STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	**1620 NORTH 7TH STREET RAPID CITY, SD 57701**

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/12/25 through 1/14/25. Avantara North was found not in compliance with the following requirements: F550, F742, F804, F880 and to have past non-compliance at F604. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 1/12/25 through 1/14/25. Areas surveyed included resident abuse and restraints. Avantara North was found in compliance.	F 000		
F 550 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	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Celina Block*
TITLE: *Administrator*
(X6) DATE: *2/7/2025*

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.

PRINTED: 01/30/2025
FORM APPROVED
OMB NO. 0938-0391

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F 550	Continued From page 1 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 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 observation, interview, record review, and policy review, the provider failed to protect the residents' right to be cared for with respect and dignity for: *One of one sampled resident (6) by one of one certified therapy assistant (COTA) (K). *One of one sampled resident (32) who had a container for rinsing his colostomy bag stored on his bedside table in full view of others. Findings include: 1. Observation on 1/13/24 at 8:33 a.m. of resident 6 in the dining room revealed: *She, three unidentified residents, and certified occupational therapy assistant (COTA) K were seated at a dining room table together. -COTA K was seated beside resident 6 to her left. *Resident 6's breakfast meal was in front of her	F 550	1.COTA K has been educated on the Resident Dignity and Privacy policy to include how to properly address a resident and educated on customer service expectations. Resident 32's container was immediately removed from the bedside table to promote privacy and dignity upon report from surveyor during survey. 2.All residents are at risk for adverse effects related to staff not following the facility dignity and privacy policy. An audit of all residents with colostomy was completed to ensure their storage containers are stored in a manner that promotes dignity and privacy. 3.The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the Resident Dignity and Privacy policy. The Admin, DON or designee will educate all staff on this policy to ensure resident dignity and privacy is completed. Further education on customer service will be initiated. Education will occur no later than February 20, 2025, and those not in attendance due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4.The Admin, DON or designee will audit 5 residents to ensure dignity & privacy are completed by staff. Audits will be weekly for 4 weeks, bi-weekly for 2 months, and monthly for 2 months. Results of the audits will be discussed by the Admin, 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 findings.	2/28/25

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F 550	Continued From page 2	F 550		

and was mostly uneaten.
*COTA K was looking at the cell phone in his lap.
-He turned his attention to resident 6 after the surveyor walked by that table.

2. Continued observation between 8:35 a.m. and 9:18 a.m. of COTA K and resident 6 at the dining room table revealed:
*The resident fed herself no more than three bites of food during that time.
*COTA K physically assisted her in bringing a fork with food on it from her plate to her mouth one time.
*COTA K either had one hand on his forehead while he looked down at a cell phone, held the phone with both hands while he looked down at it, or looked down towards the top of the table and wrote on a piece paper on the table during the observation.
*He had a face mask on and it was not known if he had verbally interacted with the resident during that time.

3. Continued observation and interview with certified nurse aide (CNA) G at 9:25 a.m. revealed:
*She sat next to resident 6 and assisted her with eating after COTA K had left the dining room.
*Two full glasses of fluid, a full-serving of mechanically altered sausage and gravy, most of her Cream of Wheat cereal, and one piece of french toast remained on resident 6's plate.
*She shook her head yes or no to CNA G's questions and responded to her verbal encouragement to eat.
*CNA G had known resident 6 had sat in the dining room for about an hour before she had arrived.
-She agreed the resident's food was cold and

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F 550	Continued From page 3 would no longer have been appetizing. 4. Interview on 1/13/25 at 9:40 a.m. with COTA K regarding the above dining room observation revealed: *Resident 6 was a "feeder." -He had not known the use of that term was considered to have been derogatory. *The resident's occupational therapy goals had included improving her self-feeding abilities. -He had verbally interacted with the resident during the meal service but agreed it was disrespectful to have not made eye contact with her during those interactions. *He agreed the resident's food was likely cold and no longer tasteful after over an hour had passed. 5. Interview on 1/14/24 at 7:45 a.m. with COTA/therapy program director L regarding the above dining room observation revealed: *"That is not our standard of care expectation." *Cell phone use was prohibited except in the case of an emergency. *Eye contact and conversation with the resident was expected of COTA K during that meal. Appropriate verbal and/or physical assistance should have been provided. Food should have remained at a palatable temperature during the meal service. *The use of terms such as "feeder" to describe a resident was unacceptable. 6. Random observations on 1/12/25 and 1/14/25 revealed resident 32's container for rinsing his colostomy bag was stored on his bedside table in full view of anyone who may have passed by or entered his room. 7. Observation on 1/13/25 at 8:15 a.m. of resident 32 while in his room revealed the colostomy	F 550		

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F 550	Continued From page 4 rinsing container was on his bedside table next to his breakfast tray while he was eating his breakfast. 8. Interview on 1/14/25 at 2:25 p.m. with infection preventionist (IP) C revealed it was her opinion that having resident 32's colostomy rinsing container exposed on his bedside table was a dignity issue. 9. Review of the provider's November 2024 Resident Dignity & Privacy policy revealed: *"Policy: 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.	F 550		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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.	F 604		

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§483.12(a) The facility must-

§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
This REQUIREMENT is not met as evidenced by:
Based on a South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review, and personnel file review, the provider failed to ensure one of one sampled resident (35) was free from physical restraint by two of two certified nursing aides (CNA) (M and Q) and one of one licensed practical nurse (LPN) (R) who physically held down the resident's lower extremities while they provided his personal care. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented immediately following the incident.
Findings include:

Past noncompliance: no plan of correction required.

1. Review of the provider's 11/23/24 SD DOH FRI revealed abuse and the physical restraint of resident 35 was identified by registered nurse (RN)/assistant director of nursing S during a review of the resident's progress notes.

Review of resident 35's electronic medical record (EMR) revealed:
*His admission date was 5/31/23 and his diagnoses included vascular dementia, anxiety,

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F 604	Continued From page 6 depression, and pain. *He had been on hospice services since 10/8/24. *His Brief Interview for Mental Status (BIMS) assessment score was 12 which indicated he had moderate cognitive impairment. *An 11/22/24 progress note documented by LPN R indicated: -"Behavior: resident refused to be changed since he went to bed. at 0400 [4:00 a.m.], this nurse was called to resident's room. when this nurse got there the resident was yelling and swearing at staff. i informed the resident that he needed to be changed. resident still refused. i informed resident that if he wasn't changed that his skin would start to break down. so we started to change the resident and he became combative. we [CNAs M and Q and LPN R] restrained him so that we could get him changed. once changed we left resident's room." Observation and interview with resident 35 on 1/12/25 at 3:40 p.m. in his room revealed he: *Sat in his recliner watching television. *Stated he was "fine" and had "no concerns". -Declined any further conversation at that time or in the future. Continued review of resident 35's EMR revealed: *A skin assessment was completed on 11/23/24 and no new skin concerns had been identified following the 11/22/24 incident. *The resident's behavioral care plan was updated on 11/25/24 and again on 1/9/25 to reflect staff were to: -Approach and reapproach the resident when he refused personal care. -Educate the resident regarding the risks of refusing care. -Utilize staff who had a rapport with the resident	F 604		

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to provide his personal care.
-Use of an incontinent brief that was more absorbent and provided better skin protection.

Interview on 1/12/25 at 6:15 p.m. with CNA M regarding the FRI revealed:
*He confirmed the content of the FRI above was factual.
*He complied with LPN R's instruction to physically restrain resident 35 when the resident had refused care knowing what he was asked to do "was not right."
-He failed to report the incident to his supervisor or any other member of management.
*Resident 35 had a history of non-compliance with personal care that escalated after his spouse passed away in the fall of 2024.
-They had resided together in the nursing home.
*Resident 35's care refusals had been managed by leaving him alone for a short period of time and then reapproaching him.
*Repeated care refusals had been reported to a nurse.
-The resident sometimes accepted a nurse's explanation of the consequences of care refusal and then allowed staff to perform that care.
*A new type of incontinent brief had been used since 11/22/24 that allowed brief changes to occur at a less frequent interval without compromising the resident's skin.
*CNA M stated no other nursing staff had ever asked him to hold a resident's arms or legs in order to have completed their personal care.
-He had not observed or known of any other instances of any staff who had been asked to or had physically restrained a resident.
*He was suspended from work pending the outcome of the 11/22/24 incident investigation.
-He was required to complete an abuse

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F 604	Continued From page 8 prevention training before he was allowed to return to work. Interview on 1/13/25 at 8:07 a.m. with RN E regarding resident 35's care refusals revealed: *He had a history of care refusal but the frequency had escalated after his spouse died. -He was moved to a private room across the hall and that seemed to have helped improve his behavior. *The resident verbally refused care by saying "No, that type of thing" which had indicated to staff he wanted to be left alone. -He was not usually physically aggressive. *The resident related better to some staff and they provided his care when possible or if he had refused care offered by another staff person. *Staff respected the resident's right to refuse care but reapproached him to offer that care again to ensure it had occurred. Review of CNAs M and Q and LPN R's personnel files revealed: *Their professional certifications or licenses were current and their pre-employment background checks identified no areas of concern. *Their mandatory resident rights, abuse/neglect, and restraint training was current. *CNA Q was terminated on 1/9/25 unrelated to the 11/22/24 incident. *LPN R was terminated on 11/25/24 related to the 11/22/24 incident. Interview on 9/14/25 at 9:45 a.m. with DON B and administrator A regarding the FRI revealed: *The incident was reported to the South Dakota Board of Nursing. *Audits of a sample of cognitively intact residents regarding their care and feelings of safety was	F 604		

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completed. A review of those audits identified no concerns.
*Audits of a sample of staff regarding resident care concerns was completed. A review of those audits identified no issues.
*All staff were re-educated at the December 2024 All Staff meeting regarding resident abuse and neglect.
-Training content was reviewed and included restraint use.

The provider's implemented systemic actions to ensure the deficient practice does not reoccur was confirmed on 1/14/25 after:
*Facility audits of sampled residents and staff identified no resident care or safety concerns.
*Education was provided to all staff regarding resident abuse/neglect and restraint use.
-Observations and interviews revealed staff understood that education regarding those topics.
*Resident 35's care plan was revised to reflect modified behavioral interventions for the management of care refusal.
-Interviews revealed staff understood the interventions for managing resident 35's care refusal according to his revised care plan.

Based on the above information, non-compliance at F604 occurred on 11/22/24, and based on the provider's implemented corrective actions for the deficient practice confirmed on 1/14/25, the non-compliance is considered past non-compliance.

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F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1)	F 742		

§483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure

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F 742	Continued From page 10 that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to document one of one sampled resident's (1) disrobing behavior that supported her continued need to have a "dignity curtain" placed inside of her room. Findings include: 1. Observation on 1/12/25 at 3:54 p.m. of resident 1 in her room revealed: *There was a corridor about five to six feet in length upon stepping inside the room. *At the end of the corridor was a piece of patterned material (a dignity curtain) velcroed between the two walls at the end of the corridor. -The curtain was about five to six feet wide and between four and five feet high. *The resident's living space was on the other side of the curtain. *The resident was able to be visualized after taking a few steps inside the corridor and looking over the curtain. *The resident was lying on her low bed, fully clothed, and watching television. -She was able to make eye contact but was not able to be understood when she tried to communicate. Interview on 1/13/25 at 8:10 a.m. with registered	F 742	1.Resident 13 had behavior monitoring, specific to her disrobing behavior, added to the CNA charting to ensure the continued need for the dignity curtain. Her care plan was updated to reflect the monitoring process. 2.All residents are at risk for mental and psychosocial concerns related to lack of behavioral monitoring for specialized devices. A house audit was completed to make sure all residents with specialized devices have proper behavioral monitoring in place. 3.The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the Psychotropic Medications policy. The Admin, DON or designee will educate all staff on this policy to ensure residents on psychotropic medications are having behaviors monitored per policy. Education will occur no later than February 20, 2025, and those not in attendance due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4.The Admin, DON or designee will audit all residents identified with specialized devices to ensure proper documentation for behaviors and the need for the specialized devices. Audits will be weekly for 4 weeks, bi-weekly for 2 months, and monthly for 2 months. Results of the audits will be discussed by the Admin, 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 findings.	2/28/25

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nurses (RN) E and T regarding resident 1's dignity curtain revealed:
*It was used to prevent visitors and residents walking by her doorway from seeing her if she had removed her clothes.
-Placement of the curtain allowed staff to step inside of the room and look over the curtain to monitor the resident.
*The resident had a history of a brain injury that resulted in cognitive impairment.

Additional observations of the resident on 1/12/25 (at 6:15 p.m.), 1/13/25 (at 8:03 a.m., 10:06 a.m., and 4:15 p.m.), and 1/14/25 (at 7:40 a.m., 10:00 a.m., and 2:00 p.m.) revealed:
*She was in her room lying on her low bed, fully clothed, and watching television.
-The dignity curtain was up.

Interview on 1/13/25 at 4:40 p.m. with administrator A and director of nursing B regarding resident 1 revealed:
*The dignity curtain was used to protect the resident's privacy due to her disrobing behavior.
-Neither knew if the frequency of the resident's disrobing behavior was being tracked to support the continued use of the dignity curtain.

Review of resident 1's care plan revealed:
*A focus area revised on 7/26/24 related to the resident's use of antidepressant and anti-anxiety medication.
-An intervention initiated on 7/30/19: "Monitor/record occurrence of target behavior symptoms of pacing, wandering, disrobing, inappropriate response to verbal communicating, violence/aggression towards staff/others, etc, and document per facility protocol."
*A focus area revised on 3/20/34 related to her

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F 742	Continued From page 12 behaviors which included disrobing. -An intervention revised on 7/30/19: "Document behaviors and my response to interventions per facility protocol." -An intervention revised on 3/20/24: "Ensure that Velcro-cloth barrier is placed to shield view of [resident 1] when lying in bed and disrobing/removing brief to promote her dignity." Review of resident 1's electronic medical record (EMR) revealed: *Her diagnoses included vascular dementia, seizure disorder, chronic pain, depression, anxiety, and an anoxic brain injury. *A behavioral symptom monitoring tool included areas to document the frequency of 13 different types of behavior on a daily basis. -Disrobing was not one of those 13 listed behaviors. *Her behavioral progress notes and interdisciplinary progress notes between 11/12/24 and 1/13/25 did not mention the resident's disrobing behavior. *An 11/5/24 Behavior/Psychotropic Interdisciplinary Team Review included a list of the resident's "behaviors that have been present the last 2 weeks." -Disrobing was not present during that time. -Targeted behaviors included "verbal behaviors, resisting care," but not disrobing. *An 11/6/24 care conference note did not include a disrobing behavior. *An 11/20/24 psychiatry progress note completed by the certified nurse practitioner: "[Resident 1's] behavior includes yelling and getting out of her chair but she has maintained a minimal amount of agitation on current medications." *Resident 1's 11/1/24, 9/11/24, and 7/19/24 Minimum Data Set assessments (Section	F 742		

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E-Behavior Symptoms/other behavior symptoms not directed toward others such as disrobing in public) indicated that behavior was not exhibited at the time of those assessments.

Interview on 1/14/25 at 8:10 a.m. with restorative therapy aide (RTA) U and certified nurse aide (CNA) J regarding resident 1's disrobing behavior revealed:
*RTA U stated the frequency of resident disrobing had improved. It had occurred "maybe a couple times per day."
*CNA J stated disrobing had occurred "maybe a couple times per month" which was a decrease from "a few days a week".

Interview on 1/14/25 at 2:15 p.m. and review of resident 1's 12/30/24 Siderail/Other Devices Evaluation form with administrator A revealed:
*The Evaluation was to be completed quarterly to evaluate the use of the dignity curtain and to ensure it was not being used as a seclusionary device.
*The Non-Physical Restraint Evaluation stated "Barrier [dignity curtain] is being used to promote [resident 1's] dignity as chooses to remove her briefs when soiled with urine or BM [bowel movement], removes clothing, and lays naked on bed."
*She agreed the lack of behavioral documentation had not supported the continued need for the dignity curtain.

Review of the provider's revised 2/10/24 Psychotropic Medications policy revealed: "8. Residents receiving psychotropic medication will have adverse side effects and target behaviors addressed in the care plan and will be monitored, recorded, and summarized each quarter.

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F 742	Continued From page 14 Assessment (User Defined Assessment) will include resident specific behaviors, non-pharmacological interventions attempted and the resident's response to the interventions."	F 742		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure residents' prepared food was served and distributed in a palatable manner during two of two observed meal services. Findings include: 1. Observation and interview on 1/12/25 from 5:00 p.m. through 6:00 p.m. with cook O and certified dietary manager (CDM) N in the kitchen during the evening meal service revealed: *Cook O removed pizza from the oven at 5:08 p.m., sliced it, and moved it onto a baking sheet. -The sheet was too large to fit inside the steam table well and too short to cover the well opening it was placed on. *A temperature probe was inserted into the pizza by cook O and read 132 degrees Fahrenheit (F) at 5:16 p.m. That temperature was too low CDM N returned the pizza to the oven. -It was expected the internal temperature of that	F 804		

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F 804	Continued From page 15 pizza was to be 165 degrees F when it was served. *At 5:23 p.m. CDM N removed the pizza from the oven and it was re-temped by cook O -The internal temperature of that pizza was 158 degrees F and returned to the oven by CDM N. *At 530 p.m. CDM N removed the pizza from the oven and it was re-temped by cook O. -The internal temperature of that pizza was 162 degrees F and served to the residents. *At 5:55 p.m. two pieces of pizza remained on the baking sheet on the steam table. -The internal temperature of that pizza was 106 degrees F and the pizza appeared dry. *CDM N would have preferred the pizza was placed on a perforated pan that fit inside of the steam table well to have maintained its internal temperature. -He had not known why re-heating the pizza in the oven had not increased its internal temperature to the acceptable temperature of 165 degrees F. 2. Observation on 1/13/25 from 8:33 a.m. through 9:00 a.m. and interview with cook P in the kitchen during the breakfast meal service revealed: *She began serving breakfast at 7:30 a.m. that morning. *At 8:33 a.m. nine residents had not arrived to the dining room for breakfast. *The uncovered food on the steam table included Cream of Wheat cereal, sausage gravy, mechanical soft sausage, pureed sausage, and pureed cinnamon french toast. -That food remained uncovered until the last resident's breakfast was plated at 8:58 a.m. *Food on the steam table retained acceptable temperatures when it was temped at 9:00 a.m. but the uncovered food had developed a dry film	F 804	1.The dietary staff have been educated on the Food Temperatures policy and to ensure food left on the steam table for extended periods of time were covered to retain moisture, heat, and prevent cross-contamination. 2.All residents are at risk for adverse effects related to failure of ensuring residents' prepared food was served in a palatable manner due to improper food temperatures and not covering food left on the steam table. 3.The Administrator, DON, ADON and the IDT in collaboration with the governing body and Medical Director reviewed the food temperatures policy that includes palatability of food. The CDM or designee will educate all staff on this policy. Education will occur no later than February 20, 2025, and those not in attendance due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4.The CDM or designee will audit 3 resident meals to ensure temperatures and palatability of meals are maintained. Audits will be weekly for four weeks, bi-weekly for two months, and then monthly for two months. Results of the audits will be discussed by the Administrator 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 findings.	2/28/25

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F 804	Continued From page 16 over the top of it or appeared dry. *Cook P agreed covering the metal food containers on the steam table would have kept the food moist and decreased the likelihood of a crust forming over the top of the food. 3. Interview on 1/13/25 at 9:30 a.m. with CDM N regarding food service revealed: *Food left on the steam table for extended periods of time was expected to have been covered to retain moisture and heat and prevent potential cross-contamination. *He had determined during the 1/12/24 evening meal the oven had been switched to a "cool down fan" which circulated air inside the oven and was not heating the pizza to the acceptable temperature. Review of the provider's revised 3/19/20 Food Temperatures policy revealed: *"5. If temperatures are not at acceptable levels and cannot be corrected in time for meal service, make an appropriate menu substitution." *"8. Palatability of foods determines appropriate temperature at bedside or tableside food. Generally hot food is palatable between 110 degrees F and 120 degrees F or greater..." *"9. Reheating foods for hot holding either in the oven or microwave must reach 165 degrees F and hold for 15 seconds."	F 804		
F 880 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	F 880		

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F 880	Continued From page 17 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880	1.LPN F was educated on the Universal Masking in General Population policy that addresses masking procedures during a COVID-19 outbreak. CNA H was educated on the Enhanced Barrier Precautions policy and the Cleaning and Disinfection of Equipment policy. CNA I was unable to receive education as they have separated employment from the facility. CNA G received education on the standard precaution policy as well as having a peri-care competency completed. RN E was educated on the Enhanced Barrier Precautions policy. Resident 32 was educated on not having his colostomy rinsing container on his bedside table. This was removed immediately after surveyor mentioned this issue. 2.All residents are at risk for adverse effects related to not following enhanced barrier precautions, hand hygiene, glove use, disinfection of equipment, and masking during a COVID-19 outbreak. 3.The Administrator, Director of Nursing (DON), Assistant Director of Nursing, and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the Universal Masking in General Population policy, Enhanced Barrier Precautions policy, Disinfection of Equipment Policy, and Standard Precautions policy. The DON or designee will educate all staff on these policies. Education will occur no later than February 20, 2025, and those not in attendance prior to that date due to vacation, sick leave, or casual work status will be educated prior to their first shift worked.	2/28/25

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F 880	Continued From page 18 (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 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 effectively implement and ensure appropriate and necessary infection prevention and control practices were followed: *When one of one observed licensed practical nurse (LPN) (F) did not wear a mask during a facility acknowledged respiratory outbreak. *When the use of appropriate enhanced barrier precautions (EBP) was not followed by one of one certified nurse aide (CNA) (H) during personal care for one of one sampled resident (7) on EBP. *When appropriate hand hygiene and glove use was not followed by one of one CNA (G) during personal care for one of one sampled resident (1). *For the cleaning of shared resident equipment	F 880	4.The Administrator/DON or designee will audit five associates performing cares to ensure appropriate masking is performed, equipment is disinfected after use, proper PPE is used on EBP rooms, proper glove use, and hand hygiene is performed. Audits will be weekly for four weeks, bi-weekly for two months, and then monthly for two months. Results of the audits will be discussed by the Administrator 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 findings.	2/28/25

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by CNAs (H and I) after use by one of one sampled resident (45) on EBP.
*When the use of EBP was not followed by one of one registered nurse (RN) (E) during the administration of nutritional formula through a tube for one of one sampled resident (17) who was on EBP.
*When the use of EBP was not done when an unidentified CNA was obtaining vital signs on resident 31.
*For resident 32 who's colostomy bagm (a bag attached to the body that collects stool and needs to be emptied and rinsed periodically) rinse container was kept on his bedside table.
Findings include:

1. Observation on 1/12/25 at 2:00 p.m. inside the enclosed entryway of the facility revealed:
*A box of surgical masks was on a table against the wall.
-An alcohol-based hand sanitizer dispenser was mounted above that table.
*A type-written notice was taped on the door that led into the facility.
-The facility was in "respiratory outbreak status" and mask use was required inside of the facility.

2. Continued observation inside of the facility revealed:
*LPN F sat behind the nurses' station without a mask on her face.
*She approached an unknown resident in front of the nurses' station and commented to that resident, "I suppose I should be wearing a mask."
*She walked towards the enclosed entry referred to above, entered a code on the wall-mounted key pad, pushed open the door, and without performing hand hygiene placed a mask over her face.

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3. Interview on 1/12/25 at 2:15 p.m. with LPN F revealed the facility was in respiratory outbreak status related to an employee who had tested positive for COVID-19.

4. Observation and interview on 1/12/25 at 2:15 p.m. with certified nurse aide (CNA) H in resident 7's room revealed:
*A notice on the room door for EBP (A set of infection control-measures that require the use of gowns and gloves to reduce the spread of multidrug-resistant organisms).
*Without putting on a gown or gloves she placed her arms under the resident's armpits and lifted her up from her wheelchair to a standing position.
-She transferred the resident to her bed.
*She moved the resident's urine catheter bag from the wheelchair, attached it to her bed, and placed it inside a cloth bag.
*CNA H stated resident 7 was on EBP because she had a catheter. She had not needed to put on a gown or gloves unless she was emptying the catheter bag.

5. Observation on 1/12/25 at 3:29 p.m. near resident 45's room revealed:
*A notice was posted on the room door for EBP to have been followed.
*CNA I exited the room with a mechanical lift that she had left along the wall near that room.
-A bag was hung on the lift that contained disinfectant wipes.
*CNA I returned to the resident's room before she exited again with CNA H.
*The mechanical lift was not cleaned by either staff after they had left the room.

6. Interview on 1/12/25 at 4:30 p.m. with CNA H

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regarding the above observation revealed:
*She and CNA I had used the mechanical lift to transfer resident 45 from his bed to his wheelchair.
*The lift was expected to have been cleaned after it was used but neither she nor CNA I had cleaned it.

7. Observation on 1/13/25 and interview with CNA G at 4:15 p.m. while in resident 1's room revealed:
*CNA G put on a gown and gloves to change the resident's soiled incontinence brief.
-She used wet wipes to clean stool off of the resident's skin then discarded those wipes into a plastic bag.
*With dirty gloves she:
-Dispensed skin barrier cream onto the dirty glove and applied it onto the resident's skin.
-Placed a clean incontinence brief on the resident.
*She then removed her dirty gown and gloves, placed them in the plastic bag, and washed her hands.
*She stated she was expected to have removed her dirty gloves, performed hand hygiene, and applied clean gloves before she had applied barrier cream and put a clean brief on the resident to prevent cross-contamination.

8. Interview on 1/14/25 at 1:45 p.m. with woundcare registered nurse (RN)/infection preventionist (IP) C revealed:
*All staff were expected to wear masks while the facility was in respiratory outbreak status.
-Hand hygiene was expected to have been performed before putting on a mask.
*All shared resident equipment was expected to have been cleaned by staff after it was used.

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*Gown and glove use was expected during the care of any resident on EBP.
*Gloves were expected to have been removed, hand hygiene performed, and new gloves put on after providing resident's personal care and before applying a barrier cream or a clean continence brief.

Review of the provider's revised 6/21/24 Enhanced Barrier Precautions policy revealed:
*"2. a. Gowns and gloves should be used during high contact resident care activities that provide opportunities for transfer of MDROs [multi drug resistant organisms] to staff hands and clothing."
-Transferring a resident was included in that list of resident care activities.

Review of the provider's 2/20/24 Cleaning and Disinfection of Equipment policy revealed "I. A. Supplies and equipment will be cleaned immediately after use."

Review of the provider's revised 2/20/24 Standard Precautions policy revealed:
*Personal Protective Equipment (PPE):
-"Gloves should be removed, hand hygiene performed, and a new pair of gloves applied before moving from a contaminated area to a clean area."

9. Observation on 1/12/25 at 3:39 p.m. in resident 17's room revealed:
*She had an EBP sign on her door.
*Hanging on the resident's door were gloves, masks, and gowns.
*An unknown staff member knocked on resident 17's door and asked if she was ready to take her

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after-dinner pill.

Review of resident 17's electronic medical record (EMR) revealed:
*She received nutritional formula through an Enteral tube two times a day.
*Resident 17 had an order for Lansoprazole (medication) Capsule Delayed Release 30 MG once a day for GERD (a digestive disease in which stomach acid irritates the food lining).
*Her diagnoses included: tubule-interstitial nephritis, moderate protein-calorie malnutrition, dementia, Alzheimer's, and dysphagia.

Observation on 1/13/25 at 2:44 p.m. with RN E while in resident 17's room revealed:
*Resident 17 was lying in bed with the head of the bed elevated.
*RN E had hand sanitized her hands and then put gloves on both hands. She:
-Had placed a clean barrier on the resident's bedside table and placed two cartons of Jevity 1.2 (the enteral nutrition formula), a measuring pitcher, three plastic cups, a pH tester strip in one of the plastic cups, and a sterile syringe.
-She filled one of the plastic cups with tap water from the bathroom faucet.
-She poured approximately 300 mL (milliliters) of Jevity 1.2 into the measuring pitcher.
-She had informed the resident that it was time for her formula administration session and the resident assisted in removing the blankets.
-RN E explained she needed to check the pH of the stomach contents.
-She opened the sterile syringe and attached it to the PEG (percutaneous endoscopic gastrostomy) tube.
-With the plunger, she injected air into the PEG tube.

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F 880	Continued From page 24 -She then pulled the plunger back and obtained residual stomach contents into the syringe. -She dripped some of the residuals onto the pH tester strip and reported that the pH was 4.5. -RN E then flushed the feeding tube with 50 CC (cubic centimeters) of water. -She then poured the liquid medication into the syringe. -After filling the syringe twice more with formula to reach the ordered amount to be given, she flushed the tube with water. -She replaced the cap on the PEG tub. -She then threw the Jevity cartons, syringe, plastic cups, measuring pitcher, and gloves into the trash can. -She went into the resident's bathroom and washed her hands. Continued interview on 1/13/25 at 3:00 p.m. with RN E regarding a resident on EBP precautions revealed she was unaware she was to be wearing a gown when she was with a resident with a feeding tube. Interview on 1/14/25 at 1:20 p.m. with DON B regarding the above observation revealed: *She stated all staff had received education regarding EBP in Relias (a learning platform that offers training for healthcare organizations) when hired. *She stated the nurses had a monthly meeting that discussed EBP. *Her expectation of staff was to follow all EBP. Review of the provider's revised March 2024 Enhanced Barrier Precautions policy revealed: Definition: "Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING ______ B. WING ______	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH STREET RAPID CITY, SD 57701

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F 880	Continued From page 25	F 880		

transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities."
"ENHANCED BARRIER PRECAUTIONS should be used for all residents or for those residents colonized/infected with a novel or targeted MDRO [multi-drug resistant organism], when they no longer meet requirements for contact Precautions:"
"1. When a resident has any of the following:
b. indwelling Medical Devices:
.Feeding Tube"

1. Observation on 1/12/25 at 4:00 p.m. during the initial tour of the facility of an unidentified CNA revealed:
*The CNA was obtaining vital signs on resident 31.
*Resident 31 was on EBP.
*There was a sign on his door indicating he was on EPB.
*The CNA was not wearing a gown or gloves.

2. Random observations throughout the survey from 1/12/25 through 1/14/25 of resident 32's room revealed:
*Resident 32 had a colostomy bag (a bag that collects stool and needs to be emptied and rinsed periodically).
*Resident 32 would assist staff with rinsing his colostomy bag.
*The container used to rinse the colostomy bag was kept on his bedside table.
*On 1/13/25 at 8:00 a.m., resident 32 was eating his breakfast in his room with the colostomy rinsing container sitting next to his breakfast tray.
*He said that he had never been asked to store

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	435064	A. BUILDING ___ B. WING ___	C 01/14/2025

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F 880	Continued From page 26 the rinsing container elsewhere by staff. 3. Interview on 1/13/25 at 9:37 a.m. with licensed practical nurse (LPN) D revealed: *She was aware resident 32 kept his colostomy rinsing container on his bedside table. *She said, "I think its gross". *She said staff have asked him to keep the rinsing container in the bathroom and he refuses. *She said that he was very particular about the way his possessions were situated in his room. 4. Interview on 1/14/25 at 2:30 p.m. with infection preventionist (IP) C revealed: *She was not aware resident 32 kept his colostomy rinsing container on his bedside table. *She said, "That's disgusting." *She agreed that was an infection control issue. *Referring to personal protective equipment used for obtaining vital signs for a resident on EBP, she wanted to review her policy before answering questions on the topic. *She agreed staff should be following the policy. 5. Interview on 1/14/25 at 3:15 p.m. with director of nursing (DON) B revealed: *She was not aware resident 32 was keeping his colostomy rinsing container on his bedside table but agreed that this was an infection control issue, and she would talk to the resident and have it moved. *Referring to EBP, she said staff should be following the policy any time direct care was being provided to a resident on EBP, this included obtaining vital signs. 6. Review of the provider's February 2024 Infection Prevention Program policy revealed: *I. Goals	F 880		

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	435064	A. BUILDING ______ B. WING ______	C **01/14/2025**

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F 880	Continued From page 27 The goals of the infection prevention and control program are to: A. Decrease the risk of infection to residents and personnel. B. Prevent, to the extent possible, the onset and spread of infection. D. Monitor for occurrence of infection and implement appropriate control measures. E. Identify and correct problems relating to infection prevention practices.	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	**1620 NORTH 7TH STREET** **RAPID CITY, SD 57701**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/14/25. Avantara North was found not in compliance with 42 CFR 483.70 (a)&(b) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K222 in conjunction with the providers commitment to continued compliance with the fire safety standards.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are	K 222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Celina Block*
TITLE: *Administrator*
(X6) DATE: *2/7/2025*

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___	**01/14/2025**

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K 222	Continued From page 1 being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the	K 222	1.The maintenance director adjusted the sensitivity of the control knobs throughout the facility to meet the delayed egress as required. 2.All residents are at risk for adverse effects of not having facility exit doors with proper delayed egress. 3.The Administrator, DON, ADON and the IDT in collaboration with the governing body and Medical Director reviewed the life safety code related to Egress Doors. The facility has ordered new magnetic locks that will meet the egress door requirement for the dining room, north wing, south wing, and east wing on 2/7/25. These will be installed when they arrive to the facility. The Maintenance Director or designee will educate all staff on this regulation and the importance of egress doors. Education will occur no later than February 20, 2025, and those not in attendance due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4.The Maintenance Director or designee will audit all the magnetic locks three times a week to ensure the sensitivity of the control knobs meet the delayed egress requirement. Audits will be weekly for four weeks, bi-weekly for two months, and then monthly for two months. Results of the audits will be discussed by the Administrator 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 findings.	2/28/25

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	435064	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**01/14/2025**

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AVANTARA NORTH	**1620 NORTH 7TH STREET** **RAPID CITY, SD 57701**

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K 222	Continued From page 2 provider failed to provide egress doors as required at two of four locations (dining room and north wing exterior EXIT doors). Findings include: 1. Observation on 1/14/25 beginning at 1:05 p.m. revealed the exterior EXIT doors for the dining room, north wing, south wing, and east wing were equipped with Stanley brand magnetic locks that prevented egress. The doors were labeled as delayed egress locked doors. Testing of the doors by applying force to the panic hardware in the direction of the path of egress revealed the audible signal would not sound for the dining room and the north wing exit doors. The required irreversible process of unlocking the door did not initiate. Interview with the maintenance director at the times of the observations and testing confirmed those conditions. He further revealed the magnetic locks had a sensitivity control knob located on the doors adjacent to the plates. He demonstrated the sensitivity could be adjusted to allow the delayed egress function to initiate as required. The sensitivity knob for the south wing EXIT door had duct tape on it to keep it from being easily adjusted. The east wing EXIT door magnetic lock worked as a delayed egress lock as required but also had a sensitivity knob. The maintenance director stated the sensitivity would be adjusted downward to prevent strong winds from activating the delayed egress function although the doors were equipped with positive latching panic hardware. The magnets when adjusted to resist wind effects would prevent egress. Failure to provide egress doors as required increases the risk of death or injury due to fire or other emergencies.	K 222		

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K 222	Continued From page 3 The deficiency affected two of four marked EXIT doors with Stanley brand magnetic locks. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.1(3)	K 222		

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

PRINTED: 01/30/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING ______ B. WING ______	01/14/2025

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 1/14/25. Avantara North was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Celina Block*
TITLE: *Administrator*
(X6) DATE: *2/7/2025*

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.

South Dakota Department of Health

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	10665	A. BUILDING: ______ B. WING ______	01/14/2025

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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 from 1/12/25 through 1/14/25. Avantara North was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/12/25 through 1/14/25. Avantara North was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Celina Block	*Administrator*	*2/7/2025*