

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435060	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/02/2025
NAME OF PROVIDER OR SUPPLIER  Avantara Saint Cloud		STREET ADDRESS, CITY, STATE, ZIP CODE  302 St Cloud Street Rapid City, SD 57701	

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)
<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>Based on South Dakota Department of Health (SD DOH) complaint intake, interview, report review, facility assessment review, and policy review, the provider failed to ensure daily posted staffing information was updated to reflect the actual number of nursing staff and the hours those staff had worked on three of four overnight shifts reviewed. Findings include:</p> <ol style="list-style-type: none"> <li>Review of the 6/23/25 SD DOH complaint intake report revealed the complainant was concerned there is not enough staff to care for the residents. The complainant wished to have their identity protected.</li> <li>Interview on 7/3/25 at 9:20 a.m. with the complainant revealed: <ul style="list-style-type: none"> <li>*The complainant had assumed the overnight shift was short-staffed because there were constant [job] postings for that shift.</li> <li>-The complainant was not able to provide specific dates or times when it was thought the overnight shift had been short-staffed.</li> </ul> </li> <li>Review of the provider's 6/25/25 facility assessment revealed one to two licensed nurses were needed during the overnight shift to ensure the needs of the residents had been met. Three to four CNAs were needed during the overnight shift to ensure the needs of the residents had been met.</li> <li>Interview on 7/3/25 at 11:00 a.m. with an anonymous staff person D revealed: <ul style="list-style-type: none"> <li>*Many nights there was only one licensed nurse and two certified nurse aides (CNA) who had worked the overnight shift to care for 75 residents.</li> <li>-June 15, 2025 was the last time that staff person recalled that had occurred.</li> </ul> </li> <li>Review of the provider's 6/14/25 through 6/17/25 daily posted staffing information for the overnight shift revealed: <ul style="list-style-type: none"> <li>*Those postings had included the type of direct care staff, the number of those staff who had worked the overnight shift, and the amount of hours each of those staff had worked during those shifts.</li> <li>*On 6/14/25:</li> </ul> </li> </ol> <p>(continued on next page)</p>

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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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Two licensed practical nurses (LPNs) had each worked a twelve-hour shift (from 6:00 p.m. to 6:00 a.m.).</p> <p>-Three CNAs had each worked an eight-hour shift (from 10:00 p.m. to 6:00 a.m.).</p> <p>*On 6/15/25:</p> <p>-Two LPNs had each worked a twelve-hour shift.</p> <p>-Four CNAs had each worked an eight-hour shift.</p> <p>*On 6/16/25:</p> <p>-Two LPNs had each worked a twelve-hour shift.</p> <p>-Four CNAs had each worked an eight-hour shift.</p> <p>*On 6/17/25:</p> <p>-Two LPNs had each worked a twelve-hour shift.</p> <p>-Four CNAs had each worked an eight-hour shift.</p> <p>6. Interview on 7/2/25 at 1:30 p.m. with administrator A and review of the provider's 6/14/25 through 6/17/25 overnight staff's time sheets compared with the above daily posted staffing information revealed:</p> <p>*On 6/14/25:</p> <p>-One LPN had worked her twelve-hour shift. A second LPN had left her twelve-hour shift at 11:42 p.m. and had not returned to work that night.</p> <p>-Four CNAs had each worked their eight-hour shift.</p> <p>*On 6/15/25:</p> <p>-One LPN had worked her twelve hour-shift. A second LPN had left her twelve-hour shift at 8:43 p.m. and had not returned to work that night.</p> <p>-Two CNAs had each worked an eight-hour shift.</p> <p>-A third CNA had left her eight-hour shift at 11:19 p.m. and she had not returned to work that night.</p> <p>-Three additional CNAs had arrived between 5:11 a.m. and 5:30 a.m. to support the overnight staff and the oncoming day staff in providing care for the residents.</p> <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-One unlicensed medication aide had arrived at 4:21 a.m. to support the overnight staff and the oncoming day staff in providing care for the residents.</p> <p>*On 6/16/25:</p> <p>-Two LPNs had each worked a twelve-hour shift. A third LPN had left her twelve-hour shift at 9:21 p.m. and she had not returned to work that night.</p> <p>-Four CNAs had each worked an eight-hour shift.</p> <p>*On 6/17/25:</p> <p>-Two LPNs had each worked a twelve-hour shift.</p> <p>-Four CNAs had each worked an eight-hour shift.</p> <p>*Administrator A confirmed the posted staffing information for 6/14/25, 6/15/25, and 6/16/25 had not been updated to reflect the staffing changes that were made for those overnight shifts.</p> <p>Continued interview with administrator A regarding the process for completing the daily staff posting information revealed:</p> <p>*It was the responsibility of the staffing coordinator to have completed any updates to the original daily posted staffing information, but there had been no staffing coordinator since April 2025. The unit manager had assumed that responsibility until she had left at the end of May 2025.</p> <p>*Administrator A stated she had not, but should have then assumed that responsibility at the end of May 2025 or until she had delegated that task to another staff person to complete.</p> <p>7. Interview on 7/2/25 at 1:45 p.m. with administrator A, Alzheimer's registered nurse (RN) supervisor B, and former assistant director of nursing (ADON) C regarding the overnight staffing on 6/15/25 revealed:</p> <p>*After former ADON C was notified of staffing concerns for the evening shift on 6/15/25, she had messaged the facility's staff to determine if any unscheduled staff would come into work that night.</p> <p>*A message was also left for the travel staffing agency to identify potential staff from there who may have been able to work.</p> <p>*The designated manager-on-duty who was a CNA and an unlicensed medication aide (UMA) stayed into the early evening and assisted with providing residents care.</p> <p>*Former ADON C returned to the facility and assisted with providing residents' care from about 5:45 p.m. through 8:00 p.m. that night.</p> <p>*Alzheimer's RN supervisor B remained in the facility and had assisted with providing the residents' cares from about 5:00 p.m. through 10:30 p.m. that night.</p> <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-She had offered to stay longer or to come back to work if she was needed, but the overnight nurse had stated to her, I think we got it.</p> <p>*All the residents except one had been in bed and were asleep when Alzheimer's RN supervisor B had left the building that night.</p> <p>*Several day shift CNAs had arrived early to work the morning of 6/16/25 (between 4:21 a.m. and 5:30 a.m.) to support the night shift staff and the oncoming day shift staff in providing care to the residents.</p> <p>*Regarding the staffing during the overnight shift on 6/15/25, Administrator A confirmed that between about 10:30 p.m. and 4:00 a.m., there had been two CNAs and one licensed nurse who had worked. Alzheimer's RN supervisor B had offered to remain in the facility during that time and support the overnight staff, but the overnight nurse had declined that additional offered assistance.</p> <p>*Administrator A stated she felt the above interventions that were implemented to support the evening and overnight shifts on 6/15/25 and re-scheduling non-urgent work tasks had been sufficient to meet all of the residents' care needs.</p> <p>Review of the provider's 6/1/23 Posting of Daily Staffing policy revealed:</p> <p>*The number of hours worked each day by RNs, LPNs, and CNAs was expected to have been posted each day.</p> <p>*4. After the start of each shift, actual hours will be updated if there are any changes to the schedule/number of staff/hours worked.</p>		