STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MOUNTAIN VIEW	916 MOUNTAIN VIEW ROAD , RAPID CITY, South Dakota, 57702

(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 1/4/26 through 1/6/26. Avantara Mountain View was found not in compliance with the following requirements: F554, F583, F658, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/4/26 through 1/6/26. The area surveyed was quality of care related to the provision of residents' care needs, and resident safety regarding accident hazards, elopement, and choking. Avantara Mountain View was found not in compliance with the following requirement: F658, and to have past noncompliance at F684.	F0000		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (34) observed with a medication left at her bedside was evaluated for her ability to safely self-administer that medication. Findings include: 1. Observation and interview on 1/4/26 at 11:40 a.m. with certified medication aide (CMA) L in resident 34's room revealed CMA L administered the resident's eye drops. She then reminded the resident to drink the clear liquid inside the plastic cup on the resident's bedside table. CMA L stated there was lactulose (a	F0554	1.A new Medication Self-Administration Evaluation for resident 34 was completed by Assistant Director or Nursing (ADON), licensed practical nurse (LPN), on 1/29/26 and resident remains unsafe to self-administer medications, and resident does not desire to self-administer medications. Resident 34's room was searched by ADON, LPN on 1/29/26 and verified that no medications were present. Resident 34 does not have physician orders to self-administer medications. Director of Nursing (DON) or designee will complete a full house audit of all resident rooms to ensure residents that have not been deemed safe to self-administer medications do not have medications present in their room no later than 02/04/2026. 2.DON or designee will educate all nurses and certified medication aides (CMA), to include CMA L, on the Self Administration of Medications policy. DON or designee will complete a medication administration competency on CMA L. Education and competency will be completed no later than February 17, 2026. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked.	2/17/2026

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F0554 SS = D	Continued from page 1 medication used to treat symptoms associated with severe liver disease) inside that cup. She left the lactulose on the resident's bedside table during a medication pass earlier that morning. CMA L stated that the lactulose was not pleasant tasting, and leaving it at the resident's bedside enabled the resident to take periodic sips of the lactulose throughout the morning rather than having to drink it all at once. 2. Review of resident 34's electronic medical record (EMR) revealed there was a 4/21/20 physician's order for lactulose to be administered three times per week. There was no order for the resident to have that medication left at her bedside or for her to self-administer it. Resident 34 was evaluated on 11/7/25 for her ability to safely self-administer melatonin, a hormone supplement commonly used to help a person sleep. The resident was deemed "Not safe to self-administer [melatonin]." Factors that determined her inability to self-administer that medication included "dementia or Alzheimer [Alzheimer's disease] that affect their [the resident's] ability to self-administer [the medication]" and "schizophrenia [a mental illness that causes distorted thinking, perception, and behavior]." There was no medication self-administration evaluation completed for the resident's lactulose. 3. Interview on 1/5/26 at 2:45 p.m. with CMA L revealed she did not know if resident 34 was evaluated or deemed safe to have her lactulose left at the bedside to self-administer. CMA L stated that sometime after 11:40 a.m. on 1/4/26, she observed that the cup that had lactulose in it was empty, and resident 34 verbally confirmed to CMA L that she had consumed it. 4. Interview on 1/6/26 at 1:30 p.m. with director of nursing (DON) C revealed she confirmed resident 34 was not safe to self-administer her own medication. CMA L was expected to observe resident 34 consume the lactulose in its entirety before leaving the resident's room and documenting that the medication had been administered. Review of the provider's January 2020 Self-Administration of Medications policy revealed, "Each resident has a right to self-administer medications should they desire, unless this practice is determined unsafe."	F0554	3.DON or designee will observe 5 nurses and/or CMAs, to include CMA L, during medication pass to ensure medications are not left with residents that have not been deemed safe to self-administer medications. Observations will be completed weekly X 4 weeks and then monthly for 2 months. Results of audits will be discussed by the DON or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F0583	1.DON provided verbal education to QMA L and LPN H immediately following the observation of failure to secure the residents protected health information in the electronic medical record (EMR) during the annual recertification survey on 01/05/2026. All residents are at risk.	2/17/2026

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F0583 SS = D	Continued from page 2 §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff protected the residents' right to privacy and confidentiality of their protected health information in their electronic medical records (EMR) that was displayed and viewable to anyone who passed by. Findings include: 1. Observation on 1/4/2026 at 9:45 a.m. revealed there was a laptop computer on top of the medication cart in front of the first-floor nurses' station. That nurses' station was near the end of a resident living unit hallway. The computer screen displayed a list of residents' full names and photographs, along with other identifying information about them. That screen was viewable to anyone passing by the medication cart. 2. Observation on 1/4/26 at 11:20 a.m. revealed the	F0583	2.DON or designee will educate all nurses and CMAs, to include CMA L and LPN H, on the Medication Administration General Guidelines policy. Education will be completed no later than February 17, 2026. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3.DON or designee will observe 5 nurses and/or CMAs, to include CMA L and LPN H, during medication pass to ensure resident protected health information is secured. Observations will be completed weekly X 4 weeks and then monthly for 2 months. Results of audits will be discussed by the 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 audit findings.	

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F0583 SS = D	Continued from page 3 same medication cart in front of the first-floor nurses' station. The computer screen was opened and displayed resident 2's medication administration record (MAR). Certified medication aide (CMA) L was standing about 10 to 15 feet away from the medication cart, administering resident 2's medications. Resident 2 spat out the medication, and CMA L returned to the medication cart and discarded it. She prepared another dose of the same medication for resident 2. CMA L then closed the computer screen before she returned to administer resident 2's medication for the second time. 3. Observation on 1/4/26 at 11:40 a.m. of CMA L revealed she prepared resident 34's eye drops for administration at the medication cart. She left the computer screen on top of the medication cart open. It displayed the resident's MAR. She then walked down the hall to the resident's room to administer those eye drops. After administering the eye drops, CMA L returned to the medication cart and documented the eye drop administration. She reviewed resident 34's opened MAR and realized the resident had additional scheduled medications to administer. CMA L prepared those medications and then closed the computer screen before she left the medication cart to administer those medications. 4. Observation on 1/5/26 at 1:16 p.m. of the first-floor hallway revealed: *A medication cart with an open computer on the top of that cart. *Resident 88's information was displayed on that open computer screen. *There were no employees in the hallway for approximately three minutes. Licensed practical nurse (LPN) H walked into the hallway with a machine used to check vital signs (measurements of the body's basic functions such as blood pressure, pulse, temperature, and respiration rate). 5. Interview on 1/5/26 at 1:19 p.m. with LPN H revealed: *She agreed that she was the last person to use the computer observed above and did not lock the screen,	F0583		

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F0583 SS = D	Continued from page 4 which left resident 88's personal information displayed on it. -*She acknowledged that the resident information was visible to anyone who would walk by that medication cart. -*She acknowledged that someone would be able to access any information and document in the facility's computer system under her name if she did not lock the computer screen. 6. Interview on 1/6/26 at 3:38 p.m. with administrator A revealed: *She expected staff to always maintain the privacy of any resident's information. *She agreed that documentation could be accessed and/or changed by anyone if the computer screen with the resident's electronic medical record was not locked before the staff member left the computer unattended. Review of the provider's September 2018 Medication Administration General Guidelines policy revealed, "18. Resident's health information needs to remain private. The pages of the MAR [medication administration record] notebook [electronic medical record] containing resident health information must remain closed or covered when not in direct use."	F0583		
F0658 SS = E	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, record review, interview, and policy review, the provider failed to ensure the staff followed professional standards of practice to ensure: *The resident's physician was notified that one of two sampled residents (31) with physician's orders for dialysis treatments refused four of those treatments from 12/5/25 through 12/31/25.	F0658	1.ADON, LPN notified Resident 31's physician of refusal to receive dialysis treatment on 12/5, 12/12, 12/19 and 12/24 on 01/05/2026. All residents receiving dialysis treatment will have a record review for dialysis refusals in the last 30 days and notify their physician accordingly no later than February 17, 2026. No immediate corrections could be made to residents 34 and 66 medication administration record (MAR) being signed prior to verifying residents' medication was administered. All residents are at risk of medication administration being documented prior to successful administration. ADON, RN, notified resident 57's physician of the medication error of insulin not being fully administered on 01/06/2026. DON, RN, updated Resident 86's order for Wanderguard on 1/5/26 upon identification during annual recertification survey to ensure order requires documentation that placement of Wanderguard was verified every shift. All residents requiring the use of a Wanderguard are at risk for lack of documentation verifying placement each shift. No immediate correction could be taken for resident 5's residual and placement not being checked appropriately by checking the pH of aspirated stomach contents prior to administration of formula. All residents with an enteral feeding tube are at risk of their residual and placement not being appropriately checked.	2/17/2026

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F0658 SS = E	Continued from page 5 *One of one observed certified medication aide (CMA) (L) administered medications according to the physician's order to ensure the full dose was given for one of one sampled resident (34) with orders for lactulose laxative medication. *One of one sampled resident's (57) insulin was administered according to the physician's order by one of one licensed practical nurse (LPN) (I). *Documentation supported that one of one sampled resident's (86) WanderGuard (a wearable door alarming device) was checked each shift to ensure it was on the resident's ankle and functioning, according to his physician's order and the provider's policy. *One of one sampled resident's (5) gastric tube was checked for placement according to the physician's order and the provider's policy for one of one sampled resident (5) with a tube for receiving nutritional formula, medication, and hydration. Findings include: 1. Review of resident 31's electronic medical record (EMR) revealed: *She was admitted on 5/30/25. *Her diagnoses included: End-stage renal disease, chronic kidney disease stage 5, renal dialysis, type 2 diabetes, and edema. *Her physician's orders included a 6/4/25 order for dialysis treatments on Monday, Wednesday, and Friday. *Her 12/5/25, 12/12/25, 12/19/25, and 12/24/25 nurse progress notes indicated she had refused to go to those dialysis treatments. There was no indication that her physician had been notified of those refusals. *Her dialysis assessment forms for her dialysis treatment dates of 12/5/25, 12/12/25, 12/18/25, 12/23/25, and 12/31/25 were initiated but not completed. There was no indication that her physician had been notified of her refusal to attend her dialysis treatments on those assessment forms. 2. On 1/5/26, resident 31 was at dialysis and not available for an interview.	F0658	2.DON or designee will educate all nurses on the Notification of Change of Condition policy and the requirement to document refusals in the medical record and to notify the physician. DON or designee will educate the nurses and CMAs, to include CMA L and CMA M, on the Medication Administration General Guidelines policy. DON or designee will educate all nurses and CMAs on the Following Physician Order policy and Medication Error policy. The DON or designee will educate all nurses on the Medication Administration Subcutaneous Insulin policy. A subcutaneous insulin pen competency will be completed for LPN I. DON or designee will educate all nurses on Point Click Care (PCC) order entry to include schedule options to allow documentation of completion. DON or designee will educate all nurses, to include LPN I, on the Enteral Feeding (Tube Feeding) policy. A medication/tube feeding competency will be completed for LPN I. Education and competency will be completed no later than February 17, 2026. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. Residents' Dialysis evaluation and progress notes will be reviewed by a nurse manager daily on business days for documentation of refusals and notification to the physician through daily clinical meeting. 3.DON or designee will audit 5 resident Dialysis evaluations, to include resident 31, and progress notes weekly, for documentation of refusals to ensure provider notification. DON or designee will observe 5 nurses and/or CMAs, to include LPN I, during medication administration to ensure documentation of the successful administration of the medication. DON or designee will observe 5 nurses during insulin administration, including LPN I, to ensure physician order is followed, med errors are recorded and reported, and proper timing for insulin injection administration to ensure appropriate dose is received. DON or designee will audit 5 orders for residents requiring a Wanderguard to ensure documentation of placement of the Wanderguard is completed. DON or Designee will observe 5 tube feeding administrations, including LPN I, to ensure appropriate checking of residual and placement of enteral feeding tubes. Audits will be completed weekly X 4 weeks and then monthly for 2 months. Results of audits will be discussed by the 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 audit findings.	

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F0658 SS = E	Continued from page 6 3. Interview and record review on 01/06/2026 at 11:09 a.m. with infection preventionist/LPN K regarding dialysis treatments revealed: *She was aware that resident 31 was to receive dialysis treatments. *When a resident refuses dialysis the nurse should document that in a progress note, and notify the physician. *She was unable to find documentation that resident 31's physician was notified of her dialysis treatment refusals on the above dates. 4. Interview and review of resident 31's EMR on 1/6/26 at 2:24 p.m. with director of nursing (DON) C revealed: *When a resident refused to attend their dialysis treatment, she expected that the resident's physician would be notified and documented by the nurse. *Confirmed there was no documentation in resident 31's EMR that supported that resident 31's physician was notified of her dialysis treatment refusals on 12/5/25, 12/12/25, 12/19/25, and 12/24/25. 5. Review of the provider's 2/20/24 Dialysis Management policy revealed it did not include the process for when a resident refused their ordered dialysis treatments. 6. Interview on 1/6/26 at 2:14 p.m. with regional nurse consultant (RNC) B and DON C regarding dialysis revealed the provider did not have a dialysis refusal policy. 7. Review of the provider's 11/18/25 Notification of Change of Condition policy revealed: *"The facility will provide care to residents and provide notification of resident change in status." *"The facility must promptly inform the resident; consult with the resident's medical provider; and notify, consistent with his or her authority, the resident representative(s) when::" *"A need to alter treatment significantly ... " *"Continued resident refusal of ordered treatments or	F0658		

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F0658 SS = E	Continued from page 7 procedures (at least three consecutive refusals)". 8. Observation and interview on 1/4/26 at 11:40 a.m. with certified medication aide (CMA) L in resident 34's room revealed CMA L administered the resident's eye drops. She then reminded the resident to drink the clear liquid inside the plastic cup that was on the resident's bedside table. CMA L stated there was lactulose (a laxative medication) in that cup. CMA L stated she left the lactulose on the resident's bedside table during a medication pass earlier that morning and planned to check back later to verify that the resident took the lactulose. 9. Review of resident 34's January 2026 medication administration record (MAR) revealed the resident's lactulose was documented as having been administered at 8:00 a.m. on 1/4/26. 10. Interview on 1/5/26 at 2:45 p.m. with CMA L regarding the above observation revealed she documented resident 34's lactulose was administered even though she knew the resident had not yet taken that medication. MAR documentation was not expected to occur until after she had confirmed a medication was taken by the resident. 11. Observation on 1/5/26 at 4:50 p.m. of CMA M preparing resident 66's medications for administration revealed she mixed the resident's MiriLAX (a laxative medication) powder with water inside a drinking cup. She crushed the resident's pills and mixed them with apple sauce inside a medication cup. CMA M had resident 66 take sips of the MiriLAX in between swallowing spoonfuls of the crushed medications. The resident ingested all of the crushed medications, and CMA M returned the cup with remaining MiriLAX in it to the medication cart. She marked that cup with the resident's initials, then documented on the resident's MAR that both the MiriLAX and the crushed medications were administered. CMA M explained she would continue to periodically offer sips of the MiriLAX to the resident until the MiriLAX was gone. This was her usual practice for administering the resident's MiriLAX. CMA M stated that she was not expected to document a medication administration on the MAR without confirming a medication was taken by the resident.	F0658		

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F0658 SS = E	Continued from page 8 12. Observation and interview on 1/6/26 at 8:35 a.m. with LPN I revealed she had checked resident 57's blood sugar level, and the amount of Humalog (insulin) she would then administer to the resident was contingent upon that blood sugar level. 13. Review of resident 57's 11/25/25 Humalog insulin order with LPN I revealed the resident was to be administered two units of Humalog based on the resident's 181 blood sugar reading. The order indicated that insulin was to be administered before meals and at bedtime. The resident also had an order to receive 18 units of scheduled Lantis (insulin). That insulin was to be administered in the morning and at bedtime. 14. LPN I entered resident 57's room with insulin administration supplies and prepared to administer the resident's insulin. She inserted the needle on the Humalog insulin pen into the resident's left lower abdomen, and then pressed the injection button for less than two seconds before removing it from the resident's abdomen. She inserted the needle on the Lantus insulin pen into the resident's lower right abdomen, and then pressed the injection button for less than three seconds before removing it from the resident's abdomen. LPN I stated she had not pressed the injection buttons of either insulin pen for an appropriate amount of time before removing them from resident 57's abdomen. She stated that the injection time should have been ten seconds. That compromised the full dose of both of the insulins from being delivered. LPN I confirmed she had not followed the physician's order to administer resident 57's Humalog before breakfast. That was a medication error. She knew that Humalog was a rapid-acting insulin that worked quickly to manage the expected rise in blood sugar that occurred after eating. 15. Review of the provider's September 2018 Medication Administration General Guidelines policy revealed, "20. The resident is always observed after administration to ensure that the dose was completely ingested."	F0658		

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F0658 SS = E	Continued from page 9 Review of the provider's revised 11/18/25 Following Physician's Orders policy revealed, "9. All physician orders should be followed as written." Review of the provider's revised 2/20/24 Medication Error policy revealed the purpose of that policy was "To ensure medication errors are identified to prevent adverse resident effects." That policy included a Medication Error Report. Section 4 of that report identified classifications of medication errors that included "Wrong Time: not given at scheduled time or interval." Review of the provider's May 2016 Medication Administration Subcutaneous Insulin policy revealed "Keep the injection button pressed all the way. Slowly count to 10 before you withdraw the needle from the skin. This ensures that the full dose will be delivered." 16. Review of resident 86's EMR revealed he was admitted to the facility on 12/2/25 from a hospital. His 12/2/25 Elopement Risk Evaluation indicated he was not at risk for elopement (leaving the facility without staff knowledge). There was no documentation in the progress notes from 12/2/25 through 12/27/25 regarding resident 86 having attempted to elope or having eloped during that time. His 12/3/25 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated his cognition was moderately impaired. A 12/28/25 progress note indicated that on 12/28/25 at about 4:00 p.m., resident 86 was not in his second-floor room. A subsequent second-floor, facility-wide, and grounds search was completed and was not successful in locating the resident. At 4:30 p.m., a code green (Elopement Alert) was called. Management staff, the resident's contact persons, power of attorney, and emergency services (911) were also notified of the elopement. At about 4:56 p.m., staff called the nearby motel where resident 86 previously lived. The resident had checked back into the same room at the motel. The resident's daughter picked the resident up from the motel and returned him to the facility. After returning to the facility on 12/28/25, a skin evaluation was completed for resident 86. No new skin issues were identified. A WanderGuard (a wearable door	F0658		

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F0658 SS = E	Continued from page 10 alarm device) was placed on the resident's left ankle. Resident 86's Elopement Risk Evaluation and care plan were updated on 12/28/25 to reflect his elopement. A 12/28/25 physician's order instructed: "WanderGuard placed to left ankle due to [the resident's] elopement risk. Ensure placement every shift." 17. Observation on 1/5/26 at 9:20 a.m. of resident 86 revealed he was lying in his bed and did not awaken after his name was called. He was wearing a WanderGuard on his left ankle. 18. Interview on 1/5/26 at 9:30 a.m. with CMA N and registered nurse (RN) O revealed that the nursing staff were responsible for visually confirming the WanderGuard was on resident 86's ankle each shift. That WanderGuard was also to be checked to ensure a red light was flashing on the device, which indicated it was properly functioning. Review of resident 86's December 2025 and January 2026 MARs and continued interview with RN O revealed there was no documentation on those MARs to support that, since 12/28/25, the WanderGuard had been checked to ensure it was on the resident's ankle and functioning. RN O did not know why there was no daily documentation to support that the 12/28/25 physician's order had been followed. 19. Interview on 1/6/26 at 1:30 p.m. with DON C and review of resident 86's December 2025 and January 2026 MARs revealed that she confirmed there was no documentation to support that, each shift, the nursing staff had confirmed resident 86's WanderGuard was on his ankle and properly functioning, but there should have been. 20. Review of the provider's revised 11/18/25 Wanderguards/Door Signaling Devices policy revealed, "6. Placement verification and testing of each Wanderguard or signaling device will be completed daily and recorded on the MAR or TAR. Replacement will be completed as necessary." 21. Review of resident 5's EMR revealed: *He had a G-tube (a tube surgically placed through the abdomen into the stomach to deliver medications, fluids, or nutritional formula). *He had provider's order to "check PEG-tube placement prior to water flushes/feeding and medication administrations."	F0658		

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F0658 SS = E	Continued from page 11 *The instructions for this order were to "check residual and placement by attaching a 60ml piston syringe to gastric tube and gently pulling back 10ml. Aspirate [remove] 5-10ml of gastric content and use pH strips to confirm pH of 1.5 to 5.5. Stop procedure and call MD [doctor] if outside these parameters. If no gastric content appears, the tube may be against the lining of the stomach or may be obstructed." 22. Observation on 1/6/26 at 10:28 a.m. with LPN I revealed: *She had a clean syringe on a clean paper towel on the arm of resident 5's chair. *She pulled 10ml (milliliter) of air into the syringe and attached it to the valve on resident 5's G-tube. *She placed her stethoscope on his stomach, pushed the air into his G-tube, and listened for the air in his stomach. *She reported that the G-tube was in the correct location. *She removed the syringe, attached the resident's nutritional formula to the G-tube, and administered the formula. 23. Interview on 1/6/26 at 2:12 p.m. with DON C revealed she would expect nursing staff to listen for placement of a G-tube with a stethoscope as well as check the pH level of the gastric content per policy. 24. Interview on 1/6/26 at 3:38 p.m. with administrator A revealed: *She would expect staff to follow the physician's orders when administering formula through a feeding tube. *She expected staff to follow the provider's policy for administering formula and medication through a feeding tube. 25. Review of the provider's 11/18/25 Enteral Feeding (Tube Feeding) policy revealed: *The nurse would "check for residual and placement by	F0658		

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F0658 SS = E	Continued from page 12 attaching a sixty milliliter [ml] piston syringe to gastric tube and gently pulling back about 10 ml. If resistance is met as stomach contents are aspirated, stop procedure and notify MD [provider]." *"If no resistance, aspirate five to ten ml of gastric contents. The appearance of gastric content implies that the tube is patent and in the stomach. Use pH strips to confirm that aspirate is at a pH of 1.5 to 5.5. If outside of these parameters, stop procedure and notify MD."	F0658		
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI), interview, record review, and policy review, the provider failed to ensure residents received quality of care for: One of one sampled resident (18) who was not repositioned and provided continence care for approximately nine hours by two of two certified nursing assistants (CNA) (U and V) between 7/18/25 and 7/19/25. One of one sampled resident (64) whose care plan was not followed by one of one CNA (S) on 12/7/25. One of one sampled resident (23) who was not provided timely continence care by one of one CNA (P) on 1/1/26. This citation is considered past non-compliance after review of the corrective actions the provider implemented following those incidents. Findings include: 1. Review of the provider's 7/22/25 FRI revealed that resident 18 was not repositioned or provided continence care for approximately nine hours between 8:30 p.m. on	F0684	"Past Noncompliance - no plan of correction required"	

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F0684 SS = E	Continued from page 13 7/18/25 and 5:41 a.m. on 7/19/25. This was confirmed after the provider reviewed their 7/18/25 and 7/19/25 camera footage. The root cause of the incident, per the provider's investigation, was that staff assignment sheets had not been updated by the nurse to reflect that CNA U and CNA V had split the 7/18/25 overnight shift. There was also no hand-off communication between those two CNAs when one CNA was finished working the split shift and the second CNA started working the split shift. Interview on 1/4/26 at 3:15 p.m. with CNA W, CNA X, and CNA Y revealed that staff assignment sheets were kept on a clipboard at the nurses' station for CNAs to know their shift assignments. If there was a shift split between two CNAs, that was reflected on the assignment sheet. "Huddles" [meetings to update staff about residents' care needs or changes] occurred between the CNAs and the nursing staff at the start of shift and as needed throughout the shift to keep the CNAs informed of changing resident needs. Outgoing and incoming CNAs also completed "walking rounds" [resident status updates that occurred while walking door to door by residents' rooms]. At the start of the shift, the outgoing (going off duty) CNA shared a brief report with the incoming (coming on duty) CNA regarding each resident they had cared for during the shift. Review of the 1/4/26 assignment sheet with CNA X revealed there were separate assignment sheets for the first and second floors. The sheets identified the nursing, CNA, and qualified medication aides assigned to work the day, evening, and night shifts that day. Each scheduled CNA was assigned specific resident room numbers that they were responsible for during their shift. Interview on 1/4/26 at 3:30 p.m. with licensed practical nurse (LPN) I revealed that the assignment sheets were made up by a nurse manager at least one day in advance. It was the responsibility of the floor nurse to notify the "on-call" nurse of any staffing changes. The on-call nurse had a copy of the current assignment sheet and worked with the floor nurse to make any necessary changes to the assignment sheet. It was the floor nurses' responsibility to update the assignment sheet with any staffing changes and communicate those changes to the floor staff. Review of the provider's 7/22/25 SD DOH FRI report regarding resident 18 and interview on 1/6/26 at 2:45 p.m. with director of nursing (DON) C and administrator A revealed the following post-incident follow-up was completed and verified while on-site:	F0684		

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F0684 SS = E	Continued from page 14 CNA U and CNA V were suspended from work pending the outcome of the incident investigation. Both CNAs received disciplinary action related to the 7/22/25 incident. Education was provided for CNA U, CNA V, and all other staff regarding the provider's Abuse/Neglect policy. Nurses were educated regarding their responsibility to update staff assignment sheets when CNA work assignments are changed. CNAs were educated regarding the expectation that hand-off communication occurs between the outgoing and oncoming CNAs. Staff were interviewed following the incident regarding their knowledge of abuse/neglect reporting, and the expectation that routine resident checks occurred. Residents were interviewed to determine if they were regularly checked on by staff, as well as their feelings of safety inside the building. Audits were initiated to confirm that routine rounding on residents was occurring and that assignment sheets had been updated when it was indicated. Resident 18's care plan was updated to reflect her and her family's request that she have every four-hour checks related to the resident's preference not to be disturbed during the overnight hours. CNA U returned to work after the completion of the investigation. CNA V is no longer employed by the facility. 2. Review of the provider's 12/15/25 FRI revealed that during the investigation of an unrelated incident, it was identified that CNA S had not followed resident 64's care plan, which indicated that the resident was to receive "Cares in Pairs," meaning the presence of two staff was expected when the resident's care was provided. CNA S assisted resident 64 with toileting without another staff person present. There were no adverse consequences that occurred as a result of this failure. The incident occurred on 12/7/25 at 8:30 p.m. Interview on 1/4/26 at 12:10 p.m. with CNA T regarding "Cares In Pairs" revealed that the term meant the presence of two staff persons was expected when resident care was provided due to reasons such as resident behavioral concerns, staff, or resident	F0684		

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F0684 SS = E	Continued from page 15 safety. There were several places a CNA could look to identify if a resident required "Cares in Pairs" including their care plan or their electronic medical record (EMR). Observation and interview on 1/6/26 at 10:40 a.m. with resident 64 revealed that two unidentified CNAs assisted her out of bed, into and out of the bathroom. After exiting the bathroom, resident 64 asked, "How did they [the CNAs] do?" That same question was redirected back to the resident for her response, and she stated the CNAs did well. She indicated she was satisfied with her caregivers. She was treated with dignity and respect by them. Resident 64 had no concerns. She had been directing her own care for two years. Review of resident 64's care plan revealed on 9/13/24, an intervention for Cares in Pairs was initiated related to the resident's history of manipulative behavior, verbal abuse towards staff, recording staff without their knowledge or permission, and making false accusations/statements about staff. Review of the provider's 12/15/25 submitted SD DOH FRI report and interview on 1/6/26 at 2:45 p.m. with director of nursing (DON) C and administrator A revealed the following post-incident follow-up was completed and verified while on-site: CNA S was suspended from work pending an investigation of the 12/7/25 event. She received written discipline and education regarding the expectation that residents' care plans were followed. She returned to work after the investigation was completed. Law enforcement, the resident's power of attorney, and her medical provider were notified of the incident. All staff were educated regarding the expectations for residents who require Cares in Pairs. 3. Review of the provider's 1/2/26 submitted SD DOH FRI report regarding resident 23 and interview on 1/5/26 at 3:45 p.m. with DON C and administrator A revealed: On 1/1/26, certified nursing assistant (CNA) P was assigned to provide resident 23's care. At 6:19 p.m., resident 23 activated her call light. At that same time, CNA P was seen exiting another resident's room. She entered resident 23's room, turned off resident 23's call light, then returned to the room she had just exited.	F0684		

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F0684 SS = E	Continued from page 16 At 6:47 p.m., CNA P exited that room and was approached by an unidentified resident's family member. It appeared that the resident's family member had requested assistance from CNA P for a resident (their relation). At 7:40 p.m. on 1/1/26, resident 23 was heard "hollering out" from inside her room. CNA Q informed CNA P that resident 23 was "hollering." CNA P responded: "[Resident 23] always does that, [the resident] just wants her [dinner] tray removed [from her room]." CNA R then asked CNA Q to check on resident 23. CNA Q entered resident 23's room and then exited that room at 8:15 p.m. after she had changed resident 23's brief. The resident had a bowel movement that "was coming out of her brief." Fecal matter was observed on the resident's bedding that "looked like it had been there awhile." Review of CNA P's personnel file revealed her date of hire was 9/22/25. She had completed training related to resident rights, mandatory incident reporting, and abuse/neglect shortly after her hire date. Her background check was reviewed. No significant findings were noted. Interview on 1/5/26 at 2:30 p.m. with resident 23 regarding the 1/1/26 incident revealed that she confirmed having soiled her brief that evening and turning on her call light to have it changed. The resident stated it was one and a half to two hours before a CNA came into her room to change her brief. The resident was not able to recall the names of the staff members she had interacted with on the evening of 1/1/26. Resident 23 stated her incontinence care was usually promptly provided by staff. She felt the 1/1/26 incident was an isolated event. It was resident 23's experience that the staff had treated her with dignity and respect. Interview on 1/6/26 at 2:45 p.m. with DON C and administrator A revealed the following post-incident follow-up was completed and verified while on-site: An assessment of resident 23's skin was completed, and no new skin concerns were identified. CNA P was suspended from work pending the outcome of the provider's investigation into the incident on 1/1/26. On 1/4/26, CNA P text messaged her resignation to the provider.	F0684		

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F0684 SS = E	Continued from page 17 Both CNA Q and CNA R were educated regarding the provider's Abuse/Neglect policy, including the expectation that the on-call nurse be contacted immediately regarding any resident abuse/neglect allegation. Education for all other staff was initiated regarding that same information. A sample of staff persons was interviewed and confirmed their knowledge and understanding of the facility's abuse/neglect policy and the expectations for reporting such allegations. A sample of residents was interviewed regarding how staff interacted with them, how staff had cared for them, and their feelings of safety. There were no negative findings. The social services director was meeting with resident 23 to monitor the resident for potential negative outcomes as a result of the incident. Interview and record review on 1/6/26 at 3:45 p.m. with DON C and administrator A revealed the interviews, education, and audits referenced in the provider's 7/22/25, 12/15/25, and 1/2/26 submitted SD DOH FRIs were completed and documented. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 1/6/26 after record review revealed the facility had followed their quality assurance process, education was initiated for all direct care staff regarding resident abuse and neglect, FRI-related audits were initiated, and observations and interviews confirmed staff understood the expectations for updating and following the staff assignment sheets, implementing Cares in Pairs, and how to identify and report alleged resident abuse and neglect. Based on the above information, non-compliance at F684 occurred on 7/18/25, 12/7/25, and 1/1/26, and based on the provider's implemented corrective actions for the deficient practice confirmed on 1/6/26, the non-compliance is considered past non-compliance.	F0684		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help	F0880	1.No immediate action could be taken for lack of hand hygiene when providing cares to residents 2, 5 or 57. All residents are at risk for adverse effects from lack of appropriate hand hygiene when providing care. 2.DON or designee will educate all CNAs and nurses, to include CNA D, CNA E, RN F, and LPN I, on the Hand Hygiene policy to ensure infection is maintained when	2/17/2026

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F0880 SS = E	Continued from page 18 prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880	providing care to a resident. 3.DON or designee will observe 10 opportunities for hand hygiene to ensure infection control is maintained when providing care to residents. These observations will include CNA D, CNA E, RN F, and LPN I. Observations will be completed weekly X 4 weeks and then monthly for 2 months. Results of audits will be discussed by the 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 audit findings.	

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F0880 SS = E	Continued from page 19 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed infection prevention and control practices regarding: *Hand hygiene (handwashing) and glove use by two of two certified nursing assistants (CNA) (D and E) observed assisting one of one sampled resident (2) with transferring, using a full body mechanical lift (a lift and sling used to lift a person's full body). *Hand hygiene and glove use by one of one wound care registered nurse (RN) (F) observed performing a wound dressing change for one of one sampled resident (2). *Hand hygiene and glove use by one of one licensed practical nurse (LPN) (I) observed cleaning a resident's glasses and administering liquid nutritional formula through a feeding tube for one of one sampled resident (5). *Glove use by one of one LPN (I) observed checking one of one sampled resident's (57) blood sugar reading. Findings Include: 1. Review of resident 2's electronic medical record (EMR) revealed he had a wound to his sacrum (the lower back in between the hip bones of the pelvis) and physician's orders to change that wound dressing twice a day. 2. Observation on 1/6/26 at 9:36 a.m. in resident 2's	F0880		

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(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
F0880 SS = E	Continued from page 20 room revealed: *He had a sign on his door for "Enhanced Barrier Precautions" with the instructions to wear a gown and gloves when providing direct contact care with the resident. *Certified nursing assistant (CNA) D and CNA E arrived at resident 2's doorway with a Hoyer lift (a mechanical lift and sling used to lift a person's full body). *Both CNAs put on gowns and gloves without first performing hand hygiene. They assisted resident 2 with incontinence care. *They both then discarded their gloves and gowns in the trash and performed hand hygiene. 3. Observation on 1/6/26 at 9:45 a.m. of wound care registered nurse (RN) F and wound care RN G in resident 2's room revealed: *They performed hand hygiene and applied gloves and gowns before entering resident 2's room. *Wound care RN G supported resident 2 in position on his side in the bed while wound care RN F performed the dressing change to his wound. Wound care RN F noted that resident 2 did not have a dressing in place to his sacral wound. * Wound care RN F cleaned resident 2's wound, removed her gloves, and discarded them. *She looked around the room and stated, "There's no hand sanitizer in here". *She then put on a new pair of gloves without first performing hand hygiene and placed a dressing on the resident's wound. 4. Review of resident 5's EMR revealed he had a G-tube (a soft tube surgically placed through the abdomen into the stomach to administer medications, fluids, or nutrition). 5. Observation on 1/6/26 at 10:28 a.m. of LPN I in resident 5's room revealed: *The supplies to administer nutritional formula and fluids through the resident's feed tube had already	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MOUNTAIN VIEW	916 MOUNTAIN VIEW ROAD , RAPID CITY, South Dakota, 57702

(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
F0880 SS = E	Continued from page 21 been placed on a clean paper towel next to the resident. *She removed the resident's glasses from his face, washed them with a paper towel and water, and placed them back on his face. *With those same gloved hands, she administered the resident's nutritional formula through his G-tube. 6. Observation and interview on 1/6/26 at 8:35 a.m. with LPN I revealed she was preparing to check resident 57's blood sugar (the amount of sugar in the blood). After she performed hand hygiene, she gathered the needed supplies and entered the resident's room. She laid a clean paper towel on top of the resident's over-the-bed table and set some of the supplies on top of the clean paper towel. She placed a clean pair of gloves on top of the resident's bedding without a barrier between the bedding and those gloves. She pricked the resident's finger, placed blood from the resident's finger on a testing strip that measured the resident's blood sugar level, and inserted that strip into the glucometer (blood glucose meter). LPN I agreed that the top of the resident's bedding was not a clean surface, and the gloves she placed directly on top of that bedding would not be considered clean. She should have laid the gloves on top of a clean paper towel or other barrier. 7. Interview on 1/6/26 at 1:43 p.m. with director of nursing (DON) C revealed: *She expected the staff to perform hand hygiene before putting on gloves and before putting on personal protective equipment (PPE) such as gowns. *She agreed that LPN I should have completed hand hygiene and put on new gloves after cleaning resident 5's glasses and before administering his tube feeding through his tube. *Gloves should be left on a clean surface to mitigate the risk of cross-contamination after they are placed on a caregiver's hands. 8. Interview on 1/6/26 at 3:38 p.m. with administrator	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MOUNTAIN VIEW	916 MOUNTAIN VIEW ROAD , RAPID CITY, South Dakota, 57702

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F0880 SS = E	Continued from page 22 A revealed she expected all staff to perform hand hygiene per the provider's policy. Review of the provider's 5/15/25 Hand Hygiene policy revealed: *All staff members were to be trained on hand hygiene as part of their initial orientation and "regularly educated on the importance of hand hygiene in preventing the transmission of healthcare-associated infections." *"All personnel shall follow the hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." *Alcohol-based hand rub was the preferred method of hand hygiene: -*"Before and after direct contact with residents." -*"When entering and leaving a resident care area/room." -*"Before donning [putting on] and after removing gloves." -*"Before handling clean or soiled dressings, gauze pads, etc." -*"Before moving from a contaminated body site to a clean body site during resident care." -*"After handling used dressings, contaminated equipment, etc." *"The use of gloves does not replace hand hygiene. Hand hygiene must be completed prior to and after removal of gloves."	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MOUNTAIN VIEW	916 MOUNTAIN VIEW ROAD , RAPID CITY, South Dakota, 57702

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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 1/6/2026. Avantara Mountain View 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
Laura Karlson	Administrator	01/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MOUNTAIN VIEW	916 MOUNTAIN VIEW ROAD , RAPID CITY, South Dakota, 57702

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 1/6/2026 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Mountain View 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
Laura Karlson	Administrator	01/30/2026

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
	10669	A. BUILDING: _____ B. WING _____	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MOUNTAIN VIEW	916 MOUNTAIN VIEW RD RAPID CITY, SD 57702

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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 1/4/26 through 1/6/26. Avantara Mountain View was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Karlson

TITLE: Administrator

(X6) DATE: 01/30/2026