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 05/14/2026
NAME OF PROVIDER OR SUPPLIER **AVANTARA MOUNTAIN VIEW**		STREET ADDRESS, CITY, STATE, ZIP CODE **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 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/12/26 through 5/14/26. Areas surveyed included resident rights, potential resident abuse, neglect, and quality of care related to staff -to resident interaction, suicidal ideation response, provision of adequate resident cares and appropriate techniques, report incidents, staff personal cell phone use at work, enteral feeding administration, and misappropriation of residents personal funds. Avantara Mountain View was found not in compliance with the following requirements: F550, F609, F699, F740, and to have past non-compliance at F658.	F0000		
F0740 SS = G	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review the provider failed to ensure a resident received the necessary behavioral health services to treat a diagnosed serious mental illness and to identify and implement interventions and effective communication processes with other healthcare entities to mitigate the resident’s risk for self-harm for one of one sampled resident (2) with diagnosed mental health illness who attempted suicide with a call light cord.	F0740	1.No immediate actions could be taken regarding resident 2 as he has not returned to the facility. All residents are at risk. A full house audit of residents receiving Deer Oaks Counseling was completed May 15, 2026, to review session notes from Feb 1, 2026, to current. Any findings of behavioral or mental health concerns will be documented in the residents’ care plan no later than June 12, 2026. 2.Social Service Director (SSD), Director of Nursing (DON) and Administrator met with Deer Oaks counselor and representative on May 21st, 2026. to outline expectations of having a post counseling session follow-up to prompt communication with facility staff regarding any follow-up needs or at-risk concerns. SSD will review Deer Oaks notes on a weekly basis once uploaded. SSD has provided education to Social Service Assistant (SSA) on the Suicide Threats Suicide Precautions policy and new process with Deer Oaks post session follow up on June 5, 2026. A shift report template was created for the nurses to prompt communication regarding high-risk events to include Suicide Ideation and or safety concerns. DON or Designee will educate all nurses on this resource. The Administrator, DON, and interdisciplinary team (IDT), in collaboration with the medical director and governing board, reviewed the Suicide Threats Suicide Precautions policy and reviewed the objectives for training to all staff on Suicidal Thoughts and Depression (West) and Mental Health Crisis Prevention & De-escalation to ensure residents are provided behavioral/mental health care and services to treat diagnosed mental illness.	June 12, 2026

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	June 5, 2026

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F0740 SS = G	Continued from page 1 Findings include: 1. Review of the provider's 5/4/26 SD DOH FRI revealed on 5/4/26 at 7:15 a.m. director of nursing (DON) B was notified by registered nurse (RN) G that on 5/3/26 at approximately 3:00 a.m. certified nursing assistant (CNA) Q notified RN G that resident 2 had a call light cord wrapped loosely around his neck. CNA Q notified RN G immediately and they removed the call light cord from around resident 2's neck and put it around the enabler bar (bar/bars attached to the bed). RN G reported the call light cord was not tight around resident 2's neck, and it did not leave marks on his neck after it was removed. When resident 2 was asked what had happened, he stared at RN G and CNA Q and said nothing. When RN G left the room, she instructed CNA Q to check on resident 2 every 15 to 30 minutes and notify her of any abnormal behaviors. RN G stated she had gotten busy and forgot to notify the on-call nurse or resident 2's provider about that incident. Resident 2's provider was notified of the call light cord having been wrapped around resident 2's neck on 5/4/26 at 7:30 a.m., and he advised that resident 2 be sent to the emergency department (ED) for evaluation and treatment of his mental health. Resident 2's family was notified that he had a call light wrapped around his neck on 5/4/26 and agreed to resident 2 being transferred to the ED. At 9:00 a.m. the ambulance transported resident 2 to the ED. Resident 2 did not have a history of harming himself. He did not behave differently than normal during the day shift on 5/3/26, after the call light cord was found around his neck. Resident 2 would not answer any questions related to the call light cord being around his neck. The oncoming day shift nurse on 5/3/26 was not notified that resident 2 was found with the call light cord around his neck during the night. 2. Review of resident 2's electronic medical record (EMR) revealed he admitted to the facility on 6/19/23. His diagnoses include depression, vascular dementia (a group of symptoms affecting memory, thinking, and social abilities) with behavioral disturbance, and adjustment disorder with depressed mood (an emotional or behavioral reaction to a stressful life event).	F0740	Additionally, the admission LGHC – Social Services Assessment was reviewed which includes Screening for Evaluating Self- Harm and Trauma Screening assessments that is completed upon admission, quarterly, annually and annually and with a significant change of condition. DON or designee will educate all staff, including CNA Q, CNA O, CNA N, and SSA I, on the Suicide Threats Suicide Precautions policy to ensure residents are provided behavioral/mental health care and services to treat diagnosed mental illness. Additionally, all staff, including CNA Q, CNA O, CNA N, SSA I, have been assigned training modules that include Suicidal Thoughts and Depression (West) and Mental Health Crisis Prevention & De-escalation to ensure residents are provided behavioral/mental health care and services to treat diagnosed mental illness. All staff will complete a competency of their knowledge of the education received. This education and competency will be added to the new hire orientation as well as annual requirement for all staff. The education and competencies will be completed no later than June 12, 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.The DON or designee will audit 5 opportunities for compliance of reviewing admissions/readmissions for behavioral/mental health needs per the new process. Administrator or designee will audit 5 Deer Oaks session notes weekly for indication of suicide ideation and/or behavioral/mental health concerns and confirmation that it was reviewed during the post session follow up. The DON or designee will audit 5 resident unit sheets that are utilized during shift report to verify communication of change of condition or changes in behavior/mental health needs. Audits will be completed weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed 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.	

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F0740 SS = G	Continued from page 2 He had 1/2/26 physician’s orders for fluoxetine (an antidepressant medication) 20 milligrams (mg) to be administered one time a day for depression, trazadone (an antidepressant medication) 50 mg to be administered at bedtime for insomnia (the inability to sleep), and Wellbutrin XL (an antidepressant medication) 150 mg one time a day for depression. His 5/14/26 care plan indicated he was seeing counseling for “inappropriate behaviors” towards the staff and sexually inappropriate behaviors. The interventions identified in the care plan related to resident 2’s depression were to monitor, document, and report to the physician signs and symptoms of depression; Encourage him to talk about his feelings and deficits; and monitor and report to the nurse, to notify the physician as needed for symptoms of depression such as sadness, irritability, anger, never being satisfied, crying, shame, worthlessness, guilt, suicidal ideations, a negative mood, slowed movements, agitation, disrupted sleep, if he does not enjoy his usual activities, changes in his cognition, and attention seeking. Resident 2’s behavioral health counseling notes indicated he was referred to a counseling service for depression symptoms, grief/loss, a history of traumas, adjustment disorder, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and depression. On 10/23/25 and 2/12/26 it was documented that he “voiced passive [expressing a wish to die without a plan to commit suicide] suicidal ideations [thoughts of suicide] during his PHQ9 [a screening tool to measure the severity of depression].”On 2/12/26, 3/5/26, 3/19/26, and 4/16/26, resident 2 had moderate blunted affect (reduced ability to express emotions), was moderately depressed, and had moderate emotional withdrawal with symptoms of anger, helplessness, anxiety, irritability, and negative thinking. A 10/23/25 progress note written by social service assistant I stated, “SS [social service] F/U [follow-up] with [the] resident’s counselor after [his] session today, as [the] resident is not very happy with the situation he is in right now. [The] Resident does not have any plans to harm himself but is having a hard time seeing the bright side of anything. SSD [Social Service Director] to F/U with [the] resident next week, along with [the] resident to continue name redacted counseling sessions.”	F0740		

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F0740 SS = G	Continued from page 3 There was no documentation in resident 2’s EMR that the recommended SSD follow up the following week was completed. Resident 2’s ED documentation indicated a 3/12/26 evaluation for abdominal pain included that resident 2, “made statements expressing suicidal intent if [he] returned to the nursing facility, specifically stating he would hang himself with a call light cord. Psychiatry was consulted for further evaluation. On psychiatric assessment, [the] patient denied active suicidal ideation, intent, or plan, and attributed prior statements to frustration with [his] current living situation…Psychiatry determined there is no indication for inpatient psychiatric admission at this time.” His 3/12/26 psychiatry evaluation indicated he answered “yes” to “Have you wished you were dead or wished you could go to sleep and not wake up?”, and “Have you actually had any thoughts of killing yourself?” His suicide risk assessment was determined to be low due to his denial of suicidal ideations, plan, and intent. The safety plan was completed with the RN in the ED and stated “including patient instruction to contact 988 [suicide hotline], 911, or return to an emergency department if suicidal.” A 3/13/26 progress note indicated resident 2 returned to the facility from the ED at 1:25 a.m. The report received from the ED was that resident 2 had a urinary tract infection, but there was no documentation in that report of his suicidal ideations while he was in the ED. His 3/12/26 after visit summary from the ED included information related to the 988 hotline but it did not include information related to resident 2’s suicidal ideations or psychiatry evaluation. On 5/4/26 resident 2’s physician was notified at 7:36 a.m., and resident 2’s representative was notified at 7:45 a.m., that resident 2 had attempted suicide by wrapping the call light cord around his neck. On 5/4/26 at 9:05 a.m., resident 2 was transferred to the ED for “Apparent suicide attempt.” A 5/5/26 progress note by DON B indicated that resident 2 was sent to the ED due to a suicide attempt on 5/3/26 at approximately 3:00 a.m. There were no other progress notes related to the suicide attempt in resident 2’s EMR. There was no skin assessment documented after resident 2’s suicide attempt by wrapping a call light cord around his neck.	F0740		

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F0740 SS = G	Continued from page 4 3. Interview on 5/12/26 at 5:00 p.m. with CNA Q revealed she had found resident 2 with his call light cord wrapped two times around his neck on 5/3/26 during her 11:30 p.m. resident rounds. She removed the call light cord from around resident 2’s neck, tied the call light cord to the bed frame so resident 2 could use the call light but would not have access to the call light cord, and notified RN G of what she found. The call light cord was wrapped tightly enough around resident 2’s neck that it left a red mark on his neck. When she asked resident 2 what happened he looked at her and did not say anything. RN G told CNA Q to check on resident 2 every 15 to 30 minutes to ensure his safety. CNA Q checked on resident 2 every 15 to 30 minutes for the rest of her shift, but did not document those checks. Resident 2 did not act out of ordinary before or after he wrapped the call light cord around his neck, except that he went to bed before 9:00 p.m., one hour earlier than he normally did. CNA Q reported to the on-coming shift staff that resident 2 was found with the call light cord around his neck. 4. Interview on 5/13/26 at 10:40 a.m. with RN G revealed that she was told by CNA Q that she found resident 2 with a call light cord around his neck, but CAN Q did not tell her that resident 2 had wrapped the call light cord around his neck. She told CNA Q to check on resident 2 every 15 to 30 minutes and let her know if anything else happened. She did not go into resident 2’s room after she was notified of the call light being on resident 2’s neck to assess him for injuries. CNA Q did not follow up with her during the night, and by morning she had forgotten about it and did not pass what happened on to the oncoming shift. RN G did not notify on-call management, resident 2’s physician, or his representative after she was told about the call light cord around his neck. RN G called DON B on 5/4/26 after RN G completed her night shift and was at home because that was when she recalled resident 2 had a call light cord wrapped around his neck on 5/3/26. 5. Interview on 5/13/26 at 11:24 a.m. with social service director (SSD) Y revealed resident 2 was seeing the same counseling service since 2023. Social service assistant I was responsible for reviewing all the residents’ counseling notes. SSD Y was not aware that resident 2 made passive suicidal	F0740		

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F0740 SS = G	Continued from page 5 ideations during his counseling on session 2/12/26. She expected to have been notified immediately of those statements so she could follow up immediately with the resident’s physician, and notify their representative. She acknowledged that not being notified immediately was a missed opportunity to address resident 2’s suicidal ideations before he attempted suicide. 6. Interview on 5/13/26 at 1:10 p.m. with CNA O revealed she worked the day shift on 5/3/26. She received a report from CNA Q, who informed her that resident 2 had wrapped the call light cord around his neck during the night. The day nurse did not talk to her about resident 2’s suicide attempt and CNA O thought resident 2 was more irritable during her day shift on 5/3/26. 7. Review of the provider’s video camera footage from 11:00 p.m. on 5/2/26 through 6:10 a.m. on 5/3/26 revealed that on 5/3/26 at 1:27 a.m. CNA N and Q entered resident 2’s room and exited at 1:39 p.m. At 1:41 a.m. CNA Q was at the nurses’ station talking with RN G and CNA Q was gesturing towards her neck. After CNA Q left the nurses station RN G wrote something on a piece of paper. CNA Q entered resident 2’s room at 2:29 a.m., 3:19 a.m., 3:51 a.m. and 5:22 a.m. She walked by resident 2’s room at 5:05 a.m. and 5:19 a.m. At 6:07 a.m. she was walking in the hallway talking with CNA O. RN G did not enter resident 2’s room between 1:41 a.m. and 6:10 a.m. 8. Interview and review of resident 2’s EMR on 5/13/26 at 4:51 p.m. with social services assistant I revealed she was aware resident 2 had suicidal ideations in the past, told the DON of his suicidal comments, and that he was “cleared” by a physician. She did not know when that had happened, but she stated he was on every 15-minute checks and his physician was notified. Social services assistant I stated the events involving resident 2 that day were not documented in resident 2’s EMR and she was unable to recall when it had happened. 9. Interview on 5/14/26 at 9:00 a.m. with physician D revealed he was resident 2’s physician. His partner was on call the day resident 2 attempted suicide, but he was aware that resident 2 was transferred to the ED due to a suicide attempt. Physician D checked	F0740		

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F0740 SS = G	Continued from page 6 resident 2’s chart that morning (5/14/26) and found resident 2 had also expressed suicidal ideations while he was in the ED for his catheter (on 3/12/26). Physician D expected he, or one of his partners, would be immediately notified if a resident had suicidal ideations or made a suicide attempt. He expected that after resident 2’s suicide attempt the nurse would have assessed resident 2, notified management staff, notified the on-call physician, and notified resident 2’s representative. Physician D did not review residents 2’ counseling notes. He expected the counselor to alert himself or the nursing staff if a resident reported suicidal ideations. He thought that the ED did the right thing by having resident 2 consult with psychiatry but there should have been communication between the ED and the facility when resident 2 returned to the facility so the staff were aware of resident 2’s suicidal ideations and could initiate interventions and monitoring of resident 2. 10. Interview and review of resident 2’s EMR on 5/14/26 at 10:15 a.m. with DON B revealed she expected the staff to notify herself or the on-call manager immediately after a resident threatened or attempted suicide. DON B stated she was notified of resident 2’s suicide attempt on 5/4/26 at 7:15 a.m. by RN G who told her that he had his call light cord around his neck on 5/3/26 at approximately 3:00 a.m., which was 28 hours before DON B was notified. DON B expected RN G to notify the on-call manager immediately after resident 2 was found with the call light cord around his neck as well as resident 2’s physician and representative. She was not aware of resident 2’s suicidal ideations on 10/23/25, 2/12/26, or 3/12/26. DON B did not watch the 5/3/26 video camera footage. She was told by RN G that she went into resident 2’s room and assessed his skin after he attempted suicide. She did not know CNA Q was the person who removed the call light cord from resident 2’s neck and that she saw a red mark on his neck when she removed it. RN G told DON B that the call light cord was loose around resident 2’s neck. She was not aware resident 2 expressed suicidal ideations to the counselor and expected the counselor would have notified the management staff of those thoughts. She was not aware resident 2 had	F0740		

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F0740 SS = G	Continued from page 7 been evaluated by a psychiatrist in the ED due to suicidal ideations and that she expected the ED to inform the nursing staff of that. There was nothing in resident 2’s EMR related to his suicidal ideations. The provider received the after-visit summary from resident 2’s ED visit on 3/12/26 but did not get the ED progress notes. They had access to retrieve them from the hospital’s electronic system, but that was something that the provider did not routinely do. She acknowledged that if they had known about resident 2’s suicidal ideations expressed to his counselor and during his 3/12/26 ED visit, interventions could have been initiated to prevent resident 2 from attempting suicide. The provider had not developed a plan for resident 2’s return after his hospitalization for his suicidal attempt. The plan was upon resident 2’s return to the facility the provider would go through resident 2’s room to look for items resident 2 could harm himself with. The plan was to replace his call light cord with a bell that he could ring when he needed assistance from the staff. DON B verified there were no progress notes in resident 2’s EMR related to his suicidal ideations on 10/23/25 other than social services assistant I’s follow up note or documentation of resident 2’s 15-to-30-minute checks after his suicide attempt on 5/3/26. She expected resident 2’s care plan to include interventions to help him with his suicidal ideations and it did not. 11. Review of the provider’s 11/18/25 Suicide Threats/Suicide Precautions policy revealed, “Staff should report any resident threats of suicide or comments of ‘wanting to die’ immediately to the Nurse Supervisor/Charge Nurse.” “The Nurse Supervisor/Charge Nurse should immediately assess the situation and notify the Charge Nurse/Supervisor and /or Director of Nursing Services of such threats.” “After assessing the resident in more detail, the Nurse Supervisor/Charge Nurse should notify the resident’s Attending Physician and resident representative.” “Provide 1:1 supervision and remove all equipment from [the] room that could be used and/or cause harm (sharps, cords, belts, etc.). 1:1 [one to one] supervision will continue until the resident is transferred or deemed to be not a threat to themselves or others by the physician or mental health professional.” “If a resident has attempted suicide: a. provide any	F0740		

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F0740 SS = G	Continued from page 8 emergency care and call 911. b. Notify VPO [vice president of operations] and RNC [regional nurse consultant] immediately…d. A suicide attempt is not a reportable event under Federal, South Dakota guidelines, however, each case should be discussed with VPO and RNC as it occurs as some situations may be reported (i.e., care plan not followed, previous threats not addressed, etc.). e. Any suicide attempt which results in any injury to the resident shall be reported to the DOH." 12. Review of the provider's 11/18/25 Notification of Change of Condition policy revealed "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 significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in wither life-threatening conditions or clinical complications)".	F0740		
F0609 SS = E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective	F0609	1.No immediate action could be taken for residents 3, 4, 5, 2. All residents are at risk for the potential delay in communication of reportable incidents. 2.DON or Designee to complete education with all staff, to include CNA P, RN E, CNA M, CNA L, CNA Q, CNA K, CNA N, on the Abuse and Neglect policy and Suicide Threat/Suicide Precautions policy. In addition, a communication tool will be posted at all kiosks and nurses' computers to prompt communication to the on-call manager and the coming shift of high-risk events. Education will be completed no later than June 12, 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 interview 15 staff, including CNA P, RN E, CNA M, CNA L, CNA Q, CNA K, and CNA N, to ensure they have not witnessed or heard of any incidents of abuse and or neglect in the last week. Additionally, they will be interviewed to ensure they know the abuse and neglect reporting requirements. Interviews will be completed weekly for 4 weeks and then monthly for 2 months. Results of interview audits will be discussed 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.	June 12, 2026

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

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F0609 SS = E	Continued from page 9 action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review, the provider failed to report incidents to the SD DOH within the required time frame, for one of one sampled resident (3) who reported to registered nurse (RN) E that his wound was caused by his bed frame, one of one sampled resident (4) who was allegedly abused by certified nursing assistant (CNA) M and was not reported until two weeks later by CNA P, one of one sampled resident (5) who was involved in a relationship with one of one licensed practical nurse (LPN) (J), and one of one sampled resident (2) who attempted suicide. Findings include: 1. Review of the provider's 1/19/26 SD DOH FRI revealed that CNA P reported to director of nursing (DON) B that CNA M was verbally rude and physically rough while providing care to resident 4. The incident had occurred two weeks prior, and CNA P was unable to remember the exact date the incident happened. CNA M was suspended pending investigation, and CNA P was immediately re-educated on reporting abuse or neglect immediately. CNA P indicated that when CNA M was "rough" with resident 4, it was "not to the level of physical pain or abuse." Resident 4 was admitted to the hospital on 1/18/26 for chronic medical issues unrelated to the incident and was readmitted to the facility on 1/19/26. A skin assessment was performed by the nursing staff upon readmission to the facility and no skin alterations were found on that assessment. Resident 4 denied any negative verbal or physical interactions from the staff and that she felt safe in the facility. 2. Interview on 5/13/26 at 1:15 p.m. with CNA P revealed that after the incident between resident 4 and CNA M, she had a busy rest of the shift and had forgotten about the incident. She had remembered the incident later and confirmed that she "should have reported it earlier." She was expected to report any allegations of abuse to management	F0609		

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F0609 SS = E	Continued from page 10 immediately. 3. Interview on 5/14/26 at 10:15 a.m. with DON B revealed that the expectation from all staff was to immediately report any suspicions of abuse so an investigation and report can be completed on time. 4. Review of the provider's 2/2/26 SD DOH FRI revealed that resident 3 was admitted to the hospital from 1/28/26 through 2/10/26 for an infected diabetic ulcer (a slow healing, open wound that often develops on the foot due to complications from diabetes) to his left outer foot. He required surgical amputation of his left fifth toe on 1/31/26 and was discharged from the hospital back to the facility on 2/10/26. Wound care nurse (WCN)/registered nurse (RN) E indicated that resident 3 had told her on 1/26/26 that the cause of this wound was from scraping his foot against the metal frame of his bed. This was not discovered until the facility conducted a chart review of resident 3 on 2/2/26 and submitted the FRI to the SD DOH. 5. Review of resident 3's electronic medical record (EMR) revealed that the left outer foot wound was discovered on 1/22/26 when the nursing staff documented that resident 3 had a blister in the area. The nurse's note indicated that resident 3's wound "might [have] happened while putting on shoes" and the wound "may have rubbed against [the] shoe." WCN/RN E assessed his wound on 1/27/26 and confirmed that resident 3 reported that he thought his wound came from hitting the metal frame of his bed and not from his shoes. 6. Interview on 5/14/26 at 9:56 a.m. with WCN/RN E revealed that resident 3 reported to her that his wound was caused by facility equipment. She "honestly didn't even think about needing to report it" and "treated it [the wound] as usual." She was suspended and reinstated after completing education regarding reporting any injury that was suspected to be caused by medical equipment. 7. Interview on 5/14/26 at 10:15 a.m. with DON B revealed she expected any injury to a resident that was caused by medical equipment to be reported to	F0609		

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F0609 SS = E	Continued from page 11	F0609		

management immediately. She considered the facility beds to be medical equipment.

8. Review of the provider’s 2/25/26 SD DOH FRI revealed on 2/25/26 at 5:30 p.m. DON B was notified by certified medication aide (CMA) X that CNA L had witnessed LPN J lying in bed with resident 5.

Resident 5 was admitted to the facility on 1/9/26 following a motor vehicle accident. He had multiple broken bones and was there to receive therapy before he returned home. Resident 5 had a Brief Interview of Mental Status (BIMS) assessment score of 14, which indicated his cognition was intact, and he was his own responsible party.

LPN J reported she and resident 5 were in a relationship in the past, but had taken a break before resident 5 was admitted to the facility. LPN J admitted she was visiting resident 5 when she was off duty and had lain with resident 5 in his bed. Resident 5 declined to be interviewed but did state he was not forced to do anything by LPN J.

During staff interviews, 12 of 25 staff members interviewed had witnessed LPN J lying with resident 5 in his bed, flirty behaviors between them, or had heard from other staff members that something was going on between LPN J and resident 5. When LPN J was lying with resident 5 in his bed, she was off duty. Two staff members had witnessed resident 5 sitting at the nurses’ station talking with LPN J, and rubbing her feet.

When the staff were asked why they did not report the relationship, they stated it was because they were uncomfortable with the situation and resident 5 was consenting to it. LPN J did not disclose the relationship to the provider after resident 5 was admitted to the facility. She stated during her interview she spent time with resident 5 during off-work hours.

Video camera footage on 2/25/26 at 6:24 p.m. revealed LPN J was wheeling resident 5 into the small dining room, she kissed him on the forehead, hugged him, and then resident 5 reached under LPN J’s sweater and was rubbing her buttocks.

9. Review of resident 5’s EMR revealed he was admitted to the facility on 1/9/26 following a motor vehicle accident. During the motor vehicle accident, he suffered multiple broken bones and needed

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F0609 SS = E	Continued from page 12 therapy before he could return home. His 1/9/26 BIMS assessment score was 14, which indicated his cognition was intact. He was discharged from the facility with LPN J on 3/5/26. At the time of discharge, LPN J was listed as his emergency contact. 10. Interview on 5/12/26 at 5:12 p.m. with CNA L revealed she had knocked and entered resident 5's room and witnessed LPN J on top of resident 5 in his bed "grinding" on him. She closed the door and did not go back into the room. She reported to RN G that she saw LPN J in resident 5's room, but did not go into detail about what she saw because there were multiple other staff members with RN G. CNA L did not know what day she had seen that happen. A few days after CNA L saw LPN J and resident 5 together in his room, she witnessed resident 5 rubbing LPN J's legs, and LPN J told him to stop because she was working. CNA L was told by other staff members that they had witnessed inappropriate touching and kissing between LPN J and resident 5, but did not report it. 11. Interview on 5/13/26 at 10:30 a.m. with CNA K revealed she was hired on 2/19/26. When she first started her training, she was told there was a nurse who was in a relationship with resident 5. On CNA K's first or second day of training, she witnessed LPN J lying in bed with resident 5. She did not report what she had heard or witnessed to a nurse or the management staff. 12. Interview on 5/13/26 at 10:30 a.m. with RN G revealed she was told by CNA L, in front of other CNAs, that she had witnessed LPN J in resident 5's room, but CNA L did not say what she saw she just made "a face", made a "squeak noise", and walked away. RN G did not ask CNA L any questions and CNA L did not come back to talk with RN G later. RN G stated she did not follow up with CNA L about what she had seen and did not report anything to the management staff. 13. Review of the provider's 5/4/26 SD DOH FRI revealed on 5/4/26 at 7:15 a.m. DON B was notified by RN G that on 5/3/26 at approximately 3:00 a.m. CNA Q notified RN G that resident 2 had a call light cord wrapped loosely around his neck. CNA Q notified RN G immediately and they removed the call light cord from around resident 2's neck and put it	F0609		

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F0609 SS = E	Continued from page 13 around the enabler bar (bar/bars attached to the bed). RN G reported the call light cord was not tight around resident 2’s neck and, it did not leave marks on his neck after it was removed. When resident 2 was asked what had happened, he stared at RN G and CNA Q and said nothing. When RN G left the room, she instructed CNA Q to check on resident 2 every 15 to 30 minutes and notify her of any abnormal behaviors. RN G stated she had gotten busy and forgot to notify the on-call nurse or resident 2’s provider about that incident. Resident 2’s provider was notified of the call light cord having been wrapped around resident 2’s neck on 5/4/26 at 7:30 a.m., and he advised that resident 2 be sent to the emergency department (ED) for evaluation and treatment of his mental health. Resident 2’s family was notified that he had a call light cord wrapped around his neck on 5/4/26 and agreed to transfer resident 2 to the ED. At 9:00 a.m. the ambulance transported resident 2 to the ED. Resident 2 did not have a history of harming himself. He did not behave differently than normal during the day shift on 5/3/26, after the call light cord was found around his neck. Resident 2 would not answer any questions related to the call light cord being around his neck. The oncoming day shift nurse on 5/3/26 was not notified that resident 2 was found with the call light cord around his neck during the night. 14. Review of resident 2’s electronic medical record (EMR) revealed he admitted to the facility on 6/19/23. There was a progress note that was entered on 5/5/26 at 2:55 p.m. by DON B that resident 2 was sent to the ED due to a suicide attempt on 5/3/26 at approximately 3:00 a.m. There were no other progress notes related to the suicide attempt in resident 2’s EMR. His 5/14/26 care plan indicated he was seeing counseling for “inappropriate behaviors” towards the staff and sexually inappropriate behaviors. The interventions identified in the care plan related to resident 2’s depression were to monitor, document, and report to the physician signs and symptoms of depression; Encourage him to talk about his feelings and deficits; and monitor and report to the nurse, to notify the physician as needed for symptoms of depression such as sadness, irritability, anger, never being satisfied, crying,	F0609		

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F0609 SS = E	Continued from page 14 shame, worthlessness, guilt, suicidal ideations, a negative mood, slowed movements, agitation, disrupted sleep, if he does not enjoy his usual activities, changes in his cognition, and attention seeking. His care plan did not include that he had expressed suicidal ideations, interventions related to his expression of suicidal ideations to keep him safe, or preventative interventions related to his mood or depression. Resident 2's behavioral health counseling notes indicated that on 10/23/25 and 2/12/26 it was documented that he "voiced passive [expressing a wish to die without a plan to commit suicide] suicidal ideations [thoughts of suicide] during his PHQ9 [a screening tool to measure the severity of depression]." On 3/12/26 during his evaluation in the ED for abdominal pain, resident 2, "expressed suicidal ideations, stating he will harm himself if discharged back to the nursing facility. He reports intent to strangle himself using items such as a call light cord." 15. Interview on 5/12/26 at 5:00 p.m. with CNA Q revealed she had found resident 2 with his call light cord wrapped two times around his neck on 5/3/26 during her 11:30 p.m. resident rounds. She removed the call light cord from around resident 2's neck and immediately notified RN G of what she found. The call light cord was wrapped tightly enough around resident 2's neck that it left a red mark on his neck. 16. Interview on 5/13/26 at 10:40 a.m. with RN G revealed that she was told by CNA Q that she found resident 2 with a call light cord around his neck, but CAN Q did not tell her that resident 2 had wrapped the call light cord around his neck. She told CNA Q to check on resident 2 every 15 to 30 minutes and let her know if anything else happened. She did not go into resident 2's room after she was notified of the call light being on resident 2's neck to assess him for injuries. CNA Q did not follow up with her during the night, and by morning she had forgotten about it and did not pass what happened on to the oncoming shift. RN G did not notify on-call management, resident 2's physician, or his representative after she was told about the call light cord around his neck.	F0609		

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F0609 SS = E	Continued from page 15 RN G called DON B on 5/4/26 after RN G completed her night shift and was at home because that was when she recalled resident 2 had a call light cord wrapped around his neck on 5/3/26. 17. Review of the provider’s video camera footage from 11:00 p.m. on 5/2/26 through 6:00 a.m. on 5/3/26 revealed on 5/3/26 at 1:27 a.m. CNA N and Q entered resident 2’s room and exited at 1:39 p.m. At 1:41 a.m. CNA Q was at the nurses’ station talking with RN G and CNA Q was gesturing towards her neck. After CNA Q left the nurses station RN G wrote something down on a piece of paper. 18. Interview on 5/14/26 at 10:15 a.m. with DON B revealed she expected the staff to notify herself or the on-call manager as soon as they suspected potential sexual abuse or exploitation and if a resident threatened or attempted suicide. DON B was notified of LPN J’s relationship with resident 5 after a CNA called her and reported it on 2/25/26. She expected the staff to have notified her of the relationship between resident 5 and LPN J immediately after they heard about it or witnessed it, even if they were aware of their previous relationship. She believed the relationship was started shortly after resident 5 was admitted to the facility on 1/9/26. DON B was notified of resident 2’s suicide attempt on 5/4/26 at 7:15 a.m. by RN G who told her that he had his call light cord around his neck on 5/3/26 at approximately 3:00 a.m., which was 28 hours before DON B was notified. DON B expected RN G would have notified the on-call manager immediately after resident 2 was found with the call light cord around his neck. She was not aware of resident 2’s suicidal ideations on 10/23/25, 2/12/26, or 3/12/26. 19. Review of the provider’s 5/14/25 Abuse and Neglect policy revealed, “Sexual abuse includes but is not limited to harassment, coercion, disparaging remarks, or sexual assault. Examples: implied or actual contact between a caregiver and resident of sexual nature.” “All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator’s Designee. All allegations of abuse will be reported to your state agency immediately (within 2 hours) after the initial allegation is received.”	F0609		

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F0609 SS = E	Continued from page 16 20. Review of the provider’s 11/18/25 Suicide Threats/Suicide Precautions policy revealed, “If a resident has attempted suicide: a. provide any emergency care and call 911. b. Notify VPO [vice president of operations] and RNC [regional nurse consultant] immediately…d. A suicide attempt is not a reportable event under Federal, South Dakota guidelines, however, each case should be discussed with VPO and RNC as it occurs as some situations may be reported (i.e., care plan not followed, previous threats not addressed, etc.). e. Any suicide attempt which results in any injury to the resident shall be reported to the DOH.”	F0609		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F0550	1.No immediate actions could be taken for resident 1. All residents are at risk of having their rights violated. 2.DON or Designee will educate all staff regarding the employee handbook policies addressing cell phone use, photographs, and videos in the workplace in addition to the abuse and neglect policy. Education will be completed no later than June 12, 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.Administrator or Designee will interview 5 residents to determine if they have observed or have had negative interactions with staff, if they have been photographed or video recorded, and if their privacy is being maintained. In addition, Administrator or Designee will observe 5 staff and resident interactions The resident interviews and staff observations will be completed weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed 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.	June 12, 2026

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F0550 SS = D	Continued from page 17 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, employee record review, and policy review, the provider failed to protect the resident's right to dignity and respect when one of one certified nursing assistant (CNA) U used her phone to record a video in the shower room while one of one CNA (S) verbally abused one of one resident (1) who was taking a shower. Findings included: 1. Review of the provider's 5/7/26 submitted SD DOH FRI report regarding resident 1 revealed on 5/7/26 at 3:40 p.m. restorative/rehab aide V notified director of nursing (DON) B and administrator A that she heard that on 4/9/26 CNA U had taken a Snapchat video of a conversation between CNA S and resident 1. The Snapchat video reportedly showed CNA S speaking to resident 1 in a tone of voice that appeared annoyed. Resident 1 was interviewed by DON B and infection preventionist/licensed practical nurse (LPN) W and she stated she had no concerns. CNA U was suspended due to violating the facility's cell phone use, photography, and video policies. CNA S was suspended pending the facility's investigation related to allegations of verbal abuse. 2. Review of resident 1's electronic medical record (EMR) revealed she admitted to the facility on 2/19/26. Her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities), anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability) and depression. Her Brief Interview of Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. 3. Interview on 5/13/26 at 2:25 p.m. with resident 1 revealed she remembered being in the shower room	F0550		

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

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F0550 SS = D	Continued from page 18 and being spoken to rudely by a staff member. Resident 1 reported she did not want to take a shower and was grabbing the grab bars and attempted to stand up, but the staff member, whose identity she could not recall, told her to stop, then grabbed her hands and pulled them off the grab bars. She recalled that she begged the staff member to stop. Resident 1 stated she does not recall any Snapchat video being taken. Resident 1 stated she has not seen the staff member since the incident and has not experienced further problems during showers. 4. Phone interview on 5/13/26 at 2:35 p.m. with restorative/rehab aide V revealed she recalled hearing that CNA U took a Snapchat video of CNA S in the shower room talking rudely to resident 1. Restorative/rehab aide V heard CNA U and CNA S laughing and making jokes about the Snapchat video. She never seen the video herself but notified DON B and administrator A of what she had heard. 5. Review of CNA S's personnel file revealed her professional certification was current, and her pre-employment background checks identified no areas of concern. She had signed her acknowledgement of the employee handbook on 10/22/24, which included the use of cell phones, photographs, and videos. She was current on abuse prevention and training, resident rights training, and HIPPA (Health Insurance Portability and Accountability Act) fundamental training. CNA S had a prior verbal warning and suspension on 2/3/26 due to taking a picture of a resident on CNA S's personal cell phone and posting it on social media. 6. Review of CNA U's personnel file revealed her professional certification was current, and her pre-employment background checks identified no areas of concern. She had signed her acknowledgement of the employee handbook on 10/22/24, which included the use of cell phones, photographs and videos. She was current on the abuse prevention and training, resident rights training, and HIPPA fundamental training. CNA U had received no disciplinary action from the facility. 7. CNA S was not available for an interview during the time of the survey. 8. CNA U was not available for an interview during	F0550		

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F0550 SS = D	Continued from page 19 the time of the survey. 9. Interview on 5/13/26 at 4:00 p.m. with administrator A and DON B revealed all staff was re-educated regarding the employee handbook policies addressing cell phone use, photographs, and videos in the workplace. The staff were re-educated on the Abuse and Neglect policy as well as the reporting requirements. Audits had not begun, they would be focused on observing whether the staff were using personal phones while on duty and to monitor staff communication with the residents. 10. Review of the provider's undated Resident Rights Admission Agreement revealed: "28. The Resident has the right to be free from verbal abuse" 11. Review of the provider's revised 11/18/25 Resident Dignity and Privacy policy revealed that "It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity, as well as, care for each resident in a manner and in an environment, that maintains resident privacy."	F0550		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on the South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI), interview, record review, and policy review, the provider failed to ensure a physician's antibiotic medication order was accurately entered into the resident's electronic medical record (EMR) by one of one registered nurse (RN) (H) for one of one sampled resident (3) who did not receive his antibiotic until a day after it was prescribed and needed his left foot's fifth toe amputated due to an infection. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident.	F0658	"Past Noncompliance - no plan of correction required"	

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F0658 SS = D	Continued from page 20 Findings include: 1. Review of the 2/2/26 SD DOH FRI revealed that resident 3's had a left foot wound that was assessed by his physician on 1/26/26. The nursing staff received orders for an oral (pill) antibiotic, an intramuscular (IM; use of a needle to inject the medication into a muscle) antibiotic, and for the staff to outline the area of redness to his left foot for monitoring purposes. The oral antibiotic order was entered by registered nurse (RN) H to be administered on 1/26/26. The IM antibiotic was entered by RN H to start on 1/27/26, which was incorrect as the physician's order indicated it was to be administered on 1/26/26. Resident 3 was admitted to the hospital from 1/28/26 through 2/10/26 for surgical intervention of an infected diabetic ulcer (a slow healing, open wound that often develops on the foot due to complications from diabetes) to his left outer foot. His left foot's 5th toe was amputated on 1/31/26. 2. Review of resident 3's EMR confirmed that his physician ordered an IM antibiotic to be given once daily on 1/26/26 and 1/27/26 for increased suspicion of an infection to his left foot. 3. Interview on 5/14/26 at 8:18 a.m. with RN H revealed she printed resident 3's antibiotic orders from his physician and entered them into resident 3's EMR. She knew both antibiotics were ordered to be given on 1/26/26. When she came back to work the next day, she realized that resident 3 did not receive the IM antibiotic. She did not double-check the order date when entering resident 3's antibiotic order and he missed his first dose of IM antibiotics on 1/26/26. The facility had her do education on double-checking all entered physician's orders for accuracy. 4. Interview on 5/14/26 at 9:00 a.m. with physician D revealed that he expected physician orders to be entered correctly and medications to be given to the resident according to that physician's order. 5. Interview on 5/14/26 at 10:15 a.m. with director of nursing (DON) B revealed that she expected physician's orders to be entered into the resident's	F0658		

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F0658 SS = D	Continued from page 21 EMR as written by the physician. 6. Review of the provider's investigation of that incident revealed that they educated RN H and placed a corrective action in her personnel file. All nursing staff completed education regarding entering accurate physician's orders in the resident's EMRs. The facility brought this incident to their 2/3/26 Quality Assurance and Performance Improvement (QAPI) meeting and audits were performed on all new physicians' orders in the previous 30 days. That audit did not find any further incorrect entries of physician's orders. 7. Review of the provider's January 2018 Medication Orders policy revealed that the seven elements to receive a complete physician's order for a medication must include: the name of the medication, the strength of the medication, the dose and dosage form, the time or frequency of administration, the route of administration, the duration of therapy, and a diagnosis for intended use. 8. Based on the above information, non-compliance at F658 occurred on 1/26/26, and based on the provider's implemented corrective actions on for the deficient practice confirmed on 5/14/26, the compliance is considered past non-compliance.	F0658		
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review, the provider failed to identify and implement specific care approaches that addressed the mental and psychosocial needs of one of one sampled resident (3) with diagnosed post-traumatic stress disorder, a disorder in which a	F0699	1.Resident 3 care plan has been updated to reflect a trauma informed care plan. Resident 2 has not returned to the facility. All residents are at risk of not having a trauma informed care plan in response to a current or history of a traumatic event. All residents will complete a current trauma screening evaluation followed by implementation of interventions and their care plan will be updated as needed. 2.Administrator or designee will educate the SSD and SSA on the Mental Health Adjustment Difficulties Related to Trauma PTSD or Other Mental Health Issues policy to ensure residents who have experienced a traumatic event have interventions in place to mitigate trauma triggers and prevent re-traumatization. Education will be completed no later than June 12, 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.	June 12, 2026

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F0699 SS = D	Continued from page 22 person has difficulty recovering after experiencing or witnessing a terrifying event (PTSD) and one of one sampled resident (2) who had experienced a traumatic event to mitigate trauma triggers and prevent re-traumatization. Findings include: 1. Review of the provider's 5/4/26 SD DOH FRI revealed on 5/4/26 at 7:15 a.m. director of nursing (DON) B was notified by registered nurse (RN) G that on 5/3/26 at approximately 3:00 a.m. certified nursing assistant (CNA) Q notified RN G that resident 2 had a call light cord wrapped loosely around his neck. CNA Q notified RN G immediately and they removed the call light cord from around resident 2's neck and put it around the enabler bar (bar/bars attached to the bed). RN G reported the call light cord was not tight around resident 2's neck, and it did not leave marks on his neck after it was removed. When resident 2 was asked what had happened, he stared at RN G and CNA Q and said nothing. When RN G left the room, she instructed CNA Q to check on resident 2 every 15 to 30 minutes and notify her of any abnormal behaviors. RN G stated she had gotten busy and forgot to notify the on-call nurse or resident 2's provider about that incident. Resident 2's provider was notified of the call light cord having been wrapped around resident 2's neck on 5/4/26 at 7:30 a.m., and he advised that resident 2 be sent to the emergency department (ED) for evaluation and treatment of his mental health. Resident 2's family was notified that he had a call light wrapped around his neck on 5/4/26 and agreed to resident 2 being transferred to the ED. At 9:00 a.m. the ambulance transported resident 2 to the ED. Resident 2 did not have a history of harming himself. He did not behave differently than normal during the day shift on 5/3/26, after the call light cord was found around his neck. Resident 2 would not answer any questions related to the call light cord being around his neck. The oncoming day shift nurse on 5/3/26 was not notified that resident 2 was found with the call light cord around his neck during the night. 2. Review of resident 2's electronic medical record (EMR) revealed he admitted to the facility on 6/19/23. His diagnoses include depression, vascular dementia (a group of symptoms affecting memory,	F0699	3.Administrator or designee will complete 5 audits of Deer Oaks notes specific to current risk factors to verify presence of a trauma informed care plan with interventions in place to mitigate trauma triggers and prevent re-traumatization when risk factors are noted. The audits will be completed weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed 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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F0699 SS = D	Continued from page 23 thinking, and social abilities) with behavioral disturbance, and adjustment disorder with depressed mood (an emotional or behavioral reaction to a stressful life event). He had 1/2/26 physician's orders for fluoxetine (an antidepressant medication) 20 milligrams (mg) to be administered one time a day for depression, trazadone (an antidepressant medication) 50 mg to be administered at bedtime for insomnia (the inability to sleep), and Wellbutrin XL (an antidepressant medication) 150 mg one time a day for depression. His 5/14/26 care plan indicated he was seeing counseling for "inappropriate behaviors" towards the staff and sexually inappropriate behaviors. The interventions identified in the care plan related to resident 2's depression were to monitor, document, and report to the physician signs and symptoms of depression; Encourage him to talk about his feelings and deficits; and monitor and report to the nurse, to notify the physician as needed for symptoms of depression such as sadness, irritability, anger, never being satisfied, crying, shame, worthlessness, guilt, suicidal ideations, a negative mood, slowed movements, agitation, disrupted sleep, if he does not enjoy his usual activities, changes in his cognition, and attention seeking. Resident 2's behavioral health counseling notes indicated he was referred to a counseling service for depression symptoms, grief/loss, a history of traumas, adjustment disorder, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and depression. On 10/23/25 and 2/12/26 it was documented that he "voiced passive [expressing a wish to die without a plan to commit suicide] suicidal ideations [thoughts of suicide] during his PHQ9 [a screening tool to measure the severity of depression]."On 2/12/26, 3/5/26, 3/19/26, and 4/16/26, resident 2 had moderate blunted affect (reduced ability to express emotions), was moderately depressed, and had moderate emotional withdrawal with symptoms of anger, helplessness, anxiety, irritability, and negative thinking. 3. Interview and review of resident 2's EMR on 5/13/26 at 11:24 a.m. with social services director (SSD) Y revealed resident 2 was seeing the same counseling service since 2023. Social services	F0699		

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F0699 SS = D	Continued from page 24 assistant I was responsible for reviewing all the residents' counseling notes and completing each resident's trauma informed care assessment on their admission to the facility and quarterly. SSD Y verified a trauma informed care assessment was not completed on resident 2. She was not aware resident 2 was referred to counseling services for past traumas. She was aware resident 2 was in a motor vehicle crash in the 1980's but stated he denied having any trauma. He normalized everything and was not open to sharing his feelings and experiences. She could have reached out to his counselor to find out more information about his past traumas and any triggers he may have had. When a resident had a history of a traumatic experience, SSD Y or social services assistant I attempted to gather information about the trauma and any triggers related to that trauma. They documented that information in the resident's care plan in an attempt to avoid retriggering a resident's past trauma. SSD Y verified resident 2 did not have a past trauma identified on his care plan or any known or potential triggers he may have had. 4. Interview and review of resident 2's EMR on 5/13/26 at 4:51 p.m. with social services assistant I revealed she was not aware that one of the reasons resident 2 was seeing a counselor was because of a past traumatic experience. Social services assistant I could reach out to the counselor for more information if a resident was known to have a past trauma, but did not disclose the trauma or did not want to talk about it. She stated a history of trauma could be added to a resident's care plan even if they did not disclose the trauma or potential triggers to that trauma. 5. Interview on 5/14/26 at 9:00 a.m. with physician D revealed he was resident 2's physician. Resident 2 was in a motor vehicle crash in the 1980's, which resulted with him becoming a paraplegic (partial or complete paralysis of the lower half of the body, including both legs). 6. Interview on 5/14/26 at 10:15 a.m. with DON B revealed the trauma informed care assessments were completed by the social services staff. She expected a resident who was identified as having past trauma	F0699		

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F0699 SS = D	Continued from page 25 would have that identified on their care plan as well as any potential triggers to avoid the retraumatization of that resident. 7. Interview on 5/13/26 at 2:55 p.m. with resident 3 in his room revealed that he had served in the Korean War. He denied having any triggers or PTSD from the war but stated that he had trauma from losing his wife of 71 years the previous year. He stated that he had been working through this with a therapist. 8. Review of resident 3’s EMR revealed he admitted to the facility on 4/17/25. He had a Brief Interview for Mental Status (BIMS) score of 7 which indicated that he had severe cognitive impairment. His diagnoses included depression, anxiety, insomnia, and cognitive communication deficit (difficulty with communication from an underlying impairment in thinking process). His 5/21/25 care plan indicated that he demonstrated significant mood distress related to his diagnosis of depression and difficulty adjusting to loss and change in role or status. The interventions identified in the care plan related to his depression were to discuss any fears or issues regarding health or other subjects. Staff were to monitor, document, and report any signs or symptoms of depression including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive complaints, and tearfulness. Resident 3 went to his first counselling session on 4/16/26. The “reason for referral” section included “issues with trauma”. Resident 3 was screened for trauma and had a positive screening with “current associated emotional symptoms.” A short-term goal of counselling included “examine the relationship between emotions and triggers” during his next sessions. 9. Interview on 5/13/26 at 11:26 a.m. with SSA I revealed that she was expected to check when a resident’s counselling notes were completed, review those notes, then upload them to the resident’s EMR. 10. Review of the provider's 11/18/25 Mental Health	F0699		

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F0699 SS = D	Continued from page 26 Adjustment Difficulties Related to Trauma, PTSD, or Other Mental Health Issues policy revealed that all residents were to be assessed to determine if services were needed. Based off that assessment, the resident's care plan should address the individualized emotional and psychosocial needs of the resident.	F0699		