STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	**1620 NORTH 7TH 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 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 9/9/26. Areas surveyed included resident safety related to fall prevention interventions, potential staff-to-resident abuse, biohazard waste (material contaminated with infectious agents, blood, or body fluids) handling, provision of community-based medical services, and provision of care. Avantara North was found not in compliance with the following requirement: F776, and to have past non-compliance at F600 and F689.	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, and interview, the provider failed to protect the resident's rights to be free from verbal abuse by one of one certified nurse aide (CNA) (F) who made disparaging and retaliatory comments to one of one sampled resident (1). This citation is considered past	F0600	"Past Noncompliance - no plan of correction required"	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Celina Block	*Administrator*	*09/28/2026*

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F0600 SS = D	Continued from page 1 non-compliance based on a review of the corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of the provider's 8/3/26 SD DOH FRI revealed that director of nursing (DON) B received written witness statements from three unidentified staff members regarding CNA F's potential verbal abuse towards resident 1. That incident occurred on 8/2/26 at 9:45 p.m. 2. Review of resident 1's electronic medical record (EMR) revealed her diagnoses included a developmental disability (chronic conditions caused by an impairment in physical, learning, language, or behavioral areas), mood disorder, seizures, and poor impulse control. Her 8/5/26 Brief Interview for Mental Status (BIMS) assessment score was 12, indicating her cognition was moderately impaired. Resident 1 admitted to the facility on 7/25/24. 3. Interview on 9/9/26 at 11:15 a.m. with resident 1 revealed that she felt she was "doing well." She verbalized no concerns regarding the care the staff provided her or how they treated her. She made no mention of the above 8/2/26 incident. 4. The provider substantiated the above allegation of resident abuse. The provider's implemented actions to mitigate the likelihood of the deficient practice from recurring were verified on 8/6/26 after record review and interview with administrator A revealed that the facility had followed its Quality Assurance and Performance Improvement (QAPI) process regarding resident abuse by suspending, then terminating CNA F's employment at the facility based on the provider's incident investigation. DON B and social services designee (SSD) G assessed resident 1's psycho-social well-being following the incident. Random staff and resident interviews were conducted to identify other potential instances of verbal abuse and to evaluate the staff's and residents' feelings of safety within the facility. All staff were educated regarding the facility's Abuse and Neglect policy and Managing Challenging Behaviors in a Person-Centered Care Environment. 5. Based on the above information, non-compliance at F600 occurred on 8/2/26, and based on the provider's corrective action plans that were initiated on 8/3/26 and implemented for the deficient practice confirmed on 9/9/26, the non-compliance is considered past non-compliance.	F0600		

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F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, and interview, the provider failed to ensure an environment free of safety hazards regarding one of one certified nursing assistant (CNA) (H) who transferred one of one sampled resident (3) using a one-person stand-pivot transfer (a single caregiver helps a person rise to a standing position, pivot on their feet, and sit down on a nearby surface) instead of by using a total body lift (a mechanical lift and sling used to lift a person's full body) and resident 3 fell. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of the provider's 6/30/26 SD DOH FRI revealed that on 6/29/26 at 5:25 p.m., CNA H assisted resident 3 in transferring from his wheelchair to his bed using a one-person stand-pivot transfer with a gait belt (a waist strap gripped as support for safe mobility and transfers). During that transfer, resident 3 slipped, lost his balance, and was lowered to the floor. Resident 3's care plan indicated the staff were to use a total body mechanical lift to transfer resident 3. CNA H notified registered nurse (RN) I of the resident's assisted fall, and RN I completed the facility's post-fall procedures. Resident 3 was assessed and found to be at his baseline with no injuries because of the assisted fall. Resident 3's physician was notified of the incident. CNA H's employment at the facility was suspended pending the facility's investigation. 2. Review of resident 3's closed electronic medical	F0689	"Past Noncompliance - no plan of correction required"	

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F0689 SS = D	Continued from page 3 record (EMR) revealed he admitted to the facility on 1/14/26 following a hospitalization. His diagnoses included atrial fibrillation (a type of abnormal heart rhythm) and congestive heart failure (a chronic condition where the heart muscle becomes too weak or stiff to pump blood efficiently). His most recent Brief Interview for Mental Status (BIMS) assessment score was 8, which indicated his cognition was moderately impaired. Resident 3 had a planned discharge to another facility on 6/30/26 and no longer resided at the facility. 3. Record review revealed that CNA H was hired at the facility on 6/16/26. His certification was current, and he had no prior disciplinary actions. 4. Interview and care sheet review on 9/9/26 at 12:38 p.m. with licensed practical nurse (LPN) E revealed that she had received education on the importance of adhering to the resident's care plans for safe resident transfers. She stated that the residents' transfer statuses could also be found on the care sheets kept at the nurses' station. She identified the care sheets and indicated where the residents' transfer statuses were located on the form. She said that the management staff frequently updated those forms. 5. Random interviews on 9/29/26 with multiple staff members revealed that they were aware a resident's transfer status could be found in the resident's care plan or on the care sheets, and those staff members demonstrated understanding and application of the education provided. 6. The provider's implemented actions to mitigate the likelihood of the deficient practice recurring were verified on 9/9/26 after record review and interview with administrator A revealed that the facility had followed its Quality Assurance and Performance Improvement (QAPI) process following this incident. Because resident 3 discharged from the facility on 6/30/26, no follow-up specific to resident 3 was possible. A facility-wide audit was completed for all residents requiring mechanical lift transfers. All residents' care plans accurately reflected the residents' transfer statuses. Education was provided to all nursing staff on the importance of adhering to individualized resident care plans to ensure safe and	F0689		

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F0689 SS = D	Continued from page 4 appropriate transfer techniques were used. CNA H received written guidance on locating residents' transfer statuses, and one-on-one education regarding the importance of following resident care plans as written to promote resident safety and quality of care. A sample of 10 cognitively intact residents were interviewed on 7/2/26 about their perceptions of safety during staff-assisted transfers. No concerns were identified, and all 10 residents reported feeling safe when transferred. Weekly transfer audits to assess ongoing compliance were conducted for two weeks. Five staff members, including CNA H, were audited on transfer techniques to verify adherence to individualized care plans and to ensure the staff were following the residents' care plan interventions for safe transfers. 7. Based on the above information, non-compliance at F689 occurred on 6/29/26, and based on the provider's corrective action plans that were initiated on 6/29/26 and implemented for the deficient practice confirmed on 9/9/26, the non-compliance is considered past non-compliance.	F0689		
F0776 SS = D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure diagnostic services for one of one sampled resident (2) whose physician-ordered ultrasound was not completed as scheduled and	F0776	1.IP/Nurse Educator J was re-educated on the facility's Notification of Change of Condition policy, including the requirement to ensure appropriate follow-up and physician notification when indicated during the appointment follow-up process. Resident 2 attended the rescheduled appointment on 6/4/26, with no significant findings identified. The facility implemented a new process for reviewing resident appointments, including physician-ordered diagnostic testing, during the daily stand-up meeting. The interdisciplinary team (IDT) will review appointment outcomes, outstanding follow-up needs, and required physician notifications to ensure timely completion and compliance with the facility's Notification of Change of Condition policy. 2.All residents with physician-ordered diagnostic testing have the potential to be affected if ordered testing is not completed as scheduled or within the timeframe specified by the physician. A house audit was completed on all current residents to ensure that all residents with physician-ordered diagnostic testing has been completed within the ordered or required timeframe from the last 60 days.	10/24/2026

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F0776 SS = D	Continued from page 5 intended. That failure delayed the resident's diagnostic results and put the resident at risk for a potential delay in receiving medical treatment. Findings include: 1. Observation and interview on 9/9/26 at 12:15 p.m. with resident 2 revealed she sat in her wheelchair in her room watching television. Her lower extremities were wrapped in Ace bandages (a brand of stretchable compression wrap), but she did not know why. Resident 2 said she did not leave the facility for medical appointments, and she did not think she was allowed to do that. She stated she had “never been seen by my doctor [while she was a resident at the facility] that I know of. I don’t worry about it.” 2. Review of resident 2’s electronic medical record (EMR) revealed she admitted to the facility on 9/22/25. Her diagnoses included obesity (overweight), congestive heart failure (a chronic condition when the heart muscle does not effectively pump blood causing fluid build-up in the body), history of a pulmonary embolism (a blockage in the lung artery most often caused by a blood clot), history of a deep vein thrombosis (DVT, a blood clot), and cognitive impairment. Her 8/21/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated she had no cognitive impairments. A 5/18/26 physician’s progress note indicated that resident 2 was seen on that day for an acute (sudden symptom onset) care visit that was requested by a facility nurse. The chief complaint was identified in that note was edema (swelling caused by fluid trapped in the body’s tissue). The note indicated that the resident had “increased edema and redness of the lower extremities [legs]. Chronic but worsening. Decreased ambulation per res [the resident].” A 5/19/26 order note indicated a new physician’s order for an ultrasound (a type of non-invasive medical imaging test) of resident 2’s lower extremities to be completed. That ultrasound was scheduled to be completed on 5/21/26 at 9:45 a.m. A 5/26/26 physician’s progress note indicated resident 2 was seen for a review of her 5/21/26 ultrasound results and a “recheck.” There was no mention of the ultrasound results or any follow-up recommendations related to the ultrasound results in that physician's progress note. A 5/26/26 appointment note read, “MH [the imaging center] called and stated the res [resident] did not	F0776	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 facility’s Notification of Change of Condition policy and the job descriptions for Registered Nurses and Licensed Practical Nurses. The Administrator, DON, or designee will educate all licensed nursing staff on the Notification of Change of Condition policy and their responsibilities for ensuring physician-ordered diagnostic testing is scheduled, completed within the ordered or required timeframe, followed up on, and that the physician is notified as indicated. Education will be completed by October 24, 2026. Licensed nursing staff who are unavailable due to vacation, leave, illness, or PRN/casual status will complete the education prior to working their next scheduled shift. 4.The Administrator, DON, or designee will audit physician-ordered diagnostic testing to ensure testing is scheduled and completed within the ordered or required timeframe, appropriate follow-up is completed, and physician notification occurs as indicated. Audits will be completed weekly for 4 weeks, bi-weekly for 1 month, and monthly for 2 months. Audit findings will be reviewed at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendations. Based on the findings, the QAPI Committee will determine the need for continuation, revision, or discontinuation of the auditing process.	

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F0776 SS = D	Continued from page 6 show or cancel [cancelled her] appt [appointment] on May 21 [2026] @ 9:45 a.m." Resident 2's 6/4/26 ultrasound report revealed that the resident had moderate arterial (a blood vessel that carries blood away from the heart) narrowing beginning at the right knee, and her left lower extremity had no arterial narrowing. 3. Interview and resident appointment information review on 9/9/26 at 10:10 a.m. with registered nurse (RN) K revealed a resident appointment book was kept at the nurses'station. Infection preventionist (IP)/nurse educator J entered all the residents' appointment information into that book. IP/nurse educator J would transfer the residents' weekly appointment information from the book to an appointment calendar that was posted at the nurses' station. The weekly calendar included resident appointment details like the resident's name, their appointment date and time, and the appointment location, address, and telephone number. 4. Interview on 9/9/26 at 1:10 p.m. with administrator A, assistant director of nursing (ADON) D, and regional nurse consultant (RNC) C revealed they acknowledged there was no documentation in resident 2's EMR to support why she did not attend her 5/21/26 ultrasound appointment or if the resident's physician was notified of the missed appointment. They thought resident 2 missed her 5/21/26 ultrasound appointment because the information in the appointment book was not transferred to the weekly appointment calendar by IP/nurse educator J. IP/nurse educator J was not available to interview during this survey. The length of time between when resident 2's physician ordered the ultrasound and when the ultrasound was completed was 15 days. ADON D agreed that was an unacceptable amount of time for resident 2's ultrasound to be completed after that order was received. The ultrasound was initially scheduled to have occurred within 72 hours of the physician's order, which ADON D stated would have been an acceptable timeframe for completion. Administrator A, ADON D, and RNC C acknowledged that although resident 2's 6/4/26 ultrasound results revealed no significant findings, there was a potential for the resident to be adversely affected by the delay in the completion of her ordered ultrasound. 5. Interview on 9/9/26 at 1:10 p.m. and 2:40 p.m. with administrator A, ADON D, RNC C, and a medical	F0776		

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F0776 SS = D	Continued from page 7 records staff person at the local hospital's imaging center revealed that a voice message was left at the nursing home on 5/21/26 by the imaging center that resident 2 missed her ultrasound appointment and it needed to be rescheduled. On 5/25/26, the imaging center called the nursing home to follow-up on their 5/21/26 message, but no one at the nursing home answered the phone. On 5/26/26, the imaging center contacted a staff member at the nursing home, and resident 2's ultrasound appointment was rescheduled for 6/4/26. The resident attended that appointment. 6. A policy related to the facility's process for scheduling residents' appointments was requested from administrator A on 9/9/26 at 2:05 p.m. At 2:30 p.m., administrator A stated the provider had no policy regarding that process. 7. Review of the provider's revised 11/18/25 Notification of Change of Condition policy revealed, "The facility will provide care to residents and provide notification of resident change in status." 8. Review of the revised 12/1/19 RN and licensed practical nurse (LPN) job descriptions revealed that their essential job functions included, safeguarding the health, safety, and welfare of the residents under their care."	F0776		