STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435060	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Saint Cloud	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, and interview, the facility failed to protect the resident's right to be free from neglect by having failed to ensure the safety of one of one sampled resident (1) who sustained femur (thigh bone) fractures after being transferred from her wheelchair to her bed by two of two certified nursing assistants (D and E) who did not follow her care plan or the facility's policy for gait belt (a waist strap gripped as support for safe mobility and transfers) use; and by one of one licensed practical nurse (LPN) C who did not perform a physical assessment of resident 1 after being notified by CNA D and CNA E of the transfer. The failure of the CNAs to follow resident 1's care plan and the provider's policy regarding the use of a gait belt when transferring a resident may have resulted in the fractures to both of her femur bones. This citation is considered past non-compliance based on the corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of the provider's 7/28/25 SD DOH FRI revealed:*On 7/27/25, CNA D and CNA E were transferring resident 1 with a sit-to-stand mechanical lift (a mechanical lift used to assist from a seated to a standing position) when her knee moved.-They lowered her to her wheelchair, notified LPN C, and assisted resident 1 to her bed from her wheelchair, without the use of a sit-to-stand mechanical lift or gait belt (a waist strap gripped as support for safe mobility and transfers).*LPN C did not assess resident 1 for pain throughout that night.*On 7/28/25 at approximately 12:30 p.m., LPN F was called to resident 1's room by CNA G as resident 1's right lower leg was flaccid [limp], painful and she was clammy and shaking.*Resident 1 was sent to the emergency department to be evaluated.*An investigation was initiated by the provider, and it was discovered that resident 1 was transferred from her wheelchair to her bed by a two-person pivot assist transfer [when assisted to a standing position, the resident then turns their body to move to another surface] by CNAs D and E, without the use of a gait belt, which was not following her [resident 1's] care plan [personalized plan that addresses a resident's care needs, goals, and interventions].*CNA D and CNA E were suspended for not following resident 1's care plan.*LPN F was suspended for not assessing resident 1 after being informed that her knee had moved in the lift as she did not feel it was presented to her as being emergent. 2. Review of the provider's final report for the 7/28/25 SD DOH FRI regarding resident 1 revealed:*During the investigation into the incident, CNA D and CNA E indicated they had been in the process of transferring resident 1 from a sit-to-stand lift when her right leg slipped backwards off the lift platform, where her feet would have been. They then lowered her into her wheelchair and transferred her from the wheelchair to her bed without the use of a gait belt.*They notified LPN C of the transfer, and she did not complete an assessment of resident 1.*On 7/28/25, LPN F and registered nurse (RN) J assessed resident 1, and found her left knee flaccid, slightly smaller in length than the right knee, and Nontender to palpation other than directly over bilateral kneecaps. *Resident 1 was transferred to the emergency department on 7/28/25. Imaging was completed at the hospital, which indicated resident 1 had fractures of both femur (thigh) bones, the right fracture was near the knee replacement prosthesis. 3. Review of resident 1's electronic medical record revealed:*Her date of admission was 8/10/21.*Her 6/6/25 Brief Interview of Mental Status assessment score was a 0, which indicated she had severe cognitive impairment.*Her diagnoses included: Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), type 2 diabetes (a condition involving disruptions in how the body regulates blood sugar), morbid obesity (excessive weight that significantly impacts health and well-being), venous insufficiency, anxiety, contractures of the right and left knees, and fractures of her left and right femur bones.*Her 7/27/25 care plan included Transfers with sit to stand [mechanical lift]. Review of resident 1's nurse progress notes revealed:*No nurse progress note included resident 1's 7/27/25 transfer from her wheelchair to her bed by CNA D and CNA E, or that they reported the incident to LPN C.*On 7/28/25, she was transferred to the emergency department for pain in her legs. The transfer form revealed she was transferred as her right front knee as very painful, swollen, flaccid. *On 7/29/25, resident 1 returned to the facility. *On 7/30/25, she was placed on hospice care (provide care and comfort during the final months of a patient's life).*On 8/1/25, resident 1 passed away at the facility. Review of resident 1's 7/28/25 hospital notes revealed she had a fracture of her left femur and a fracture of her right femur that included angulation (a broken bone that tilts at an angle) of the bone fragments. 4. ----Interview on 8/13/25 at 4:02 p.m. with administrator A, director of nursing B, assisting administrator H, and regional nurse consultant I regarding the 7/28/25 SD DOH FRI revealed Administrator A confirmed that the investigation into resident 1's right and left fractured femurs substantiated (proved) neglect by CNA D and