STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435060	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SAINT CLOUD	302 ST CLOUD STREET RAPID CITY, SD 57701

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F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 3/27/25. The area surveyed included resident abuse related to potential physical abuse of residents by a former staff member. Avantara Saint Cloud was found to have past non-compliance with the following requirement: F600.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, record review, observation, and interview, the provider failed to protect the residents' right to be free from physical abuse for two of two sampled cognitively impaired residents (1 and 2) by one of one certified nursing assistant (CNA) (C). This citation is considered past non?compliance based on a review of the corrective actions the provider	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashley Altena | TITLE: Administrator | (X6) DATE: 04/14/25

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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implemented immediately following the incident. Findings include:

1. Review of the provider's 1/2/25 SD DOH FRI revealed:
*On 1/2/25, dementia champion E reported CNA C "forcibly grabs her [resident 1] arms back and forces her [resident 1] down to the chair, forces her [resident 1] to bend her [resident 1] knees, and she [resident 1] started crying."
*CNA C was suspended immediately, pending investigation.
*A full investigation was initiated that included staff interviews, video surveillance, and immediate notification to administrator/abuse coordinator A.
*After the investigation was completed, the allegations of abuse towards the resident by CNA C were not verified, and he was allowed to return to work with daily check-ins with director of nursing (DON) B and assistant director of nursing (ADON) G; he was assigned dementia-related education that was completed by 1/31/25.
*Education was provided to all staff that included types of abuse, how to report abuse, and the importance of timely reporting.

2. Review of resident 1's electronic medical record (EMR) revealed:
*She was admitted on 3/15/23, and her diagnoses included Alzheimer's disease, falls, urinary tract infections, cognitive communication deficit, dementia, depressive disorder, and insomnia.
*Her Brief Interview for Mental Status (BIMS) assessment score was 0, which indicated she was severely cognitively impaired.
*A skin assessment was completed on 1/2/25 with no injuries noted from the incident.

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3. Observation on 3/27/25 at 10:33 a.m. of resident 1 revealed she:
*Was ambulating around the secured memory unit.
*Was dressed, had non-slip socks on her feet, and her hair was pulled back in a pony tail
*Was tearful the first time around the unit, but on the second loop around, she smiled at the surveyor.

4. Dementia champion E was a former employee and was unavailable for an interview.

5. Interview on 3/27/25 at 2:00 p.m. with administrator/abuse coordinator A and DON B regarding the 1/2/25 incident revealed:
*They stated they were unsuccessful in retrieving the camera footage.
*They had randomly selected 20 staff members and asked them if they had witnessed any staff abusing resident 1.
-All the staff members had answered no.
*They did not verify the abuse allegations for CNA C reported by dementia champion F.
*CNA C was allowed to go to work and was supervised by DON B and ADON G with daily check-ins, and was assigned dementia-related education, to be completed by 1/31/25.
*Education was provided to all staff on all types of abuse, how to report the type of abuse, and the importance of timely reporting.

6. Review of CNA C's personnel file revealed he had completed the dementia-related education by 1/31/25.

7. Review of the provider's 2/25/25 SD DOH FRI revealed:

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*On 2/25/25, activity director F reported CNA C was assisting resident 2 out of the dining room, and she began yelling, "I do not want to go, don't make me go." Activity director F intervened and asked CNA C to walk away.
*CNA C was suspended immediately, pending an investigation.
*A full investigation was initiated that included staff interviews, video surveillance, and immediate notification to administrator/abuse coordinator A.
*After the investigation was completed, the allegations of abuse towards the residents by CNA C was verified, and CNA C's employment was terminated.
*Education was provided to all staff on the abuse and neglect policy.

8. Review of resident 2's EMR revealed:
*She was admitted on 7/1/24 and her diagnoses included Alzheimer's disease, dementia, urinary tract infection, and insomnia.
*Her BIMS assessment score was 1, which indicated she was severely cognitively impaired.
*On 2/25/25 at 9:30 a.m. a progress note was completed as follows: "CNA was noted to be pulling on [the] resident [resident 2] to have her go with him to the bathroom. Resident was yelling that she did not want to go with him. Activities Director intervened and had [the] CNA leave [the] resident alone at the time and told him that she has the right to refuse. CNA did leave [the] resident alone at the time of intervention by [the] Activities Director. Resident was assessed and found to have two small red marks on her bilateral wrists. These did resolve. [The resident's] Daughter in law [was] notified of [the] incident and [the] provider [was] notified. Both were thankful for [the] notification."

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*Her care plan was updated as follows:
-"Focus: I [am] at risk for altered mood/behaviors, I present with the following behaviors: Yelling/Screaming, Kicking/Hitting, Grabbing, Wandering seeking social interaction with others, Abusive Language, Threatening behavior, Rejection of care, delusions."
--"Interventions: Weekly check ins [check-ins] with Social Service Director for 4 weeks"
---"Date Initiated: 3/6/25"
*No further notes were documented for this incident.
*A skin assessment was also completed on 2/25/25.
*No further skin assessment was documented regarding the 2/25/25 incident.

9. Interview with activities director F regarding the 2/25/25 incident revealed:
*She was in her office and heard a resident screaming.
*She observed resident 2 hanging onto a pole in the dining room while CNA C was forcing resident 2 to go with him.
*She had informed CNA C that he could not force a resident to go with him.
*She stated CNA C had gotten upset with her and "stormed off".
*She said resident 2 was better after CNA C left and sat back down into a chair in the dining room.
*The activities director stated she reported what she observed to the administrator.

10. Interview on 3/27/25 at 1:18 p.m. with CNA D revealed:
*She had witnessed CNA C grab resident 2 arms and force her to go with him.
*She had not witnessed any other staff member being physical with the residents.

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11. Observation on 3/27//25 at 1:35 p.m. of resident 2 revealed she:
*Was ambulating around the secured memory unit.
*Was dressed, and her hair was combed.
*Would randomly stop and look around.

12. Interview on 3/27/25 at 2:30 p.m. with administrator/abuse coordinator A and director of nursing (DON)B regarding the 2/25/25 incident revealed:
*They had reviewed the camera footage, and it verified that resident 2 was physically abused by CNA C as reported by activities director F.
*They interviewed twelve random staff members and four staff members had said had witnessed CNA C had grab resident 2 in the dining room trying to get her to go with him before the activities director intervened.
*CNA C's employment was terminated and CNA C was reported to the South Dakota Board of Nursing related to the event.

The provider implemented actions to ensure the deficient practice does not recur was confirmed after record review revealed the facility had followed their quality assurance process, education was provided to all staff regarding types of abuse, how to report the abuse, the importance of timely reporting, and the abuse and neglect policy. The administrator and DON walked and observed the facility daily to ensure resident safety. Interviews and observations indicated staff understood the education provided.

Based on the above information, non-compliance at F600 was determined to occur on 2/25/25, and

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F 600	Continued From page 6 the provider's implemented 3/26/25 corrective actions for the deficient practice confirmed on 3/27/25; the non-compliance is considered past non-compliance.	F 600		