STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/15/26 through 9/17/26. Avantara Norton was found not in compliance with the following requirements: F641, F684, F695, F698. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/15/26 through 9/17/26. Areas surveyed included potential resident abuse and safety, quality of care related to potential poor hygiene and a potential missed feeding tube feeding. Avantara Norton was found not in compliance with the following requirements: F684, and F658 at past noncompliance.	F0000		
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: A. Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) report, record review, interview, observation, and policy review, the provider failed to ensure quality of care was provided to the residents by the staff regarding following the residents care planned (a personalized plan that addresses a resident's care needs, goals, and interventions) interventions by one of one former certified nursing assistant (CNA) (Z) who independently provided care to one of one sampled resident (6) identified as needing two caregivers to	F0684	1. Resident 6's care plan reviewed and remains appropriate. C.N.A. Z was terminated for failure to follow Resident 6's care plan requirement for cares in pairs. Resident 91's care plan reviewed and revised reflect interventions for heel boots and repositioning. Resident 43, 61preferences for bathing were reviewed and updated bathing schedule and care plan to reflect preferences. Resident 125 reassessed for assistive bilateral side rails, side rails implemented based on assessment, care plan reviewed and revised to reflect side rail utilization. 2. All residents are at risk for deficient practice. Root Cause Analysis identified Care plan interventions were not effectively communicated, reinforced, or incorporated into daily assignment workflows for staff. Administrator, Director of Nursing and IDT reviewed Care Plan policy, Bed Rail policy, Bathing policy, Skin and Pressure Injury Prevention Program policy on 10/6/26. A comprehensive audit completed for residents that require cares in pairs to ensure care plans are appropriate and accurate for cares in pairs.	10/10/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Nickel	Administrator	10/06/2026

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F0684 SS = E	Continued from page 1 provide her care, by one of one contracted travel CNA (T) who did not put heel boots (specialized, cushioned booties worn on the feet to completely lift the heels off a bed, stopping painful bedsores from forming) or reposition one of one sampled resident (91) on hospice for eight hours, and for two of two sampled residents (43 and 61) identified as preferring to bathe two times a week, and did not receive one bath, shower, or bed bath within a week. Findings include: 1. Review of the provider's 8/10/26 SD DOH FRI report revealed that on 8/10/26 around 8:00 a.m. resident 6 reported she was physically and sexually assaulted by CNA Z. Resident 6 was to have two staff members provide her care (cares in pairs) due to her history of making accusations against the staff associated with her diagnosis of paranoid schizophrenia (a severe mental health condition where a person loses touch with reality and feels an intense fear that others are trying to harm or spy on them) and history of trauma. CNA Z provided resident 6 care independently on the overnight shift on 8/9/26. Licensed practical nurse (LPN) unit manager E resident 6's skin assessment and did not find any new skin alterations. She was offered an exam at the emergency room and she declined. CNA Z was suspended pending the facility's investigation and terminated for not following the resident's care plan. Resident 6 had psychiatry services provided. Other staff members and residents were interviewed regarding the care provided by former CNA Z and no further concerns were identified. The provider educated the staff on following resident care plans and abuse and neglect. Administrator or designee completed audits to ensure the residents who needed two staff members assistance for care was provided with that. 2. Review of resident 6's electronic medical record (EMR) revealed she admitted to the facility on 8/21/20. Her 8/7/26 Brief Interview for Mental Status (BIMS) assessment score was 11, which indicated her cognition was moderately impaired. Her diagnoses included paranoid schizophrenia, schizoaffective disorder (a serious mental illness with symptoms of impaired reality perceptions, mood swings, disorganized thinking, and altered behavior), anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and	F0684	A comprehensive audit of residents with high-risk Braden scores care plans will be reviewed and revised for interventions repositioning and heel boots. A comprehensive audit of resident bathing preferences and care plans reviewed and revised to reflect bathing preferences. A comprehensive audit of residents with side rail/mobility bars to ensure accuracy of assessment and care plan. A tracking process implemented to ensure side rail/ mobility bar assessments requiring installation are reviewed in morning meeting and maintenance work orders are generated and installation verified. DON or Designee will complete education with all staff following care plan for cares in pairs, bathing preferences, side rails/mobility bars, repositioning and heel boots. DON or designee will educate staff not in attendance prior to next shift worked. 3. DON or designee will complete observations and care plan reviews of 5 residents weekly to ensure care plans are followed for repositioning, heel boots, bathing preferences, side rails, and cares in pairs weekly x4 weeks then monthly x2 months. DON or designee will present audit findings to QAPI meeting monthly for progress review and recommendations	

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F0684 SS = E	Continued from page 2 symptoms such as restlessness or irritability), major depressive disorder (a serious medical condition that causes a deep, ongoing feeling of sadness, emptiness, and a loss of interest in life that lasts for more than a few weeks), and cerebral infarction (stroke). Resident 6's 9/13/26 care plan indicated she "exhibits maladaptive, attention seeking, accusatory, verbally abusive and makes derogatory racial statements towards others." She "has a history of trauma and demonstrates preferences regarding caregiver gender." She "may express concerns or allegations to certain male caregivers at times and may be more receptive to care from staff with whom she has established trust." She "receives psych services from the [name redacted] Behavioral counselor that comes to the facility." She "will make frequent accusations of staff. Listen to [resident 6]. Report any allegations of abuse to abuse coordinator. Notify ombudsman with any new incidents as needed." She "has a history of being sexually assaulted (raped) by a black man and will report rape if a black man is in her room." There were to be two staff members present when providing her care, and one was to be a female staff member when available. The staff were to reassure her during cares and explain what they were doing and why. Resident 6 was dependent on the staff for personal hygiene care, dressing, repositioning, and transferring. 3. Interview on 9/15/26 at 2:44 p.m. with resident 6 and her family member in her room revealed that resident 6 stated she was not physically or sexually assaulted by anyone at the nursing home. Her family member stated that resident 6 told him about it but that she sometimes lied so he was not sure what to believe. 4. Interviews with residents 15, 20, 24, 28, 31, 60, 67, 73, 74, 78, 94, and 100 from 9/15/26 through 9/17/26 during the survey process did not indicate that the staff were abusive to the residents. 5. Interview on 9/17/26 at 9:35 a.m. with CNA AA and CNA/restorative aide BB revealed that they had worked with former CNA Z and did not have any concerns with how he cared for the residents and no residents had reported concerns regarding the care he provided to them. The staff were to provide care to resident 6 with two staff members present	F0684		

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F0684 SS = E	Continued from page 3 because resident 6 made accusations against the staff members. 6. Interview on 9/17/26 at 2:16 p.m. with LPN unit manager E revealed that former CNA Z did not follow resident 6's care plan when he provided the resident's care without another staff member present for resident 6 on the night of 8/9/26 and she expected that he would have. She did not have any concerns brought to her attention by the staff or other residents regarding the care former CNA Z provided. 7. Interview on 9/17/26 at 2:29 p.m. with staffing coordinator CC revealed she did not have other residents or the staff report concerns regarding the care former CNA Z provided to the residents. 8. Interview on 9/17/26 at 3:46 p.m. with administrator A and director of nursing (DON) B revealed they confirmed they could not verify that physical or sexual abuse had occurred by former CNA Z, but he did not follow resident 6's care plan and provide her care independently. Resident 6 was to have two staff members provide her care due to her history of trauma, with at least one staff member being female. If resident 6 wanted two females, the facility would have been able to accommodate that. Administrator A and DON B had no other concerns reported from the staff or the residents regarding the care former CNA Z provided for the residents. 9. Observation on 9/15/26 at 7:44 a.m. in resident 91's room revealed resident 91 lying on her back in a bed lowered to the floor with fall mats placed on the right side of the bed. Her heel boots were not on her heels. 10. Observation on 9/15/26 at 10:03 a.m. of resident 91 in her room revealed she was in her bed positioned on her back. 11. Observation on 9/15/26 at 11:26 a.m. of resident 91 in her room revealed she was in her bed positioned on her back. 12. Observation on 9/15/26 at 12:18 p.m. of resident	F0684		

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F0684 SS = E	Continued from page 4 91 in her room revealed she was in her bed positioned on her back. 13. Observation on 9/15/26 at 1:55 p.m. of resident 91 in her room revealed she was in her bed positioned on her back. 14.Observation on 9/15/23 at 3:23 p.m. of resident 91 in her room revealed she was lying on her back, with the foot of her bed elevated and heel boots on her feet. 15. Review of resident 91's EMR revealed she admitted to the facility on 3/27/26. Her 4/7/26 BIMS assessment score was 3, which indicated her cognition was severely impaired. Her care plan indicated she was receiving hospice services for congestive heart failure (a chronic medical condition where the heart muscle does not pump blood efficiently enough to meet the body's needs) and weight loss. Care-plan goals initiated on 3/27/26 included "maintain dignity and comfort" and "needs will be anticipated and met by facility and hospice staff." A care-plan focus area initiated on 3/27/26 identified "an actual impairment to skin integrity related to occasional incontinence [involuntary urine or bowel leakage] and impaired mobility." The staff interventions included encouraging offloading (reducing or completely removing pressure and weight from a specific area of the body to help a wound heal or prevent one from forming) of heels with heel boots and encouraging and assisting the resident to turn and reposition at least every two hours and as needed. 16. Interview on 9/15/26 at 3:55 p.m. with contracted travel LPN U revealed resident 91 did not wear the heel boots earlier that day. She confirmed that the boots were first applied at 3:23 p.m. when she assisted contract travel CNA T with repositioning. She stated resident 91 should have frequently been repositioned throughout the day. 17. Interview on 9/16/26 at 4:50 p.m. with contracted travel CNA T regarding repositioning resident 91 on 9/15/26 revealed she had worked the scheduled day shift that day and stated, "I tried." When informed the resident remained in the same position for	F0684		

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F0684 SS = E	Continued from page 5 approximately eight hours, contracted travel CNA T stated, “I did the best I could.” She stated she did not put resident 91’s heel boots on her on 9/15/26 because she (CNA T) did not know she was supposed to. 18. Interview and EMR review on 9/16/26 at 6:29 p.m. with contracted travel LPN U regarding her documentation that resident 91 was “repositioned and changed frequently” on 9/15/26 revealed she documented that note after repositioning the resident in the afternoon at 3:23 p.m. and based the documentation on the scheduled frequency of repositioning resident 91 was supposed to receive. She assumed contracted travel CNA T followed the resident’s repositioning schedule but stated, “I guess I cannot verify that.” 19. Interview on 9/17/26 at 3:11 p.m. with DON B revealed she expected the staff to encourage and assist residents with repositioning according to their care plan. She stated the facility used low air-loss mattresses (specialized mattress that uses continuous airflow escaping through tiny holes in the fabric to keep a patient’s skin cool and dry) for pressure-injury prevention. 20. Review of the provider’s 5/14/25 Care Plan policy revealed, “Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident’s stay to promote optimal quality of life while in residence.” The policy indicated that “Interventions act as the means to meet the individual’s needs,” and “It is the responsibility of all direct care members to familiarize themselves with the care plans and review them routinely for changes.” 21. Interview on 9/15/26 at 10:00 a.m. with resident 43 in her room revealed she did not receive her shower yesterday sometimes they are short staffed and she will not get it. She indicated she received showers on Mondays and Thursdays every week. 22. Interview on 9/15/26 at 1:36 p.m. with resident 61 in his room revealed he did not have a shower in over a week. He was supposed to receive a shower on Tuesdays and Fridays. He was due to receive his shower that day (9/16/26), but he did not receive one yet. His last shower was given seven days ago.	F0684		

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F0684 SS = E	Continued from page 6 23. Interview on 9/16/26 at 11:54 a.m. with resident 43 revealed she did not get her shower on 9/15/26 and did not receive one yet that day (9/16/26). She hoped that she would get a shower on 9/17/26 due to her hair being “greasy.” 24. Review of resident 43’s electronic medical record (EMR) revealed she admitted to the facility on 5/6/22. Her 7/21/26 BIMS assessment score was 15, which indicated her cognition was intact. Her diagnoses included diabetes mellitus Type II (a condition involving disruptions in how the body regulates blood sugar), morbid obesity (excessive weight that significantly impacts health and well-being), and lymphedema (chronic condition causing swelling in the body’s tissues, most often legs and arms). Her care plan had an 11/15/23 revised intervention that indicated she needed one staff member’s assistance with bathing and that she preferred one shower a week before breakfast. There was a 12/7/23 revised focus area that indicated she required assistance with ADL’s (bed mobility, transfers, dressing, personal hygiene, and toileting) related to weakness, neuropathy, foot drop, and obesity. Her bathing task documentation indicated she preferred bathing two times a week and that her last shower was on 9/10/26. There was no documentation that she was offered a bed bath or that she had refused bathing. 25. Review of resident 61’s EMR revealed he admitted to the facility on 12/13/24. His 8/11/26 BIMS assessment score was 15, which indicated his cognition was intact. His diagnoses included diabetes mellitus Type II, and morbid obesity. His care plan identified a 2/15/26 revised focus area indicating he required assistance with ADL’s. An intervention initiated on 12/13/24 and revised on 12/10/25 which indicated the staff were to assist him with showering two times a week on Mondays and Fridays. His bathing task documentation indicated he was to receive a shower two times a week and that his last shower was on 9/8/26. There was no documentation that he was offered a shower or that he refused showering. 26. Review of the facilities updated 7/8/26 East T-Wing Bath Schedule revealed that resident 43 was scheduled to receive showers on Mondays and	F0684		

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F0684 SS = E	Continued from page 7 Thursdays every week. Resident 61 was scheduled to receive showers on Tuesdays and Fridays every week. 27. Interview on 9/16/26 at 12:38 p.m. with CNA P revealed there was a list of the resident showers and what time they were to be completed. Sometimes the resident showers did not get done, so the staff passed them onto the next shift to do them. The residents were sometimes given a bed bath which would be documented in the bathing tasks in the residents EMR as a bed bath. 28. Interview on 9/17/26 at 10:09 a.m. with CNA/certified medication aide (CMA) Q revealed she gave the residents showers. If she was unable to get a resident to the shower on her scheduled shift, she would offer a bed bath to the resident. Once the shower or bed bath was completed, she would document that in the bathing tasks in the resident's EMR. She would report to the next scheduled shift if residents shower still needed to be completed, or it would be offered to the resident the next day. She could document a shower was given on a non-scheduled day or if a resident refused their shower in the task documentation area in the residents EMR. 29. Interview on 9/17/26 at 10:33 a.m. with contracted travel registered nurse (RN) R revealed if a resident refused a shower/bath it would be offered the next day. A bed bath would be offered as well during the day or offered on the next scheduled shift. That information would be documented under the resident task area in their EMR if completed. 30. Interview on 9/17/26 at 10:38 a.m. with RN unit manager D revealed the staff were supposed to offer a shower/bath to the residents until it was completed. A bed bath was an option, and the staff would document that under the tasks area in the residents EMR as a bed bath or a as needed (PRN) shower when completed. 31. Interview on 9/17/26 at 11:11 a.m. with DON B revealed she expected the residents showers/bathes to be given when scheduled, and if they refused, the staff were to offer a bed bath, offer a different person to complete the task, or a different time. If a shower /bath was not given, the CNAs were to report it to the nurse. Each resident unit had a list by the computer if a resident's shower/bath was not completed. The staff were to offer a shower/bath to the resident again the next scheduled shift or next day. If the resident refused their shower, bath, or bed bath she expected that tasks documentation in	F0684		

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F0684 SS = E	Continued from page 8 their EMR to reflect that refusal. 32. Review of the provider's reviewed 5/14/25 Bathing Policy revealed "The purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. The resident has the right to choose timing and frequency of bathing activity. Bathing preferences should be asked upon admission and during quarterly care conferences. -Document bathing activity or refusal of bathing activity. If a resident refuses bathing, reapproach resident at a later time or offer another day to bathe the resident." 33. Review of the provider's Certified Nursing Assistant (CNA) job description indicated CNAs are responsible for safeguarding the health, safety, and welfare of residents under their care by following applicable laws, regulations, and established nursing policies and procedures. Essential job functions included providing individualized attention to maintain each resident's physical, mental, and psychosocial well-being; carrying out activities of daily living; providing care to maintain skin integrity, including turning and repositioning immobile residents; and being knowledgeable of individual care plans to ensure residents receive person-centered care. B. Based on interview, observation, and record review, the provider failed to ensure residents were provided assistive devices for one of one sampled resident (125), who was identified as needing side rails to both sides of the bed as assistive devices for the resident's safe bed mobility. 1. Interview and observation on 9/15/26 at 3:40 p.m. with resident 125 revealed she was assessed by the nursing staff as needing bilateral (both sides) side rails to assist with bed mobility. She reported the side rails were never attached to her bed frame for her to use. 2. Interview on 9/16/26 at 2:21 p.m. with RN, Unit Manager V, revealed she completed resident 125's side rail assessment on 7/22/26. She stated that, based on that assessment, she would have submitted a work order to the maintenance department to install the side rails. 3. Interview on 9/16/26 at 2:30 p.m. with director of	F0684		

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F0684 SS = E	Continued from page 9 maintenance X revealed the nursing staff did not submit a work order to the maintenance department requesting to install side rails on resident 125's bed. 4. Interview and documentation review on 9/17/26 at 1:54 p.m. with physical therapy assistant (PTA) W, revealed that resident 125 was screened on 7/15/26, as the resident had requested an overhead trapeze bar to be installed on her bed. The documentation revealed that the resident's independence would increase with improved bed mobility and reduce caregiver burden. 5. Interview on 9/17/26 at 2:17 p.m. with resident 125 and her spouse revealed the resident was assessed for side rails and expected to have side rails or another assistive device to hold on to for assistance while in bed, but she never received any device. 6. Interview on 9/17/26 at 3:00 p.m. with DON B revealed resident 125 was assessed and determined that she would benefit from the use of side rails. She agreed that the side rails were documented in resident 125's care plan for bilateral mobility bars on the bed but have since been documented as resolved as of 9/16/26. 7. Review of resident 125's EMR revealed she had a diagnosis of chronic inflammatory demyelinating polyneuritis (rare long term immune system disorder that causes progressive muscle weakness and loss of feeling), cerebral infarction (death of brain tissue caused by a sudden loss of blood flow and oxygen), hemiplegia (total or partial paralysis on one entire side of the body), and hemiparesis (muscle weakness or partial loss of movement on one entire side of the body, including the arm, leg, and face) following cerebral infarction affecting the left non-dominant side. Her Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her undated care plan indicated that on 6/19/26, resident 125 needed the staff's assistance with activities of daily living (ADLs) for bed mobility, transfers, dressing, walking, personal hygiene, eating, and toileting.	F0684		

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F0684 SS = E	Continued from page 10 The resident's side rail device evaluation completed on 7/22/26 indicated the bilateral side rails would increase her independence with bed mobility. A physical-device informed consent for bilateral side rails was documented as completed on 6/29/26 and indicated the side rails were not considered a restraint. That consent was signed by resident 125 on 6/29/26.	F0684		
F0695 SS = E	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 infection control practices were followed for cleaning continuous positive airway pressure (CPAP) machines (a device that uses air pressure to keep breathing airways open) for four of six sampled resident (54, 111, 113, and 120) that had a physician's order for the use of a CPAP machine and that a physician's order was obtained for the resident's use of a CPAP machine for one of six sampled residents (120). Findings include: 1. Observation and interview on 9/15/26 at 9:39 a.m. with resident 120 in his room revealed there was a CPAP machine and a facemask lying on top of his bedside table. The water chamber of the CPAP machine remained connected to the CPAP machine. After removing and opening the water holding chamber it was observed to have a dried white film on the bottom of it. There was a dried white and brown film around the bottom of the CPAP machine where the water holding chamber connects to the CPAP machine.	F0695	1. Resident 120, 111, 54 CPAP machines were cleaned 9/17/2026. Resident 120 CPAP order obtained. Resident 113 Discharged on 9/20/26. 2. All residents with CPAP machines are at risk for potential deficient practice. Root cause analysis identified that lack of ownership in cleaning process, Orders for cleaning not up to date, and lack of staff understanding of cleaning procedures. Administrator, Director of Nursing and IDT reviewed CPAP and BIPAP Cleaning Policy on 10/6/26. A comprehensive audit of all residents with CPAPs to ensure CPAPs are clean and CPAP orders are in EMR was completed. DON or designee will educate all nurses on CPAP cleaning procedures and CPAP orders. Those not in attendance at education sessions will be educated prior to their next shift worked. 3. DON or designee will complete observations and EMR review of 5 residents weekly to ensure CPAP's are clean and CPAP orders are entered weekly x4 weeks monthly x2 months. DON or designee will present audit findings to QAPI meeting monthly for progress review and recommendations.	10/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

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F0695 SS = E	Continued from page 11 Resident 120 stated the staff were not cleaning his CPAP machine or his facemask. 2. Review of resident 120's electronic medical record (EMR) revealed he admitted to the facility on 8/18/26. His diagnoses included pneumonia (an infection that inflames the air sacs in your lungs), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe (COPD). His 9/9/26 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated his cognition was moderately impaired. Resident 120's 8/18/26 through 9/15/26 physician order summary indicated there was no physician's order for the resident's use of the CPAP machine. 3. Interview on 9/16/26 at 2:32 p.m. with contracted travel registered nurse (RN) O revealed she was aware that resident 120 used his CPAP machine at night, as the scheduled night-shift nurses informed her each morning that they placed the CPAP on resident 120's face to use during the night. Contracted travel RN O stated she did not clean resident 120's facemask or CPAP machine because there were no physician's orders for that in his EMR. She did not think anyone was responsible for cleaning resident 120's facemask or CPAP machine until the order for the cleaning was added to his EMR recently. 4. Observation and interview on 9/15/26 at 10:05 a.m. of resident 113 in his room revealed a CPAP machine and facemask on top of his bedside table. The water chamber of the CPAP machine remained connected to the CPAP machine and was half full of water. After removing and opening the water holding chamber it was observed to have a moist brown film on the bottom of the CPAP machine where the water holding chamber connects to the CPAP machine. Resident 113 reported that he used his CPAP machine every night and the CPAP machine has never been cleaned. 5. Review of resident 113's EMR revealed he admitted to the facility on 8/21/26 and his 8/21/26 BIMS score was 10, which indicated his cognition was moderately impaired. His diagnoses included obstructive sleep apnea (sleep disorder where throat muscles relax and block your airway, causing repeated stops and starts in breathing). He had an 8/21/26 physician's order for his CPAP to be applied at night and removed in the morning. He had an 8/21/26 physician's order for the CPAP's mask/reservoir to be wiped with warm soapy water	F0695		

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F0695 SS = E	Continued from page 12 per the manufacturer instructions, rinsed, and placed dry on a paper towel after each use. The CPAP machine was to be wiped and cleaned with a disinfectant. 6. Observation and interview on 9/15/26 at 10:35 a.m. of resident 111 in his room revealed there was a CPAP machine on top of his bedside table. The water reservoir in the CPAP machine was half full of water and the mask was hanging off the edge of the bedside table. Resident 111 stated that he did not use the CPAP machine and it had not been cleaned. 7. Review of resident 111's EMR revealed he admitted to the facility on 9/3/26 and his 9/9/26 BIMS assessment score was 12, which indicated his cognition was moderately impaired. His diagnoses included chronic diastolic heart failure (chronic progressive condition where the heart muscle is too weak to pump blood effectively) and paroxysmal atrial fibrillation (irregular rapid heart rate). He had a 9/4/26 physician's order for the CPAP's mask/reservoir to be wiped with warm soapy water per the manufacturer instructions, rinsed, and placed dry on a paper towel after each use. The CPAP machine was to be wiped and cleaned with a disinfectant. 8. Observation and interview on 9/15/26 at 10:44 a.m. with resident 54 in her room revealed a CPAP machine and a facemask was lying on top of her bedside table. The water chamber was connected to the CPAP machine and had water in the chamber. Resident 54 stated she has not used her CPAP machine for several days, and that the staff did not clean the CPAP machine. 9. Review of resident 54's EMR revealed she admitted to the facility on 8/6/26. Her diagnoses included heart failure, and obesity (excessive accumulation of body fat). Her 8/18/26 BIMS assessment score was 8, which indicated her cognition was moderately impaired. She had an 8/6/26 physician's order physician's order for the CPAP's mask/reservoir to be wiped with warm soapy water per the manufacturer instructions, rinsed, and placed dry on a paper towel after each use. The CPAP machine was to be wiped and cleaned with a disinfectant. 10. Interview on 9/17/26 at 7:43 a.m. with director of nursing (DON) B revealed that the nursing staff were responsible for cleaning the residents' CPAP facemask and the [water] reservoir [chamber]. She was unaware that resident 120 had a CPAP machine until recently. She expected the staff to follow the	F0695		

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F0695 SS = E	Continued from page 13 physician's orders regarding the cleaning of the CPAP machines. 11. Interview on 9/17/26 at 9:21 a.m. with licensed practical nurse (LPN) unit manager/infection preventionist (IP) L revealed that not cleaning the CPAP machines per the physician's order and the provider's policy could increase the residents' risk of acquiring a respiratory infection. 12. Review of the provider's revised January 2026 CPAP policy revealed, "After each use, the mask/reservoir will be wiped with warm soapy water per manufacturer instructions, rinsed, and placed upside down to dry on a paper towel/clean dry hand towel." 13. Review of the CPAP manufacturer's user guide revealed "Daily: Empty the humidifier tub [water chamber] and wipe it thoroughly with a clean disposable cloth. Allow it to dry out of direct sunlight."	F0695		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each	F0641	1. Resident 109 was discharged on 9/21/26, MDS modification for section N and K will be completed and submitted/corrected to CMS by 10/10/26. 2. All residents are at risk for potential deficient practice. The facility root cause analysis identified lack of a standardized MDS coding validation process for medication and IV fluid categories prior to completion and transmission. To ensure accurate coding for Section N (antidepressants) and Section K(IV fluids) will be reviewed weekly during CMI meetings with IDT. DON or Designee will complete comprehensive audit of Section N(antidepressants) and Section K(IV fluids) completed during the look back period for accuracy and corrected as necessary for MDS's submitted in the last 3 months. DON or designee will complete education with MDS coordinators on RAI manual coding requirements for Section N and Section K, and verification of source documentation prior to MDS submission, assessment modification process when errors are identified. DON or designee will educate IDT on communication of Section N (Anti-depressants), Section K (IV fluids) involved in CMI meeting by 10/10/2026. Those not in attendance will be	10/10/2026

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F0641 SS = D	Continued from page 14 assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1. 20. 1 October 2025 review, the provider failed to ensure one of one sampled resident's (109) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop and individualized care plan to manage the resident's care needs) assessments were accurately coded for the areas of medications and nutrition intake by an artificial route. Findings include: 1. Review of resident 109's electronic medical record (EMR) revealed he admitted to the facility on 8/24/26 with end stage renal disease (a permanent stage of chronic kidney disease) and received dialysis treatments (removes waste products and excess fluid from blood when the kidneys are unable to function) three times a week. He had an 8/24/26 physician's order for Mirtazapine (an antidepressant medication) 15 milligrams (mg) by mouth at bedtime for insomnia (a common sleep disorder that makes it hard to fall asleep, stay asleep, or get good quality rest). His 8/30/26 admission MDS assessment section N (medications) did not indicate he was taking an antidepressant medication during that assessment's look-back period (the time period over which the resident's condition or status is captured by the MDS assessment). Section K, swallowing/nutritional status, item K0520, indicated that he received parenteral/IV (the delivery of fluids, medications, or nutrition directly into a vein, entirely bypassing the digestive system) nutritional formula administrations while not a resident at the facility. The referenced hospital records dated 8/22/26 through 8/24/26 indicated that he was administered 200 milliliters (mL) of sodium chloride 0.9% (percent) with his dialysis treatment on 8/24/26.	F0641	be educated prior to next shift worked. DON or designee will complete validation of Section N and K coding during weekly CMI meetings prior to MDS submission. 3. DON or designee will review 5 MDS's weekly of Section N (antidepressants) and Section K (IV fluids) to ensure accuracy. Audits will be completed weekly x 4 weeks then monthly x 2 months. DON or designee will present audit findings to QAPI meeting monthly for progress review and recommendations	

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F0641 SS = D	Continued from page 15 2. Interview and record review on 9/17/26 at 10:47 a.m. with director of clinical reimbursement C, MDS F, and MDS G revealed they confirmed that resident 109 received Mirtazapine and that it should have been coded on his 8/30/26 admission MDS assessment as an antidepressant received in section N. They also confirmed that section K, item K0520, should not have been coded as parenteral/IV nutritional formula that was administered while not a resident because the sodium chloride administration occurred as part of resident 109's dialysis treatments while he did not reside in the facility. Director of clinical reimbursement, MDS F, and MDS G stated that MDS F and MDS G were responsible for accurately coding resident 109's admission MDS assessment dated 8/30/26 and that they used the CMS Long-Term Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 as a reference to code MDS assessments. 3. Review of the CMS Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed: "Section N, Page N-6, Steps for Assessment: 1. Review the resident's medical record for documentation that any of these medications [antidepressants] were received by the residents and for the indication of their use during the 7-day look-back period (or since admission/entry or reentry if less than 7 days)… Check [enter on the MDS] if the resident is taking any medications by pharmacological classification [antidepressant] during the 7-day observation period (or since admission/entry or reentry if less than 7 days). "Section K, pages K-12 and K-13, Steps for Assessment: Review the medical record to determine if any of the listed nutritional approaches were performed during the look-back period. The following items are NOT to be coded in K0520A: Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis. "	F0641		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by:	F0658	"Past Noncompliance - no plan of correction required"	

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F0658 SS = D	Continued from page 16 Based on the South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review, the provider failed to ensure professional standards of nursing were followed by one of one registered nurse (RN) (H) failed to follow physician's orders for administering one of one sampled resident (5)'s nutritional formula through a percutaneous endoscopic gastrostomy (PEG, a tube surgically placed through the abdomen into the stomach to administer liquid nutrition, fluids, and medications) tube on the evening of 6/17/26. Findings include; 1. Review of the provider's 6/18/26 SD DOH FRI involving resident 5 revealed that on 6/18/26, at approximately 7:00 a.m., licensed practical nurse (LPN) J reported to director of nursing (DON) B that resident 5 did not receive her bolus administration (delivering a measured liquid formula directly into the stomach using a large syringe over a short period of time) of nutritional formula on the evening of 6/17/26. Upon reviewing resident 5's chart, it was found that RN H documented that he administered the resident's nutritional formula on resident 5's medication administration record (MAR). During an initial interview, RN H stated that resident 5 refused the nutritional formula bolus administration. When director of nursing (DON) B further questioned RN H about his documentation that indicated he administered resident 5's nutritional formula through the resident's PEG tube, RN H claimed he had administered it. RN H's employment at the facility was suspended pending the facility's investigation. LPN J revealed that certified nursing assistant (CNA) I had expressed concerns that RN H did not administer the nutritional formula to resident 5 as the physician's order stated. An interview with resident 5 found she could not recall if she had received the nutritional formula through her PEG tube. CNA I stated she did not believe RN H followed the physician's orders for administering resident 5's nutritional formula. The facility promptly notified the resident's physician, dietitian, and family regarding the incident. The facility's camera footage confirmed that RN H did not administer resident 5's nutritional formula as	F0658		

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F0658 SS = D	Continued from page 17 ordered on 6/17/26. The facility initiated 72-hour monitoring of resident 5, which revealed no adverse effects. Resident 5 was followed and observed monthly by a registered dietitian due to her dependence on enteral (delivers liquid nutrition, fluids, and medications directly into the stomach or small intestine through a specialized feeding tube) nutrition. The facility reviewed Physician Orders and Medication Error policies with the nursing staff, and no policy changes were made. The facility implemented a new process requiring labeling, dating, and in-room (medication room) storage of PEG tube feeding supplies to improve tracking the usage of those supplies. Nursing education was initiated on the new process and compliance expectations under professional standards. The DON or designee initiated weekly audits of nutritional formula administration for four weeks, followed by monthly audits for two additional months. Those findings were reported at the monthly Quality Assurance and Performance Improvement (QAPI) meeting on 7/8/26. As a result of the investigation, RN H's employment with the facility was terminated on 6/23/26. 2. Review of resident 5's electronic medical record (EMR) revealed she admitted to the facility on 8/31/20. Her diagnoses were Multiple Sclerosis (MS, (chronic autoimmune disease of the central nervous system), Cerebral Vascular Disease (CVA, (stroke), hemiplegia (total paralysis of one side of the body), hemiparesis (weakness or partial loss of strength) affecting the right dominant side, and Gastro-Esophageal Reflux Disease (GERD, (chronic condition in which stomach acid and digestive enzymes flow back into the esophagus). Her 8/11/28 Brief Interview for Mental Status (BIMS) assessment score was 8, which indicated her cognition was moderately impaired. Her MAR indicated she had a 6/16/26 physician's order for enteral feeding with Jevity (high nutritional formula) 1.5 calories per milliliter (mL) and Isosource (high-calorie nutritional formula) 1.5 calories per mL, 240 mL bolus one time a day. Her undated care plan indicated she had potential	F0658		

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F0658 SS = D	Continued from page 18 for altered nutrition status due to her primary diagnoses of MS, and that she was dependent on the staff for all nutrition and hydration. 3. An interview with resident 5 was attempted, and she could not provide answers to the surveyor's questions. 4. Interview on 9/16/26 at 11:49 a.m., CNA I revealed that on the evening of 6/17/26, she observed PEG tube feeding supplies labeled with the date 6/16/26 still present in resident 5's room. She stated she questioned RN H because she was concerned that resident 5 did not receive the scheduled nutritional feeding for 6/17/26. RN H told her resident 5 refused her nutritional feeding after CNA I questioned him. She had told RN H that resident 5 had never refused her nutritional feedings before, which caused RN H to become upset and tell her he was the nurse and that she should not question him. She then reported her concern to LPN J regarding resident 5 not receiving her nutritional feeding. She stated that was the first time she had concerns regarding residents not receiving their ordered nutritional feedings. 5. Interview on 9/16/26 at 6:00 p.m. with LPN J regarding resident 5's incident revealed LPN J had gone into resident 5's room on 6/18/26 to check the resident's nutritional formula administration supplies and noted that all of those supplies for resident 5 were dated 6/16/26. She explained that the supplies used for the resident's enteral nutritional formula administration were labeled with the date to indicate when they were to be used. She stated that RN H was difficult to talk to and often became defensive when questioned about his work, so she brought the concern directly to DON B. 6. Interview on 9/16/26 at 12:45 p.m. with DON B confirmed that the incident that involved resident 5 not receiving her nutritional formula through her PEG tube had occurred on 6/17/26 and not 6/18/26, as the SD DOH FRI indicated. She expected formerly employed RN H to administer resident 5's formula as the physician ordered. 7. Interview with RN H could not be conducted, as he was no longer employed at the facility.	F0658		

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F0658 SS = D	Continued from page 19 8. Review of the provider's updated 11/18/25 Following Physician Orders Policy revealed "To correctly and safely receive and transcribe physician's orders so the correct order is followed and administered. All physician orders should be followed as written. The prescriber should be contacted if any order is not clear and understood. The physician should be notified when an order is not followed for any reason (omission, medication not in stock, repeated resident refusals for medications and treatments, etc.)." 9. Based on the above information, noncompliance at F658 occurred on 6/17/26 and based on the provider's implemented corrective actions on 6/18/26 for the deficient practice confirmed on 9/17/26, the noncompliance is considered past noncompliance.	F0658		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, record review, and policy review, the provider failed to ensure the staff assessed residents for potential complications or changes in condition after receiving dialysis (a treatment for kidney failure that removes waste and excess fluid from the blood when the kidneys are unable to) treatments by one of one contracted travel licensed practical nurse (LPN) (U), who did not assess one of one sampled resident (40) who received dialysis treatments. Findings include: 1. Interview and observation on 9/15/26 at 1:49 p.m. with resident 40 in her room revealed that she received a dialysis treatment earlier that day. A dressing was present on her right upper arm over her arteriovenous (AV) fistula (a surgically created connection between an artery and a vein designed to provide access to the bloodstream for dialysis) site.	F0698	1. Resident 40 assessment unable to be corrected due to inability to obtain vitals for previous date. 2. All residents receiving dialysis are at risk for deficient practice. Root cause analysis identified a lack of nurses understanding of post dialysis assessment completion and failure to verify assessment completion. Administrator, DON and IDT reviewed Dialysis Management Policy on 10/6/2026. DON or designee will complete education with all nurses on how to complete post dialysis assessment and documentation by 10/10/2026. Staff not in attendance will be educated prior to next shift worked. Process implemented to review post dialysis assessments in morning meeting to verify accuracy and completion. 3. DON or designee will review residents receiving dialysis post dialysis assessments for accuracy and completion weekly x4 weeks then monthly x2 months. DON or designee will present audit findings to QAPI meeting monthly for progress review and recommendations	10/10/2026

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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
F0698 SS = D	Continued from page 20 Resident 40 stated that the staff did not check her vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate), assess her dressing, or evaluate her fistula site after she returned from dialysis. She stated, "They just put me in bed." 2. Review of resident 40's electronic medical record (EMR) revealed that she admitted to the facility on 1/20/21. Her diagnoses included essential hypertension (high blood pressure), end-stage renal disease (kidney failure), and type 2 diabetes (a condition involving disruptions in how the body regulates blood sugar). Her 8/24/26 Brief Interview for Mental Status (BIMS) assessment score was 11, which indicated her cognition was moderately impaired. A 7/1/26 physician's order directed her to have dialysis treatments every Tuesday, Thursday, and Saturday. Her care plan (personalized plan that addresses a resident's care needs, goals, and interventions) included a goal initiated on 8/20/25 that she "will not exhibit complications related to dialysis services," with interventions for the staff to monitor her AV fistula access in her right upper extremity for bleeding and signs and symptoms of infection, obtain her vital signs and weight per the facility's protocol, and report any significant changes immediately. Her 9/15/26 Post-Dialysis Evaluation completed at 3:06 p.m. documented her vital signs, an assessment for post-dialysis complications, and an AV fistula assessment. The fistula assessment documented a positive bruit (a swishing or whooshing sound heard with a stethoscope over the fistula) and thrill (a buzzing or vibrating sensation felt with your fingers over the fistula site), and "No Adverse Signs and Symptoms" and "Site is without a Dressing." 3. Interview on 9/16/26 at 6:29 p.m. with contracted travel licensed practical nurse (LPN) U about the post-dialysis assessment revealed that she did not take resident 40's vital signs upon her return from dialysis. She entered the resident's vital signs that were documented on the dialysis center communication form into resident 40's EMR because another nurse advised her to copy the information exactly from that form. She stated that it was her first day working at the facility, and that she did not remember the nurse's name who told her that. Contracted travel LPN U stated that she assessed resident 40's fistula site before going to the dialysis center but did not assess the site after resident 40	F0698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

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F0698 SS = D	Continued from page 21 received her dialysis treatment and returned to the facility. 4. Interview on 9/17/26 at 3:11 p.m. with director of nursing (DON) B revealed that she expected the nurses to assess residents when they returned from dialysis treatments, including checking their vital signs, assessing for post-dialysis complications, assessing their fistula site, and completing the post-dialysis assessment in the resident's EMR. 5. Review of the provider's 5/14/25 Dialysis Management policy revealed that, "Upon return from Dialysis Center, review information provided on Dialysis communication form. Communicate and address as appropriate. Complete post-dialysis information and record on UDA [user-defined assessment] in PCC [provider's EMR]." The policy further directed staff to "Assess and manage-post dialysis complications which may include, but are not limited to," the following: fever, headache, nausea/vomiting, back pain, dementia (a group of symptoms affecting memory, thinking, and social abilities), anaphylaxis (a severe, sudden, and potentially life-threatening allergic reaction that affects the whole body), hypotension or hypertension, cardiac arrhythmia (an irregular heartbeat), air embolus (medical emergency that happens when air enters a vein or artery and block blood flow), hemorrhage (a heavy or uncontrolled loss of blood from damaged blood vessels), metabolic problems, seizures, muscle cramps, restlessness, and insomnia.	F0698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 09/16/2026

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

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 9/16/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Norton was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K223, K355, and K920 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0355 SS = E Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to perform monthly inspection checks of fire extinguishers in accordance with NFPA 10 on four randomly checked fire extinguishers (east dining room, outside the east tub room, across from the central nurse station, across from the east nurse station) since the annual inspection on 3/10/26. Findings include: 1. Observation on 9/16/26 at 11:48 a.m. revealed the fire extinguisher on the east wall of the east dining room did not have a monthly inspection check written on the fire extinguisher tag for the month of August 2026. Interview with the maintenance director at the time of the observation revealed he was unaware of that condition. He stated his maintenance technician must have missed that inspection check for that extinguisher.	K0355	1. Fire extinguishers on East wall of east dining room, wall of corridor across from east tub room, wall in corridor across from center nurses station, and on the wall of the corridor across from east nurses station were inspected and signed off on by maintenance director on 9/17/26. 2. Administrator and Maintenance Director reviewed fire extinguisher protocol. Administrator or designee to complete education with Maintenance staff on Fire Extinguisher Protocol completed by 10/10/2026. Maintenance Director or designee completed facility wide audit of all fire extinguishers to ensure all were inspected and signed off for inspection. 3. Maintenance Director or designee will complete Fire extinguisher inspection audit monthly x 6 months. Maintenance Director or designee will present audit findings to QAPI meeting monthly.	10/10/2026

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
Ashley Nickel	Administrator	10/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **09/16/2026**

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

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K0355 SS = E Bldg. 01	Continued from page 1 2. Observation on 9/16/26 at 12:02 p.m. revealed the fire extinguisher on the wall of the corridor across from the east tub room did not have a monthly inspection check written on the fire extinguisher tag for the month of August 2026. Interview with the maintenance director at the time of the observation revealed he was unaware of that condition. He stated his maintenance technician must have missed that inspection check for that extinguisher. 3. Observation on 9/16/26 at 2:10 p.m. revealed the fire extinguisher on the wall of the corridor across from the central nurse station did not have a monthly inspection check written on the fire extinguisher tag for the month of August 2026. Interview with the maintenance director at the time of the observation revealed he was unaware of that condition. He stated his maintenance technician must have missed that inspection check for that extinguisher. 4. Observation on 9/16/26 at 2:24 p.m. revealed the fire extinguisher on the wall of the corridor across from the east nurse station did not have a monthly inspection check written on the fire extinguisher tag for the month of August 2026. Interview with the maintenance director at the time of the observation revealed he was unaware of that condition. He stated his maintenance technician must have missed that inspection check for that extinguisher. These deficiencies have the potential to affect the whole of each of their respective smoke compartments.	K0355		
K0223 SS = D Bldg. 01	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke	K0223	1. Door in clock in room will have lockable handle and anchor on door to ensure that door will close appropriately 9/28/2026. 2. Administrator and Maintenance Director reviewed Door Closure monitoring protocol. Administrator or designee completed education with Maintenance staff on Door Closure protocol by 10/10/26. Maintenance Director or designee completed facility wide audit of all Door Closures to ensure all door closures are closing/latching. 3. Maintenance Director or designee will complete inspection of 5 door closures weekly x 4 weeks then monthly x 2 months. Maintenance Director or designee will present audit findings to QAPI meeting monthly.	10/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **09/16/2026**

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K0223 SS = D Bldg. 01	Continued from page 2 passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observation, testing, interview, and record review, the provider failed to ensure one randomly observed corridor door (time clock room) was equipped with functioning positive latching hardware. Findings include: 1. Observation and testing on 9/16/26 at 12:22 p.m. revealed the door into the corridor from the time clock room was equipped with a closer, but it did not automatically latch into the door frame. Testing of that door revealed its closer stopped the door short of the latch when closing and kept it from latching. Review of the previous survey conducted on 3/24/26 revealed that door was cited as not correctly latching at the time of that survey. Doors provided with closers are required to latch into their frames automatically. Interview with the maintenance director at the time of the observation and testing confirmed those findings. He stated he was unaware of those conditions and added that door had recently been audited at was correctly working at that time. That Door was adjusted and operating properly before the end of the survey that day.	K0223		
K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g.,	K0920	1. Northernmost bed in room 304 power strip replaced with medical grade power strip for patient-care-related electrical equipment (PCREE). 2. Administrator and Maintenance Director reviewed regulation for Electrical Equipment-Power cords and extension cords. Administrator or Designee completed education with Maintenance on Regulation expectations for Electrical Equipment-power cords and extension cords by 10/10/2026. Maintenance Director or	10/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 09/16/2026

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K0920 SS = D Bldg. 01	Continued from page 3 personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to ensure extension cords and power strips used for non-patient-care-related (PCREE) met all requirements in one randomly observed location (resident room 304). Findings include: 1. Observation on 9/16/26 at 11:16 a.m. revealed the northernmost bed in room 304 was plugged into a power strip which also had the bed's air mattress, a phone charger, and a fan attached. Power strips in the patient care vicinity may not be used for non-patient-care-related electrical equipment (PCREE). Power strips for PCREE are required to meet UL 1363A or UL 60601-1. Interview with the maintenance director revealed he thought a family member must have brought that power strip into the facility.	K0920	designee completed facility wide audit of all power strips in the facility to ensure medical grade power strips. 3. Maintenance Director or designee will complete observation of 5 rooms with power strips to ensure medical grade power strips are being utilized weekly x 4 weeks then monthly x2 months. Maintenance Director or designee will present audit findings to QAPI meeting monthly.	

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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 on 9/16/26. Avantara Norton was found in compliance.	E0000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Nickel	Administrator	10/06/2026

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
	10682	A. BUILDING: _____ B. WING _____	09/17/2026

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AVANTARA NORTON	3900 S NORTON AVENUE SIOUX FALLS, SD 57105

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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 9/15/26 through 9/17/26. Avantara Norton was found in compliance.	S 000		

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

Ashley Nickel | Administrator | 10/06/2026