STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara North	1620 North 7th 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on a South Dakota Department of Health (SD DOH) complaint review, interview, record review, and policy review, the provider failed to follow their policy to ensure one of one closed record sampled resident's (1) discharge plan was documented and appropriate information was communicated to the nursing home that had accepted that resident for admission. Findings include: Review of the 6/24/25 SD DOH complaint intake revealed concerns that the nursing home where resident 1 was transferred and admitted to on 6/18/25 had not received the information needed to properly care for her before she was discharged on that same day by the provider. 1 Interview on 8/7/25 at 3:15 p.m. with Medical Records Director K revealed:She maintained a log of referral information that was sent to other healthcare providers on a resident's behalf. She had no documentation to support that she had sent any referral information to another healthcare provider on resident 1's behalf.Review of resident 1's closed electronic medical record (EMR) revealed:A 6/17/25 progress note: Medicare A last covered day 6/18[25] with daughter stating resident to be transferring to facility [in another town]. Arrangements are in place for transportation.There were no progress notes that indicated any communication had occurred between the provider and the nursing home that admitted resident 1 to their facility on 6/18/25. The 6/18/25 Instruction and Summary for Discharge UDA (user defined assessment) revealed:Section I of that assessment was a summary of the resident's status. That section included information regarding the resident's sensory impairments, mental and psychosocial status, cognitive status, attitude about discharge, and discharge status. A social services designee (SSD) was expected to have completed that section, but there was no SSD at the time of resident 1's discharge. No other staff had completed that section.Section II of that assessment was signed as having been completed by nurse supervisor/licensed practical nurse (LPN) F. That section included information regarding the resident's reason for admission, progress made and any complications the resident may have had, any assistive devices that were needed by the resident, and any pertinent antibiotic and laboratory information. Documentation in that section failed to include the following resident-specific information:The dates and results of resident 1's June 2025 COVID testing, and if there was a nurse assessment completed for signs and symptoms of COVID-19 on the day she was discharged . The documented vital signs in that section were dated 6/15/25. The resident had a Foley catheter. She also had shown signs and symptoms of a possible urinary tract infection (UTI) on 6/16/25. The results of a urine analysis (UA) test were pending.The resident had a physician's order for continuous oxygen to be worn.She had used a wheelchair cushion and a low air low-air-loss mattress at the facility. On 6/16/25, her medical provider was notified that her wounds had worsened. There were no new wound orders written at that time.The resident had completed a course of Vancomycin (an antibiotic) during her stay at the nursing home for treatment of C. difficile (a contagious bacterium that causes diarrhea).Section IV of that assessment was a summarization of the resident's rehabilitative services. A representative from the rehabilitation department was expected to have completed that section, but it was incomplete and unsigned. The medical provider was expected to have signed and dated Section V of that assessment, but it was incomplete and unsigned. Interview on 8/7/25 at 1:30 p.m. with director of nursing (DON) B confirmed:There was no documentation to support that discharge planning communication regarding resident 1 between the provider and the receiving nursing home facility had occurred.The above Instruction and Summary for Discharge documentation had not included resident-specific information that promoted a safe transition in care and assisted the receiving nursing home facility in providing resident 1's care needs.The SSD was the point of contact for resident discharges to other nursing home facilities. At the time of resident 1's discharge, there was no SSD to fulfill that responsibility, and another primary contact person was not identified to assume that responsibility.Review of the provider's revised 4/28/25 Discharge and Transfer of Residents/Bed Hold policy revealed:Policy: To ensure a safe transition is planned for any resident with a discharge or transfer to another setting.The LGHC [Legacy Healthcare] Instruction and Summary for Discharge UDA [User Defined Assessment] will be completed with all planned discharges. If proceeding with discharge, a copy of the UDA will be given to resident upon discharge. A copy will be signed by the physician for the summary of stay and will be scanned to electronic record or a copy maintained in closed medical record.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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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 0690 Level of Harm - Actual harm Residents Affected - Few	Based on South Dakota Department of Health (SD DOH) complaint intake review, record review, interview, and policy review, the provider failed to:Ensure there was a physician's order for one of one closed record sampled resident's (1) urinary catheter.Ensure there was a documented clinical indication for urinary catheter use by one of one closed record sampled resident (1) that included a physician's order for catheter removal when it was no longer clinically indicated.Identify and implement measures to mitigate of one of one closed record sampled resident (1) with a urinary catheter from developing a urinary tract infection.Findings include: Review of the 6/24/25 SD DOH complaint intake revealed:On 6/18/25, the provider discharged resident 1. She was transferred and admitted to a different nursing home later that same day with a urinary catheter. When resident 1 was admitted to the receiving nursing home, her catheter had a significant amount of sediment. It was not reported [to the receiving nursing home by the provider] that the resident had a UTI [urinary tract infection] or that a urine sample was obtained prior to transfer for possible UTI. She [resident 1] has had her catheter removed [by the receiving nursing home] as well as started an antibiotic to treat her UTI [after her admission to the receiving nursing home facility].Review of resident 1's closed electronic medical record (EMR) revealed:Neither her 6/3/25 hospital discharge orders nor her 6/3/25 nursing home admission orders had included a urinary catheter. Resident 1's 6/3/25 Nurse admission Assessment indicated that the resident had a urinary catheter. A question in that assessment, Is there a plan to discontinue [the catheter]? was answered no.Resident 1's 6/14/25 through 6/17/25 Nursing-Daily Evaluation assessments had included a checklist (Section A) that included Vital Signs/Devices and Treatments. There was space on that checklist to indicate if a resident had a urinary catheter and whether or not it was chronic or new. On that same assessment, Section B. Skilled Nursing, there was space (12 a.) to identify if a resident had an indwelling catheter. There was additional space in the Comments section (23.) to document nursing comments relevant to those resident care needs that were identified in Section A that applied to a resident.Resident 1's 6/14/25 through 6/17/25 Nursing-Daily Evaluation assessments failed to identify that she had a urinary catheter, and there was no documentation in the comment section of those assessments regarding resident 1 having signs or symptoms of a possible urinary tract infection. There was no Nursing-Daily Evaluation assessment completed on the date of resident 1's discharge, 6/18/25.A 6/16/25 progress note: Staff reported the resident's urine to be thick and yellowish in color. The resident's medical provider was notified, and a urine analysis (UA) was ordered. The results of that UA were not available on 6/18/25 when the resident was discharged . UA results were faxed to the receiving facility on 6/19/25. There was no documentation to support a hand-off communication between the provider's nursing staff and the receiving nursing home facility nurse had occurred on the day of resident 1's discharge. Interview on 8/7/25 at 9:55 a.m. with Minimum Data Set (MDS)/Care Plan Coordinator D revealed:She confirmed resident 1 had a urinary catheter during her 6/3/25 through 6/18/25 nursing home stay. Resident 1's hospital discharge orders and nursing home admission orders had not included resident 1's use of a urinary catheter. It was MDS/Care Plan Coordinator D's responsibility to ensure residents admitted to the facility with urinary catheters had a physician's order for that catheter, a diagnosis that supported its medical necessity, and a removal plan for the catheter if that was clinically indicated. Implementing those interventions would have decreased resident 1's risk of developing a UTI, but that had not occurred.Because resident 1's admission orders had not included a urinary catheter, MDS/Care Plan Coordinator D assumed the resident had no catheter, and her catheter follow-up referred to above had not occurred. Interview on 8/7/25 at 12:45 p.m. with director of nursing (DON) B revealed:A floor nurse was responsible for completing the Nurse admission Assessment, and a nurse manager was responsible for entering admission orders. DON B agreed that the nurse manager should have completed a visual assessment of resident 1 to have known she had a urinary catheter, and that the expected standards of practice for catheter use had been followed. Review of the provider's revised 5/15/25 Catheter Associated Urinary Tract Infection (CAUTI) Prevention Guidelines revealed:1) Verify that there is a physician's order for a catheter procedure.3) d) Do not use the indwelling catheter unless medically necessary: Appropriate indications for the continuation of use/justification of an indwelling urethral catheter beyond 14 days .

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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. Based on South Dakota Department of Health (SD DOH) complaint review, record review, interview, and policy review, the provider failed to ensure one of one closed record sampled resident (1) had documentation to support physician-ordered oxygen was arranged and provided for her to use while being transported from the provider's facility to another nursing facility where she had been accepted for admission. Findings include: Review of a 6/24/25 SD DOH complaint revealed:The provider discharged resident 1 on 6/18/25, and she was transferred that same day to another nursing home approximately 100 miles away. The resident was transported to the receiving nursing home via a public transportation service.The resident was not provided with continuous oxygen when she was transported between the two nursing homes. 1 Review of resident 1's closed electronic medical record (EMR) revealed:A 6/3/25 physician's order for the resident to receive three liters of continuous oxygen via nasal cannula (a flexible tube that goes around the head into the nose for oxygen delivery) for a diagnosis of chronic respiratory failure with hypoxia (absence of enough oxygen). There was no documentation regarding what arrangements had been made to ensure that resident 1 was safely transported to the receiving nursing home with continuous oxygen as ordered. Telephone interview on 8/7/25 at 11:50 a.m. with registered nurse (RN) J revealed:She was responsible for discharging resident 1 on 6/18/25. She thought she had given a hand-off report to the receiving facility, but confirmed there was no documentation to support that it had occurred. RN J had not known if arrangements were made for resident 1 to have oxygen while she was transported to the receiving nursing home. She had not known if resident 1 was wearing oxygen at the time she was discharged from the facility. Interview on 8/7/25 at 1:40 p. m. with director of nursing (DON) B and assistant DON (ADON) C revealed:It was RN J's responsibility to confirm that resident 1 had portable oxygen available to use while being transported to the receiving facility. If the receiving facility had not sent portable oxygen for resident 1 to use, the sending facility should have sent theirs. Review of the provider's revised 11/19/24 Oxygen Administration policy revealed 3. If portable oxygen is used, staff should ensure the tank has adequate volume to ensure oxygen does not run out.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, and record review, the provider failed to validate the status of one of one social services designee's (SSD) (G) temporary nursing license while she was employed in that capacity between February 2025 and May 2025. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Interview on 8/6/25 at 8:30 a.m. with administrator A and director of nursing (DON) B and review of the provider's 5/7/25 SD DOH FRI final report regarding SSD G revealed:SSD G had been the facility's SSD since 2/1/21.She had completed her practical nursing degree in December 2024. Her temporary nursing license was issued on 1/2/25. She began training as a floor nurse at the facility shortly thereafter. SSD G had worked mostly evening shifts. There were two licensed nurses who worked those shifts with SSD G.SSD G was a certified nurse aide (CNA), but she was not a certified medication aide (CMA).She had told facility management staff that she had passed her National Council Licensure Examination (NCLEX-a standardized examination used to assess the knowledge, skills, and abilities of entry-level nurses) in February 2025. Upon passing the NCLEX, a permanent nursing license would have been issued to SSD G by the South Dakota Board of Nursing (SD BON).Human Resources (HR) director H requested from SSD G a copy of that permanent nursing license for her personnel file.On 5/5/25, HR director H had noticed there was still no copy of SSD G's permanent nursing license in her personnel file. On 5/5/25 and 5/6/25, she again requested a copy of that nursing license from SSD G. On 5/6/25, when SSD G failed to provide that copy, HR director H notified DON B.Referring to the SD BON website, DON B was unable to confirm SSD G had a valid nurse license.A 5/7/25 email sent to administrator A, DON B, and HR director H from SSD G attributed DON B's inability to find her nursing license on the website to a clerical error. On 5/7/25, DON B emailed the SD BON. Their 5/7/25 email response confirmed that SSD G had failed the NCLEX. Her temporary nursing license was invalid after she had failed that examination. That occurred on or about 2/10/25.SSD G was suspended from working on 5/7/25 pending a full investigation. On 5/8/25, SSD G sent a cropped screenshot of a temporary nursing license to administrator A. The effective and expiration dates on that license had been altered from the original temporary nursing license that was issued by the SD BON.SSD G was terminated from employment on 5/8/25. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 8/6/25 after record review revealed the facility had followed their quality assurance process and:Local law enforcement, the SD BON, the SD Department of Social Services, the SD Department of Health (DOH), the facility's medical director, and the Office of the Inspector General were notified SSD G had falsified her temporary nursing license. An audit and review of SSD G's documentation between 1/18/25 and 5/7/25 in all residents' electronic medical records (EMR) was completed. An audit of medication administration variances for SSD G during that time frame was completed. A risk audit was completed to identify tasks SSD G had completed that would have been outside of her scope of practice. An audit was completed of skilled nursing care SSD G had provided for Medicare, managed care, and VA (Veterans Administration). An Ad Hoc QAPI (Quality Assurance and Process Improvement) meeting was held on 5/8/25 to identify a process for improving the tracking and management of staff's professional certifications and licenses. This resulted in a facility-wide audit of all applicable staff certifications and licenses. No additional staff were identified as having lapsed or absent certifications or licenses. Monthly audits will continue, and the findings will be discussed during QAPI meetings. HR director H was educated on 5/9/25 regarding professional certification and license verification, and background check expectations. Administrator A and DON B were educated on 5/13/25 regarding their responsibility for ensuring facility staff had completed their roles and responsibilities, certifications, and licenses of all applicable staff were verified, and the newly established process regarding licensed nurses working in the facility with a temporary nurse license was followed. Based on the above information, non-compliance at F726 occurred on 1/18/25, and based on the provider's implemented corrective actions beginning on 5/7/25, for the deficient practice confirmed on 8/6/25, the non-compliance is considered past non-compliance.

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) complaint intake review, record review, interview, and policy review, the provider failed to ensure:During a June 2025 facility COVID-19 outbreak, all residents' COVID-19 testing and test results had been appropriately documented per the provider's policy.Prior to discharge of one of one closed record sampled resident (1) to another nursing home on 6/18/25, the receiving nursing home received disclosure of a COVID-19 outbreak at the provider's nursing home.Accurate and appropriate documentation of the administration of one of one closed record sampled resident's (1) second step of a 2-step tuberculosis (TB) test was conducted. Findings include: 1 Review of the 6/24/25 SD DOH complaint intake revealed:The provider had discharged resident 1 on 6/18/25. She was transported via public transportation and admitted to another nursing home approximately 100 miles away on that same day. The resident was wearing a face mask upon arriving at the receiving nursing home. The driver who transported the resident told staff at the receiving nursing home that the discharging provider had an active COVID-19 outbreak. The driver indicated the resident was coughing quite a bit on the way down [during the drive to the receiving facility]. We [the receiving nursing home] were not informed of the COVID [COVID-19] outbreak at their [the provider's] facility. The above information provided by the driver prompted the receiving nursing home to change the resident's initial room assignment from a semi-private room to a private room, and plans to ensure prevention of [a] COVID [COVID-19] outbreak were initiated.Upon arrival at the receiving nursing home, She [resident 1] stated she had chills, and she was assessed as having a productive cough. Resident 1 was tested at that time for COVID-19 test and the test result was positive.Review of resident 1's EMR revealed:Her admission date was 6/3/25.She was tested for COVID-19 during the provider's June 2025 COVID-19 outbreak on 6/13/25. That test was negative. There was no documentation in her EMR that indicated she had any other COVID-19 tests completed in June 2025.Review of her 6/15/25 through 6/17/25 Nursing Daily Evaluation assessments revealed that resident 1 was assessed and she was non-symptomatic (had no symptoms) for the following: her respirations, lung sounds, and respiratory virus monitoring (cough, running nose/sneezing, sore throat, headache, shortness of breath, temperature, and muscle aches). No Nursing Daily Evaluation assessment was documented on 6/18/25, the day of resident 1's discharge. Interview on 8/7/25 at 8:20 a.m. with Infection Preventionist (IP) E revealed:A symptomatic resident had tested positive for COVID-19 on 6/9/25. A second symptomatic resident had tested negative on 6/9/25, was retested again a short time later, and was positive for COVID-19. A nurse manager used a resident list with the residents' room numbers on it to ensure all residents were tested for COVID-19 on 6/9/25, 6/11/25, and 6/13/25. The test result for each resident's test was noted beside their name on those lists. The dates of all residents' COVID-19 testing and the results of all those tests were then expected to have been transferred from those lists to their EMR by the nurse manager who administered the COVID-19 test. The above resident lists had been discarded after test results had been transferred to a resident's EMR.IP E had only kept a spreadsheet that listed the names of those residents who had tested positive for COVID-19 during the June 2025 outbreak. There were progress notes in their EMRs regarding their COVID-19 testing and COVID-19 test results.Twenty-four residents had tested positive for COVID-19 during the June 2025 outbreak. The facility's census on 6/10/25 was 67 residents.Continued interview with IP E and review of resident 1's EMR revealed:There was documentation that resident 1 had only been tested for COVID-19 on 6/13/25. That COVID-19 test result was negative.There was no documentation to support that the provider had communicated to the receiving nursing home that they had a COVID-19 outbreak when resident 1 was transferred to their facility on 6/18/25. IP E agreed that communication failure had potentially placed the receiving nursing home at risk for its own COVID-19 outbreak.Interview on 8/7/25 at 11:15 a.m. with administrator A, director of nursing (DON) B, and assistant DON C revealed:Resident 1 was admitted to the facility on [DATE].All residents were tested for COVID-19 on 6/9/25, 6/11/25, and 6/13/25. ADON C had administered and read all residents' 6/13/25 COVID-19 tests. Documentation of those administered tests, and test results were entered in all residents' EMRs by ADON C. There was no similar documentation completed by other nurse managers for their 6/9/25 and 6/11/25 COVID-19 test administration and test results.Only the 6/13/25 COVID-19 test administration and negative test result was documented in resident 1's EMR. The nurse manager who had completed the 6/9/25 and 6/11/25 resident COVID-19 tests was expected to have documented the negative COVID-19 test results for all applicable residents, but that had