| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/30/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA NORTON | 3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105 |

| (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<br><br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 12/23/25, and 12/29/25 through 12/30/25. Areas surveyed included quality of care and treatment related to resident weight loss, wound care, and catheter care, and accident hazards related to resident elopements and hot liquid spills. Avantara Norton was found to have past non-compliance with the following requirements: F689 and F804. | F0000 | | |
| F0689<br>SS = D | Free of Accident Hazards/Supervision/Devices<br><br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br><br>The facility must ensure that -<br><br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, record review, and policy review, the provider failed to ensure the safety of two of two sampled residents (2 and 3) who eloped (left the facility without staff knowledge) from the front door of the facility on 7/26/25 and 9/12/25. Both residents had been mistaken for visitors at the time of their elopements. The facility's front door alarm system had been bypassed during the elopements by using an employee's badge.<br><br>Findings include:<br><br>1. Review of the provider's 7/26/25 SD DOH FRI involving resident 2 revealed: | F0689 | "Past Noncompliance - no plan of correction required" | |

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 |
|---|---|---|
| Ashley Nickel | LNHA | 01/13/26 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/30/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA NORTON | 3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105 |

| (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 |
|---|---|---|---|---|
| F0689 SS = D | Continued from page 1<br>*On 7/26/25 at approximately 1:47 p.m., certified nursing assistant E returned to the facility after being on break and noticed resident 2 sitting outside in his wheelchair on the sidewalk near the entrance by himself.<br><br>*According to the provider's investigation, the resident left the facility at approximately 1:27 p.m. when a visitor had opened the front door.<br><br>*Resident 2's goal was to go outside and enjoy the sun and the warm weather. He maneuvered his wheelchair independently.<br><br>*Resident 2 willingly returned with licensed practical nurse (LPN) K to the facility at approximately 1:47 p.m. with the assistance of a staff member.<br><br>*After his return inside, his vitals were taken and were stable. His skin assessment was completed and found to be normal.<br><br>*The resident's family, his primary care physician, the administrator, and the director of nursing (DON) were notified of the resident's elopement.<br><br>*Elopement audits were updated to include staff identifying residents named in the elopement binder as at risk for elopement.<br><br>2. Review of resident 2's electronic medical record (EMR) revealed:<br><br>*He was admitted to the facility on 10/2/24.<br><br>*He had an elopement risk evaluation on admission 10/2/24, and it was determined he was not at risk for eloping.<br><br>*His brief Interview for Mental status (BIMS) score was ten, which indicated he was moderately cognitively impaired.<br><br>*His diagnoses included Hypertension (high blood pressure), venous thrombosis (blood clot that blocks a vein), transient ischemic attack (TIA) (brief blockage of blood flow to the brain), and tachycardia (fast heart rate).<br><br>Interview on 12/30/25 at 12:32 p.m. with resident 2 revealed he was not aware of the date, time, his location, or past events when asked questions.<br><br>3. Interview on 12/29/25 at 5:18 p.m. with certified | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/30/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA NORTON | 3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105 |

| (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 |
|---|---|---|---|---|
| F0689 SS = D | Continued from page 2<br>nurse assistant (CNA) E revealed:<br><br>*He remembered on 7/26/25, after returning from his break, he saw resident 2 sitting outside of the facility alone and stated, “I just knew he could not be alone.”<br><br>*He knew that resident 2 was to be with a staff member when being outside.<br><br>*He alerted nursing staff, and the resident was brought back into the facility, assessed, and found to be stable.<br><br>*He indicated there is an elopement binder at both nurses' desks and at the front desk that has information on which residents are at an elopement risk, with a picture of each resident.<br><br>4. Review of the provider’s 9/12/25 SD DOH FRI involving resident 3 revealed:<br><br>*On 9/12/25 at approximately 6:42 p.m., LPN K had seen resident 3 sitting outside of the facility with another resident who had been safely assessed to go outside alone.<br><br>*According to the provider's investigation, the resident left the facility at approximately 6:31 p.m. when certified nurse aide (CNA) F and H were exiting the facility through the front door after their scheduled shift.<br><br>*Resident 3’s goal was to sit outside with her friend and enjoy the weather.<br><br>*She willingly returned to the facility at approximately 6:42 p.m. with the nursing manager and was assessed by LPN K and found to be stable.<br><br>*The resident's family, her primary care physician, the administrator, and the director of nursing (DON) were notified of the resident's elopement.<br><br>5. Review of resident 3’s electronic medical record (EMR) revealed:<br><br>*She was admitted to the facility on 10/13/22.<br><br>*She last had an elopement risk evaluation on 6/9/25, and it was determined she was a high risk.<br><br>*She had a history of wandering in the hallways, and this was documented on her care plan. | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/30/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA NORTON | 3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105 |

| (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 |
|---|---|---|---|---|
| F0689 SS = D | Continued from page 3<br><br>*Her BIMS score was 3, which indicated her cognition was severely impaired.<br><br>*Her diagnoses were anxiety, depression, and dementia.<br><br>Interview on 12/30/25 at 12:38 p.m. with resident 3 revealed:<br><br>*She did not recall the incident that had occurred on 9/12/24, but did know that if she wanted to go outside, she must go with a staff member.<br><br>6. Interview on 12/29/25 at 3:50 p.m. with CNA F revealed:<br><br>*He remembered on 9/12/25, after completion of his working shift, he exited the front door of the facility with CNA H and held the door open so resident 3 could exit the building.<br><br>*He indicated that he was not aware that resident 3 was a resident at the facility and stated he thought she was a visitor.<br><br>*He stated that he had only worked at the facility for a couple of months, so he was not sure who all the residents were who resided at the facility.<br><br>*He indicated that after the incident had occurred, he found out that there was an elopement binder at both nurses' desks and at the front desk that had information on which residents were an elopement risk, with a picture of each resident for staff to reference.<br><br>*He stated he remembered he received education on elopements and the elopement binders when he was first hired, but had forgotten about the elopement binder.<br><br>7. Interview on 12/29/25 at 4:33 p.m. with CNA H revealed:<br><br>* She remembered on 9/12/25, after completion of her working shift, she exited the front door of the facility with CNA F, who held the door open so resident 3 could exit the building.<br><br>*She indicated that she was not aware that resident 3 was not allowed to go outside without a staff member.<br><br>*She stated resident 3 was with another resident who had always gone outside alone, so she thought it was okay for resident 3 to go outside with that resident. | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/30/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA NORTON | 3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105 |

| (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 |
|---|---|---|---|---|
| F0689 SS = D | Continued from page 4<br>*She indicated that after the incident had occurred, she had learned there was an elopement binder at both nurses' desks and at the front desk that had information on which residents were an elopement risk, with a picture of each resident.<br><br>*She stated she remembered she received education on elopements and the elopement binders when she was first hired.<br><br>8. LPN K, who had assessed residents 2 and 3 after their elopements in July and September 2025, was not available for interview during the survey.<br><br>9. Interview on 12/30/25 at 2:36 p.m. with administrator A and director of nursing (DON) B regarding residents 2 and 3 revealed:<br><br>*Camera footage was reviewed for 7/26/25 when the resident eloped. They indicated resident 2, who used a wheelchair independently, had left the facility and gone through the front door around 1:27 p.m. that day.<br><br>*The front door that the resident had exited out of had been locked, but the alarm sensor was bypassed with the use of a staff member's badge. The badge allowed the sensor on the front door to release the lock, allowing the visitor and the resident to open the door and exit the facility.<br><br>*Camera footage for resident 3 was reviewed for 9/12/25 when the resident eloped. They indicated resident 3, who used a wheelchair independently, had left the facility and gone through the front door around 6:31 p.m. that day.<br><br>*The front door that resident 3 had exited out of had been locked, but the alarm sensor was bypassed with the use of one of the CNAs ' badges. The badge allowed the sensor on the front door to release the lock, allowing both CNAs and resident 3 to exit the facility.<br><br>*They had indicated that at the time of the residents' elopements, the elopement binder was at both nurses' desks and at the front desk. The binder has information on which residents are at an elopement risk, with a picture of each resident for staff to reference.<br><br>10. Review of the provider's elopement drills that were first initiated on 7/31/25 through 11/27/25 and the 9/16/25 -9/17/25 Staff In-Service Sheets revealed that all staff were educated on the provider's elopement policy, the binders, and the residents who were currently at risk for elopement. | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/30/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AVANTARA NORTON** | **3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105** |

| (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 |
|---|---|---|---|---|
| F0689 SS = D | Continued from page 5<br><br>11. Review of the provider's elopement policy that was last revised on 5/14/25 revealed:<br><br>*"Policy"<br><br>-"The facility must take steps to keep the resident safe and assess residents to identify those who are at risk for elopement. Facility personnel must investigate all reports of missing residents. Elopement drills should be conducted monthly."<br><br>*"Procedures"<br><br>-"1. Each resident will be evaluated upon admission to ascertain elopement risk. Care plan interventions will be initiated based on results. Elopement evaluations will be completed upon admission, readmission, significant change, and quarterly. Additionally, the evaluation will be completed should a resident have an elopement."<br><br>-"2. It is the responsibility of all personnel to report any resident attempting to leave the premises or suspected of going missing to the charge nurse immediately. A resident who has been evaluated as safe for leave of absence (LOA) should have a physician's order and sign out before leaving the facility."<br><br>-"...4. Upon return of the resident to the facility, the Director of Nursing or charge nurse should:"<br><br>--"a. Examine the resident for injuries."<br><br>--"b. Contact the attending physician and report what happened."<br><br>--"c. Contact the resident's representative and inform him/her of the incident."<br><br>--"d. Complete an incident report in the Risk Management section of PointClickCare (PCC)."<br><br>--"e. Make appropriate notations in the resident's medical record and update the care plan."<br><br>--"f. Complete the Elopement Risk Evaluation UDA."<br><br>12. The provider's 7/31/25 implemented actions to ensure the deficient practice does not reoccur was confirmed on 12/30/25 after record review revealed the facility had followed their quality assurance process, education was provided to all staff regarding resident elopements, all staff were educated on elopements, | F0689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/30/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA NORTON | 3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105 |

| (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 |
|---|---|---|---|---|
| F0689 SS = D | Continued from page 6<br>interviews revealed staff understood the education provided regarding those topics, observations revealed that staff are present at the front entrance when residents are present to ensure safety, and review of the provider's weekly and monthly elopement drills, and follow up elopement risk assessments revealed substantial compliance.<br><br>Based on the above information, noncompliance at F689 occurred on 7/26/25 and 9/12/25, and the provider's 7/31/25 and 9/12/25 and implemented corrective actions for the deficient practice confirmed on 12/30/25. The noncompliance is considered past noncompliance. | F0689 | | |
| F0804 SS = D | Nutritive Value/Appear, Palatable/Prefer Temp<br><br>CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br><br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, policy review, observation, interview, and record review, the provider failed to ensure that one of one employee (cook J) served food at a safe temperature, according to the provider's policy, which potentially led to one of one resident (4) having skin redness after spilling soup on himself. This citation is considered past noncompliance based on review of the corrective actions the provider implemented immediately following the incident.<br><br>Findings include:<br><br>1. Review of the provider's 12/19/25 FRI revealed that at about 7:30 p.m. on 12/19/25, resident 4 was eating tomato soup in his room. "The soup was 180 degrees Fahrenheit on the steam table line in the kitchen as it was plated." When resident 4 was about finished with his soup, he accidentally spilled the soup on the left upper quadrant of his chest and his left upper arm. He alerted nursing staff and reported no pain at that time. | F0804 | "Past Noncompliance - no plan of correction required" | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/30/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA NORTON | 3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105 |

| (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 |
|---|---|---|---|---|
| F0804 SS = D | Continued from page 7<br><br>His skin was assessed and “noted light redness to the areas where the soup had been…No blisters were seen and the skin remained intact.” His skin returned to his normal color about 15 minutes later. Resident 4 continued to report no pain. The provider planned to continue skin assessments daily for three days to monitor the area.<br><br>The last hot beverage assessment performed on 12/16/25 indicated that resident 4 was deemed appropriate for eating and drinking hot beverages. Resident 4 agreed to having hot beverages and soup served in a cup with a lid after the spilling incident.<br><br>2. Review of the provider’s 3/19/20 Food Temperatures policy revealed that acceptable serving temperatures for hot entrée items, like soups, casseroles, and meats, were acceptable to be served between 140 to 165 degrees Fahrenheit. “If temperatures do not meet acceptable serving temperatures, reheat the product or chill the product to the proper temperature. Take the temperature of each pan of product before serving.”<br><br>3. Observation and interview on 12/29/25 from 5:02 p.m. to 5:50 p.m. in the kitchen with cook I revealed the supper menu was chicken tenders, baked potato casserole, season green peas, bread and margarine, pear crumble, and beverage of choice.<br><br>Cook I measured the temperature of the food items. The baked potato casserole was at 170 degrees, the brown gravy was at 171 degrees, the plain mashed potatoes were at 180 degrees, the ground chicken was at 169 degrees, the pureed peas were at 145 degrees, and the regular peas were at 181 degrees. Cook I indicated that the chicken tenders were in the fryer at that moment, and they cooked them in batches to maintain crispiness.<br><br>Cook I said that some of the food items were too hot to serve. She first turned down the temperature of the steam wells and removed the covers from the food pans. She said that 165 degrees was the “top ideal temp” according to the policy. She added room temperature liquid butter alternative to the regular peas to bring the temperature down. She temped the peas again, which were 165 degrees. The fried chicken strips were measured at 169 degrees. She confirmed she was aware of the provider's policy for serving temperatures for the safety of residents.<br><br>4. Interview on 12/29/25 at 5:50 p.m. with dietary manager (DM) C revealed that there were soups on the current menu cycle. She was aware of the soup spill | F0804 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/30/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA NORTON | 3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105 |

| (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 |
|---|---|---|---|---|
| F0804 SS = D | Continued from page 8<br>that occurred on 12/19/25. At that time, the entire facility was on isolation due to a flu outbreak, so all residents were served room trays. Because of the room trays, and the increased amount of time from when the food was plated to when it was delivered, they wanted to keep higher temperatures on the steam table. The food loses temperature during transportation, even when using the insulated covers and carts. Resident 4's room was far away from the kitchen, so it would have taken more time to deliver his food, so the food temperatures "would have decreased significantly" after it was plated until it was served.<br><br>Immediately after the resident's spill incident, she spoke with cook J on the phone and provided education about the food temperature policy, and to cool down the food if it was too hot prior to serving to the residents. She educated cook J on ways to cool the food to bring it down to an acceptable and safe temperature.<br><br>5. Interview on 12/30/25 at 1:29 p.m. with administrator A revealed that the provider's December 2025 monthly staff meeting included the topic of hot liquid safety. She and the director of nursing provided education to all staff starting on 12/17/25.<br><br>6. Interview on 12/30/25 at 1:50 p.m. with resident 4 revealed that he described the soup as "scalding" on the day he spilled it on himself. He was sitting in bed while eating his supper that day. He confirmed the head of his bed was raised so he was seated in an upright position for eating his meal. All meals were served in their rooms at that time because of the flu.<br><br>He said that as he was lifting the bowl to take a drink of the soup, he accidentally spilled it on his chest and left arm. He was covered with a blanket, so most of the soup was spilled on the blanket. He yelled for help to get cleaned up. He said the burn was not painful, but "it stung." His skin was reddened a bit after the spill but returned to its normal color within two hours. He confirmed that hot liquids were now served to him in a cup with a handle and lid. He mentioned that he was fine with the hot liquids being served in those cups, but he did not enjoy his hot cereal served in those cups.<br><br>7. Phone interview on 12/30/25 at 1:54 p.m. with cook J revealed that he did not modify the soup prior to serving to the residents on 12/19/25. The final cooking temperature of the tomato soup was 181 degrees, and the temperature when he started plating the food that day was 171 degrees. He confirmed that he received education regarding safe food temperatures and steps to | F0804 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/30/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA NORTON | 3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105 |

| (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 |
|---|---|---|---|---|
| F0804 SS = D | Continued from page 9<br>take if the food was too hot before serving it to the residents.<br><br>8. Interview on 12/30/25 at 2:24 p.m. with DM C revealed that the provider's monitoring system after the spill accident for resident 4 on 12/19/25 included observational audits of meal service to ensure the cooks were properly temping the foods and modifying the foods if the temperatures were outside the acceptable and safe serving temperatures. She provided immediate education to staff if their process deviated from the policy expectations. She also reviewed the food temperature logs each day to ensure the cooks were recording the food temperatures for each food item served.<br><br>9. Review of the provider's menu for supper on 12/19/25 revealed that the meal included tomato soup, grilled cheese sandwich, creamy cucumber salad, spiced peaches with ice cream, and beverage of choice.<br><br>10. Review of the provider's meal temperature log from 12/19/25 revealed that the soup had a final cooking temperature of 181 degrees and a serving temperature of 171 degrees.<br><br>11. Review of the provider's 12/19/25 Staff In-Service Sheet revealed that all dietary staff were educated on the food temperature policy and what to do if the food was too hot or too cold prior to serving to the residents.<br><br>12. Review of the provider's 12/17/25 through 12/19/25 December All Staff Meeting In-Service Sheets revealed that all staff across all departments received education on the provider's hot liquid safety policy.<br><br>13. Review of resident 4's electronic medical record revealed that on 12/19/25 at around 7:20 p.m., a staff member heard resident 4 screaming in his room. "…upon entering [resident 4's] room, it could be seen [that] resident had tomato soup on his throat, upper left quadrant of his chest and left arm. When questioning resident on how [the] situation occurred he stated he was eating his soup, put it on his table and was turning [the] side table away, he then 'smacked the bowl with the back of his hand', when attempting to move [his] arm back."<br><br>Resident 4 was cleaned up and the nurse assessed his skin. His skin was intact and there were no blisters. His skin was mildly red and "blanchness noted to skin," meaning that it remained pale when pressed which could indicate reduced blood flow to the area. He had mild | F0804 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/30/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AVANTARA NORTON** | **3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105** |

| (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 |
|---|---|---|---|---|
| F0804 SS = D | Continued from page 10<br>pain to the area. His power of attorney (POA), primary care provider, and the director of nursing were notified about the incident.<br><br>A new intervention was added to his care plan on 12/20/25 that read “hot liquids will now be put in a cup for resident to better access/use cup, [resident 4] agreed and is very pleased with the intervention.”<br><br>His skin was evaluated for three days following the accident with no alterations noted.<br><br>Resident 4 admitted to the facility on 12/13/24. His admission hot liquids safety assessment completed that day indicated that he required hot liquid safety measures such as a lidded cup and staff assistance with hot liquids.<br><br>A hot liquid safety assessment was completed upon his admission to the facility and every three months afterwards. On 3/15/25, he was reassessed as safe and “resident is not considered to be at risk related to hot liquids at this time.” The lidded cup was removed from the intervention list. On 6/16/25, he was reassessed as needing hot liquid safety interventions of “staff assistance” and “hot beverage at table.” On 9/16/25, he was assessed as “not a risk at this time,” with the interventions remaining the same as 6/16/25. On 12/18/25, he was assessed as “not a risk at this time.”<br><br>Resident 4 was reassessed for hot liquid safety on 12/19/25 after his spill of the hot soup, which indicated he was a low risk. A comment was added that read, “Resident has a history of hot liquid spill/injury, new intervention is required. The intervention included using a lid on the cup or mug.<br><br>14. Review of the provider’s 11/18/25 Hot Liquid Safety policy revealed that staff should “serve the hot beverages between 140 and 155 degrees. Hot liquid temperatures should be taken and recorded at every meal and/or when prepared to ensure the temperature is within the above parameters before being served.”<br><br>15. The provider’s 12/19/25 implemented actions to ensure the deficient practice does not reoccur was confirmed on 12/30/25 after record review revealed the facility had followed their quality assurance process, education was provided to dietary staff regarding acceptable serving temperatures, all staff were educated on hot liquid safety, interviews revealed staff understood the education provided regarding those topics, observations revealed that the dietary staff | F0804 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/30/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AVANTARA NORTON** | **3600 SOUTH NORTON AVENUE , SIOUX FALLS, South Dakota, 57105** |

| (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 |
|---|---|---|---|---|
| F0804 SS = D | Continued from page 11<br>appropriately adjusted the temperature of the food to ensure safety, and a review of the provider's follow-up monitoring process revealed substantial compliance.<br><br>Based on the above information, noncompliance at F804 occurred on 12/19/25, and the provider's 12/19/25 implemented corrective actions for the deficient practice confirmed on 12/30/25, the noncompliance is considered past noncompliance. | F0804 | | |