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	01/27/2026

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 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. Based on observation, interview, and policy review, the provider failed to ensure medications and biologicals were labeled, stored, and discarded regarding:*Expired medications and supplies were discarded in two of two observed storage rooms.*One of one medication cart that was left unattended and unlocked by one of one registered nurse (RN) (I) in the dining room, where residents, unauthorized staff, and visitors could access it. *Medications with shortened expiration dates (medications that expire in a timeframe after opening that is prior to the manufacturer's expiration date) stored in one of one medication carts were labeled when they were opened. Findings include:1. Observation on 1/26/26 at 1:52 p.m. in the main storage room revealed: *One box of a three-layer compression bandage system [bandages layered to provide sustained and cushioned compression for treating venous issues such as leg wounds with swelling) that expired on 9/6/24. *One box of Optifoam AG Nonadhesive Dressing with Antibacterial Silver (non-stick dressing infused with silver to act as an antibacterial agent) that expired on10/3/24.*Two boxes of Opticell Chitosan-Based Gelling Fiber (dressing with absorbent fibers that gel when soaked with wound drainage) that expired on11/21/24. *A plastic storage container filled with nine individually packaged lemon-flavored glycerin swab sticks (disposable, single-use, cotton swabs to moisten, clean, and refresh the mouth) that expired on 2/25. *A plastic storage container filled with catheter (a flexible tubing placed in the bladder to drain urine) urine collection leg bags (a bag that can strap to the leg) that expired on 10/23. *There was a metal shelf in the main storage room with an individually packaged Lidocaine 5% medicated patch (for pain) on it. 2. Observation and interview in the dining room on 1/27/26 at 8:27 a.m. with RN I revealed: *The medication cart was placed near the entrance to the dining room. RN I was across the room with her back to the medication cart, administering medications to a resident. *Multiple staff members and residents were in the dining room and walked past the medication cart. *The unattended medication cart was unlocked and accessible to any resident, unauthorized staff, or visitor who passed by. *RN I acknowledged that she did not lock the medication cart and was not directly observing it. *She should have locked the cart before she left it unattended. *She stated she usually locked the cart before walking away from it. 3. Interview on 1/27/26 at 11:53 a.m. with Administrator A in the main storage room revealed: *She (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

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	01/27/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	acknowledged that there were various supplies in the storage room that were expired based on the manufacturer's printed expiration date on the packages. *She was disappointed because the staff were to be performing audits on the supplies and discarding expired supplies. *She stated that the specialized wound care dressings (with silver and chitosan-based gelling fiber) were no longer effective if they were past the manufacturer's printed expiration date. *She thought that the Lidocaine 5% patch on the shelf belonged to a resident. She would remove the medicated patch from the room and dispose of it. 4. Observation and interview on 1/27/26 at 2:10 p.m. with assistant director of nursing (ADON) C in the small storage room revealed: *Eight of eight sterile catheter insertion kits expired on 10/31/25, and one of those kits was opened. *ADON C confirmed that those kits were expired and should not be available for use. *She thought the opened kit was used for training and stated it should have been labeled Training. *Medical records director J was responsible for removing outdated supplies from the small storage room. 5. Observation and interview on 1/27/26 at 2:41 p.m. with director of nursing (DON) B of a medication cart in the main storage room revealed: *Resident 61' s Lispro (rapid-acting insulin) was not dated to indicate when it was opened. *Resident 61's Lantus (long-acting insulin) was not dated to indicate when it was opened. *DON B was aware that those medications had shortened expiration dates, based on the date they were opened, and confirmed there was no date to indicate when they were opened. *She was unable to tell if or when the medications were expired since they were not labeled with the date they were opened. *Resident 73's nystatin-triamcinolone (a medication used to treat fungal skin infections and reduce inflammation) expired on 9/30/25. *She confirmed that medication was expired, and should have been removed from the medication cart and discarded. 6. Interview on 1/27/26 at 3:45 p.m. with DON B regarding the observation of the unattended, unlocked medication cart in the dining room revealed that she expected the staff to lock the medication carts before they walked away from them. 7. Review of the provider's September 2018 Medication Administration General Guidelines policy revealed: *Medication Administration: -Check expiration date on package/container. No expired medication will be administered to a (continued on next page)

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	01/27/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident. --The nurse shall place a 'date opened' sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened. --Certain products or package types . have specified shortened end-of-use dating, once opened, to ensure medication purity and potency. -During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. Review of the provider's September 2018 Storage of Medication policy revealed: *Policy -Medications and biologicals are stored properly, following the manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. *Procedures -In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access. -Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used. -Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists. -Medication storage conditions are monitored on a regular basis as a random quality assurance (QA) check. As problems are identified, recommendations are made for corrective action to be taken. Review of the undated List of Medications with Shortened Expiration Dates that the provider used for reference revealed: *Lispro should be discarded 28 days after opening. *Lantus should be discarded 28 days after opening. An Outdated Supplies policy was requested, but no policy specific to outdated supplies was provided by the end of the survey.

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	01/27/2026

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 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: *One of one observed certified nursing assistant (F) who assisted three of three sampled residents (62, 56, and 22) with eating during one of one observed noon meal service. *One of one observed licensced practical nurse (E) who assisted two of two sampled residents (1 and 38) with eating during one of one noon meal service. Findings include: 1. Observation on 1/25/26 at 11:53 a.m. in the main dining room during the noon meal revealed: *Resident 62, 56, and 22 sat at the same dining table (table 6). *Certified nursing assistant (CNA) F helped resident 62 apply a clothing protector, moved her wheelchair closer to the dining room table, and locked resident 62's wheels. *Without washing or sanitizing her hands, CNA F went to the serving counter and picked up two meal plates and served them to the residents. She returned to the serving counter and used an alcohol-based hand rub (ABHR) to sanitize her hands. She picked up two meal plates and served them to two other residents. *CNA F then sat down at a chair in between resident 56 and resident 62 and gave resident 62 a bite of food with her right hand. *CNA F stood up and adjusted resident 62's wheelchair. She removed the leg supports from the wheelchair and placed them in a storage bag on the back of that wheelchair. CNA F sat back down and readjusted resident 62's wheelchair closer to the dining table. *Without sanitizing her hands, CNA F scooped a bite of food on a spoon with her right hand. She gave resident 62 that bite of food and placed the spoon back on resident 62's plate. -CNA F then scooped a bite of food on a spoon from resident 56's plate and gave it to resident 56 with her right hand. -Without washing or sanitizing her hands, CNA F scooped a bite of food on a spoon from resident 62's plate and gave it to resident 62 with her right hand. Without washing or sanitizing her hands, she gave resident 56 a bite of food with her right hand. *Resident 22 started to back away from the dining table. CNA F got up, moved him back to the table and encouraged him to eat. Without washing or sanitizing her hands, she used her right hand to give resident 22 a bite of food. -CNA F continued that same pattern while she helped residents 62, 56, and 22 to eat their meals without washing or sanitizing her hands between assisting each of those residents. 2. Observation on 1/25/26 at 12:17 p.m. in the main dining room during the noon meal revealed: *Licensed practical nurse (LPN) E was sitting in between residents 1 and 38 at table 3. *LPN E used her right hand and gave resident 1 a bite of food. *Without washing or sanitizing her hands, she gave resident 38 a bite of food with her right hand. *LPN E continued that pattern three more times while she helped residents 1 and 38 eat their meals without washing or sanizing her hands between assisting each of those residents. 3. Further observation on 1/25/26 at 12:32 p.m. in the main dining room revealed: *CNA F remained seated at table 6. She stood up was still at the dining table with resident 62, 56, and 22. *CNA F remained seated at table 6. She stood up and walked over to the side of the table where resident 22 sat in his wheelchair. CNA F moved resident 22's plate to the side and used two forks to gather several pieces of food that had fallen off the resident's plate onto the table into a pile on the table. *CNA F scooped up that food pile with those two forks and then assisted resident 22 with eating that same food. 4. Interview on 1/27/26 at 1:36 p.m. with CNA F revealed: *She acknowledged that the table was not a clean surface and it is not her normal practice to feed residents food that fell onto the table. 5. Interview on 1/27/26 at 1:50 p.m. with administrator A revealed: *She expected the staff to wash or sanitize their hands after providing any care to a resident or after touching personal equipment such as wheelchairs. *She expected the staff to discard food that fell off a resident's plate into the trash can and not to serve it to the resident. 6. Interview on 1/27/26 at 2:01 p.m. with director of nursing (DON) B and registered nurse (RN) regional clinical consultant D revealed: *Staff were expected to wash or sanitize their hands before and after providing resident care and in between assisting each resident with eating. *They both expected staff to wash or sanitize their hands after moving or manipulating a resident's wheelchair. *They stated that the dining room table was not a clean surface and the residents should not be given food off of that surface to eat. 7. Review of the provider's 5/15/25 Hand Hygiene policy (continued on next page)

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	01/27/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed: *All personnel shall follow the hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. *Hand hygiene consists of using alcohol-based hand rub or washing at a sink with soap and water. *Staff were expected to perform hand hygiene before and after direct contact with residents, before and after eating or handling food, after contact with a resident's intact skin, and after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident.

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	01/27/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure staff followed professional standards of practice regarding the respiratory care for one of one sampled resident (78), who received oxygen when he previously resided at a hospital from [DATE] through his admission to the provider's facility on 1/21/26, when staff failed to clarify and provide the resident's oxygen needs. Findings include:1. Observation and interview on 1/25/2026 at 1:49 p.m. with resident 78 in his room revealed:*He was sitting in his recliner chair with an oxygen concentrator machine (a device that filters room air into purified oxygen) stored between the chair and his bed. *There was a plastic storage bag attached to the oxygen concentrator machine, which had 1/26/26 and initials handwritten on it in black ink.*An unopened package of Procure brand seven-foot nasal cannula (a flexible tube with two prongs inserted into the nostrils to deliver oxygen) was sitting on his bedside table. *He thought he used oxygen, but did not know how often. 2. Review of resident 78's electronic medical record (EMR) revealed:*He admitted to the facility on [DATE] from a hospital.*His diagnoses included Chronic Obstructive Pulmonary Disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe), and dementia (a group of symptoms affecting memory, thinking, and social abilities).*His 1/27/26 Brief Interview for Mental Status (BIMS) assessment score was 7, which indicated he had severe cognitive impairment.*The hospital progress note from the physician dated 7/31/25 at 3:12 p.m. revealed:-He was to use 3L [3 liters of] O2 [oxygen] via NC [nasal cannula] at bedtime. *His discharge orders from the hospital dated 1/14/26 by the physician did not discontinue his admitting hospital order for oxygen dated 7/31/25.*The hospital physician's progress notes revealed that resident 78 had no new, changed, or discontinued oxygen orders. *An admission nursing note dated 1/21/26 at 1:25 p.m. regarding resident 78 read, He wears oxygen at 3 liters at night.*His oxygen saturation (percentage of oxygen in the blood) levels were documented twice since his admission to the facility and were at 92% (percent) on 1/21/26 at 11:44 a.m. and 95% on 1/25/26 at 6:09 a.m., both while on room air (without oxygen). 3. Resident 78's 1/21/26 baseline care plan revealed:*A focus area of: Alteration in respiratory functioning related to COPD.*The goal for that focus area was: He [resident 78] will not have respiratory distress, and his respiratory functioning will improve or maintain through the next review.*The interventions were:-Administer oxygen and other medications and respiratory treatments as ordered.-Assess respiratory status: Observe for shortness of breath, check lung sounds, call MD [doctor] for any changes and/or abnormalities.-Elevate head of bed as needed.-Keep call light within reach. 4. Interview on 1/26/2026 at 3:23 p.m. with certified nursing assistant (CNA) H revealed: *She did not know why resident 78 had an oxygen concentrator machine or why the unopened oxygen tubing was not connected to it. *She was unsure if he needed to wear oxygen or what his oxygen instructions were, but she would ask the nurse. 5. Interview and observation on 1/26/2026 at 3:25 p.m. with licensed practical nurse (LPN) G in resident 78's room revealed: *Resident 78 was sitting in his recliner chair.*The unopened nasal cannula tubing package remained on his bedside table. *She thought the hand-off report (communication of transferring residents' information) received from the hospital nurse and the provider's nurse indicated that resident 78 was to receive 3 liters (L) of oxygen at night.*She stated that she would have to check his orders.*She asked resident 78 if he used oxygen, and he stated, Yes, yes, I do. *She acknowledged there was an oxygen concentrator machine in the resident's room with no oxygen tubing connected to it, and an unopened package of nasal cannula tubing on his bedside table. 6. Interview on 1/26/2026 at 4:17 p.m. and again at 4:31 p.m. with LPN G revealed:*Resident 78 did not have physician's orders for oxygen use. *She stated that she called resident 78's daughter who thought the resident was to receive oxygen at night.*LPN G received an oxygen order for resident 78 from his previous hospital physician.-She [physician] indicated he was to have oxygen administered at a rate of 3 liters per minute through a nasal cannula every night. *She (continued on next page)

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	01/27/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thought his oxygen needs were not clarified during the hand-off report when he was admitted to the facility, and he did not receive oxygen at night since his admission on [DATE]. 7. Interview and record review on 1/26/2026 at 4:42 p.m. with director of nursing (DON) B revealed:*She confirmed the hand-off report from the hospital nurse to the provider nurse indicated that resident 78 was to receive 3 liters of oxygen at night.*She stated that if any details in the nurse hand-off report between the two facilities were unclear, the nursing staff should have clarified them with resident 78's physician.*She acknowledged that resident 78's 7/31/25 admission progress note from his physician at the hospital had an oxygen order that read, use 3L [liters] O2 [of oxygen] via NC [nasal cannula] at bedtime. *She acknowledged resident 78's 1/21/26 admission nurse's note read, He wears oxygen at 3 liters at night.*She confirmed there was no current physician order for resident 78's oxygen use. 8. Interview on 1/27/2026 at 1:50 p.m. and again at 3:30 p.m. with director of nursing (DON) B revealed:*She stated that resident 78 may not have received oxygen at night since his admission on [DATE].*The facility didn't have a policy regarding the nurse hand-off reporting.*She stated that the staff followed the nurse hand-off reporting process indicated in the Fundamentals of Nursing book. 9. Interview on 1/27/2026 at 5:15 p.m. with administrator A revealed:*The facility didn't have a policy regarding nurse hand-off reporting. *She expected the nursing staff to follow the physician's order policy. *She acknowledged that the hand-off report between the nurses indicated that resident 78 was to be on 3 liters of oxygen at night. *She acknowledged that the provider's 1/21/26 admission nurse's note at 1:25 p.m. for resident 78 read, He wears oxygen at 3 liters at night. *She acknowledged that resident 78's 1/21/26 baseline care plan indicated needed oxygen at night.*She expected the nurse who received the hand-off report to notify resident 78's physician to clarify his oxygen needs upon his admission to the facility.*She agreed there was no document to support that resident 78 received oxygen for four nights. 10. Review of the providers Fundamentals of Nursing, Tenth Edition, Copyright 2021 by Elsevier Inc. revealed:*Hand-off reporting was a real-time process.*Offers accepting provider to clarify and confirm important details about a patient's [resident's] plan of care, patient progress, and continuing needs during the transfer of information.*The report should include accurate, up-to-date, and pertinent information to the next nurse assuming patient [resident] care.*Hand-off report is to ensure continuity of care for a patient [resident] and prevent errors or delays in providing nursing interventions. 11. Review of the provider's revised November 18, 2025, Following Physician Orders policy revealed:*To correctly and safely receive and transcribe physician's orders so correct order is followed/administered.*All physician's orders will be received by a licensed nurse, therapist, or dietician.*Orders may be received through written communication in the resident's chart, verbally, by fax, electronically entered into PCC, or per the telephone.*New admission/readmission physician orders and all transcription of orders should be transcribed by a nurse and be double checked by a second nurse to ensure that all steps have been carried out to avoid errors.*All physician orders should be followed as written. The prescriber should be contacted if any order is not clear/understood. 12. Review of the provider's revised November 18, 2025, Oxygen Administration policy revealed:*Verify that there is a physician's order for oxygen that includes route (via mask or nasal cannula), liter flow, and duration (i.e., continuous, prn, at night, etc).