lantus insulin pen into the resident's lower right abdomen, and then pressed the injection button for less than three seconds before removing it from the resident's abdomen. LPN I stated she had not pressed the injection buttons of either insulin pen for an appropriate amount of time before removing them from resident 57's abdomen. She stated that the injection time should have been ten seconds. That compromised the full dose of both of the insulins from being delivered. LPN I confirmed she had not followed the physician's order to administer resident 57's Humalog before breakfast. That was a medication error. She knew that Humalog was a rapid-acting insulin that worked quickly to manage the expected rise in blood sugar that occurred after eating. 15. Review of the provider's September 2018 Medication Administration General Guidelines policy revealed, 20. The resident is always observed after administration to ensure that the dose was completely ingested. Review of the provider's revised 11/18/25 Following Physician's Orders policy revealed, 9. All physician orders should be followed as written. Review of the provider's revised 2/20/24 Medication Error policy revealed the purpose of that policy was To ensure medication errors are identified to prevent adverse resident effects. That policy included a Medication Error Report. Section 4 of that report identified classifications of medication (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	errors that included Wrong Time: not given at scheduled time or interval. Review of the provider's May 2016 Medication Administration Subcutaneous Insulin policy revealed Keep the injection button pressed all the way. Slowly count to 10 before you withdraw the needle from the skin. This ensures that the full dose will be delivered. 16. Review of resident 86's EMR revealed he was admitted to the facility on [DATE] from a hospital. His 12/2/25 Elopement Risk Evaluation indicated he was not at risk for elopement (leaving the facility without staff knowledge). There was no documentation in the progress notes from 12/2/25 through 12/27/25 regarding resident 86 having attempted to elope or having eloped during that time. His 12/3/25 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated his cognition was moderately impaired. A 12/28/25 progress note indicated that on 12/28/25 at about 4:00 p.m., resident 86 was not in his second-floor room. A subsequent second-floor, facility-wide, and grounds search was completed and was not successful in locating the resident. At 4:30 p.m., a code green (Elopement Alert) was called. Management staff, the resident's contact persons, power of attorney, and emergency services (911) were also notified of the elopement. At about 4:56 p.m., staff called the nearby motel where resident 86 previously lived. The resident had checked back into the same room at the motel. The resident's daughter picked the resident up from the motel and returned him to the facility. After returning to the facility on [DATE], a skin evaluation was completed for resident 86. No new skin issues were identified. A WanderGuard (a wearable door alarm device) was placed on the resident's left ankle. Resident 86's Elopement Risk Evaluation and care plan were updated on 12/28/25 to reflect his elopement. A 12/28/25 physician's order instructed: WanderGuard placed to left ankle due to [the resident's] elopement risk. Ensure placement every shift. 17. Observation on 1/5/26 at 9:20 a.m. of resident 86 revealed he was lying in his bed and did not awaken after his name was called. He was wearing a WanderGuard on his left ankle. 18. Interview on 1/5/26 at 9:30 a.m. with CMA N and registered nurse (RN) O revealed that the nursing staff were responsible for visually confirming the WanderGuard was on resident 86's ankle each shift. That WanderGuard was also to be checked to ensure a red light was flashing on the device, which indicated it was properly functioning. Review of resident 86's December 2025 and January 2026 MARs and continued interview with RN O revealed there was no documentation on those MARs to support that, since 12/28/25, the WanderGuard had been checked to ensure it was on the resident's ankle and functioning. RN O did not know why there was no daily documentation to support that the 12/28/25 physician's order had been followed. 19. Interview on 1/6/26 at 1:30 p.m. with DON C and review of resident 86's December 2025 and January 2026 MARs revealed that she confirmed there was no documentation to support that, each shift, the nursing staff had confirmed resident 86's WanderGuard was on his ankle and properly functioning, but there should have been. 20. Review of the provider's revised 11/18/25 Wanderguards/Door Signaling Devices policy revealed, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Placement verification and testing of each Wanderguard or signaling device will be completed daily and recorded on the MAR or TAR. Replacement will be completed as necessary. 21. Review of resident 5's EMR revealed: *He had a G-tube (a tube surgically placed through the abdomen into the stomach to deliver medications, fluids, or nutritional formula). *He had provider's order to check PEG-tube placement prior to water flushes/feeding and medication administrations. *The instructions for this order were to check residual and placement by attaching a 60ml piston syringe to gastric tube and gently pulling back 10ml. Aspirate [remove] 5-10ml of gastric content and use pH strips to confirm pH of 1.5 to 5.5. Stop procedure and call MD [doctor] if outside these parameters. If no gastric content appears, the tube may be against the lining of the stomach or may be obstructed. 22. Observation on 1/6/26 at 10:28 a.m. with LPN I revealed: *She had a clean syringe on a clean paper towel on the arm of resident 5's chair. *She pulled 10ml (milliliter) of air into the syringe and attached it to the valve on resident 5's G-tube. *She placed her stethoscope on his stomach, pushed the air into his G-tube, and listened for the air in his stomach. *She reported that the G-tube was in the correct location. *She removed the syringe, attached the resident's nutritional formula to the G-tube, and administered the formula. 23. Interview on 1/6/26 at 2:12 p.m. with DON C revealed she would expect nursing staff to listen for placement of a G-tube with a stethoscope as well as check the pH level of the gastric content per policy. 24. Interview on 1/6/26 at 3:38 p.m. with administrator A revealed: *She would expect staff to follow the physician's orders when administering formula through a feeding tube. *She expected staff to follow the provider's policy for administering formula and medication through a feeding tube. 25. Review of the provider's 11/18/25 Enteral Feeding (Tube Feeding) policy revealed: *The nurse would check for residual and placement by attaching a sixty milliliter [ml] piston syringe to gastric tube and gently pulling back about 10 ml. If resistance is met as stomach contents are aspirated, stop procedure and notify MD [provider]. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*If no resistance, aspirate five to ten ml of gastric contents. The appearance of gastric content implies that the tube is patent and in the stomach. Use pH strips to confirm that aspirate is at a pH of 1.5 to 5.5. If outside of these parameters, stop procedure and notify MD.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed infection prevention and control practices regarding: *Hand hygiene (handwashing) and glove use by two of two certified nursing assistants (CNA) (D and E) observed assisting one of one sampled resident (2) with transferring, using a full body mechanical lift (a lift and sling used to lift a person's full body). *Hand hygiene and glove use by one of one wound care registered nurse (RN) (F) observed performing a wound dressing change for one of one sampled resident (2). *Hand hygiene and glove use by one of one licensed practical nurse (LPN) (I) observed cleaning a resident's glasses and administering liquid nutritional formula through a feeding tube for one of one sampled resident (5). *Glove use by one of one LPN (I) observed checking one of one sampled resident's (57) blood sugar reading. Findings Include: 1. Review of resident 2's electronic medical record (EMR) revealed he had a wound to his sacrum (the lower back in between the hip bones of the pelvis) and physician's orders to change that wound dressing twice a day. 2. Observation on 1/6/26 at 9:36 a.m. in resident 2's room revealed: *He had a sign on his door for Enhanced Barrier Precautions with the instructions to wear a gown and gloves when providing direct contact care with the resident. *Certified nursing assistant (CNA) D and CNA E arrived at resident 2's doorway with a Hoyer lift (a mechanical lift and sling used to lift a person's full body). *Both CNAs put on gowns and gloves without first performing hand hygiene. They assisted resident 2 with incontinence care. *They both then discarded their gloves and gowns in the trash and performed hand hygiene. 3. Observation on 1/6/26 at 9:45 a.m. of wound care registered nurse (RN) F and wound care RN G in resident 2's room revealed: *They performed hand hygiene and applied gloves and gowns before entering resident 2's room. *Wound care RN G supported resident 2 in position on his side in the bed while wound care RN F performed the dressing change to his wound. Wound care RN F noted that resident 2 did not have a dressing in place to his sacral wound. * Wound care RN F cleaned resident 2's wound, removed her gloves, and discarded them. *She looked around the room and stated, There's no hand sanitizer in here. *She then put on a new pair of gloves without first performing hand hygiene and placed a dressing on the resident's wound. 4. Review of resident 5's EMR revealed he had a G-tube (a soft tube surgically placed through the abdomen into the stomach to administer medications, fluids, or nutrition). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Observation on 1/6/26 at 10:28 a.m. of LPN I in resident 5's room revealed: *The supplies to administer nutritional formula and fluids through the resident's feed tube had already been placed on a clean paper towel next to the resident. *She removed the resident's glasses from his face, washed them with a paper towel and water, and placed them back on his face. *With those same gloved hands, she administered the resident's nutritional formula through his G-tube. 6. Observation and interview on 1/6/26 at 8:35 a.m. with LPN I revealed she was preparing to check resident 57's blood sugar (the amount of sugar in the blood). After she performed hand hygiene, she gathered the needed supplies and entered the resident's room. She laid a clean paper towel on top of the resident's over-the-bed table and set some of the supplies on top of the clean paper towel. She placed a clean pair of gloves on top of the resident's bedding without a barrier between the bedding and those gloves. She pricked the resident's finger, placed blood from the resident's finger on a testing strip that measured the resident's blood sugar level, and inserted that strip into the glucometer (blood glucose meter). LPN I agreed that the top of the resident's bedding was not a clean surface, and the gloves she placed directly on top of that bedding would not be considered clean. She should have laid the gloves on top of a clean paper towel or other barrier. 7. Interview on 1/6/26 at 1:43 p.m. with director of nursing (DON) C revealed: *She expected the staff to perform hand hygiene before putting on gloves and before putting on personal protective equipment (PPE) such as gowns. *She agreed that LPN I should have completed hand hygiene and put on new gloves after cleaning resident 5's glasses and before administering his tube feeding through his tube. *Gloves should be left on a clean surface to mitigate the risk of cross-contamination after they are placed on a caregiver's hands. 8. Interview on 1/6/26 at 3:38 p.m. with administrator A revealed she expected all staff to perform hand hygiene per the provider's policy. Review of the provider's 5/15/25 Hand Hygiene policy revealed: *All staff members were to be trained on hand hygiene as part of their initial orientation and regularly educated on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. *All personnel shall follow the hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. *Alcohol-based hand rub was the preferred method of hand hygiene: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-*Before and after direct contact with residents. -*When entering and leaving a resident care area/room. -*Before donning [putting on] and after removing gloves. -*Before handling clean or soiled dressings, gauze pads, etc. -*Before moving from a contaminated body site to a clean body site during resident care. -*After handling used dressings, contaminated equipment, etc. *The use of gloves does not replace hand hygiene. Hand hygiene must be completed prior to and after removal of gloves.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (34) observed with a medication left at her bedside was evaluated for her ability to safely self-administer that medication. Findings include:1. Observation and interview on 1/4/26 at 11:40 a.m. with certified medication aide (CMA) L in resident 34's room revealed CMA L administered the resident's eye drops. She then reminded the resident to drink the clear liquid inside the plastic cup on the resident's bedside table. CMA L stated there was lactulose (a medication used to treat symptoms associated with severe liver disease) inside that cup. She left the lactulose on the resident's bedside table during a medication pass earlier that morning. CMA L stated that the lactulose was not pleasant tasting, and leaving it at the resident's bedside enabled the resident to take periodic sips of the lactulose throughout the morning rather than having to drink it all at once. 2. Review of resident 34's electronic medical record (EMR) revealed there was a 4/21/20 physician's order for lactulose to be administered three times per week. There was no order for the resident to have that medication left at her bedside or for her to self-administer it. Resident 34 was evaluated on 11/7/25 for her ability to safely self-administer melatonin, a hormone supplement commonly used to help a person sleep. The resident was deemed Not safe to self-administer [melatonin]. Factors that determined her inability to self-administer that medication included dementia or Alzheimer [Alzheimer's disease] that affect their [the resident's] ability to self-administer [the medication] and schizophrenia [a mental illness that causes distorted thinking, perception, and behavior]. There was no medication self-administration evaluation completed for the resident's lactulose. 3. Interview on 1/5/26 at 2:45 p.m. with CMA L revealed she did not know if resident 34 was evaluated or deemed safe to have her lactulose left at the bedside to self-administer. CMA L stated that sometime after 11:40 a.m. on 1/4/26, she observed that the cup that had lactulose in it was empty, and resident 34 verbally confirmed to CMA L that she had consumed it. 4. Interview on 1/6/26 at 1:30 p.m. with director of nursing (DON) C revealed she confirmed resident 34 was not safe to self-administer her own medication. CMA L was expected to observe resident 34 consume the lactulose in its entirety before leaving the resident's room and documenting that the medication had been administered. Review of the provider's January 2020 Self-Administration of Medications policy revealed, Each resident has a right to self-administer medications should they desire, unless this practice is determined unsafe.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, record review, and policy review, the provider failed to ensure the staff protected the residents' right to privacy and confidentiality of their protected health information in their electronic medical records (EMR) that was displayed and viewable to anyone who passed by. Findings include: 1. Observation on 1/4/2026 at 9:45 a.m. revealed there was a laptop computer on top of the medication cart in front of the first-floor nurses' station. That nurses' station was near the end of a resident living unit hallway. The computer screen displayed a list of residents' full names and photographs, along with other identifying information about them. That screen was viewable to anyone passing by the medication cart. 2. Observation on 1/4/26 at 11:20 a.m. revealed the same medication cart in front of the first-floor nurses' station. The computer screen was opened and displayed resident 2's medication administration record (MAR). Certified medication aide (CMA) L was standing about 10 to 15 feet away from the medication cart, administering resident 2's medications. Resident 2 spat out the medication, and CMA L returned to the medication cart and discarded it. She prepared another dose of the same medication for resident 2. CMA L then closed the computer screen before she returned to administer resident 2's medication for the second time. 3. Observation on 1/4/26 at 11:40 a.m. of CMA L revealed she prepared resident 34's eye drops for administration at the medication cart. She left the computer screen on top of the medication cart open. It displayed the resident's MAR. She then walked down the hall to the resident's room to administer those eye drops. After administering the eye drops, CMA L returned to the medication cart and documented the eye drop administration. She reviewed resident 34's opened MAR and realized the resident had additional scheduled medications to administer. CMA L prepared those medications and then closed the computer screen before she left the medication cart to administer those medications. 4. Observation on 1/5/26 at 1:16 p.m. of the first-floor hallway revealed: *A medication cart with an open computer on the top of that cart. *Resident 88's information was displayed on that open computer screen. *There were no employees in the hallway for approximately three minutes. Licensed practical nurse (LPN) H walked into the hallway with a machine used to check vital signs (measurements of the body's basic functions such as blood pressure, pulse, temperature, and respiration rate). 5. Interview on 1/5/26 at 1:19 p.m. with LPN H revealed: *She agreed that she was the last person to use the computer observed above and did not lock the screen, which left resident 88's personal information displayed on it. -*She acknowledged that the resident information was visible to anyone who would walk by that medication cart. (continued on next page)

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	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Mountain View	916 Mountain View Road Rapid City, SD 57702

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-*She acknowledged that someone would be able to access any information and document in the facility's computer system under her name if she did not lock the computer screen. 6. Interview on 1/6/26 at 3:38 p.m. with administrator A revealed: *She expected staff to always maintain the privacy of any resident's information. *She agreed that documentation could be accessed and/or changed by anyone if the computer screen with the resident's electronic medical record was not locked before the staff member left the computer unattended. Review of the provider's September 2018 Medication Administration General Guidelines policy revealed, 18. Resident's health information needs to remain private. The pages of the MAR [medication administration record] notebook [electronic medical record] containing resident health information must remain closed or covered when not in direct use.