STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Pierre	950 East Park Street Pierre, SD 57501

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure residents were assessed for their ability to safely self-administer their medications, had a physician's order to self-administer their medications and store those medications in their room, according to the provider's policies for:*One of one sampled resident (54) observed self-administering a medication through a nebulizer (a device that converts liquid medication into an inhaled mist) in her room, who was not assessed for the ability to safely self-administer medications and did not have a physician's order to self-administer that medication.*One of one sampled resident (7) who self-administered her medications had her Symbicort inhaler (a medication to prevent and control inflammation in the lungs and open the airways) and a fluticasone nasal spray (allergy medication) securely stored when they were not being self-administered. Findings Include: 1.Observation on 6/30/26 at 9:50 a.m. in resident 54's room revealed she was sitting in her recliner, and coughing up phlegm and spitting it in the trash can next to her recliner. Resident 54 stated she did not received her 10:00 a.m. nebulizer treatment yet, did not refuse the nebulizer treatment, and believed registered nurse (RN) G was running late. 2. Review of resident 54's electronic medical record (EMR) revealed she admitted to the facility on [DATE]. Her diagnoses included pneumonia (an infection that inflames the air sacs in the lungs and can fill with fluid), and chronic obstructive pulmonary disease (COPD a progressive incurable lung disease that restricts airflow causing difficulty to breathe). Her 5/29/26 Brief Interview of Mental Status (BIMS) assessment score was 9, which indicated her cognition was moderately impaired. She had a 12/29/25 physician's order for, DuoNeb Solution 0.5-2.5 (3) MG [milligram]/3ML [milliliter] (Ipratropium-Albuterol) 3 ml inhale orally via nebulizer three times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE. Resident 54's did not have a self-administration of medication assessment completed or a physicians order to self-administer. A care conference note on 3/16/26 indicated that resident 54's power of attorney (POA- someone designated on a legal document to act on behalf of a resident) expressed concern that resident 54 was not receiving her full nebulizer treatments. Resident 54's medication administration record (MAR) indicated her nebulizer treatments were to be administered at 10:00 a.m., 4:00 p.m., and 9:00 p.m., and her that she had refused that morning nebulizer treatment. 3. Interview on 6/30/26 at 10:25 a.m. with RN G revealed that at 6:30 a.m. that day resident 54 stated she did not want the 10:00 a.m. nebulizer treatment. When RN G was informed that resident 54 was in her room waiting for her 10:00 a.m. nebulizer, RN G stated that resident 54 was forgetful and probably forgot she refused earlier, but that she could give resident 54 her 10:00 a.m. nebulizer treatment. 4. Observations on 6/30/26 from 10:47 a.m. to 11:22 a.m. in resident 54's room revealed that her nebulizer treatment was running and was alone in her room. She was fidgeting with the nebulizer (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mouthpiece and repeatedly removed it from her mouth and placed it back in. At 10:54 a.m., resident 54 then fell asleep, and the nebulizer mouthpiece fell out of her mouth and rested at her side away from resident 54's mouth. RN G walked past resident 54's room seven times without checking in on resident 54. At 11:22 a.m., RN G walked away from the medication cart positioned in the hallway, and resident 54's nebulizer treatment was on and still running. 5. Interview on 6/30/26 at 2:22 p.m. with RN G revealed that she was aware that resident 54 did not have a self- administration of medication assessment completed. She was not aware that she should have remained with resident 54 during her nebulizer treatment. 6. Interview and EMR review on 6/30/26 at 3:30 p.m. with director of nursing (DON) B revealed that she acknowledged that resident 54 did not have a self-administration of medication assessment completed or a physician's order to self-administer her nebulizer treatment. 7. Review of the provider's revised January 2018 Medication Administration Preparation and General Guidelines policy revealed staff will, Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer. 8. Observation and interview on 6/29/26 at 2:00 p.m. with resident 7 in her room revealed she had a Symbicort inhaler and a fluticasone nasal spray on her bedside table. Resident 7 stated she took those medications when she woke up in the morning. After she took the medications, she would tell the nurse she was done with them. Sometimes she forgot to tell the nurse she had taken them, and the inhaler and the nasal spray would stay on her bedside table for hours, and at times overnight. 9. Review of resident 7's electronic medical record revealed she admitted to the facility on [DATE]. Her 5/21/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnoses included chronic obstructive pulmonary disease (COPD; a group of lung diseases that block airflow and make it difficult to breathe) and allergic rhinitis (inflammation of the nasal passages). She had a 11/14/23 physician's order for fluticasone propionate suspension 50 micrograms per activation (MCG/ACT) two sprays to be administered in each nostril one time per day at 12:00 p.m. and a 3/1/24 physician's order for Symbicort Inhalation Aerosol 80-4.5 MCG/ACT two puffs to be administered orally two times per day at 12:00 p.m. and 8:00 p.m. A 4/23/25 physician's order indicated she, May self administer medications as listed cough drops maybe [may be] kept at bedside. Fluticasone nasal spray and symbacort [Symbicort] inhaler may be self admin [self-administered] and return to [the] medication cart after use daily. Resident 7's 5/28/26 Medication Self-Administration Evaluation indicated that fluticasone nasal spray and the Symbicort inhaler were two of the medications she was evaluated for and found able to self-administer. The 5/28/26 Medication Self-Administration Evaluation form indicated, No to the question Is there an order to keep medications at bedside (medications cannot be kept at bedside without an order)? To the question, Where will the medications be stored? Medication cart was indicated as the locations of medication storage. 10. Interview and review of resident 7's EMR on 7/1/26 at 10:23 a.m. with RN P revealed resident 7 self-administered her inhaler and nasal spray. On 6/29/26 her Symbicort inhaler was documented as administered at 12:18 p.m. and her fluticasone nasal spray was documented as administered at 12:15 p.m. by LPN L. RN P stated resident 7 liked to sleep in in the morning so the nurse would place the (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Symbicort inhaler and fluticasone nasal spray on her bedside table. After resident 7 woke up she was take her Symbicort inhaler and fluticasone nasal spray and then she would alert a certified nursing assistant (CNA) to bring the medication to the nurse, or she would tell the nurse that she had taken the Symbicort inhaler and the fluticasone nasal so the medications could be returned to the medication cart. RN P was not concerned that another resident could wander into resident 7's room and take her inhaler and nasal spray. She acknowledged there were residents who wander into other residents' rooms. 11. Observation on 7/1/26 at 2:02 p.m. of resident 7's room revealed the Symbicort inhaler and the fluticasone nasal spray were sitting on resident 7's bedside table. 12. Interview on 7/1/26 at 5:01 p.m. with director of nursing (DON) B revealed that residents' medications were stored in the medication carts. Resident 7 administered her own nasal spray and inhaler. Staff would leave at her bedside and when she woke up, she would take the nasal spray and inhaler and alert the staff when she had taken them. She was not aware her inhaler and nasal spray were left in her room for hours and overnight. She acknowledged resident 7 did not have a physician's order to store her medications in her room and her physician's order indicated the medications were to be returned to the medication cart after they were administered. 13. Review of the provider's January 2018 Self-Administration of Medications policy revealed, Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer. Then the interdisciplinary team determines that bedside or in-room storage of medications would be a safety risk to other residents, the medications of residents permitted to self-administer are stored in the central medication cart or medication room. The resident requests each dose from the medication nurse, who provides the medication to the resident in the unopened package for the resident to self-administer. The nurse then records each self-administration on the MAR by placing a check mark in the appropriate space and noting in the nursing comments the initials of the nurse who obtained the information from the resident.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, observation, and interview, the provider failed to protect the resident's rights to be free from verbal, mental, or physical abuse for one of one sampled resident (28) who was verbally abused by one of one certified nurse aide (CNA) Q who called resident 28 a derogatory name, one of one sampled resident (58) who was emotionally and physically abused by one of one contracted travel CNA (Y) who had put her hand inside the residents brief to check if she was incontinent (involuntary urine or bowel leakage) and one of one sampled resident (58) by one of one contracted travel CNA (BB) who was rough while transferring resident 58 and two of two sampled residents (38 and 65) who were emotionally and physically abused by one of one contracted travel CNA (BB) who did not provide appropriate perineal care and who entered resident 38's room and with a rude tone of voice told her that her room smelled.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 5/11/26-submitted SD DOH FRI regarding resident 28 revealed that at 6:00 p.m. on 5/10/26, CNA Q approached resident 28, who had just returned to the facility with her family member, and said, Midget is back. CNA Q then looked at resident 28's family member and said, You look just like her. This information was reported to the staff by resident 28's family member on 5/11/26 at 1:30 p.m. Administrator A was notified at 1:50 p.m. that same day. CNA Q was suspended pending the outcome of the facility's investigation into the above incident. CNA Q provided a statement in response to the allegation, confirming that she had called resident 28 midget but did not intend to be mean. The facility verified the allegation of verbal abuse and decided to terminate her employment, but CNA Q self-terminated her employment with the facility on 5/14/26 in response to the allegation and investigation. The facility reported CNA Q to the South Dakota Board of Nursing. 2. Review of resident 28's electronic medical record (EMR) revealed she admitted to the facility on [DATE]. Her diagnoses included recurrent major depressive disorder (a clinical mood disorder where a person experiences two or more distinct major depressive episodes, separated by at least two months of normal mood). Her 5/28/26 Brief Interview of Mental Status (BIMS) assessment score was 8, which indicated her cognition was moderately impaired. 3. Interview on 6/30/26 at 1:40 p.m. with resident 28 revealed that she did not recall the 5/10/26 incident. She denied any psychosocial impact from the incident and stated that she felt things were going well at the facility. 4. Interview on 6/30/26 at 3:07 p.m. with licensed practical nurse (LPN) L revealed that she received training on abuse identification, prevention, and reporting requirements all the time. If she became aware of any allegation of abuse, she would report it immediately. We report allegations even if we're not sure about them. It is not up to us to make that determination. The DON [director of nursing] will investigate. 5. Interview on 6/30/26 at 3:20 p.m. with contracted travel CNA N revealed that she had received training on abuse identification, prevention, and reporting requirements many times because I've [I have] been a CNA for 10 years. There was training and testing when she started working at the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility. If she became aware of any allegations of abuse, she would report them to the nurse immediately. If she could not find the nurse, she would report them to DON B. 6. Review of CNA Q's personnel file revealed that she was hired at the facility on 4/23/25. She had completed training in abuse prevention, care for individuals with cognitive impairments, effective communication, resident rights essentials, and dementia care. CNA Q's CNA certification was current, and there were no known disciplinary actions associated with it. Her background check was completed and had no notable findings. 7. The providers' actions to mitigate the likelihood of the deficient practice recurring were verified on 7/1/26. A record review and an interview with DON B revealed that the facility had followed its Quality Assurance and Performance Improvement (QAPI) process regarding verbal abuse toward residents by interviewing resident 28 on 5/11/26 about the above incident. Resident 28 did not recall the incident and voiced no concerns regarding her care. Her psychosocial well-being was assessed and determined to be at her baseline, according to DON B and social services designee (SSD) E. They monitored and documented resident 28's behavior and psychosocial well-being following the incident. They ensured resident 28's care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was reviewed in relation to her impaired cognition. Resident 28's family member participated in care plan meetings and denied any concerns regarding resident 28's care. In addition, 40 residents were interviewed about their sense of safety, whether they were addressed by any term other than their name, and whether they had observed the staff calling other residents inappropriate names. No concerns were identified. The facility interviewed 23 staff members about whether they had witnessed the staff calling residents terms other than their names, whether they had witnessed the staff being mentally or verbally abusive toward residents, and whether they knew whom to report allegations or observations of verbal or mental abuse to. No concerns were identified. All staff were reeducated to ensure they call residents by their name and do not use terms or names that may be perceived as derogatory. The incident was brought to the facility's QAPI meeting for further review and recommendations. Based on the above information, non-compliance at F600 occurred on 5/10/26, and based on the provider's corrective action plans that were initiated on 5/11/26 and implemented for the deficient practice confirmed on 7/1/26, this occurrence of non-compliance is considered past non-compliance. 8.Review of the provider's 3/12/26 submitted SD DOH FRI report regarding resident 58 revealed that at approximately 1:00 p.m. on 3/12/26, SSD E informed administrator A that resident 58 reported to CNA V that contracted travel CNA Y had come into her room and stated that her room stunk and asked resident 58 if her incontinence (involuntary urine or bowel leakage) brief was soiled and when resident 58 replied no, contracted travel CNA Y put her hand inside of resident 58's brief and rubbed her buttocks up and down twice then proceeded to the front and rubbed up and down twice checking to see if her brief was soiled. Resident 58 reported that incident happened on 3/12/26 at approximately 7:00 a.m. Contracted travel CNA Y was suspended on 3/12/26 pending the facility's investigation. During the facilities investigation they interviewed LPN Z and resident 99, who was resident 58's roommate at that time, and both confirmed seeing contracted travel CNA Y in the room with resident 58 that morning. LPN Z completed skin assessments on resident 58 on 3/16/26 and 3/18/26 with no skin concerns found. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. Review of resident 58's EMR revealed she admitted to the facility on [DATE]. Her diagnoses included cerebral palsy (a disorder that affects a person's ability to move and maintain balance and posture), and the need for assistance with personal care. Her 5/27/26 BIMS assessment score was 15, which indicated her cognition was intact. 10. Resident 58 was out of the facility and was not available for interview during the time of the survey. 11. Review of contracted travel CNA Y's personnel file revealed she had completed education for abuse, and neglect on 12/23/25. Her certification was current, and there were no known disciplinary actions associated with that certification. Her background check was completed on 7/12/25 and had no remarkable findings. 12. Interviews with contracted travel CNA N and CNA AA confirmed they had received education regarding perineal care, and the facility abuse and neglect policy. 13. Record review confirmed that the staff were educated about perineal care, and the facility's abuse and neglect policy. 14. The providers implemented actions to mitigate the likelihood of the deficient practice from reoccurring were verified on 6/29/26 after record review, and interview with DON B revealed that the facility had followed its QAPI process regarding mental and emotional abuse towards a resident. Clinical staff received education on perineal care and the facility's abuse and neglect policy. Resident 58's well-being was monitored and documented by SSD E visits conducted twice weekly for two weeks. Resident 58 was offered counseling services but declined. Both the resident and the medical provider were notified of the investigation's findings. In addition, a sample of residents were interviewed regarding any care concerns they had, how to report allegations of abuse, and whether residents felt safe in the facility. A sample of the staff were interviewed regarding any observations of inappropriate staff behavior toward residents and their understanding of the facility's abuse reporting procedures. Contracted travel CNA Y was permanently removed from eligibility to work in the facility. The incident was brought to the facility's QAPI meeting for further review by the interdisciplinary team. Based on the above information, non-compliance at F600 occurred on 3/12/26, and based on the provider's corrective action plans that were initiated on 3/12/26 and implemented for the deficient practice confirmed on 6/29/26, this occurrence of non-compliance is considered past non-compliance. 15.Review of the provider's 4/17/26 submitted SD DOH FRI report regarding resident 65 revealed that at 2:00 p.m. on 4/17/26, CNA V notified DON B that resident 65 had expressed concerns about contracted travel CNA BB. DON B interviewed resident 65 who reported that contracted travel CNA BB assisted her to the bathroom and contracted travel CNA BB handed resident 65 the wipes to clean herself. When resident 65 stated she needed assistance, contracted travel CNA BB discarded the wipes and pulled up resident 65's pants without providing the necessary perineal care. Contracted travel CNA BB was suspended pending the facility's investigation. During the facility's investigation, DON B interviewed resident 65 as well as additional staff members. Their statements corroborated the resident 65's allegations of abuse from contracted travel CNA BB. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's medical provider and her power of attorney (POA someone designated on a legal document to act on behalf of a resident) were notified of the incident and the investigation findings. 16. Review of resident 65's EMR revealed she admitted to the facility on [DATE]. Her diagnosis included the need for assistance with personal care. Her 4/30/26 BIMS assessment score was 15, which indicated her cognition was intact. 17. Interview on 6/29/26 at 2:05 p.m. with resident 65 regarding the abuse incident on 4/17/26 revealed that she and contracted travel CNA BB were in the hallway bathroom when contracted travel CNA BB handed her the wipes. Resident 65 told contracted travel CNA BB that she could not wipe herself. At that point, contracted travel CNA BB threw the wipes away without cleaning her, pulled up resident 65's pants, and took her back to her room without speaking to her during the interaction. 18. Review of the provider's 4/17/26 SD DOH FRI report regarding resident 38 revealed that at 2:00 p.m. on 4/17/26 resident 38 reported to CNA V that on the evening of 4/16/26 contracted travel CNA BB entered her room and stated that her room stinks. Resident 38 reported feeling upset by the tone used by contracted travel CNA BB. CNA V reported the concern to DON B, who then notified administrator A. Contracted travel CNA BB was suspended pending the facility's investigation. During the facility's investigation, administrator A assisted resident 38 in completing a grievance form regarding the incident involving contracted travel CNA BB. Based on witness statements from other staff members, the facility was able to confirm the allegations of abuse from contracted travel CNA BB. Resident 38's medical provider and POA were notified of the incident and the investigation findings. 19. Review of resident 38's EMR revealed she admitted to the facility on [DATE]. Her diagnosis included heart failure, and multiple sclerosis (disabling disease of the central nervous system where the immune system attacks the protective sheath covering the nerve fibers.) Her 5/20/26 BIMS assessment score was 15, which indicated her cognition was intact. 20. Interview on 6/29/26 at 2:50 p.m. with resident 38 revealed she did not remember the 4/17/26 incident above. 21. Review of the provider's 4/17/26 submitted SD DOH FRI report regarding resident 58 revealed that at 2:00 p.m. on 4/17/26 CNA V informed DON B that resident 58 reported contracted travel CNA BB was rough and rushing during her transfer the previous evening o 4/16/26. DON B interviewed resident 58, who stated that contracted travel CNA BB had raised the bed too high, nearly causing her leg to fall out of the bed. LPN Z assessed resident 58 and noted no injuries. Contracted travel CNA BB was suspended pending the facility's investigation. During the facility's investigation DON interviewed additional staff members, and based on their statements, the facility was able to confirm the allegations of physical abuse by contracted travel CNA BB. Resident 58 and her medical provider were notified of the incident and the investigation findings. 22. Review of resident 58's EMR revealed she admitted to the facility on [DATE]. Her diagnoses included cerebral palsy (disorder that affects a person's ability to move and maintain balance and posture), and the need for assistance with person care. Her 5/27/26 BIMS assessment score was 15, which indicated her cognition was intact. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and policy review, the provider failed to follow professional standards of nursing by one of one licensed practical nurse (LPN) (L) who did not assess and document one of one sampled resident's (44) pain level before she administered that resident a pain medication, and did not document that pain medication administration on the resident's medication administration record (MAR). Findings include: 1. Observation and record review on 6/29/26 at 3:50 p.m. with LPN L revealed she responded to resident 44's request to be seen by a nurse. The resident complained of a cough and a headache. She thought she had a slight stroke because she felt unable to control her mouth secretions. Resident 44 sat calmly in a chair in her room. She was alert, oriented, and able to answer LPN L's questions. The resident's vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were within normal limits (WNL). Resident 44 winced when the blood pressure cuff inflated around her arm, but she demonstrated no other verbal or non-verbal indications of pain. The resident's pulse and oxygen saturation levels (the percentage of hemoglobin in the blood carrying oxygen) were WNL. LPN L completed a stroke assessment that included evaluating the resident's arm strength, her vision, speech, facial symmetry, and orientation. That assessment was negative for any remarkable findings. LPN L failed to assess the resident's headache pain by not asking questions such as the location of the headache pain, the type of headache she had, how long she had the headache, if anything helped to relieve the headache, or how intense her headache pain was. After exiting the resident's room and reviewing resident 44's MAR, LPN L prepared a 5 milligram (mg) oxycodone (controlled pain medication) tablet to administer to resident 44. The oxycodone was scheduled to be administered PRN (as needed) every four hours for pain. LPN L returned to the resident's room and administered the oxycodone to the resident. 2. Review of resident 44's June 2026 MAR revealed that the resident was expected to assign a numerical value between 0 and 10 (0 being no pain and 10 being excruciating pain) to her pain level that the nursing staff were to document on the MAR before administering the resident's PRN oxycodone. There was no pain level or PRN oxycodone administration documented on her MAR for the PRN oxycodone that was administered to the resident by LPN L on 6/29/26. 3. Record review and interview on 6/30/26 at 10:00 a.m. with LPN L revealed that she acknowledged failing to assess, identify, or document resident 44's pain level on 6/29/26, before she administered the resident's PRN oxycodone. She also did not document the PRN oxycodone administration on the resident's MAR after it was given on 6/29/26 at 4:00 p.m. 4. Interview on 6/30/26 at 5:20 p.m. with director of nursing (DON) B revealed that LPN L was expected to complete and document resident 44's pain assessment score on the resident's MAR before she administered the resident her PRN oxycodone. LPN L was also expected to document on resident 44's MAR the PRN oxycodone administration immediately after that administration was completed. (continued on next page)

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	435047	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Pierre	950 East Park Street Pierre, SD 57501

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Review of the provider's revised 4/28/25 Pain Management policy revealed-5. Conduct a comprehensive pain assessment upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. 6. Review of the provider's revised December 2019 Medication Administration Preparation and General Guidelines policy regarding medication administration documentation revealed: The individual who administers the medication dose records the administration on the resident's MAR/eMAR [electronic MAR] directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR/eMar to ensure necessary doses were administered and documented.

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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), record review, observation, interview, and policy review, the provider failed to ensure the staff provided accident prevention interventions and device use according to the resident's care plans (personalized plan that addresses a resident's care needs, goals, and interventions) for one of one sampled resident (29) who needed to be transferred with the use of a full body mechanical lift (a mechanical lift and sling used to lift a person's full body) and sustained a laceration (cut or torn skin) on his right lower leg when certified nursing assistant (CNA) R and contracted travel CNA S assisted the resident to pivot-transfer (when assisted to a standing position, the resident then turns their body to move to another surface) as directed by one of one licensed practical nurse (LPN) K. The resident subsequently was transferred to the emergency room for evaluation and laceration repair with staples and stitches. Findings include:1. Review of the provider's 6/9/26 SD DOH FRI revealed that on 6/9/26 at approximately 11:00 a.m., contracted travel CNA T transferred resident 29 into a shower chair with the use of a full body mechanical lift. After resident 29's shower, CNA T attempted to transfer the resident with a sit-to-stand mechanical lift (a mechanical lift used to assist a person from a seated to a standing position). Resident 29 became upset and refused to transfer with the use of the sit-to-stand lift, stating that he could stand. Contracted travel CNA T moved the shower chair in front of a grab bar and assisted resident 29 to stand using the grab bar and a gait belt (a waist strap gripped as support for safe mobility and transfers), positioned his wheelchair behind resident 29, and he sat down in the wheelchair.At approximately 11:20 a.m. CNA R and contracted travel CNA S were going to transfer resident 29 from his wheelchair to his bed. There was not a full body mechanical lift sling under resident 29 in his wheelchair. CNA R asked licensed practical nurse (LPN) K how they should transfer resident 29 since he did not have a full body mechanical lift sling under him, and LPN K advised them to transfer resident 29 with a two-person assisted pivot transfer.CNA R and contracted travel CNA S pivot transferred resident 29 from his wheelchair to his bed without the use of a gait belt. During that pivot transfer, resident 29 told CNA R and contracted travel CNA S that his legs were tangled. When resident 29 was in his bed, CNA R and contracted travel CNA S noticed resident 29 was bleeding from his leg that which caused by an area on the bed frame that was missing a cover plug.LPN K was notified of the bleeding and assessed resident 29's leg. LPN K found a large skin tear and a puncture on the outside of resident 29's right lower leg. Resident 29 was transported by ambulance to the emergency room for evaluation of his right lower leg laceration. While in the emergency room, resident 29's laceration was repaired with staples and stitches. He returned to the facility with physician's orders for wound care every shift and cephalexin (an antibiotic) to be administered four times per day until 6/16/26. 2. Review of resident 29's electronic medical record (EMR) revealed he admitted to the facility on [DATE]. His 5/18/26 Brief Interview of Mental Status (BIMS) assessment score was 9, which indicated his cognition was moderately impaired. His diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) with agitation. Resident 29's 6/29/26 care plan indicated he used a two-person full body mechanical lift for all transfers since 11/8/24. The care plan did not indicate the full body lift sling was supposed to be left under resident 29 after a transfer was completed, according to the provider's policy.A 6/9/26 Skin Alteration Evaluation indicated resident 29's laceration on the outside of his right lower leg was one centimeter (cm) in length by six cm in width with an unknown depth. There was a large amount of bloody drainage from the laceration and Yes was answered to the question, Is the resident experiencing any pain?A progress note on 6/9/26 at 4:50 p.m. written by LPN K stated, Resident [29] returned from [name redacted] ER [emergency room] accompanied by [the] staff. RT [right] leg is wrapped with [an] ACE bandage and elevated on [a] foot rest. Dressing is dry/intact. Denies any (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	pain. New orders received: Cephalexin 500 mg [milligrams] po [by mouth] qid [four times per day] x [for] 7 days, F/U [follow up] with [redacted name] wound care on 6/11/26 and F/U with [redacted physician name] prn [as needed]. [The] Resident was also given a Tetanus boost [booster] in the ER. 3. Observation and interview on 6/29/26 at 12:45 p.m. with resident 29 in his room revealed he had a full body mechanical light sling draped over his wheelchair. He was resting in bed. There were bed plugs (plugs placed in the open holes in the bed frame to cover the sharp edges of the holes) in the frame of the bed. Resident 29 did not know if he had ever been transferred in any other way than with a full body mechanical lift. He did not know if he had a cut on his leg. 4. Interview on 7/1/26 at 7:49 a.m. with administrator A revealed that the maintenance department staff did not check the residents' beds routinely to be sure the beds were working and that they did not require maintenance. The staff were educated to put a work order into the computer system for the maintenance staff to review if there were any issues identified with the residents' beds that required intervention. After resident 29 cut his leg on his bed frame there was a full facility sweep (check) of the residents' beds which identified the beds that were missing cover plugs on the bed frames. Coban (a cohesive elastic wrap) was placed on the bed frames with missing bed plugs until the bed plugs that were ordered arrived for installation. 5. Review of the 6/9/26 Full House Sweep on Bed Plugs documentation revealed there were 38 beds identified as missing bed plugs. The bed plugs were ordered for those beds missing bed plugs, and the bed plugs were installed on those beds, once they arrived at the facility. 6. Interview on 6/30/26 at 5:45 p.m. with contracted travel CNA S revealed that on 6/9/26 CNA R had asked her to help pivot transfer resident 29 from his wheelchair to his bed. Contracted travel CNA S told CNA R that resident 29 was to use a full body mechanical lift to transfer from his wheelchair to his bed. CNA R told contracted travel CNA S that she got permission from LPN K to transfer resident 29 by pivot transfer because there was no full body mechanical lift sling under him in his wheelchair. Contracted travel CNA S and CNA R completed a pivot transfer with resident 29 from his wheelchair to his bed without the use of a gait belt. When the pivot transfer was completed, they noticed resident 29's leg was bleeding, and notified LPN K. Contracted travel CNA S thought resident 29's leg got caught on the bed frame, which caused the laceration on his right leg. 7. A scheduled phone interview was attempted on 7/1/26 at 9:00 a.m. with contracted travel CNA T. Contracted travel CNA T did not answer the phone call and did not return the phone call by the completion of the survey. 8. Phone interview on 7/1/26 at 11:01 p.m. with LPN K revealed she was the nurse on duty when resident 29's leg was cut by the bed frame during a transfer. CNA R told her that resident 29 did not have a full body lift sling under him in his wheelchair and CNA R needed to transfer him into bed. LPN K knew that resident 29's care plan indicated he was supposed to transfer with the full body mechanical lift, but she did not think the CNAs would be able to put the full body lift sling under him while he was in the wheelchair. LPN K advised CNA R to pivot transfer resident 29 from his wheelchair to his bed. LPN K thought the CNAs would be able to pivot transfer resident 29 safely but stated that was a bad call.CNA R had alerted LPN K that resident 29's leg was bleeding after the pivot transfer from his wheelchair into his bed was completed. LPN K assessed resident 29's legs, which were swollen and he had thin skin. When his legs were against the bed frame he sustained a laceration on his right leg. She described the laceration as a big gash that bled a lot. LPN K felt that resident 29 needed to go to the emergency department to have the laceration evaluated. She covered the laceration with gauze dressing and an ace wrap and sent resident 29 to the emergency room by ambulance. 9. Phone interview on 7/1/26 at 11:30 a.m. with CNA R revealed she and contracted travel CNA S were going to transfer resident 29 from his wheelchair into his bed after his shower on 6/9/26. He did not have a full body mechanical lift sling under him in his wheelchair. CNA R asked LPN K how to transfer him because the full body mechanical lift sling was not under him, and LPN K told her to pivot transfer him. CNA R and contracted travel CNA S pivot transferred resident 29. CNA R did not know resident 29's leg was against the metal bed frame, and the metal bed frame punctured his leg. CNA R stated that she knew that resident 29 was supposed to be transferred (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	with a full body mechanical lift, but she did not think they could get the sling under him when he was already in the wheelchair. 10. Interview and review of the staff education documentation on 7/1/26 at 3:35 p.m. with director of nursing (DON) B revealed she expected the staff to follow each resident's care plan when they provided care for that resident. She acknowledged resident 29's care plan was not followed by LPN K, CNA R or contracted CNAs S and T. She expected all staff to review the education that was provided to them related to the provider's care plan policy, the abuse and neglect policy, the policy related to transferring a resident with the use of a gait belt, and the mechanical lift policy. She acknowledged that all of the contracted travel staff failed to sign the education documentation to indicate they had received the education after 6/9/26 incident. 11. Review of the provider's 5/14/25 Care Plans policy revealed, 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. Each staff member working with the individual resident is responsible to read, utilize and offer input to improve the care plan content ongoing. 12. Review of the provider's 11/18/25 Transfer or Gait Belt Use policy revealed, A transfer belt or gait belt must be used with each assisted transfer and assisted ambulation, unless [the] care plan indicates otherwise. 13. Review of the provider's 5/14/25 Mechanical Lifts policy revealed, Staff will be trained on the use of mechanical lifts upon hire and annually with return demonstrations. The sling may be left under the resident after the transfer if it is resident preference or if removing/placing sling may cause resident pain or skin problems. If sling is left under the resident, the reason for such should be care planned.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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 ensure:The staff completed and documented controlled medications (medications at risk for abuse and addiction) supply counts for two of two medication carts (East and West), and one of one sampled resident (24) who had one tablet of oxycodone (a controlled pain medication) unaccounted for.The residents were safe from medication errors for one of one sampled resident (66) who was not administered the prescribed dose of antihistamine medication by one of one RN (G). Findings include:1. Review of the provider's 5/5/26 SD DOH FRI revealed that on 5/5/26 at approximately 5:19 a.m. licensed practical nurse (LPN) J notified director of nursing (DON) B that when LPN J checked her controlled medication at approximately 3:45 a.m. that morning she noticed resident 24 was missing one oxycodone 5 milligram (mg) tablet. LPN J counted the controlled medications on the East medication cart with registered nurse (RN) W, and verified that resident 24 was missing one tablet of oxycodone 5 mg. The evening of 5/4/26, LPN L and LPN J completed the controlled medication count, and that count was accurate.LPN J and RN W checked the locked drawer on the medication cart together and searched the hallway near where LPN J was when she last administered a dose of oxycodone to resident 24. Resident 24's room and surrounding areas were searched for the missing oxycodone tablet. The oxycodone tablet was not found.Resident 24's medication administration record (MAR) indicated he had received all of his scheduled doses of oxycodone, and he did not have a physician's order for an as needed (PRN) oxycodone dose.DON B Interviewed resident 24 on 5/5/26 at 8:20 a.m.and but he did not recall receiving an extra dose of oxycodone after his 4:00 p.m. dose on 5/4/26 or being given two tablets of oxycodone. 2. Observation, interview, and review of the East medication carts controlled substances binder on 6/30/26 at 11:08 a.m. with LPN L revealed the 6/30/26 day to evening Shift Verification of Controlled Substances Count was signed by LPN L as the off-going nurse. There was no signature for the on-coming nurse. LPN L stated the controlled medications were to be counted by the on-coming and the off-going nurse at each shift change. The signatures on the Shift Verification of Controlled Substances Count form indicated the controlled medications were counted and the count was accurate.LPN L verified it was her signature in the off-going nurse count column. She did not count the controlled medications with the on-coming nurse because that would happen at change of shift and the change of shift would not happen until that evening. She acknowledged she documented with her signature that the controlled medications were counted and the count was accurate before having counted the controlled medications. 3. Review of resident 24's electronic medical record (EMR) revealed he admitted to the facility on [DATE]. His Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. He had a 5/13/25 physician's order for oxycodone 5 mg one tablet to be administered four times a day at 4:00 a.m., 10:00 a.m., 4:00 p.m., and 10:00 p.m. 4. Interview on 6/30/26 at 2:45 p.m. with LPN L revealed she worked the night before (5/4/26) and the morning after resident 24's oxycodone tablet was found to be missing on 5/5/26. LPN L counted the controlled medications the evening of 5/4/26 with LPN J. During that controlled medication count, LPN L noticed she had forgotten to document that she removed resident 24's 4:00 p.m. oxycodone on his Controlled Drug Receipt/Record/Disposition Form. After she documented that she had removed it from the locked drawer for administration, the controlled medication count was accurate.The next morning, when LPN L returned for her scheduled shift, she was informed that resident 24 was missing one oxycodone tablet. LPN L counted the controlled medications with LPN J and verified that resident 24 was missing one oxycodone tablet. 5. Observation on 7/1/26 at 10:00 a.m. of the East medication cart controlled substance binder revealed there was a signature on 7/1/26 for the off-going nurse on the Shift Verification of Controlled (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Substances Count sheet, but there was no signature for the on-coming nurse. LPN L was preparing medications on the East medication cart during the observation. 6. Observation and interview on 7/1/26 at 2:04 p.m. of LPN L documenting on a Controlled Drug Receipt/Record/Disposition Form revealed that she administered resident 24's oxycodone at 10:00 a.m. She tried to document on the Controlled Drug/Receipt/Record/Disposition Form at the time she removed the controlled medication from the medication cart, but after the medication pass was completed she went back through the Controlled Drug/Receipt/Record/Disposition Forms to be sure she documented that she had removed the controlled medications that she administered to each resident.She rounded the time she documented the removal of the controlled medication to the hour, not the actual time she removed the controlled medication to be administered. 7. Review of the East medication cart Shift Verification of Controlled Substance Count sheets from January 2026 through June 2026 revealed two nurses did not sign that the controlled medication count was completed and accurate on 2/16/26 for the night to day shift change and the day to evening shift change, on 2/19/26 for the night to day shift change or the day to night shift change, on 2/25/26 for the night to day shift change, on 3/22/26 for the night to day shift change, on 3/23/26 for the day to night and the night to day shift change, on 3/31/26 for the day to night shift change, and on 4/19/26 for the day to night shift change. 8. Review of resident 24's Controlled Drug Receipt/Record/Disposition Form for his oxycodone 5 mg tablets from January 2026 through June 2026 revealed there were three doses of oxycodone not accounted for on 6/24/26. There was no oxycodone 5mg Controlled Drug Receipt/Record/Disposition Form from 6/1/26 through 6/8/26. 9. Review of resident 24's May 2026 and June 2026 MAR and Controlled Drug Receipt/Record/Disposition Form revealed that on 5/1/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:39 a.m. On 5/4/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:16 a.m.On 5/7/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:21 p.m. On 5/10/26 at 4:00 p.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 5:11 p.m. On 5/11/26 at 4:00 p.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 5:44 p.m. On 5/14/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:04 a.m. On 5/15/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:17 a.m. On 5/18/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:56 a.m.On 5/19/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:27 a.m.On 5/19/26 at 4:00 p.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 5:07 p.m. On 5/22/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:04 a.m. On 5/22/26 at 4:00 p.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 6:15 p.m. On 5/23/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medication cart and documented in his MAR as being administered at 11:37 a.m. On 5/23/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 4:00 p.m. and documented in his MAR as being administered at 5:45 p.m. On 5/27/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 9:00 a.m. and documented in his MAR as being administered at 11:04 a.m.On 6/15/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 4:00 p.m. and documented in his MAR as being administered at 6:30 p.m. On 6/17/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 10:00 a.m. and documented in his MAR as being administered at 11:36 a.m. On 6/20/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 10:00 a.m. and documented in his MAR as being administered at 11:17 a.m. On 6/22/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 10:00 a.m. and documented in his MAR as being administered at 11:34 a.m. On 6/22/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as being removed from the locked drawer on the medication cart at 4:00 p.m. and documented in his MAR as being administered at 6:09 p.m. On 6/25/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 4:00 p.m. and documented in his MAR as being administered at 5:06 p.m. On 6/30/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 10:00 a.m. and documented in his MAR as being administered at 11:15 a.m. 10. A phone interview on 7/1/26 at 3:05 p.m. with LPN J was attempted and she did not return the call by the end of the survey. 11. Phone interview on 7/1/26 at 3:28 p.m. with RN W revealed she had removed five tablets of oxycodone from the Nexsys (an automated medication dispensing machine used for single doses or emergency medication dispensing) on 6/24/26 to administer resident 24's 4:00 a.m. dose because his bubble packed (presorted medication cards where doses are organized into sealed, clear compartments by day and time) supply from the pharmacy had run out.DON B informed her on 7/1/26 that she was supposed to initiate a Controlled Drug Receipt/Record/Disposition Form to document when each dose oxycodone was removed from the locked drawer on the medication cart for administration and to document the number of pills that remained in the locked drawer when she removed the oxycodone from the Nexsys. RN W did not know she was supposed to do that.RN W did not work the night resident 24's oxycodone tablet was discovered to be missing. 12. Interview and review of resident 24's EMR, resident 24's oxycodone Controlled Drug/Receipt/Record/Disposition forms and the Shift Verification of Controlled Substance Count Sheet on 7/1/26 at 3:35 p.m. with DON B revealed she expected the on-coming nurse and the off-going nurse to count the controlled medications at each change of shift. When the nurse signed the Shift Verification of Controlled Substance Count Sheet it indicated that the controlled medications were counted and the count was accurate. She acknowledged there were missing signatures in May and June on the Shift Verification of Controlled Substances Count sheets for the East and [NAME] medication carts.She expected the nurse to sign out controlled medications on the Controlled Drug Receipt/Record/Disposition Form with the time the medication was administered, not the scheduled time or a rounded time. She acknowledged that the times documented on the Controlled Drug Receipt/Record/Disposition form did not match the times the controlled medications were documented in resident 24's MAR as administered.She expected the nurse to initiate a Controlled Drug Receipt/Record/Disposition form when removing a controlled medication from the Nexsys. She was not aware that the nurses had removed oxycodone from the Nexsys for resident 24 and did not document it on a Controlled Drug Receipt/Record/Disposition Form.Once all the controlled medications were used or destroyed from a medication bubble pack, she expected the Controlled Drug Receipt/Record/Disposition Form to be placed in a basket to be scanned into that resident's EMR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Pierre	950 East Park Street Pierre, SD 57501

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She was not aware that resident 24's Controlled Drug Receipt/Record/Disposition Form was not scanned into his EMR for 6/1/26 through 6/8/26. She verified that the form was unable to be found in the EMR, on the medication cart, or in the basket to be scanned into the EMR.She acknowledged that on 6/24/26 there was no documentation on resident 24's Controlled Drug/Receipt/Record/Disposition Form that his oxycodone was removed from the locked drawer on the medication cart to be administered at 4:00 a.m., 10:00 a.m., and 4:00 p.m., but it was documented on resident 24's EMR that he was administered his oxycodone at those times. She stated the oxycodone was removed from the Nexsys by RN W. RN W administered resident 24's 4:00 a.m. oxycodone from the supply she removed from the Nexsys. His 10:00 a.m. dose was administered by RN/minimum data set (MDS) coordinator D from the supply that was removed from the Nexsys, and LPN K administered his 4:00 p.m. dose of the oxycodone removed from the Nexsys because he had run out of his oxycodone that was dispensed from the pharmacy. 13. Review of the provider's January 2018 Controlled Substances policy revealed, Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): Date and time of administration (MAR , Accountability Record). Amount administered (Accountability Record). Remaining quantity (Accountability Record). Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record). 14. Observation on 7/1/26 at 8:20 a.m. of RN G revealed that after she reviewed resident 66's medication administration record (MAR), she removed a stock bottle (a supply of over-the-counter medications kept on hand by the facility) of 60 milligram (mg) fexofenadine (an antihistamine medication) tablets from her medication cart. She placed one 60 mg fexofenadine tablet, a multivitamin tablet, and an 81 mg tablet of aspirin into a medication cup. The cup was taken into resident 66's room, and those medications were administered to the resident. 15. Interview and review of resident 66's MAR on 7/1/26 at 9:10 a.m. with RN G revealed that the physician's order read- Fexofenadine HCl [hydrochloride] Oral Tablet, 180 MG. Give 1 tablet by mouth one time a day related to seasonal allergic rhinitis [inflammation of the mucous membrane inside the nose]. RN G had read only the medication administration instructions and not the entire fexofenadine medication order when she prepared that medication for administration. Based on the above physician's order, she should have prepared and administered three 60 mg tablets (180 mg) to resident 66. 16. Interview on 7/1/26 at 2:00 p.m. with DON B revealed that RN G should have compared the fexofenadine stock bottle label to the MAR, and the medication administration instructions for accuracy. Any identified discrepancy was expected to be reconciled with the resident's physician before that medication was administered. 17. Review of the provider's revised December 2019 Medication Administration Preparation and General Guidelines policy revealed: 4). Five Rights-Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away.