STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435059	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LAKE NORDEN	803 PARK STREET POST OFFICE BOX 139, LAKE NORDEN, South Dakota, 57248

(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 7/7/26 through 7/9/26. Avantara Lake Norden was found not in compliance with the following requirements: F744, and F883.	F0000	1. Resident 7's care plan as been re-viewed to ensure individualized dementia care interventions are in place to address activities, wandering, and exit seeking. Resident 7's elopment evaluation was completed on July 30, 2026. The blood glucose testing supplies and sharps containers were removed from Resident 40,1, and 26's room. All residents out-side of the secured Alzheimer's Unit have the potential to be affected by a wandering resident's behaviors; un-secured blood glucose testing supplies/ lancets. Residents assessed to be at risk for elopement are at risk of leaving the facility without staff knowledge. 2. All resident rooms were checked and all unsecured blood glucose testing supplies and sharps container were removed from resident rooms. All residents outside of the secured Alzheimer's Unit have an elopement evaluation completed and care plan reveiwed to ensure risk is identified and interventions are in place. The Alzheimer's Care Director provided education to all staff on care techniques and interventions for those with dementia, wandering, and elopement risk. The Director of Nursing (DON) eduated all nursing staff that unsecured blood glucose testing supplies cannot be stored in any resident room. Education will occur no later than August 23, 2026. Those not in attendance at education sessions will be educated prior to their first shift worked.	8/23/26
F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to develop and implement interventions to address dementia (a group of symptoms affecting memory, thinking, and social abilities) care needs for one of one sampled resident (7), who wandered the hallways, attempted and successfully opened the facility's exit doors, and entered other residents' rooms that contained potentially hazardous blood sugar monitoring supplies. Findings include: 1. Observation on 7/7/26 at 9:22 a.m. from 9:22 a.m. through 11:25 a.m. revealed that resident 7 walked up and down the hallway outside of her room, telling the staff, "I just have to keep busy." Director of nursing (DON) B attempted to redirect resident 7 to a recliner near the nurse's station, telling her to "rest and put your feet up for a while." Resident 7 moved between the recliner in the living area, the main dining room, and the assisted dining room during the next two hours. 2. Interview on 7/7/26 at 9:28 a.m. with resident 30 revealed that she used her call light to summon the staff when resident 7 entered her room.	F0744		

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
Margaret Grimm	Administrator	07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435059	A. BUILDING B. WING	07/09/2026

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F0744 SS = D	Continued from page 1 3. Interview on 7/7/26 at 9:30 a.m. with resident 37 revealed that he kept a mesh stop sign on his doorway to prevent resident 7 from entering his room. 4. Observation on 7/7/26 at 11:17 a.m. in the living area revealed that resident 7 got up from an electric recliner in the living area. She spoke to another resident sitting in a recliner, touched the other resident's shoulder, and tried to get the resident to get up and walk with her. A staff member who was nearby in the dining area told resident 7 "no" and directed her to sit down in a recliner, gave her a blanket, and told her to "relax." At 11:25 a.m., resident 7 attempted to get out of the recliner. When she could not manually put the recliner's footrest down, she climbed out of the chair. She then moved among other residents in the main dining room, retrieved a clothing protector and a napkin from one table, and carried it with her into the assisted dining room. Staff members greeted her as they escorted other residents into the assisted dining room for the noon meal. 5. Interview on 7/7/26 at 11:31 a.m. with administrator A revealed that all doors were alarmed, and any residents who were an elopement risk resided in the Alzheimer's Care Unit (ACU). She stated, "[Resident 7] is not an elopement risk." 6. Observation on 7/7/26 at 11:36 a.m. revealed there was a stop sign on the exit door in the assisted dining room. Resident 7 wandered into the assisted dining room and stated she wanted to go home to her mom and dad because school was almost done. 7. Observation on 7/7/26 at 11:49 a.m. revealed resident 7 wandering in the main dining room. She collected a set of silverware and a glass of water from one table, went into the assisted dining room and sat down at a table. She attempted to get up from the chair, and the staff redirected her to sit back down. 8. Observation on 7/7/26 at 11:51 a.m. revealed that resident 7 exited out the assisted dining room door and stood holding it open as she looked around at the parking lot. At 11:52 a.m., assistant director of nursing (ADON) F reached the door that resident 7 was holding open. She redirected resident 7 back inside and to her seat in the assisted dining room. 9. Interview on 7/7/26 at 11:52 a.m. with ADON F indicated that resident 7 sometimes pushed on the	F0744	3. The DON or designee will audit the following: Five random observations of hallways or other common areas at random times of the day to ensure residents are not wandering/exit seeking and Residents appear engaged in meaningful activities/activities of their choice. The DON or designee will also audit 5 random rooms to ensure there are no unsecured blood testing supplies or sharps containers in resident rooms. Audits will be weekly for four weeks and then monthly for two months. The audits will be presented by the DON at the monthly QAPI meeting for analysis and recommendations for continuation, discontinuation or revision of audits based on findings.	

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F0744 SS = D	Continued from page 2 door handles, depending on her mood. 10. Observation on 7/7/26 at 12:04 p.m. in the assisted dining room revealed resident 7 was agitated, stuck her tongue out at the nurse, told the nurse to go home, refused to take her medication from the nurse, and threatened to throw her medication in the nurse's face. 11. Interview on 7/7/26 at 12:10 p.m. with licensed practical nurse (LPN) K revealed that resident 7 could become agitated when there was a lot of activity going on. LPN K said resident 7 tried to push open the edit doors at times but had never gotten outside. She thought the staff had once found resident 7 in the entryway between the two front exit doors. 12. Observation on 7/7/26 at 12:11 p.m. revealed that dietary aide J stopped resident 7 from attempting to follow her into the locked kitchen and laundry hallway. Resident 7 called the aide a "a battleaxe" and walked down the hallway toward her room. Social services director (SSD) P intercepted resident 7 and CNA R took resident 7 back to the assisted dining room. 13. Observation on 7/7/26 at 12:21 p.m. revealed that a staff member directed resident 7 to sit next to her in the assisted dining room. Resident 7 was holding a stack of clothing protectors and asked, "Why is everyone picking on me today?" At 12:26 p.m., resident 7 stood up and the staff told her to sit down. Resident 7 stated, "No, why don't you?" Meals were served to other residents at her table and resident 7 tried taking another resident's glass of water. A CNA said, "This is not your water," and asked resident 7 to sit down. At 12:27 p.m., resident 7 was served her lunch. She stood up, picked up her plate and tried to walk away with it. The CNA attempted to redirect her and resident 7 told her to "back up." Resident 7 started to walk away with the plate of food. 14. Observation on 7/7/26 from 12:28 p.m. through 12:45 p.m. revealed that resident 7 exited the assisted dining room with her plate and a glass of water. She told ADON F she wanted to eat in her room. ADON F redirected resident 7 to a recliner in the living area. Resident 7 refused to sit in the recliner and returned to her seat at the assisted dining table. At 12:31 p.m., resident 7 left the assisted dining room with ADON F and went to her room. ADON F brought resident 7 back to the assisted dining room at 12:45 p.m.	F0744		

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F0744 SS = D	Continued from page 3 15. Observation on 7/7/26 at 2:15 p.m. revealed resident 7 rocking two baby dolls in a recliner near the nurse's station while listening to music. 16. Observation 7/7/26 at 2:31 p.m. in the living area revealed that DON B put resident 7's feet up in the recliner. Resident 7 told her, "No." DON B told her to try to go to sleep and walked away from her. Resident 7 became anxious and called out for someone to come over to her. A surveyor walked over to her and talked to her. 17. Review of resident 7's electronic medical record (EMR) revealed that she admitted to the facility on 6/19/25. She had diagnoses of severe cognitive impairment related to dementia, poor short-term memory, akathisia (an inability to control movements such as pacing or rocking), and a history of repeated falls related to her wandering behaviors. Her 6/1/26 Brief Interview for Mental Status (BIMS) assessment score was zero, indicating she had severe cognitive impairment. Resident 7's 6/2/26 elopement assessment had a score of five, meaning she was a low risk for elopement. The assessment indicated she had not "attempted or had an actual elopement in the last year;" she wandered throughout the facility "and does not respond to staff direction;" she "attempts to leave the facility unsupervised and does not respond to staff redirection;" she required frequent monitoring; and that the staff should be made aware of resident 7's risk of wandering and/or eloping. SSD P commented on the assessment, "She has attempted [to] exit, but not trying to leave necessarily." Resident 7's 7/7/26 care plan indicated that her care should enable her to "function at [her] most practical level and support the process that will enable [resident 7] to be comfortable in the LTC [long term care] setting." Her behaviors included moving care items and her roommate's items throughout her room, striking out at the staff, collecting items throughout the facility, rummaging, and making accusatory statements and negative comments toward others. Behavior interventions in her care plan included frequent monitoring, one-to-one time with the staff, and providing a blue basket of belongings for her to rummage through, along with a therapy baby, a stuffed cow, and magazines. Resident 7's care plan indicated she was able to independently move about the facility. It read, "Resident is potential for elopement," and directed the staff to "gently redirect away from the door if attempting to exit seek."	F0744		

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F0744 SS = D	Continued from page 4 Review of resident 7's EMR and the provider's grievance log revealed that resident 7 had resident-to-resident altercations on 11/29/25 and was to be redirected from entering other residents' rooms. On 2/10/26, she slapped another resident's hand. On 4/11/26, resident 7 threw a box of Kleenex at her roommate. On 4/30/26, when she wandered into resident 15's room and moved some of her belongings, the grievance resolution was for the staff to "attempt to close [resident 15's] privacy curtain when she leaves her room to redirect [resident 7] from entering and rummaging through her belongings." 18. Observation on 7/8/26 at 8:03 a.m. revealed that resident 7 wandered into the resident hallway by ACU entrance door, carrying a stuffed animal and a blanket. The staff redirected her to sit in a recliner in the day area. 19. Observation on 7/8/26 at 8:06 a.m. revealed resident 7 standing by the exit door in the activity area. She moved items off the activity cart to the counter and reached into the drawers. SSD P redirected her to the assisted dining room. 20. Observation on 7/8/26 at 8:12 a.m. in resident 7's room revealed she did not have a basket of activity items and had stuffed animals on her bed. 21. Observation on 7/8/26 at 10:30 a.m. at the nurse's station revealed resident 7 walk between the staff offices and the main entry door. She attempted to open locked doors to restrooms and the staff's medication room and then entered DON B's office. At 10:34 a.m. she entered resident 1's room and was redirected back to the hallway by a staff member. At 10:42 a.m., resident 7 wandered into the business office, and business office and human resources manager I redirected her out of the office. 22. Observation on 7/8/26 at 11:02 a.m. in resident 40's room revealed that her blood glucose testing supplies were stored in an unlocked pencil box in her closet, next to a container storing used blood glucose testing strips, bloody cotton swabs, and used lancets (a small, sharp, sterile needle designed for a single-use skin prick, primarily used to draw a small drop of capillary blood for testing blood sugar levels in diabetes management). The container's lid was open to provide access to the used supplies. 23. Review of resident 40's electronic medical record (EMR) revealed that she had a Brief Interview for Mental Status (BIMS) assessment score of 6,	F0744		

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F0744 SS = D	Continued from page 5 indicating she was severely cognitive impaired. She had a diagnosis of type 2 diabetes mellitus (a chronic condition where the body cannot resists insulin or cannot produce enough of it, leading to high blood sugar) and moderate dementia (a group of symptoms affecting memory, thinking, and social abilities). Her care plan indicated she had fluctuating cognitive impairment and poor safety awareness, and that the staff were to use cueing and task breakdown while allowing her to do as much on her own as possible. She was able to propel herself around her room independently using her wheelchair and used a handheld bell to alert the staff when resident 7 entered her room. 24. Interview on 7/8/26 at 11:05 a.m. with registered nurse (RN) D revealed that while blood glucose testing supplies for residents in the Alzheimer's Care Unit (ACU) were kept in the unit's locked med cart, testing supplies for all non-ACU residents were stored in unlocked pencil boxes in the residents' closets. She said the supplies were not a potential hazard for resident 40, resident 7, or others who were cognitively impaired or wandered into other residents' rooms, because they "don't usually open closet doors." 25. Observation on 7/9/26 at 8:34 a.m. in resident 1's room revealed that her blood glucose testing supplies were kept in an unlocked pencil box in her closet. A small container next to the pencil box was open to provide access to used lancets and bloody testing strips and cotton swabs. 26. Review of resident 1's EMR revealed that she had a BIMS assessment score of zero, indicating she was severely cognitively impaired. She had a diagnosis of type 2 diabetes mellitus, unspecified symptoms and signs involving cognitive functions and awareness, and aphasia (a neurological disorder that impairs a person's ability to speak, write, and understand language). Her care plan indicated she was unable to verbalize needs but used hand gestures to communicate. The staff were to use simple, direct communication and repeat themselves if resident 1 was unable to understand. She used a walker and a wheelchair to independently propel herself around the facility, and she used a bell to alert staff when resident 7 entered her room. 27. Observation on 7/9/26 at 8:36 a.m. in resident 26's room revealed that his blood glucose testing supplies were kept in an unlocked pencil box in his closet. A small container next to the pencil box was open to provide access to used lancets and bloody testing strips and cotton swabs.	F0744		

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F0744 SS = D	Continued from page 6 28. Review of resident 26's EMR revealed that he had a BIMS assessment score of 8, indicating he was moderately cognitively impaired. He had a diagnosis of type 2 diabetes mellitus, unspecified moderate dementia with behavioral disturbance, and severe bipolar disorder. His care plan indicated he had fluctuating impaired mental status and a tendency to wander independently throughout the facility using his front-wheeled walker (a mobility aid with two fixed front wheels and two rear glide caps, offering steady, weight-bearing support). His care plan included an intervention to keep potentially harmful items out of reach, including his cigarettes and lighter, which the staff kept in a locked box at the nurse's station. 29. Review of resident 46's EMR revealed that she wandered the halls and had poor safety awareness. She had a BIMS assessment score of zero, indicating she was severely cognitively impaired. She had a diagnosis of severe dementia with behavioral disturbance and Alzheimer's Disease (a progressive, irreversible brain disorder that accounts for 60 to 80 percent of dementia cases). Her care plan indicated she also had aphasia, used cueing and gestures to communicate, and exhibited behaviors that included urinating in inappropriate places. Resident 46's care plan revealed that she previously resided in the ACU but transferred to the non-ACU part of the facility on 6/3/26. To deter her roommate from rummaging through her belongings, resident 7 had child safety locks installed on her nightstand drawers. 30. Interview on 7/9/26 at 10:14 a.m. with CNAs G and H revealed that when resident 7 wandered into other residents' rooms, the staff were to redirect her to rest in a reclining chair or her bed, or to give her an activity to do at one of the dining room tables. CNA H stated resident 7 has tried to open "any and every door." CNA G said, "We [the staff] just try to keep a good eye on her and try to intervene if we see her bothering another resident or going into someone's room." 31. Interview and observation of the ACU resident rooms on 7/9/26 at 10:48 a.m. with RN L confirmed that all blood glucose testing supplies for the ACU's diabetic residents were kept in the unit's locked med cart. RN L stated that because the ACU residents are cognitively impaired, no medications or supplies are kept in their rooms, other than incontinence supplies. She said resident 7 was "not a good fit" for the ACU because she would be bothered by some of the unit's residents who	F0744		

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F0744 SS = D	Continued from page 7 constantly followed others around. 32. Interview on 7/9/26 at 11:30 a.m. with resident 20 revealed that she kept her door closed to prevent resident 7 from entering her room and stealing her belongings. 33. Interview on 7/9/26 at 12:27 p.m. with business office and human resources manager I revealed that all facility staff received training to care for residents with dementia, including how to handle aggressive behaviors and respond to resident elopements. 34. Interview on 7/9/26 at 3:13 p.m. with DON B revealed she agreed resident 7's cognitive impairment meant she was vulnerable and relied on the staff to meet her daily needs. She expected the staff to reference a resident's care plan to know how to care for them, including how to redirect cognitively impaired residents. She approved of the staff's repeated attempts to have resident 7 sit in a recliner near the nurse's station, stating it would benefit resident 7 to elevate her feet and rest. To minimize resident 7's interference with the rights of other residents, DON B said the staff were trained to respond to handheld bells the residents use to indicate resident 7 is in their room, and residents were told not to yell at resident 7 to prevent resident-to-resident altercations from occurring. "We talk to the residents who really have a problem with her, that's how we handle it." DON B said resident 7 used to reside in the ACU but moved to the general care area after the staff determined she was not at risk for eloping. She felt the door alarm systems were successful at deterring resident 7 from exiting the building, despite her lunchtime elopement attempt on 7/7/26. "She [resident 7] has opened doors but we've followed her out," she stated. "We are set up to succeed. Our system worked." DON B confirmed that all diabetic testing supplies for non-ACU residents were kept in an unlocked pencil box in the residents' closets. She stated that the lancets were safety needles (featuring a spring-loaded, auto-retracting needle to prevent reuse) and agreed that the used lancets and blood glucose testing strips were not secure when stored in the residents' closets. 35. Interview on 7/9/26 at 4:11 p.m. with ACU director Q revealed that appropriate redirection for resident 7 would include having her rock baby dolls, listen to music, or fidget with items such as magazines or books. "Basically, you create an	F0744		

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F0744 SS = D	Continued from page 8 environment where she accidentally has to rest, such as rocking her 'babies' while listening to music. But only for a few minutes, tops, because she's busy, busy and going all the time." 36. Review of the provider's current ACU Admission/Discharge Criteria indicated that residents were assessed on a case-by-case basis to determine whether they were appropriate for the ACU. The residents' medical needs should not outweigh the provider's programming needs, and behaviors could include wandering. 37. Review of the provider's 5/14/25 Elopement policy revealed that the facility should take steps to keep the residents safe and assess residents to identify those who were at risk for elopement. 38. Review of the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard revealed that the improper disposal of used lancets and needles is a safety hazard that increases the risk of exposure to bloodborne pathogens from needlestick injuries, including HIV/AIDS (a virus that attacks the body's immune system), hepatitis B (a highly contagious viral liver infection), and hepatitis C (a bloodborne viral infection that causes liver inflammation). Under OSHA's Bloodborne Pathogens Standard, a safe sharps container must be puncture-resistant, leakproof on its sides and bottom, and have a closable lid to prevent spillage or hand entry. 39. Review of the provider's 1/2018 Disposal of Medications and Medication-Related Supplies policy revealed that to avoid risk of needle-sticks, immediately after use, syringes and needles are to be placed into puncture-resistant, one-way sharps containers specifically designed for that purpose. The policy stated, "Whether kept in the medication room or affixed to the medication cart, the disposal containers are fitted with a lid that prohibits reaching into the container."	F0744		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives	F0883		

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F0883 SS = D	Continued from page 9 education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F0883	1. Resident 38 was offered the Pneumococcal vaccine on April 13, 2026, and the vaccine administered July 9, 2026. All newly admitted residents are at risk for not being offered the vaccine upon admission. An audit of all residents will be completed to ensure they have received or declined the vaccine. Audit will be completed by August 23, 2026. 2. The Regional Nurse Consultant educated the Administrator, DON and Infection Prevention nurse on the pneumococcal vaccine policy and that residents should be offered regardless of payor source. Education will occur no later than July 30, 2026. 3. The DON or designee will audit all new admissions to ensure the pneumococcal vaccine is offered upon admission. Audits will be weekly for four weeks and then monthly for two months. The audits will be presented by the DON at the monthly QAPI meeting for analysis and recommendations for continuation, discontinuation or revision of audits based on findings.	08/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435059	A. BUILDING B. WING	**07/09/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0883 SS = D	Continued from page 10 This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to minimize the risk of residents acquiring and transmitting pneumococcal disease by ensuring that one of six sampled residents (38) was offered the pneumococcal vaccination. Findings include: 1. Review of resident 38's electronic medical record (EMR) revealed that he admitted to the facility on 4/13/26 with a diagnosis of pneumonia (an infection that inflames the air sacs in one or both lungs, causing them to fill with fluid or pus). There was no documentation that he was offered and received or declined the pneumococcal vaccine. 2. Interview on 7/9/26 at 2:26 p.m. with assistant director of nursing (ADON) F revealed that she used a spreadsheet to track the residents' vaccination statuses. The facility provided different types of pneumococcal vaccines based on the residents' health status and age, and that some pneumococcal vaccines were two doses administered a year apart. Resident 38 did not receive the pneumococcal vaccine because "Medicare charges the price of the vaccine to the facility, so we are waiting until he's off Medicare to make sure his insurance company pays for the vaccine." 3. Interview on 7/9/26 at 3:13 p.m. with director of nursing (DON) B revealed that she reviewed the resident vaccination statuses during a daily team meeting. She said, "I wish payer source didn't play into that," and that the team would be auditing resident records to determine whether additional residents needed the pneumococcal vaccine. 4. Review of the provider's 1/14/26 Pneumococcal Vaccination - Resident policy revealed that residents were offered the pneumococcal vaccine upon admission to the facility, unless the vaccine had already been received or was medically contraindicated (inadvisable because it carries a high risk of harming the resident). Documentation of vaccine administration or refusal was stored in the resident's EMR.	F0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435059	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2026

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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 7/7/26. Avantara Lake Norden 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
Margaret Grimm	Administrator	07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435059	A. BUILDING **01 - MAIN BUILD...** B. WING	**07/07/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LAKE NORDEN	**803 PARK STREET POST OFFICE BOX 139, LAKE NORDEN, South Dakota, 57248**

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 7/7/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Lake Norden was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K321 & K293 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0293 SS = D Bldg. 01	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain EXIT signs for one of one EXIT sign in the service wing. Findings include: 1. Observation and interview on 7/7/26 at 8:23 a.m. revealed the EXIT sign for the exterior door from the service wing was not illuminated. Further observation revealed the two lamps in the sign were not functioning. Interview with the maintenance director at the time of the observation confirmed that finding.	K0293	1. Lighting for the exit sign for the exterior door from the service wing was replaced on July 9, 2026. All residents have a potential to be impacted by the exit sign not being illuminated. 2. Audit of all other exit signs completed on July 9,2026, with no issues. 3. Housekeeping Director or designee will conduct audits on exit signs that illuminate three times a week for four weeks. Then weekly for four weeks and then monthly for two months. Monitoring results will be reported by the Housekeeping Director or designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	08/23/26

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
Margaret Grimm	Administrator	07/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435059	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 07/07/2026

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K0293 SS = D Bldg. 01	Continued from page 1 The deficiency affected one of numerous requirements for egress signage.	K0293		
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to maintain the laundry room corridor door (would not self-close and latch). Findings include:	K0321	1. The wood floor wedge was removed from the corridor door for the laundry room on July 7, 2026. All residents have potential to be impacted by the wood floor wedge being under the door. 2. Education provided to housekeeping and laundry staff by Maintenance Director on July 8, 2026 regarding the propped open door and the reason why it needs to be closed. 3. Maintenance Director or designee will conduct audits on the laundry door to ensure it is not propped open. Audits will be daily for two weeks, then weekly for four weeks. Audits will be completed monthly for two months. Monitoring results will be reported by the Maintenance Director or designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	08/23/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435059	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/07/2026**

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K0321 SS = D Bldg. 01	Continued from page 2 1. Observation on 7/7/26 at 8:15 a.m. revealed the corridor door for the laundry room was propped open with a wood floor wedge. The laundry was over 100 square feet in area with two commercial gas dryers. Holding the door open would short-circuit the outside combustion air being provided by the 12-inch by 12-inch damper behind the dryers. There was an air draft into the laundry room from the corridor. Interview with the maintenance director at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for hazardous rooms.	K0321		

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
	10639	A. BUILDING: _____ B. WING _____	07/09/2026

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AVANTARA LAKE NORDEN	803 PARK ST POST OFFICE BOX 139 LAKE NORDEN, SD 57248

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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 7/7/26 through 7/9/26. Avantara Lake Norden was found not in compliance with the following requirement: S157.	S 000		
S 157	44:73:02:13 Ventilation A facility shall provide electrically powered exhaust ventilation in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation for the housekeeping storage room and the housekeeping/janitor room in the service wing. Findings include: 1. Observation on 7/7/26 at 8:15 a.m. revealed there was no exhaust ventilation in the housekeeping storage room adjacent to the laundry room. The storage room was over 100 square feet in area and held copious amounts of combustible items. 2. Observation and testing on 7/7/26 at 8:20 a.m. revealed the housekeeping/janitor room in the service wing was over 100 square feet in area and held copious amounts of combustible items. Testing of the exhaust ventilation grille with tissue paper at the time of the observation revealed the	S 157	1. The Maintenance Director ordered new exhaust ventilation for the housekeeping storage room and housekeeping/janitor room on July 8, 2026. The exhaust ventilation was installed in both areas on July 14, 2026. 2. Monthly inspection will be completed on the exhaust ventilation and recorded in TELs by the Maintenance Director. 3. Audits will be conducted by the Housekeeping Director or designee to ensure exhaust ventilations are functioning as they should. Audits will be three times a week for two weeks, then weekly for four weeks, then monthly for two months. Findings from the audits will be presented to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	08/23/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret Grimm
TITLE: Administrator
(X6) DATE: 07/30/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10639	A. BUILDING: _____ B. WING _____	07/09/2026

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S 157	Continued From page 1 exhaust was not functioning. 3. Interview with the maintenance director at the time of the above observations confirmed those findings.	S 157		