STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435058	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Clark City	201 8th Avenue NW Clark, SD 57225

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, interview, observation, document review, South Dakota Department of Health (SD DOH) facility reported incidents (FRI), and policy review, the provider failed to ensure: *An environment was free of flammable materials where two of two sampled resdients (2 and 26) were observed smoking. *Assistive devices were used for one of one 1 sampled resident (2) who used cigarette holders to prevent a burn. *Appropriate supervision for one of three sampled resident (26) while smoking. *Facility exit and interior doors functioned appropriately, and staff were re-educated as stated in the corrective actions in the 11/16/25 and 11/26/25 FRI regarding one of one closed sampled resident (37) who eloped outside and entered a room where chemicals were stored. Findings include: 1. Review of resident 2's electronic medical record (EMR) revealed: *His 10/15/25 Brief Interview for Mental Status (BIMS) score was 13, which indicated his cognition was intact. *He did not have a physician's orders to smoke. *He had diagnoses of nicotine dependence and mild vascular dementia (a group of symptoms affecting memory, thinking, and social abilities). *His 10/15/25 smoking evaluation risk assessment indicated: -He was careless with smoking materials. -He was unable to safely light a cigarette. -He was not considered a safe smoker and required smoking management and supervision consistent with facility policy and may not have access to smoking material outside of supervised smoking. -He was to wear a smoking apron, be seated under the folding table, and a staff member was to light his cigarette. -He often attempted to smoke cigarettes down to the filter. *His 10/15/25 care plan indicated: -All smoking materials were kept at the nurses' station. (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He was to be supervised, wear a smoking apron, and to use a cigarette holder when he smoked to prevent him from getting burned because he smoked the cigarette down past the filter. -He needed to be pushed up to the table when he smoked due to his history of burns to his feet from dropping ash. -At any time if it was determined that he could not smoke safely with the available levels of support and supervision as indicated on his care plan, the resident's individual smoking methods may need to be adjusted. *Resident 2's physician was notified on 1/4/26 that he had cigarette burns to his right thumb that measured 0.7 x 0.6 and right pointer finger that measured 0.7 x 0.4 that were brown and tan in color without signs of infection. 2. Interview on 1/6/26 at 3:56 p.m. with certified nursing assistant (CNA) J regarding resident 2 revealed: *Resident 2 smoked twice a day, once in the morning and once in the late afternoon. *His cigarettes were kept locked up at the nurses' station. *He had to wear a smoking apron, and the staff had to go outside with him when he smoked. 3. Observation and interview on 1/6/26 at 4:08 p.m. and 1/7/26 at 11:22 a.m. with CNA L in the designated smoking area revealed: *She took resident 2 outside to smoke. *The smoking area was just outside the staff entrance door and was in a partially covered area that had a wood privacy panel as a barrier to the area. *She put resident 2's coat and smoking apron on him and handed a cigarette. Resident 2 put it in his mouth, and CAN L lit the cigarette for him with a lighter. *Resident 2 sat at a folding table in the designated smoking area that had two ashtrays on top of it. A snow blower with a closed gas can on the ground beside it was along the interior side of the wood privacy panel, in the designated smoking area. -CNA L verified that the gas can was about half full and was approximately 8 to 10 feet away from resident 2 who was smoking at the folding table. *She encouraged resident 2 to put the cigarette out. When he did not, she removed the cigarette from his hand and put it out for him because he smoked it close down to the filter. *She did not usually take residents out to smoke, and she was not sure how long the gas can had been sitting there. *Staff were to dump the ashtrays out in the red metal trash can that sat next to the building. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The facility shall establish and maintain safe resident smoking practices while protecting the rights of the individual resident. * .all residents who smoke will be assessed for their ability to safely smoke with or without assistance or supervision and such will be included on the care plan. The Smoking Assessment will be completed at admission, readmission, quarterly, annually, and with a change in condition. Facility will provide staff, family or volunteer supervision when assessment determines supervision is required. The facility may impose smoking restrictions on residents at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. *Designated smoking areas include: .b. Smoking aprons, or devices to assist residents in smoking per assessment findings. The location of the designated smoking area and provisions to ensure residents with the need for supplemental oxygen do not access the area while smoking is taking place. *Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the resident's individual care plan. *The staff shall consult with the Attending Physician and/or the Director of Nursing to determine any restrictions on a resident's smoking privileges. 18. Review of the providers facility reported incident (FRI) regarding an incident involving resident 37 on 11/16/25 revealed: *Resident 37 had been able to exit the building and reviewed security camera footage. At 6pm on 11/16/25, resident 37, was self-propelling wheelchair throughout the facility and exited building unsupervised via a storage area door. Resident left wheelchair, was able to walk to door and push open emergency exit door which shut behind him and he was not able to get back inside. Resident then walked to employee entrance door and knocked on the door where a CNA saw him and assisted him inside. *Resident was outside for a total of 4 minutes. *Maintenance inspected emergency exit door on Monday 11/17 [11/17/25] and saw that a wire had come loose from [the] alarm plug in, causing it not to alarm when opened. Maintenance repaired the wiring in the alarm and the door and alarm are operational again. All exit doors are inspected weekly by maintenance and recorded in TELS [electronic platform to manage building maintenance]. Door check audits will be done daily to ensure the alarm and door remains functioning properly. *Point of care charting updated to ensure staff are checking and charting what [this] resident is doing every 30 minutes and CNA assignment sheets have been updated to notify all staff who [which residents] is an elopement risk. *Residents care plan updated to reflect elopement incident and risks. All staff will be re-educated on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*All exit doors were to be locked and alarmed. They no longer used the WanderGuard system. *Door audits were completed daily. *She completed weekly staff knowledge audits regarding elopements. *Maintenance completed the door audits Monday through Friday, and the manager on duty completed them on the weekends. *Two-door alarms were tested in the hallway where resident 37 had resided and were functioning. *The green button at the front desk needed to be pushed to open the door or staff could use their badge to open it. *If the green button was pushed, it would unlock the front door for three seconds. *After business hours, the button that opened the front door was not always monitored. *She verified that a resident could potentially leave the facility without the staff's knowledge. *Department heads educated their staff regarding elopements. *She verified that 29 staff did not receive education regarding elopements before working their next shift, as indicated in the 11/16/25 Facility Reported Incident report. *It was her responsibility to make sure all education had been completed for all staff before their next shift worked. *All staff should have been educated on the elopement policy, and signed a form once completed. Education regarding door safety was done verbally, and staff signed a form that they received that education. *An elopement risk assessment was not completed after resident 37's second elopement on 11/26/25, and per their policy, it should have been. 26. Review of the providers' 5/14/25 elopement policy revealed: *Each resident will be evaluated upon admission to ascertain elopement risk. Care plan interventions will be initiated based on results the evaluation will be completed should a resident have an elopement.

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	435058	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Clark City	201 8th Avenue NW Clark, SD 57225

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the provider failed to ensure the staff followed infection control practices regarding: *Foley catheters (flexible tubing placed in the bladder to drain urine), tubing and urinary drainage bag placement for two of two sampled residents with foley catheter. *Hand hygiene by one of one registered nurse (RN) D observed administering medications to multiple residents during a noon meal service without sanitizing her hands in between each resident's medication administrations.*One of one certified nursing assistant (CNA) (F) observed without wearing a gown and gloves when transferring a resident (26) on enhanced barrier precautions (EBP), and did not clean the lift after transferring the resident. Findings include:1. Observation on 1/6/26 at 11:25 a.m. of RN D in the dining area administering medications to residents as they were seated for the noon meal revealed she did not sanitize her hands after each administration before preparing medications for the next resident. 2. Observation and interview on 1/6/26 at 3:49 p.m. of resident 2 being pushed in his wheelchair to his room revealed: *He was sitting in a wheelchair while CNA J pushed him from the dining room to his room. His urinary catheter tubing dragged on the floor, and he stepped on it numerous times. *CNA J stated she was not aware that the catheter tubing was not supposed to be on the floor and reported it was typical to see it on the floor. 3. Observation and interview on 1/6/26 at 2:56 p.m. of CNAs G and K transferring resident 3 in his room revealed: *He was sitting in a wheelchair with a urinary drainage bag about half full of urine that hung on the wheelchair. *A sign on his door indicated he was on enhanced barrier precautions, meaning gloves and gowns needed to be worn when providing direct care to the resident (EBP). *CNAs G and K put on gowns and gloves, and then used a total body lift (a mechanical lift and sling used to lift a person's full body) to transfer him to his bed. *They hung his urinary drainage bag on the sling, above the level of his bladder. *After lying him in bed his urinary drainage bag was attached to the side of the bed, below the level of his bladder. *CNA G emptied the urine from his urinary drainage bag into a designated container and dumped the urine into the toilet. *They then lowered his bed to the lowest position, and his urinary drainage bag was lying on the floor. *CNA G, using the same gloves, wiped off the mechanical lift with cleaning wipes. *CNA G removed her gloves, left the room with a garbage bag, entered the dirty utility room, exited (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that room and then sanitized her hands. *CNA G stated she did not receive education that the urinary drainage bag was to remain below the resident's level of the bladder to prevent backflow of urine into the resident's bladder. *CNA G stated that the urinary drainage bag was not supposed to be on the floor without a barrier. She then went to obtain a bin, returned to the room with a bin, and put the urinary drainage bag into it. 4. Observation and interview on 1/7/25 at 12:43 p.m. with CNA F revealed: *He was exiting resident 26's room, who was on EBP with a sit-to-stand lift (a manual lift used to assist from a seated to a standing position). *He stated he had used a stand lift to transfer resident 26 from his wheelchair to the recliner chair. *He placed the stand lift into room [ROOM NUMBER], a room with no resident residing in it. *When asked if he wore a gown or gloves while transferring the resident, he responded that he did not because he was not required to wear a gown and gloves when transferring resident 26. *When asked if he cleaned the stand lift after use with resident 26, he replied yes. When no cleaning wipes were seen in resident 26's trash receptacle, he replied that he cleaned the lift in room [ROOM NUMBER]. -There were no cleaning wipes in the trash can of room [ROOM NUMBER]. 5. Interview on 1/7/26 at 12:50 p.m. with housekeeper N revealed that she witnessed CNA F did not clean the stand lift after use. 6. Interview on 1/8/25 at 12:47 with RN/infection preventionist (IC) C revealed: *She expected staff to sanitize their hands between medication administration to different residents. *She expected staff to follow the facility's EBP policy and to gown and glove when transferring a resident on EBP. 7. Review of resident 3's EMR revealed: *His 11/4/25 BIMS assessment score was 9, which indicated his cognition was moderately impaired. *He had a physician's order: -On 3/14/25 for a Foley catheter for urine retention. -On 4/25/25 to irrigate his Foley catheter with 60 ml (milliliter) of sterile water as need for occlusion (blockage). -On 11/19/25 to change his Foley catheter monthly and as needed for occlusion. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 12/22/25 to change his urinary drainage bag every two weeks and to date the bag. *His 12/2/25 care plan indicated he: -Was to be on enhanced barrier precautions (EBP) because he had a catheter. -Had a history of urine retention and urinary tract Methicillin-resistant Staphylococcus aureus (MRSA) (a drug-resistant infection) infection, so staff were to use infection control precautions when dealing with his urine. 8. Review of resident 2's EMR revealed: *His 10/15/25 BIMS score was 13, which indicated his cognition was intact. *His 10/15/25 care plan indicated: -He had a long-term Foley catheter for chronic urinary retention with a goal to remain free from catheter-related trauma. -He required EBP because he had a Foley catheter. *He had a physician's order: -On 4/1/25 to flush his Foley catheter with 60 cc (cubic centimeter) of sterile water to prevent blockages. -On 8/27/25 to change his Foley catheter monthly. -On 11/10/25 to change his urinary drainage bag every two weeks and to date the bag. *His EMR progress notes revealed: -On 6/30/25, his physician was notified that he had a large amount of mucous and sediment in his urine with a malodorous smell that was clogging his catheter, and an order for a urinary analysis (UA) was received. -On 7/27/25, resident's physician was notified he had purulent discharge from his urethra for a few days and foul-smelling urine, and an order for UA was received. -He had a UA collected on 7/30/25, and per the lab report his urine culture grew out Proteus mirabilis, Enterococcus faecalis, and stated that multiple microflora were present (which could represent contamination of the urine sample), and to recollect the specimen if urine culture was clinically indicated. His physician ordered for him to receive Rocephin by intramuscular injection (IM) daily for seven days on 8/4/25. -On 8/21/25, the physician notified the facility of urine culture results that grew out Pseudomonas Aeruginosa infection and ordered Augmentin (an antibiotic) 875 mg by mouth twice daily for three days. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Interview on 1/8/26 at 3:16 p.m. with director of nursing (DON) B revealed: *They did not have a bladder irrigation policy. *She acknowledged that resident 2 had frequent urinary tract infections. *She expected the staff to keep urinary drainage bags below the level of the resident's bladder and off the floor. *She expected the resident's Foley catheter tubing to be off of the floor. *She expected the staff to remove their dirty gloves before cleaning mechanical lifts. *She expected staff to wash their hands after removing their gloves, when leaving a resident's room, and not to touch the keypad on the dirty utility room door with uncleaned hands. 10. Review of the provider's 5/15/25 Enhanced Barrier Precautions policy revealed: *Enhanced Barrier Precaution (EBP): refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. *Multi Drug Resistant Organism (MDRO) are defined as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents. Although the names of certain MDROs describe resistance to only one agent (e.g., MRSA, VRE), these pathogens are frequently resistant to most available antimicrobial agents. *ENHANCED BARRIER PRECAUTIONS should be used for all resident or for those residents colonized/infected with a novel or targeted MDRO, when they no longer meet requirements for Contact Precautions: *a. Gowns and Gloves should be used during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing: Dressing, Bathing/showering, transferring, providing hygiene, changing linen, changing briefs or assisting with toileting, device care or use of a device, as listed above, wound care. 11. Review of the providers 2/21/25 Catheter Care policy revealed: *The purpose of this policy is to prevent urinary catheter-associated urinary tract infections. *.the urinary drainage bag should still be positioned lower than the bladder to promote proper drainage. *Be sure catheter tubing and drainage bag are kept off the floor. 12. Review of the provider's 5/15/25 Hand Hygiene policy revealed: *This facility considers hand hygiene the primary means to prevent the spread of infections. Hand Hygiene is part of Standard Precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*All personnel shall follow the hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. *In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub a. Before and after direct contact with residents b. When entering and leaving a Resident care area/room c. Before donning [putting on] and after removing gloves . e. Before preparing or handling medications. *Hand hygiene is always the last step after removing and disposing of personal protective equipment.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, interview, and policy review, the provider failed to report to the South Dakota Department of Health (SD DOH) that one of one sampled residents (2) received cigarette burns to his fingers. Findings include: 1. Review of resident 2's electronic medical record (EMR) revealed: *His 10/15/25 Brief Interview for Mental Status (BIMS) score was 13, which indicated his cognition was intact. *He did not have a physician's orders to smoke. *He had diagnoses of nicotine dependence and mild vascular dementia (a group of symptoms affecting memory, thinking, and social abilities). *His 10/15/25 smoking evaluation risk assessment indicated: -He was careless with smoking materials. -He was unable to safely light a cigarette. -He was not considered a safe smoker and required smoking management and supervision consistent with facility policy and may not have access to smoking material outside of supervised smoking. -He was to wear a smoking apron, be seated under the folding table, and a staff member was to light his cigarette. -He often attempted to smoke cigarettes down to the filter. *His 10/15/25 care plan indicated: -He was to be supervised, wear a smoking apron, and was to use a cigarette holder when he smoked to prevent him from getting burned because he smoked the cigarette down past the filter.-He needed to be pushed up to the table when he smoked due to his history of burns to his feet from dropping ash. -At any time if it was determined that he could not smoke safely with the available levels of support and supervision as indicated on his care plan, the resident's individual smoking methods may need to be adjusted. *Resident 2's physician was notified on 1/4/26 that he had cigarette burns to his right thumb that measured 0.7 x 0.6 and right pointer finger that measured 0.7 x 0.4 that were brown and tan in color without signs of infection. 2. Observation and interview on 1/6/26 at 4:08 p.m. of resident 2 outside smoking with CNA L revealed: *She put his coat and smoking apron on him, handed him the cigarette, he put it in his mouth, and she lit the cigarette for him with the lighter. *When the cigarette was close to the filter, she encouraged him to put the cigarette out, and when he did not, she removed the cigarette from his hand and put it out for him, and said he typically tried to smoke it close to the filter. 3. Interview on 1/7/26 at 3:27 p.m. with administrator A revealed: *She expected resident 2 to use cigarette holders when smoking if that was indicated on his smoking evaluation risk assessment. *They had been out of cigarette holders for about a week, and resident 2 should not have been allowed to smoke without the use of the cigarette holders. 4. Interview on 1/8/26 at 3:35 p.m. with administrator A revealed she was not aware that resident 2 had cigarette burns to his fingers and would have reported that to the SD DOH within 24 hours of the incident had she known. 5. Interview on 1/8/26 at 4:04 p.m. with registered nurse (RN) E revealed: *If an injury was found on a resident, she would try to determine the cause of the injury, correct it, notify management, the resident's physician, and the resident's family. 6. Interview on 1/8/26 at 4:06 p.m. with director of nursing (DON) B revealed she expected the nursing staff to report resident injuries to administration immediately. 7. Review of the provider's 5/14/25 Abuse and Neglect policy revealed: *Neglect is the failure to provide necessary and adequate (medical, personal or psychological) care. Neglect is the failure to care for a person in a manner, which would avoid harm and pain, or the failure to react to a situation which may be harmful. Staff may be aware or should have been aware of the service the resident requires but fails to provide that service. *If abuse/neglect is suspected the facility will: 1.Take immediate steps to assure the protection of the resident(s). 2.Notify the appropriate/designated organization/authority that an investigation is being initiated immediately following intervention for the resident's safety 5.Report the investigation findings to all necessary state/and or local agencies and any other identified persons as required by law.*VII. Reporting/Response.-All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee.