DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435060	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/25/26 through 1/27/26. Avantara Saint Cloud was found not in compliance with the following requirements: F695, F761 and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/25/26 through1/27/26. The areas surveyed were quality of care related to resident elopements(left the facility without staff knowledge) and resident rights related to a staff member who potentially video recorded residents. Avantara Saint Cloud was found in compliance.	F0000		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure staff followed professional standards of practice regarding the respiratory care for one of one sampled resident (78), who received oxygen when he previously resided at a hospital from 7/31/25 through his admission to the provider's facility on 1/21/26, when staff failed to clarify and provide the resident's oxygen needs. Findings include: 1. Observation and interview on 1/25/2026 at 1:49 p.m.	F0695	1. LPN G obtained orders for oxygen at a rate of 3 liters per minute through a nasal cannula on 1/26/26 upon identification during the annual recertification survey. All residents with orders for oxygen are at risk of not receiving oxygen due to not clarifying admission orders to ensure oxygen is provided. 2. Director of Nursing (DON) or designee will educate all licensed nurses on the Following Physician Orders policy and the Oxygen Administration policy to ensure admission physician orders are clarified and orders for oxygen are implemented per physician order. Education will be completed no later than March 10, 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 audit all new resident admission orders to ensure orders are clarified and initiated per their physician orders. Audits will be completed weekly X 4 weeks and then monthly for 2 months. Results of audits will be discussed by the DON or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting with the Interdisciplinary Team (IDT) and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	March 10, 2026

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F0695 SS = D	Continued from page 1 with resident 78 in his room revealed: *He was sitting in his recliner chair with an oxygen concentrator machine (a device that filters room air into purified oxygen) stored between the chair and his bed. *There was a plastic storage bag attached to the oxygen concentrator machine, which had "1/26/26" and initials handwritten on it in black ink. *An unopened package of Procure brand seven-foot nasal cannula (a flexible tube with two prongs inserted into the nostrils to deliver oxygen) was sitting on his bedside table. *He thought he used oxygen, but did not know how often. 2. Review of resident 78's electronic medical record (EMR) revealed: *He admitted to the facility on 1/21/26 from a hospital. *His diagnoses included Chronic Obstructive Pulmonary Disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe), and dementia (a group of symptoms affecting memory, thinking, and social abilities). *His 1/27/26 Brief Interview for Mental Status (BIMS) assessment score was 7, which indicated he had severe cognitive impairment. *The hospital progress note from the physician dated 7/31/25 at 3:12 p.m. revealed: -He was to "use 3L [3 liters of] O2 [oxygen] via NC [nasal cannula] at bedtime." *His discharge orders from the hospital dated 1/14/26 by the physician did not discontinue his admitting hospital order for oxygen dated 7/31/25. *The hospital physician's progress notes revealed that resident 78 had no new, changed, or discontinued oxygen orders. *An admission nursing note dated 1/21/26 at 1:25 p.m. regarding resident 78 read, "He wears oxygen at 3 liters at night". *His oxygen saturation (percentage of oxygen in the	F0695		

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F0695 SS = D	Continued from page 2 blood) levels were documented twice since his admission to the facility and were at 92% (percent) on 1/21/26 at 11:44 a.m. and 95% on 1/25/26 at 6:09 a.m., both while on room air (without oxygen). 3. Resident 78's 1/21/26 baseline care plan revealed: *A focus area of: "Alteration in respiratory functioning related to COPD." *The goal for that focus area was: "He [resident 78] will not have respiratory distress, and his respiratory functioning will improve or maintain through the next review." *The interventions were: -"Administer oxygen and other medications and respiratory treatments as ordered." -"Assess respiratory status: Observe for shortness of breath, check lung sounds, call MD [doctor] for any changes and/or abnormalities." -"Elevate head of bed as needed." -"Keep call light within reach." 4. Interview on 1/26/2026 at 3:23 p.m. with certified nursing assistant (CNA) H revealed: *She did not know why resident 78 had an oxygen concentrator machine or why the unopened oxygen tubing was not connected to it. *She was unsure if he needed to wear oxygen or what his oxygen instructions were, but she would ask the nurse. 5. Interview and observation on 1/26/2026 at 3:25 p.m. with licensed practical nurse (LPN) G in resident 78's room revealed: *Resident 78 was sitting in his recliner chair. *The unopened nasal cannula tubing package remained on his bedside table. *She thought the hand-off report (communication of transferring residents' information) received from the hospital nurse and the provider's nurse indicated that resident 78 was to receive 3 liters (L) of oxygen at	F0695		

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F0695 SS = D	Continued from page 3 night. *She stated that she would have to check his orders. *She asked resident 78 if he used oxygen, and he stated, "Yes, yes, I do". *She acknowledged there was an oxygen concentrator machine in the resident's room with no oxygen tubing connected to it, and an unopened package of nasal cannula tubing on his bedside table. 6. Interview on 1/26/2026 at 4:17 p.m. and again at 4:31 p.m. with LPN G revealed: *Resident 78 did not have physician's orders for oxygen use. *She stated that she called resident 78's daughter who thought the resident was to receive oxygen at night. *LPN G received an oxygen order for resident 78 from his previous hospital physician. -She [physician] indicated he was to have oxygen administered at a rate of 3 liters per minute through a nasal cannula every night. *She thought his oxygen needs were not clarified during the hand-off report when he was admitted to the facility, and he did not receive oxygen at night since his admission on 1/21/26. 7. Interview and record review on 1/26/2026 at 4:42 p.m. with director of nursing (DON) B revealed: *She confirmed the hand-off report from the hospital nurse to the provider nurse indicated that resident 78 was to receive 3 liters of oxygen at night. *She stated that if any details in the nurse hand-off report between the two facilities were unclear, the nursing staff should have clarified them with resident 78's physician. *She acknowledged that resident 78's 7/31/25 admission progress note from his physician at the hospital had an oxygen order that read, "use 3L [liters] O2 [of oxygen] via NC [nasal cannula] at bedtime". *She acknowledged resident 78's 1/21/26 admission nurse's note read, "He wears oxygen at 3 liters at	F0695		

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F0695 SS = D	Continued from page 4 night". *She confirmed there was no current physician order for resident 78's oxygen use. 8. Interview on 1/27/2026 at 1:50 p.m. and again at 3:30 p.m. with director of nursing (DON) B revealed: *She stated that resident 78 may not have received oxygen at night since his admission on 1/21/26. *The facility didn't have a policy regarding the nurse hand-off reporting. *She stated that the staff followed the nurse hand-off reporting process indicated in the Fundamentals of Nursing book. 9. Interview on 1/27/2026 at 5:15 p.m. with administrator A revealed: *The facility didn't have a policy regarding nurse hand-off reporting. *She expected the nursing staff to follow the physician's order policy. *She acknowledged that the hand-off report between the nurses indicated that resident 78 was to be on 3 liters of oxygen at night. *She acknowledged that the provider's 1/21/26 admission nurse's note at 1:25 p.m. for resident 78 read, "He wears oxygen at 3 liters at night". *She acknowledged that resident 78's 1/21/26 baseline care plan indicated needed oxygen at night. *She expected the nurse who received the hand-off report to notify resident 78's physician to clarify his oxygen needs upon his admission to the facility. *She agreed there was no document to support that resident 78 received oxygen for four nights. 10. Review of the providers Fundamentals of Nursing, Tenth Edition, Copyright 2021 by Elsevier Inc. revealed: *"Hand-off reporting was a real-time process."	F0695		

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F0695 SS = D	Continued from page 5 *"Offers accepting provider to clarify and confirm important details about a patient's [resident's] plan of care, patient progress, and continuing needs during the transfer of information." *"The report should include accurate, up-to-date, and pertinent information to the next nurse assuming patient [resident] care." *"Hand-off report is to ensure continuity of care for a patient [resident] and prevent errors or delays in providing nursing interventions." 11. Review of the provider's revised November 18, 2025, Following Physician Orders policy revealed: *"To correctly and safely receive and transcribe physician's orders so correct order is followed/administered." *"All physician's orders will be received by a licensed nurse, therapist, or dietician." *"Orders may be received through written communication in the resident's chart, verbally, by fax, electronically entered into PCC, or per the telephone." *"New admission/readmission physician orders and all transcription of orders should be transcribed by a nurse and be double checked by a second nurse to ensure that all steps have been carried out to avoid errors." *"All physician orders should be followed as written. The prescriber should be contacted if any order is not clear/understood." 12. Review of the provider's revised November 18, 2025, Oxygen Administration policy revealed: *"Verify that there is a physician's order for oxygen that includes route (via mask or nasal cannula), liter flow, and duration (i.e., continuous, prn, at night, etc)."	F0695		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F0761	1. No immediate corrective action could be taken for the storage of expired medical supplies and expired medications. Central Supply clerk discarded the box of three-layer compression bandages, box of Optifoam AG Nonadhesive Dressing with Antibacterial Silver, 2 boxes of Opticell Chitosan-Based Gelling Fiber dressings, nine individually packaged lemon-flavored glycerin swab sticks, the catheter urine collection leg bags, and the individual Lidocaine 5%	March 10, 2026

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F0761 SS = E	Continued from page 6 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure medications and biologicals were labeled, stored, and discarded regarding: *Expired medications and supplies were discarded in two of two observed storage rooms. *One of one medication cart that was left unattended and unlocked by one of one registered nurse (RN) (I) in the dining room, where residents, unauthorized staff, and visitors could access it. *Medications with shortened expiration dates (medications that expire in a timeframe after opening that is prior to the manufacturer's expiration date) stored in one of one medication carts were labeled when they were opened. Findings include: 1. Observation on 1/26/26 at 1:52 p.m. in the main storage room revealed: *One box of a three-layer compression bandage system [bandages layered to provide sustained and cushioned compression for treating venous issues such as leg wounds with swelling) that expired on 9/6/24.	F0761	medicated patch on 01/26/26 upon identification during the annual recertification survey. All residents are at risk for the use of expired medical supplies during cares. DON, Unit Manager, MDS Coordinator, and Central Supply clerk completed a full house audit of the central supply storage rooms and treatment supply cart on 02/06/26 and discarded any other expired medical supplies. No immediate correction could be taken for RN I failing to lock her medication cart to ensure all medications are secured when not in sight of nurse. All residents are at risk of their medications not being secured when not in sight of nurse or certified medication aides (CMAs). RN I discarded Resident 61's Lispro and Lantus with shortened expiration dates that were not dated when opened for administration and Resident 73's nystatin-triamcinolone upon discovery during the annual recertification survey on 1/27/26. All residents are at risk of receiving medications that are expired. Charge Nurse, RN completed a full house audit of all medication carts on 2/3/26 and removed any expired medications and medications that were undated that have a shortened expiration date. 2. The DON or designee will educate all nursing staff and Central Supply clerk to ensure medical supplies are discarded no later than the expiration date present on the package. DON or designee will educate all licensed nurses and CMAs, including RN I, on the Medication Administration General Guidelines policy, the updated List of Medication with Shortened Expiration Dates, and Storage of Medication policy to ensure medications are secured in the medication carts when not in sight of nurse or CMA, ensure medications with shortened expiration dates are dated when opened to prevent using beyond the shortened expiration date, and to ensure medications are discarded upon expiration date to ensure expired medications are not administered. Education will be completed no later than March 10, 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 complete an audit of all central supply storage rooms, all medication carts, and the treatment supply cart to ensure no expired medications or medical supplies are being stored and medications with shortened expiration dates are dated when they are opened. DON or designee will audit 5 nurses and/or CMAs, including RN I, during a medication pass to ensure the medication cart is locked securing medications when not in sight of nurse or CMA. Audits will be completed weekly X 4 weeks and then monthly for 2 months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F0761 SS = E	Continued from page 7 *One box of "Optifoam AG Nonadhesive Dressing with Antibacterial Silver" (non-stick dressing infused with silver to act as an antibacterial agent) that expired on10/3/24. *Two boxes of "Opticell Chitosan-Based Gelling Fiber" (dressing with absorbent fibers that gel when soaked with wound drainage) that expired on11/21/24. *A plastic storage container filled with nine individually packaged lemon-flavored glycerin swab sticks (disposable, single-use, cotton swabs to moisten, clean, and refresh the mouth) that expired on 2/25. *A plastic storage container filled with catheter (a flexible tubing placed in the bladder to drain urine) urine collection leg bags (a bag that can strap to the leg) that expired on 10/23. *There was a metal shelf in the main storage room with an individually packaged Lidocaine 5% medicated patch (for pain) on it. 2. Observation and interview in the dining room on 1/27/26 at 8:27 a.m. with RN I revealed: *The medication cart was placed near the entrance to the dining room. RN I was across the room with her back to the medication cart, administering medications to a resident. *Multiple staff members and residents were in the dining room and walked past the medication cart. *The unattended medication cart was unlocked and accessible to any resident, unauthorized staff, or visitor who passed by. *RN I acknowledged that she did not lock the medication cart and was not directly observing it. *She should have locked the cart before she left it unattended. *She stated she usually locked the cart before walking away from it. 3. Interview on 1/27/26 at 11:53 a.m. with Administrator A in the main storage room revealed: *She acknowledged that there were various supplies in	F0761		

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F0761 SS = E	Continued from page 8 the storage room that were expired based on the manufacturer's printed expiration date on the packages. *She was "disappointed" because the staff were to be performing audits on the supplies and discarding expired supplies. *She stated that the specialized wound care dressings (with silver and chitosan-based gelling fiber) were no longer effective if they were past the manufacturer's printed expiration date. *She thought that the Lidocaine 5% patch on the shelf belonged to a resident. She would remove the medicated patch from the room and dispose of it. 4. Observation and interview on 1/27/26 at 2:10 p.m. with assistant director of nursing (ADON) C in the small storage room revealed: *Eight of eight sterile catheter insertion kits expired on 10/31/25, and one of those kits was opened. *ADON C confirmed that those kits were expired and should not be available for use. *She thought the opened kit was used for training and stated it should have been labeled "Training." *Medical records director J was responsible for removing outdated supplies from the small storage room. 5. Observation and interview on 1/27/26 at 2:41 p.m. with director of nursing (DON) B of a medication cart in the main storage room revealed: *Resident 61' s Lispro (rapid-acting insulin) was not dated to indicate when it was opened. *Resident 61's Lantus (long-acting insulin) was not dated to indicate when it was opened. *DON B was aware that those medications had shortened expiration dates, based on the date they were opened, and confirmed there was no date to indicate when they were opened. *She was unable to tell if or when the medications were expired since they were not labeled with the date they were opened. *Resident 73's nystatin-triamcinolone (a medication	F0761		

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F0761 SS = E	Continued from page 9 used to treat fungal skin infections and reduce inflammation) expired on 9/30/25. *She confirmed that medication was expired, and should have been removed from the medication cart and discarded. 6. Interview on 1/27/26 at 3:45 p.m. with DON B regarding the observation of the unattended, unlocked medication cart in the dining room revealed that she expected the staff to lock the medication carts before they walked away from them. 7. Review of the provider's September 2018 Medication Administration General Guidelines policy revealed: *"Medication Administration:" -"Check expiration date on package/container. No expired medication will be administered to a resident." --"The nurse shall place a 'date opened' sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened." --"Certain products or package types... have specified shortened end-of-use dating, once opened, to ensure medication purity and potency." -"During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse." Review of the provider's September 2018 Storage of Medication policy revealed: *"Policy -Medications and biologicals are stored properly, following the manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications." *"Procedures" -"In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as	F0761		

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F0761 SS = E	Continued from page 10 medication aides) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access." -"Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used." -"Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists." -"Medication storage conditions are monitored on a regular basis as a random quality assurance ("QA") check. As problems are identified, recommendations are made for corrective action to be taken." Review of the undated List of Medications with Shortened Expiration Dates that the provider used for reference revealed: *Lispro should be discarded 28 days after opening. *Lantus should be discarded 28 days after opening. An Outdated Supplies policy was requested, but no policy specific to outdated supplies was provided by the end of the survey.	F0761		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880	1.No immediate corrective action could be taken for CNA F and LPN E failing to perform hand hygiene when assisting residents 62, 56, 22, 1, and 38 with their meals. All residents are at risk for adverse effects due to infection control not being maintained from lack of appropriate hand hygiene when assisting residents with their meals. 2. DON or designee will educate all CNAs and nurses, to include CNA F and LPN E, on the Hand Hygiene policy to ensure infection control is maintained with hand hygiene being performed while assisting residents with their meals. Education will be completed no later than March 10, 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.	March 10, 2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435060	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 11 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport	F0880	3. DON or designee will observe 10 opportunities for hand hygiene during meals to ensure infection control is maintained with hand hygiene being performed while assisting residents with their meals. These observations will include CNA F and LPN E. Observations will be completed weekly X 4 weeks and then monthly for 2 months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435060	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 12 linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of one observed certified nursing assistant (F) who assisted three of three sampled residents (62, 56, and 22) with eating during one of one observed noon meal service. *One of one observed licensced practical nurse (E) who assisted two of two sampled residents (1 and 38) with eating during one of one noon meal service. Findings include: 1. Observation on 1/25/26 at 11:53 a.m. in the main dining room during the noon meal revealed: *Resident 62, 56, and 22 sat at the same dining table (table 6). *Certified nursing assistant (CNA) F helped resident 62 apply a clothing protector, moved her wheelchair closer to the dining room table, and locked resident 62's wheels. *Without washing or sanitizing her hands, CNA F went to the serving counter and picked up two meal plates and served them to the residents. She returned to the serving counter and used an alcohol-based hand rub (ABHR) to sanitize her hands. She picked up two meal plates and served them to two other residents. *CNA F then sat down at a chair in between resident 56 and resident 62 and gave resident 62 a bite of food with her right hand. *CNA F stood up and adjusted resident 62's wheelchair. She removed the leg supports from the wheelchair and placed them in a storage bag on the back of that wheelchair. CNA F sat back down and readjusted resident 62's wheelchair closer to the dining table. *Without sanitizing her hands, CNA F scooped a bite of food on a spoon with her right hand. She gave resident	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435060	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = E	Continued from page 13 62 that bite of food and placed the spoon back on resident 62's plate. -CNA F then scooped a bite of food on a spoon from resident 56's plate and gave it to resident 56 with her right hand. -Without washing or sanitizing her hands, CNA F scooped a bite of food on a spoon from resident 62's plate and gave it to resident 62 with her right hand. Without washing or sanitizing her hands, she gave resident 56 a bite of food with her right hand. *Resident 22 started to back away from the dining table. CNA F got up, moved him back to the table and encouraged him to eat. Without washing or sanitizing her hands, she used her right hand to give resident 22 a bite of food. -CNA F continued that same pattern while she helped residents 62, 56, and 22 to eat their meals without washing or sanitizing her hands between assisting each of those residents. 2. Observation on 1/25/26 at 12:17 p.m. in the main dining room during the noon meal revealed: *Licensed practical nurse (LPN) E was sitting in between residents 1 and 38 at table 3. *LPN E used her right hand and gave resident 1 a bite of food. *Without washing or sanitizing her hands, she gave resident 38 a bite of food with her right hand. *LPN E continued that pattern three more times while she helped residents 1 and 38 eat their meals without washing or sanizing her hands between assisting each of those residents. 3. Further observation on 1/25/26 at 12:32 p.m. in the main dining room revealed: *CNA F remained seated at table 6. She stood up was still at the dining table with resident 62, 56, and 22. *CNA F remained seated at table 6. She stood up and walked over to the side of the table where resident 22 sat in his wheelchair. CNA F moved resident 22's plate to the side and used two forks to gather several pieces of food that had fallen off the resident's plate onto the table into a pile on the table.	F0880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435060	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = E	Continued from page 14 *CNA F scooped up that food pile with those two forks and then assisted resident 22 with eating that same food. 4. Interview on 1/27/26 at 1:36 p.m. with CNA F revealed: *She acknowledged that the table was not a clean surface and it is not her normal practice to feed residents food that fell onto the table. 5. Interview on 1/27/26 at 1:50 p.m. with administrator A revealed: *She expected the staff to wash or sanitize their hands after providing any care to a resident or after touching personal equipment such as wheelchairs. *She expected the staff to discard food that fell off a resident's plate into the trash can and not to serve it to the resident. 6. Interview on 1/27/26 at 2:01 p.m. with director of nursing (DON) B and registered nurse (RN) regional clinical consultant D revealed: *Staff were expected to wash or sanitize their hands before and after providing resident care and in between assisting each resident with eating. *They both expected staff to wash or sanitize their hands after moving or manipulating a resident's wheelchair. *They stated that the dining room table was not a clean surface and the residents should not be given food off of that surface to eat. 7. Review of the provider's 5/15/25 Hand Hygiene policy revealed: *"All personnel shall follow the hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." *Hand hygiene consists of using alcohol-based hand rub or washing at a sink with soap and water. *Staff were expected to perform hand hygiene before and after direct contact with residents, before and after eating or handling food, after contact with a resident's intact skin, and "after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident".	F0880		

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F0880 SS = E		F0880		

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	435060	A. BUILDING B. WING	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 1/26/26 through 1/27/26. Avantara Saint Cloud was found in compliance.	E0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashaley Altena	Administrator	02/20/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435060	A. BUILDING 01 - MAIN BUILDING B. WING	01/27/2026

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K0000	INITIAL COMMENTS A recertification survey was conducted from 1/26/26 to 1/27/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Saint Cloud was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0712 Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on document review the provider failed to complete five of the twelve minimum required fire drills in 2025. That affected 100% of facility residents and staff who lived and worked in the facility. Findings include:Review of the provider's 2025 fire drill documentation on 1/26/2026 at 4:10 p.m. in the resident dining room revealed no documentation that the facility completed five of the required twelve fire drills in 2025. Seven fire drills were documented as completed in 2025, but those drills were not rotated to ensure they were performed equally across all shifts.	K0712	1.No immediate corrective action could be taken for the missing documentation of five fire drills from 2025. This has the potential to affect all residents who live and all staff who work within the facility. 2.Administrator or designee will educate the facilities Interim Maintenance Director on fire drill completion and fire alarm signal transmission requirements to ensure fire drills are completed on all three shifts at a minimum of once per quarter. Education will be completed no later than March 10, 2026. 3.Administrator or designee will audit for completion and documentation of the monthly fire drills and transmission of the fire alarm system. Audits will be completed monthly for 4 months. Results of audits will be discussed by the Administrator or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting with the Interdisciplinary Team (IDT) and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	March 10, 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
Ashaley Altena	Administrator	02/20/26

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10667	A. BUILDING: _____ B. WING _____	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted on 1/25/26 through 1/27/26. Avantara Saint Cloud was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Ashaley Altena | Administrator | 02/20/26