STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH STREET , RAPID CITY, South Dakota, 57701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/18/26 through 2/20/26. Avantara North was found not in compliance with the following requirements: F658 and F695.	F0000		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure professional standards were met regarding one of one sampled resident (64) who was not prescribed a dose amount for his lidocaine (pain) medication by his physician, and two of two registered nurses (RN) (E and F) administered that medication without knowing the recommended amount. Findings include: 1. Observation and interview on 2/19/26 at 5:37 p.m. with registered nurse (RN) E in the main dining room revealed: *RN E was preparing medications for resident 64. He had a physician's order on his medication administration record (MAR) to receive "Lidocaine Viscous HCL Mouth/Throat Solution 2% [percent]" with the instructions to apply "one application [to the] mucous membrane (inside of the mouth) three times a day for oral pain, apply the medication directly to the affected area with a cotton swab, allow to sit TID (three times a day) before meals." The medication came in a bottle with those same instructions printed on the	F0658	1.RN E and RN F have been educated on the facility policy for "Medication Administration General Guidelines" to include review and confirmation of medication orders for each individual resident on the Medication Administration Record. Resident 64 was seen by the provider on 2/20/26, to address mouth pain and the oral lidocaine order. The oral lidocaine was discontinued as resident 64's mouth pain has resolved. 2.All residents are at risk for adverse effects related to nursing staff not reviewing and confirming medication orders for each individual resident. A house audit of all orders for each resident was completed to ensure dose amounts are prescribed. 3.The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the Medication Administration General Guidelines policy. The Admin, DON or designee will educate nursing on this policy to ensure review and confirmation of medication orders for each individual resident on the Medication Administration Record. Education will occur no later than April 6, 2026, and those not in attendance due to vacation, sick leave, or casual work status will be educated prior to their first shift worked.	04/06/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Celina Block	Administrator	03/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

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AVANTARA NORTH	1620 NORTH 7TH STREET , RAPID CITY, South Dakota, 57701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0658 SS = D	Continued from page 1 label. The lidocaine medication label and resident 64's MAR did not indicate the dose of lidocaine to be given per application. *RN E prepared resident 64's lidocaine medication. She stated that she usually poured about 5 mL (milliliters) of the medication into a clean medication cup. She would then use a clean cotton-tipped applicator to soak up the medication and apply the medication-soaked cotton-tipped applicator to resident 64's gums. She performed this process and administered the medication to resident 64. 2. Review of resident 64's electronic medical record (EMR) revealed: *His dentist removed the last six of his remaining teeth on 11/6/25. His goal was for his mouth to heal and then obtain dentures. *His primary care provider assessed him on 12/9/25 and noted that he had swelling along his top left gum line and a white pustule (a small blister or pimple containing pus) present in that area. The provider referred resident 64 back to the dentist and ordered "Lidocaine ointment 5%: apply to affected oral mucosa TID PRN (as needed) before meals; adults may use up to 5 grams (250 mg [milligrams] lidocaine base) per application, with a maximum of 17-20 g [grams] (850-1000mg) per day." *A 12/10/26 nursing progress note indicated "per Pharmerica [the resident's pharmacy], Lidocaine ointment 5% cannot be applied to oral mucosa. Pharmacy does have viscous lidocaine 2% that they can send which is a thick consistency and can be applied to that area. VERBAL ORDER RECEIVED TO CHANGE TO VISCOUS LIDOCAINE - see MAR". -The order got changed to the instructions in finding 1. *He had a dentist's appointment on 12/17/25. Upon return to the facility, the resident had two surgical incisions on his top left gums from the dentist draining the pustule. *Resident 64 continued to get lidocaine 2% viscous solution to his gum line until the order was discontinued on 2/20/26. His recorded pain levels from 12/10/25 through 2/20/26 ranged from zero to eight on the 10 point pain scale.	F0658	4.The Admin, DON or designee will audit 5 residents to ensure medication orders have dose amounts are prescribed. Audits will be weekly for 4 weeks, bi-weekly for 2 months, and monthly for 2 months. Results of the audits will be discussed by the Admin, DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	

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F0658 SS = D	Continued from page 2 3. Interview and observation on 2/20/26 at 7:34 a.m. with RN F revealed: *She gave resident 64 his lidocaine dose that morning before he ate breakfast. She opened the medication cart upon request, and the lidocaine box that held the bottle of lidocaine medication indicated that the usual dosage for adults was "15 mL (one tablespoon)". *She acknowledged that she did not measure the dose of lidocaine before she administered it to resident 64 earlier that day, and that she used less than the box's recommended amount. *She reported that resident 64 complained of occasional pain in his mouth while eating. 4. Interview on 2/20/26 at 10:13 a.m. with assistant director of nursing (ADON) C and director of nursing (DON) B revealed: *They acknowledged that resident 64 did not have a dosage amount for his lidocaine, and that this was one of the five rights of medication administration. *They felt resident 64 could have been underdosed or overdosed by not having a dosage amount listed on his MAR for the administration of that medication. 5. Interview on 2/20/26 at 10:22 a.m. with resident 64 revealed: *He communicated by using "yes" or "no" questions. When asked if he had pain, he held up nine fingers. When asked if he had pain in his gums, he was able to answer "no". He could not answer where his pain was located to this surveyor. 6. Interview on 2/20/26 at 11:13 a.m. with administrator A revealed: *She acknowledged that resident 64 did not have a dosage amount for the lidocaine medication. She expected the residents to have complete orders for medication administration and the staff to reach out to the provider for clarification if a medication did not have a dosage amount to administer. 7. Review of the provider's September 2018 medication	F0658		

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F0658 SS = D	Continued from page 3 administration policy revealed: *"Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR with the medication label. If the label and MAR are different…or if there is any other reason to question dosage instructions, the prescriber's orders are checked for the correct dosage schedule."	F0658		
F0695 SS = E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure infection control practices were followed regarding the residents' nasal cannulas being dated and stored in plastic bags when they were not in use for four of four sampled residents (1, 9, 11, and 15) who required the use of oxygen, and one of one sampled resident (11) who used a nebulizer (a device that converts liquid medication into an inhalable mist) machine that was not cleaned after each use by the nursing staff. Findings include: 1. Observation and interview on 2/18/26 at 9:01 a.m. with resident 15 in his room revealed: *He was lying in his bed. *He had an oxygen concentrator in his room that was running, and it had oxygen tubing and a nasal canula (flexible tubing with prongs that deliver oxygen through the nose) connected to it. *The oxygen tubing and nasal canula were lying on the floor.	F0695	1.Residents 1, 9, 11, and 15 had their oxygen tubing and nasal canula changed, dated, and stored properly. Resident 11 also had their nebulizer machine cleaned and stored properly per policy. 2.All residents are at risk for adverse effects related to staff not following the facility Oxygen Administration and Nebulizer Cleaning policies. An audit of all residents with oxygen orders was completed to ensure all oxygen tubing and nasal canula's were changed, dated and are stored properly. An audit of all residents with nebulizers was completed to ensure they are cleaned and stored properly per policy. 3.The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the Oxygen Administration and Nebulizer Cleaning policies. The Admin, DON or designee will educate all staff on these policies to ensure infection control practices are followed regarding oxygen tubing, nasal cannulas and nebulizers. Education will occur no later than April 6, 2026, and those not in attendance due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4.The Admin, DON or designee will audit 5 residents to ensure infection control practices are followed regarding oxygen tubing, nasal cannulas and nebulizers. Audits will be weekly for 4 weeks, bi-weekly for 2 months, and monthly for 2 months. Results of the audits will be discussed by the Admin, DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	04/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

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F0695 SS = E	Continued from page 4 *He said, "I don't really need it [oxygen], but they're making me wear it." Further observation on 2/18/26 at 11:56 a.m. in resident 15's room revealed he was sitting in his wheelchair, with the oxygen tubing and nasal cannula attached to the portable oxygen tank. The part of the nasal cannula that would go into the resident's nose was touching the wheel of the wheelchair that had contact with the floor. Observation and interview on 2/20/26 at 10:55 a.m. with infection preventionist (IP) G in resident 15's room revealed: *The oxygen tubing and nasal canula connected to the concentrator were wrapped around the bedrail. *That did not meet her expectation of how the oxygen tubing and nasal canula should be stored. She would expect the oxygen tubing and nasal canula to be stored in a plastic bag while not in use by the resident according to the provider's policy. 2. Observation on 2/18/26 at 9:44 a.m. in resident 1's room revealed: *He was sitting in his wheelchair. *He had an oxygen concentrator in his room with oxygen tubing and a nasal canula connected to it. The oxygen tubing and nasal canula were draped across his bed and hanging off the side of it. Further observation on 2/18/26 at 4:06 p.m. in resident 1's room revealed that the oxygen tubing and nasal canula that were attached to the concentrator were lying on the floor. 3. Observation on 2/18/26 at 12:03 p.m. in resident 9's room revealed: *She had an oxygen concentrator with a nasal cannula attached to it. There was no date on the tubing of that nasal cannula to indicate when it was last changed. Review of resident 9's EMR revealed:	F0695		

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F0695 SS = E	Continued from page 5 *She had a physician's order for "one to two liters as needed to keep oxygen saturation (percentage of oxygen in the blood) above 90% [percent]." The progress notes indicate that she would occasionally need oxygen after experiencing a seizure (a sudden, uncontrolled electrical activity in the brain that can cause temporary changes in behavior, movement, awareness, or sensation). *There was no physician's order to change the resident's nasal cannula tubing. 4 Observation on 2/18/26 at 12:09 p.m. with resident 11 in her room revealed: *She was sitting in her wheelchair that had a portable oxygen tank on the back. The oxygen tubing and nasal canula that were attached had a label dated "12/28." *There was an oxygen concentrator in her room that had oxygen tubing and a nasal canula connected to it dated "12/28." *There was a nebulizer machine on her nightstand that had the tubing and mask connected to it, and the medication chamber had liquid inside. The nebulizer mask was lying directly on the nightstand, uncovered. Further observation and interview on 2/19/26 at 11:02 a.m. with resident 11 in her room revealed: *The nebulizer machine was in the same condition as observed on 2/18/26. *She used the nebulizer machine three times per day. *She said some staff members do take the nebulizer mask off, rinse it, and let it dry between treatments, and others did not. Observation and interview on 2/20/26 at 10:53 a.m. with IP G in resident 11's room revealed: *The nebulizer machine was in the same condition as observed on 2/18/26 and 2/19/26. *She acknowledged that the nebulizer machine was not being cleaned and stored according to the provider's policy. She would expect staff to rinse the medication chamber and mask, then place them on a clean paper towel or cloth to dry.	F0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

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F0695 SS = E	Continued from page 6 5. Interview on 2/20/26 at 8:51 a.m. with registered nurse (RN) H revealed: *The residents who needed oxygen had a physician's order to change their nasal cannula and oxygen tubing weekly. Those orders generated a task for the staff to document when it was completed. That task was performed on Sunday nights by the overnight staff. *The staff were expected to discard the resident's soiled nasal cannulas and write the current date on the new nasal cannulas. *She confirmed that resident 9 did not have a physician's order to change her nasal cannula. *She confirmed that the nasal cannula in resident 9's room did not have a date written on it and confirmed that the nasal cannula change was not documented in her electronic medical record (EMR). She agreed that without a date or documentation of the nasal cannula change, it was unknown how old that nasal cannula was. 6. Interview on 2/20/26 at 10:13 a.m. with assistant director of nursing (DON) B and director of nursing (ADON) C revealed: *That if a resident did not have a physician's order to change their nasal cannula, then the staff would not be prompted to change it weekly per the provider's policy. They acknowledged that there was no indication of when resident 9's nasal cannula was last changed. 7. Interview on 2/20/26 at 11:02 a.m. with DON B and ADON C regarding the above observations of storage and cleaning of respiratory equipment revealed: *They agreed that the respiratory equipment was not being properly stored and cleaned following the provider's policy, which increased the risk of infection control issues. They expected the staff to follow the provider's cleaning policies for resident medical equipment. 8. Review of the provider's 11/18/25 Oxygen Administration policy revealed: *"The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose.	F0695		

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F0695 SS = E	Continued from page 7 The nasal cannula and tubing will be changed weekly and as needed. Change of tubing and cannula should be documented. When not in use, the nasal cannula should be stored in a plastic bag." 9. Review of the provider's 1/14/26 Nebulizer Cleaning policy revealed: "After each use, the mask/reservoir will be cleaned. Rinse mask/reservoir with tap water and place upside down to dry on a paper towel or cloth towel." 10. Review of the provider's undated Guidelines for Legionella Control revealed: *"Identify Areas Subject to Legionella, Colonization and Growth" -"5.) Respiratory therapy equipment" *"Control Measures & Corrective Action" -"...Nebulizers are cleaned after each use by nursing."	F0695		

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 2/18/2026. Avantara North was found in compliance.	E0000		

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 reverse for further 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
Celina Block	Administrator	03/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 2/18/2026 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara North was found in compliance.	K0000		

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 reverse for further 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
Celina Block	Administrator	03/09/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10665	A. BUILDING: _____ B. WING _____	02/20/2026

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/18/26 through 2/20/26. Avantara North was found in compliance.	S 000		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Celina Block

TITLE
Administrator

(X6) DATE
03/09/2026