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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on record review, interview, and Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual review, the provider failed to ensure 19 of 19 sampled residents (5, 6, 7, 23, 24, 28, 29, 34, 35, 36, 37, 38, 39, 43, 44, 53, 54, 55, and 57) Minimum Data Set (MDS) assessments (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) were signed by a registered nurse (RN), to verify their MDS assessments were completed, within 14 days after the assessment reference date (ARD) (the specific end date of the observation period used to complete the MDS) and a discharge assessment was completed for one of one sampled discharged resident (31) who was transferred to a hospital and did not return to the facility. Findings include:1. Review of resident 36's electronic medical record (EMR) revealed her entry tracking MDS ARD was 6/1/26, and the RN signature completion date was 6/16/26.2. Review of resident 24's EMR revealed his annual MDS ARD of 5/22/26, and the RN signature completion date was 6/12/26.3. Review of resident 54's EMR revealed her annual MDS ARD was 5/29/26, and the RN signature completion date was 6/23/26.4. Review of resident 55's EMR revealed his end of PPS stay MDS ARD was 5/28/26, RN signature completion date was 6/17/26. His significant change MDS assessment ARD was 5/26/26, and the RN signature date was 6/17/26.5. Review of resident 5's EMR revealed her quarterly MDS ARD was 5/27/26, and the RN signature completion date was 6/18/26.6. Review of resident 6's EMR revealed his quarterly MDS ARD date was 5/16/26, and the RN signature completion date was 6/5/26.7. Review of resident 7's EMR revealed her quarterly MDS ARD was 5/21/26, and the RN signature completion date was 6/12/26.8. Review of resident 23's EMR revealed her quarterly MDS ARD was 5/6/26, and the RN signature completion date was 5/28/26.9. Review of resident 28's EMR revealed her quarterly MDS ARD was 5/31/26, and the RN signature completion date was 6/26/26.10. Review of resident 29's quarterly MDS ARD was 5/18/26, and the RN signature completion date was 6/9/26.11. Review of resident 34's EMR revealed her quarterly MDS ARD date was 5/27/26, and the RN signature completion date was 6/17/26. 12. Review of resident 35's EMR revealed her quarterly MDS ARD was 5/11/26, and the RN signature completion date was 6/3/26.13. Review of resident 37's EMR revealed his quarterly MDS ARD was 2/25/26, and the RN signature completion date was 4/10/26.14. Review of resident 38's EMR revealed her quarterly MDS ARD was 5/20/26, and the RN signature completion date was 6/9/26.15. Review of resident 39's EMR revealed her quarterly MDS ARD was 5/12/26, and the RN signature completion date was 6/3/26.16. Review of resident 43's EMR revealed his quarterly MDS ARD was 5/25/26, and the RN signature completion date was 6/12/26.17. Review of resident 44's EMR revealed her quarterly MDS ARD was 5/25/26, and the RN signature completion date was 6/15/26.18. Review of resident 53's EMR revealed his quarterly MDS ARD was 5/20/26, and the RN signature completion date was 6/12/26.19. Review of resident 57's EMR revealed her quarterly MDS ARD was 5/10/26, and the RN signature completion date was 5/30/26.20. Review of resident 31's EMR revealed she was transferred to the hospital on 3/11/26, did not return, and was discharged from the facility on 3/16/26. There was no discharge return anticipated or return not anticipated MDS assessment completed.21. Interview on 7/1/26 at 8:05 a.m. with RN/MDS coordinator D regarding the process for MDS assessment completion revealed (continued on next page)

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

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she used the RAI manual that was located within the provider's electronic medical record system for reference. She was not certain which version of the RAI manual it was.RN/ MDS coordinator D confirmed she was responsible for reviewing each resident's MDS assessment for completion and for signing the Z0500 section of the MDS. She knew the requirement was for an RN to review and sign that the MDS was completed within 14 days of the MDS ARD. She was aware the MDS's were not always signed within those 14 days.Regarding resident 31's discharge MDS assessment, RN/MDS coordinator D confirmed there was no discharge MDS completed. She stated, I must have missed that.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the provider failed to ensure insulin pens with shortened expiration dates (medications that, after opening, expire before the manufacturer's expiration date) were labeled for two of two sampled residents (10 and 27) insulin pens stored in one of one observed medication cart.Findings include:1. Observation and interview on [DATE] at 4:46 p.m. with licensed practical nurse (LPN) L while she was administering insulin revealed resident 10's NovoLog insulin pen had a blank yellow expiration label on it. The nurse who first used the insulin pen was to determine when the insulin's shortened expiration date was and to write that date on the yellow expiration label.2. Interview and review of the provider's guidelines for determining the expiration date of insulin pens after opening on [DATE] at 8:28 a.m. with director of nursing (DON) B revealed that the insulin pen had a pre-placed yellow label on them that had a blank space to document the date when the pen was first opened for use, and a blank space to document when the insulin pen would expire. She expected the nurse who opened the pen and used it for the first time to document the date the insulin pen would expire. She indicated that each insulin type may have a different number of days it could safely be used after opening based on the provider's guidelines. 3. Observation and interview on [DATE] at 2:35 p.m. with LPN L regarding insulin pens stored in the medication cart revealed there were two insulin pens for resident 10, one was NovoLOG FLexPen Subcutaneous Solution Pen-injector 100 unit/milliliters (mL) (Insulin Aspart), and the other was Lantus SoloStar Subcutaneous Solution-Pen Injector 100 unit/mL (Insulin Glargine). There was one insulin pen of Lantus SoloStar Subcutaneous Solution-Pen Injector 100 unit/mL (Insulin Glargine) for resident 27. LPN L confirmed none of those three insulin pens had an expiration date recorded on the yellow expiration date labels. She stated she was not the licensed nurse who first opened those pens, and there was no way to determine which nurse did.4. Review of the provider's [DATE] guidelines for determining expiration of open insulin pens revealed that NovoLog FLexPen Subcutaneous Solution Pen-injector 100 unit/mL (Insulin Aspart) and Lantus SoloStar Subcutaneous Solution-Pen Injector 100 unit/mL (Insulin Glargine) both expired after 28 days of opening.5. Review of the provider's [DATE] Preparation and General Guidelines for Vials and Ampules of Injectable Medications revealed: Expiration Dates: Unopened vials expire on the manufacturer's expiration date. Opening a vial triggers a shortened expiration date that is unique for that product. The date opened and this triggered expiration date are both important to be recorded on the multidose vials (on the vial label or an accessory label affixed for that purpose). At a minimum, the date opened must be recorded. These labels are not required on single-use vials or ampules. Triggered expiration dates may be found in the manufacturer's package insert, on the package, provided, or on a reference chart by the pharmacy, or by contacting the pharmacist.

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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:The cleaning of a pulse oximeter (a device that clips onto a finger to measure blood oxygen saturation and pulse rate) by one of one licensed practical nurse (LPN) (L) after it was used by one of one sampled resident (44).Hand hygiene (handwashing with soap and water or a hand sanitizer) and glove use by one of one registered nurse (RN) (G) and one of one LPN (L) during medication administration for two of two sampled residents (65 and 44).One of one dietary aide (O) who touched ready to eat foods without the use of gloves.One of one LPN (L) who did not remove personal protective equipment (PPE) after she performed resident cares and before she exited the resident's room.One of one RN (P) and one of one LPN (L) who did not perform hand hygiene before and after the use of gloves while performing resident cares.One of one LPN (L) who did not bag a potentially contaminated wash cloth before she exited the resident's room. Findings include:1. Observation on 6/29/26 at 3:50 p.m. in resident 44's room revealed that LPN L reached into her smock pocket and removed a pulse oximeter. Without first cleaning the device, she placed it on the resident's index finger. LPN L returned the oximeter to her smock pocket after the resident's oxygen saturation level and pulse rate were obtained. 2. Interview on 6/30/26 at 10:00 a.m. with LPN L regarding the above observation revealed that she acknowledged the pulse oximeter should have been cleaned before it was placed on resident 44's finger to mitigate the possibility of cross-contamination. 3. Observation on 7/1/26 at 8:15 a.m. of RN G preparing to administer resident 65's eye drops revealed she removed a pair of gloves from her smock pocket, and without performing hand hygiene, put on the pair of gloves. She then administered resident 65's eye drops, removed her gloves, discarded them, and performed hand hygiene. 4. Interview on 7/1/26 at 9:10 a.m. with RN G regarding the above observation revealed that she acknowledged that gloves should not be placed inside a potentially unclean smock pocket. She agreed that she should have completed hand hygiene before she put on a pair of gloves. 5. Interview on 7/1/26 at 11:20 a.m. with director of nursing (DON) B regarding the above observations revealed that after the oximeter was removed from a potentially unclean smock pocket, it should have been cleaned before it was placed on resident 44's finger and gloves should not be kept inside a smock pocket either. Hand hygiene was expected to be performed before putting on gloves. 6. Review of the provider's revised December 2019 Medication Administration Preparation and General Guidelines revealed, 9. Hands are washed before putting on examination gloves . 7. Review of the provider's revised 2/20/24 Cleaning and Disinfection of Equipment policy revealed, A. Supplies and equipment will be cleaned immediately after use. 8. Observation on 6/29/26 at 11:57 a.m. in the dining room revealed dietary aide O brought resident 52 her noon meal. Dietary aide O removed the paper wrapper from a straw. A piece of that paper wrapper fell into resident 52's mashed potatoes and gravy. Dietary aide O touched resident 52's mashed potatoes and gravy with her ungloved hand as she removed the piece of paper from the mashed potatoes and gravy. Dietary O placed the piece of paper on the table beside resident 52's plate, returned to the kitchen service window, performed hand hygiene with alcohol-based hand sanitizer (ABHS), and continued to deliver meal trays to other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Observation and interview on 6/30/26 at 2:28 p.m. of resident 73's medication administration and a nutritional supplement through his percutaneous endoscopic gastrostomy (PEG) tube (a tube surgically placed through the abdomen into the stomach to administer liquid nutrition, fluids and medications) revealed LPN L was standing at the medication cart positioned outside resident 73's room and removed resident 73's cyclobenzaprine 10 milligram (mg) tablet (a muscle relaxer) from the packaging, placed the tablet in a clear packet, and crushed the tablet. She placed that crushed tablet into a plastic cup of water, picked up that cup and took it into resident 73's room, and set it on his bedside table. There was a sign on resident 73's room door that indicated he was on enhanced barrier precautions (EBP; glove and gown use when providing contact care). In resident 73's room, LPN L washed her hands, put on a gown, and put on a pair of gloves. LPN L requested assistance from RN P to boost resident 73 up towards the head of the bed. Without performing hand hygiene, RN P put on a pair of gloves and did not put on a gown. After RN P repositioned resident 73, RN P with those same gloved hands, walked over to the other side of the room, and placed resident 26's fall mat (a padded mat on the floor beside the bed for residents who fall out of bed) on the floor beside his bed. With those same gloved hands, she picked a wet washcloth up from resident 73's bedside table, placed the washcloth in a plastic bag, removed her gloves and discarded them in the trash can, and did not perform hand hygiene. RN P then exited the room, opened the medication cart, removed a container of pH strips (strips to test for acidity) from the medication cart, brought the pH strips into resident 73's room, gave them to LPN L, and exited the room without performing hand hygiene. LPN L raised the head of resident 73's bed, positioned resident 73's shirt to expose his PEG tube, and placed a washcloth below his PEG tube. She used a syringe to withdraw a liquid from his stomach through his PEG tube and into the syringe. She put a pH test strip into the liquid she withdrew to confirm that the contents removed were acidic to verify that the PEG tube was in resident 73's stomach. LPN L reinserted the remaining liquid in the syringe back into resident 73's PEG tube. LPN L turned to resident 73's bedside table and stated the medication she had brought into the room was not on the bedside table where she had placed it. She looked around the room for the medication and could not locate it. She removed her gloves and discarded them in the trash can, did not perform hand hygiene, did not remove her gown, exited resident 73's room, and opened the medication cart. RN P was in the hallway, and when LPN L stated she could not find the cup with resident 73's medication in it. RN P stated she threw the cup that was on the bedside table away because she thought it was left in the room from earlier that day. LPN L did not perform hand hygiene, prepared another cyclobenzaprine tablet for administration, and went back into resident 73's room. Without preforming hand hygiene, LPN L put on a pair of gloves, attached the syringe to resident 73's PEG tube, put water into the PEG tube, and then put the water with the cyclobenzaprine into the PEG tube. LPN L then flushed the PEG tube with more water, administered 250 milliliters of Nutren 1.5 (liquid nutrition), and flushed the PEG tube again with water. LPN L removed the syringe from resident 73's PEG tube, closed the PEG tube, and pulled his shirt down over his stomach. LPN L removed her gown and gloves, disposed of them in the trash can, and washed her hands. With her bare hands, LPN L removed the washcloth from below resident 73's PEG tube on his stomach, folded the washcloth, carried the washcloth into the hallway and set it on the medication cart. Without performing hand hygiene, gave a hug to a visitor, and then documented in resident 73's electronic medical record (EMR) on the computer that she had administered the cyclobenzaprine and Nutren 1.5. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN L stated resident 73 was on EBP because he had a PEG tube. LPN L acknowledged she had worn the gown into the hallway and did not perform hand hygiene before putting on a pair of gloves and after taking off the gloves. 10. Interview on 7/1/26 at 3:35 p.m. with DON B revealed she expected the staff to complete hand hygiene when the staff entered and exited the residents' rooms, before putting on and after removing gloves. She expected gloves to be worn any time a staff member touched a resident's ready to eat food. She expected the staff to wear a gown when providing direct care for a resident on EBP, including administering medications and nutritional supplements in PEG tubes. She expected gowns to be removed and disposed of in the resident's room and not to be worn into the hallway. She expected dirty laundry for a resident on EBP to be bagged prior to exiting the resident's room and not placed on the medication cart. 11. Review of the provider's 9/26/25 Enhanced Barrier Precautions policy revealed Enhanced Barrier Precautions (EBP): refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs targeted gown and glove use during high contact resident care activities. Enhanced Barrier Precautions (EBP) should be used for all residents with wounds or indwelling devices. Gowns and Gloves should be used during high contact resident care activities that provide opportunities for transfer of MDROs [multi-drug resistant organisms] to staff hands and clothing. 12. Review of the provider's 5/11/26 Hand Hygiene policy revealed, All personnel shall follow the hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. If hands are not visibly soiled, use an ABHR [alcohol based hand rub] containing 60-95% [percent] ethanol or isopropanol or 65% alcohol if hand wipes utilized, for all of the following situations: Before and after direct contact with residents, When entering and leaving a Resident care area/room, Before donning [putting on] and after removing gloves and other personal protective equipment (PPE).Before preparing or handling medications.After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident. Hand hygiene must be completed prior to and after removal of gloves. 13. Review of the provider's 1/14/26 Linen and Laundry Handling policy revealed, All laundry is considered potentially contaminated. Laundry and Nursing Healthcare Personnel (HCPs) will use Standard Precautions and use personal protective equipment (PPE), (e.g, gloves etc.) as appropriate while handling all these soiled items. All soiled laundry will be placed directly into a bagged receptacle or bagged and transported to the bagged laundry receptacle. 14. Review of the provider's 1/14/26 Standard Precautions policy revealed, PPE should be appropriately discarded prior to leaving the room after resident care and hand hygiene completed. Gowns should be removed after resident care and disposed of in the resident [resident's] room. 15. Review of the provider's 4/15/20 Handwashing and Glove Use policy revealed, Gloves may be used when working with food to avoid contact with hands. Gloves must be worn when touching any ready-to-eat food.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and policy review, the provider failed to protect the resident's right for dignity for one of one sampled resident (17) who was dressed in clothing that had his first name written in black marker on the top of his left pant leg and on the left side of his shirt. Findings include:1. Observation and interview on 6/30/26 at 9:45 a.m. with resident 17 in his room revealed that he sat in his wheelchair watching television. His first name was written in black marker vertically, along the top of his left pant leg. His first name was also written vertically in black marker on the left side of his shirt. Resident 17 said he wrote his name on the clothes he was wearing with a black marker because sometimes his clothes were not returned from the laundry after they were washed. He indicated that his roommate's clothes had personalized labels affixed to the inside of them. Resident 17's clothes were not labeled like that. Resident 17 had other clothes that were not labeled with a black marker, but he did not wear them because he was concerned they would not be returned to him after they were washed. Resident 17 relied on donated clothes from the facility to wear. He had no local family support. Before he admitted to the facility, he had lived locally in his own apartment. He did not know what happened to his personal belongings he had in his apartment. 2. Interview on 6/30/26 at 10:45 a.m. with laundry aide M revealed she used a heat-activated device to affix name individualized labels to the residents' clothing. She was aware that not all of resident 17's clothing were labeled in that manner. Laundry aide M previously told the resident she would label his clothes, but she did not do that yet. 3. Interview on 6/30/26 at 1:30 p.m. with social services designee (SSD) E revealed that resident 17 admitted to the facility in October 2025. She confirmed that he lived in a local apartment before he admitted to the facility, and he had no local family support. SSD E did not contact the resident's former landlord to retrieve any of his personal belongings from the apartment after he admitted to the facility. SSD E confirmed that most of resident 17's clothing was donated to him by the facility. That clothing should have been labeled with the resident's name before they were provided to him to wear. She knew he had some clothing that was not returned to him after it was laundered because the facility had not labeled them. She agreed that having resident 17's first name printed with a black marker on his clothes was a privacy issue and compromised his self-esteem. Staff, other than those who worked in laundry, including herself, should have ensured resident 17's clothes were labeled in a dignified manner to mitigate the resident writing his name on them with a marker. 4. Review of the provider's revised 11/18/25 Resident Dignity and Privacy policy revealed, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity, as well as, care for each resident in a manner and in an environment, that maintains resident privacy.

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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. **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 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 (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. (continued on next page)

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to complete a trauma informed care assessment for two of two sampled residents (5 and 6) with a post-traumatic stress disorder (PTSD-a disorder in which an individual has difficulty recovering after experiencing or witnessing a traumatic event) diagnosis. Finding included:1. Review of resident 5's electronic medical record (EMR) revealed she admitted to the facility on [DATE]. Her diagnoses included PTSD, major depressive disorder (a mental health condition that causes persistent feelings of sadness, hopelessness, and a total loss of interest in activities), and anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable worry or fear). Her 7/1/26 Brief Interview for Mental Status (BIMS) assessment score was 5, which indicated her cognition was severely impaired. Her revised 4/20/26 care plan did not include goals or interventions identified related to her PTSD. Resident 5 had no documentation indicating that a trauma informed care assessment was completed to identify her related needs or that behavioral health counseling was offered. 2. Observation on 6/29/26 at 2:20 p.m. of resident 5 in her room revealed she was in her bed with the television on and unable to be interviewed as she was nonverbal when questioned. 3. Interview on 6/29/26 at 5:02 p.m. with resident 5's emergency contact revealed that staff updated him with any information or changes in resident 5's care. He attended resident 5's care meetings and visited resident 5 twice a month. Resident 5's emergency contact voiced no concerns regarding her care and services. He stated that resident 5 was in a good place, she was doing well at the facility, and that the facility provided her with good care. 4. Review of resident 6's EMR revealed he admitted to the facility on [DATE]. He had a diagnosis of PTSD. His BIMS assessment score was 15, which indicated his cognition was intact. His 3/18/26 care plan indicated he had altered mood and behaviors related to his PTSD. The interventions identified in the care plan related to his PTSD were to allow him to choose his activities, stop and talk to him as the staff were passing by, and allow positive interactions. Resident 6 had no documentation indicating that a trauma informed care assessment was completed to identify his related needs, or that behavioral health counseling was offered. 5. Interview on 6/29/26 at 1:52 p.m. with resident 6 revealed he had PTSD from combat. He stated the facility did not offer him much support regarding his PTSD, he was not offered any counseling services, and he would like to be referred for counseling services. 6. Interview on 6/30/26 at 4:00 p.m. with social services designee (SSD) E revealed she was the SSD for three years at the facility. She was unaware she was responsible for completing the resident's trauma informed care assessments until approximately three months ago. 7. Interview on 6/30/26 at 4:16 p.m. with director of nursing (DON) B revealed that she acknowledged residents 5 and 6 did not have trauma informed care assessments completed in their EMRs and that they were not offered any counseling services for their PTSD. She expected staff to follow the provider's policy and complete a trauma informed care assessment for residents diagnosed with PTSD to identify the residents' needs and to offer them counseling services. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Review of the provider's revised 9/30/24 Mental Health Adjustment Difficulties Related to Trauma, PTSD, or Other Mental Health Issues policy revealed staff, Assess the resident to determine if services are needed

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure continued behavioral health services to treat a diagnosed mental illness were provided and to identify and implement interventions and effective communication processes with other healthcare entities for one of one sampled resident (10) with depression symptoms and suicidal thoughts. Findings include:1. Interview on 6/30/26 at 7:56 a.m. with resident 10 revealed she felt like she wanted to give up. She did not have an interest in participating in activities anymore. She worried about her finances. She received counseling in the past, but she no longer did. She did not know why those counseling sessions stopped. She thought the counseling helped her when she had counseling sessions. 2. Review of resident 10's electronic medical record (EMR) revealed she admitted to the facility on [DATE]. Her 5/22/26 Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated her cognition was moderately impaired. Her diagnoses included major depressive disorder.Resident 10's 3/4/25 PHQ-9 (a tool used to assess for depression) assessment score was 00, which indicated she did not have any depression symptoms. On 11/18/25 her PHQ-9 assessment score was 5, which indicated she had mild depression symptoms. She reported feeling down, depressed, or hopeless for two to six days in the past fourteen days. She had trouble falling asleep or staying asleep for seven to eleven of the past fourteen days. She felt tired or had little energy for seven to eleven of the past fourteen days.Resident 10's 2/18/26 PHQ-9 assessment score was 9, which indicated she had mild depression symptoms. She reported feeling down, depressed, or hopeless for seven to eleven of the past fourteen days. She felt tired or had little energy for two to six of the past fourteen days. She felt bad about herself for two to six of the past fourteen days. She had trouble concentrating on things for two to six of the past fourteen days.Resident 10's 5/22/26 PHQ-9 assessment score was 5, which indicated she had mild depression symptoms. She reported that she had felt down, depressed, or hopeless for seven to eleven of the past fourteen days. She felt tired or had little energy for seven to eleven of the past fourteen days. She felt bad about herself for two to six of the past fourteen days.Her 7/1/26 care plan had a focus area of I receive an antidepressant medication related to Depression. The interventions for that focus area were, Attempt gradual dose reductions (GDR) for me for anti-depressant medications based on my progress and stability, Give antidepressant medications ordered by my attending physician. Observe me for any side effects every shift. Antidepressant side effects: dry mouth, dry eyes, constipation, urinary retention, suicidal ideations. Observe for and report to my physician any ongoing s/sx [signs and symptoms] of depression unaltered by antidepressant meds [medications]: Sadness, irritability, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideation, neg. [negative] mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, doesn't enjoy usual activities, changes in condition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, & [and] concern with body functions. Her 7/1/26 care plan did not indicate any non-pharmacological interventions (treatments and preventative measures that do not rely on medication) that staff could use if resident 10 expressed symptoms of depression. 3. Review of resident 10's 2/24/26 and 3/24/26 paper psychiatry notes revealed she was being seen by a psychiatrist for psychiatric evaluation and medication management. During her 2/24/29 initial visit, it stated that resident 10, whimpers throughout the visit stating she needs a mom and is lonely. Her mood was described as Down, her appetite and energy were Poor, and she had anxiety Daily, related to losing family members and grief. Her suicidal risk assessment indicated she was at moderate risk for suicide due to suicidal thoughts without a plan or intent. Resident 10 indicated she had little interest or pleasure in doing things nearly every day. She felt down, depressed, or hopeless nearly every day. She had trouble falling or staying asleep, or sleeping too much, nearly every day. She had (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trouble concentrating on things, such as reading a newspaper or watching television more than half the days. She either moved or spoke slowly, or was so fidgety and restless that she was moving around more than usual nearly every day. She indicated there were several days when she had thoughts that she would be better off dead or had thoughts of hurting herself. Her PHQ-9 score was 18, which indicated she had moderately severe depression symptoms.During the 2/24/26 psychiatry visit, anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability) was added to her diagnoses. Her sertraline (an antidepressant medication) was changed to duloxetine (an antidepressant medication) to help her mood and her chronic pain. A plan was made for a follow-up appointment in one month, and a referral was made for mental health therapy.Resident 10's 3/24/26 psychiatry visit notes revealed she had continued depression, grief, and pain. Her sleep was described as poor and her interests were low. She had continued thoughts of suicide without a plan or intent. Her PHQ-9 score was 19, which indicated moderately severe depression symptoms.Resident 10 had been previously referred to therapy and the psychiatrist felt that it would be beneficial due to resident 10's depression. Resident 10's duloxetine was stopped, and she started on Prozac (an antidepressant medication). The plan was made for a follow-up appointment in one month. There were no paper psychiatry visit notes after 3/24/26. 4. Interview on 7/1/26 at 2:04 p.m. with licensed practical nurse (LPN) L revealed resident 10 was a very emotional person. Resident 10 did not express to LPN L that she felt depressed. LPN L stated resident 10 could be down one minute and then be rearranging things in her room the next. 5. Interview and review of resident 10's EMR on 7/1/26 at 2:34 p.m. with social service designee (SSD) E revealed she completed the resident's PHQ-9 assessments. She thought she offered resident 10 counseling services but indicated that there was no documentation in resident 10's EMR to support that counseling services were offered to her, or that she declined counseling.Resident 10 would come into her office when she was feeling down and they would talk. SSD E did not document any of those visits with resident 10 in her EMR. SSD E verified there were no non-pharmacological interventions identified for resident 10's depression in her care plan. 6. Interview on 7/1/26 at 3:18 p.m. with assistant director of nursing (ADON) U revealed she was responsible for setting up and attending the residents' psychiatry appointments with the residents. She would request the visit notes from the psychiatrist because they did not get sent to the provider automatically. Resident 10's psychiatry notes were not in her EMR or reviewed by ADON U before the notes were requested by the surveyor for review on 6/30/26 and were received by the provider from the psychiatrist on 7/1/26.ADON U was not aware that resident 10 had additional diagnoses identified in her psychiatry visit nots. She was not aware that resident 10 had expressed suicidal thoughts, that her PHQ-9 assessments indicated moderately severe depression, or that resident 10 was referred to therapy due to her depression. She acknowledged that not having all the information related to resident 10's current mental health status and needs had the potential for a decline in resident 10's mental health and quality of life. 7. Interview on 7/1/26 at 5:01 p.m. with ADON U revealed resident 10 did not have a follow-up appointment scheduled with psychiatry, and she was not scheduled with the therapist she was referred to on 2/24/26. 8. Review of the provider's 11/18/25 Mental Health Adjustment Difficulties Related to Trauma, PTSD or Other Mental Health Issues policy revealed, To ensure appropriate treatment and services are provided to all residents with adjustment difficulties to achieve the highest practicable mental and psychosocial well-being. 'Appropriate' means based upon assessment and care plan, should be person-centered, and the facility must make attempts to provide the services or assist residents with accessing such services. Assess the resident to determine if services are needed. Services Provided need to address individualized approaches that address the assessed needs of the resident. Care Plan should address the individualized emotional and psychosocial needs of the resident. Staff must consistently implement the care approaches identified in the Care Plan.

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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)

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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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)

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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.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, record review, and policy review, the provider failed to ensure an in-room call light (a device activated by a resident to alert staff for assistance) was accessible for one of one sampled resident (2) to use. Findings include:1. Observation and interview on 6/29/26 at 5:00 p.m. with resident 2 in his room revealed that he sat in his wheelchair near the television. The resident's hands had a tremor. The television was on the west wall of his room. There was a red mat on the floor on the exit side of the resident's bed. The head of the resident's bed was on the east wall of the room. The resident stated that the non-skid red mat was used to steady his feet and reduce his risk of falling when he stood up from his bed. He was not supposed to stand up without having staff with him. He had Parkinson's disease (a progressive neurological disorder that primarily affects movement). The resident's call light was wrapped around and secured with medical tape to the top of a positioning pole near the head of his bed. The call light was attached to the call light cord. The part of that cord near where it was attached to the call light device was taped to the center of the positioning pole. The remainder of the call light cord was tucked behind the resident's bedside table against the wall. The resident confirmed he had no access to his call light when he sat in his wheelchair watching television. He would have to turn his wheelchair around and move it towards his bed to activate the call light for staff assistance. 2. Observation on 6/30/26 at 10:15 a.m. of resident 2 in his room revealed that he sat in his wheelchair watching television. He had no access to his call light that was taped to the positioning pole near the head of his bed. 3. Review of resident 2's electronic medical record (EMR) revealed he had a revised 8/11/25 activities of daily living (basic self-care tasks) care plan that indicated the resident had self-care deficits related to unsteadiness on his feet, dementia, and Parkinson's disease diagnoses, and needed the staff's assistance with his personal care. A revised 6/16/25 intervention read, Encourage me to use my call light to call for assistance. A revised 8/11/25 fall risk care plan revealed that resident 2 was at risk for falling related to a history of falling. Interventions included, I have been educated by [the] nurse to call for assistance. Date Initiated: 12/19/2025. Please make sure that my call light is within my reach and encourage me to use it to call for assistance. Date Initiated: 06/16/2025. 4. Interview on 6/30/26 at 4:15 p.m. with certified nursing assistant V revealed that she knew that resident 2's call light was secured to the positioning pole on his bed. She stated that that was where the resident wanted it. She agreed that securing the call light to that pole prevented it from being accessible to the resident when he sat in his wheelchair to watch television. 5. Interview on 6/30/26 at 5:15 p.m. with director of nursing (DON) B revealed that resident 2 was able to access the call light taped to his positioning pole only if he was in his bed or able to move his wheelchair to the bed to activate the call light. She agreed that in the event the resident fell out of his wheelchair and onto the floor in his room while watching television, he would not be able to summon staff assistance without access to a call light. 6. Review of the provider's revised 9/30/24 Call Lights policy revealed, 4. Ensure call lights are placed within reach of residents.