STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 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
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/8/25 through 4/10/25. Areas surveyed included abuse and neglect, and verbal abuse. Avantara Norton was found not in compliance with the following requirements: F624 and F658. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/8/25 through 4/10/25 The area surveyed included potential drug diverson of a resident's medication. Avantara Norton was found to have past non-compliance at F602.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §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. This REQUIREMENT is not met as evidenced by: Based on the South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, and policy review, the provider failed to ensure two of two sampled residents' (1 and 2) prescribed controlled (medications with risk for abuse and addiction) pain medications were not diverted (when prescribed medication is obtained or used illegally by another person) by one registered nurse (RN)	F 602	Past noncompliance: no plan of correction required.	

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

Ashley Nickel | LNHA | 04/28/25

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(E). Failure to ensure prevention of diversion of those medications had the potential to cause those residents increased pain and potentially placed all residents' safety at risk who were under RN E's care. This citation is considered past non-compliance based on the provider's identification of the potential diversion and actions implemented following the incident.
Findings include:

1. Review of the provider's 3/3/25 SD DOH FRI revealed:
*Director of nursing (DON) B notified registered nurse (RN) E's Health Professional Assistance Program (HPAP) caseworker regarding concerns that RN E may have been diverting controlled medications from the facility due to his agitated behavior.
*The HPAP caseworker notified DON B on 3/3/25 that RN E's random drug test was positive for hydrocodone and oxycodone (controlled pain medications) and he was not currently prescribed those medications.
*RN E did not work any further shifts at the facility and had resigned his position on 3/4/25.
*During an interview with administrator A and DON B, RN E admitted to diverting oxycodone from residents (1 and 2).
*He reported diverting the residents' PRN (as needed) pain medication when the residents did not ask for it, explaining that the residents did not go without pain medication if they needed it.
*He reported that he began diverting oxycodone while working in the facility in mid to late January 2025.
*He was unable to give an exact amount of oxycodone that he had diverted from the residents.
*A review of resident 1's medication

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administration record (MAR) revealed RN E had documented that he had:
-Administered one tablet of oxycodone 5 milligrams (mg) four times in February 2025.
-Administered two tablets of oxycodone 5 mg 25 times in February 2025.
*A review of resident 2's MAR revealed RN E had documented that he had:
-Administered four doses of oxycodone 7.5 mg tablet in December 2024.
-Administered 14 doses of oxycodone 7.5 mg tablets in January 2025.
-Administered 11 doses of oxycodone 7.5 mg tablets in February 2025.
*The local police department was notified of the event and performed an investigation.
*That police department's detective who investigated the incident reported the information shared in RN E's interview matched the information RN E had given to the provider.

2. Interview on 4/9/25 at 1:55 p.m. with DON B revealed:
*RN E was hired in December 2024.
*DON B was aware RN E was in the HPAP program but was not aware of the reason he was in the HPAP program.
*DON B was to evaluate and report to RN E's caseworker every three months on his job performance.
*He had not completed the first evaluation of RN E before the above reported incident on 3/3/25.

3. Interview on 4/10/25 at 2:00 p.m. with DON B revealed:
*DON B reported when narcotic (controlled) sign-out sheets were completed, they were scanned into the resident's EMR.
*If no discrepancies were noted (the number of

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remaining pills matching the number on the sign-out sheet), no further review was completed.
*When reviewing the narcotic sign-out sheets, there was no comparison made between the narcotic sign-out sheet and the resident's MAR, they only verified that the number of the resident's remaining pills matched the pill count that was documented on the sign-out sheet.

4. Interview on 4/9/25 at 10:18 a.m. with resident 1 revealed:
*He did not recall asking for pain medication and not receiving it.
*He felt his pain was adequately controlled.
*His Brief Interview for Mental Status (BIMS) score was 14, which indicated he was cognitively intact.

5. Review of resident 1's MAR revealed:
*During February 2025, his PRN 5 mg oxycodone was documented as administered seven times.
-Three of those times, the dose was documented as administered by RN E.
*During February 2025, his PRN 10 mg oxycodone was documented as administered 61 times.
-Twenty-six of those times, the dose was documented as administered by RN E.

6. Review of the narcotic sign-out sheet and resident 1's MAR revealed:
*On 2/9/25 at 7:30 p.m., two oxycodone pills were signed out on the narcotic sheet by RN E, but only one pill was documented as administered in the MAR.
*On 2/17/25 at 1:16 a.m., two oxycodone pills were documented in the MAR as administered by RN E, but no pills were signed out on the narcotic sheet.

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*On 2/18/25 at 1:30 a.m., two oxycodone pills were signed out on the narcotic sheet by RN E, but no pills were documented as administered in the MAR.
*On 2/23/25 at 4:00 a.m., one oxycodone pill was signed out on the narcotic sheet by RN E, but no pills were documented as administered in the MAR.

7. Interview on 4/9/25 at 1:15 p.m. with resident 2 revealed:
*She did not recall asking for pain medication and not receiving it.
*She felt her pain was adequately controlled.
*Her BIMS score was 7, which indicated she may have severe cognitive impairment.

8. Review of resident 2's MAR revealed:
*During January 2025, her PRN 7.5 mg oxycodone dose was documented as administered 14 times, all by RN E.
*During February 2025, her PRN 7.5 mg oxycodone dose was documented as administered 11 times, all by RN E.

9. Review of the provider's Staff In-Service Sheet and Opioids audits revealed:
*On 4/9/25, a staff in-service was held.
-"When administering prn/scheduled narcotics the narc [narcotic] book and MAR should match. Need to document timely."
*Audits included "DON or designee will audit the medication administration record for 10 residents receiving prn opioids weekly x [times] 4 weeks, then monthly for 3 months to determine if there is a suspicious pattern of specific nurses administering prn doses of opioids."
-Audits had been completed on 3/14/25, 3/21/25, 3/28/25, and 4/4/25 with no identified concerns.

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F 602	Continued From page 5 10. Review of the provider's February 2024 abuse and neglect policy revealed: *"Policy Statement: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. " 11. Review of the provider's drug diversion prevention policy revealed: *Policy, "It is the policy of this facility to set forth standards related to preventing the diversion of medications. Medications classified by the Drug Enforcement Administration (DEA) as controlled substances are subject to special handling, storage, disposal, and record keeping." *"3. Administration of Controlled Substances: a. Documentation of each administered dose of a controlled substance is to occur on the resident's Medication Administration Record (MAR) and the specific medication's inventory sheet at the time of administration." The provider's implemented actions to ensure the deficient practice does not recur was confirmed after record review revealed the facility had followed their quality assurance process, a thorough investigation was completed, staff education was provided regarding patterns of certain nurses administering narcotic medications, interviewing residents to ensure they received their medications, comparing residents' MAR to narcotic sheets, record review and interviews revealed staff understood the education provided, completed audits revealed no identified concerns, and the auditing is ongoing as part of their QAPI plan and process to prevent drug diversion.	F 602		

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F 602	Continued From page 6 Based on the above information, non-compliance at F602 occurred on 3/3/25, and based on the provider's implemented corrective action for the deficient practice confirmed on 4/9/25, the non-compliance is considered past non-compliance.	F 602		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint report, record review, interview, and policy review, the provider failed to ensure one of one sampled resident (3) had received discharge instructions and education on the risks versus benefits prior to leaving against medical advice (AMA). Findings include: 1. Review of the SD DOH complaint intake report received on 4/9/25 revealed: *A resident had been admitted to the facility on April 2025. *There were concerns of the resident being unhappy with her medication administration and the lack of explanation of her medication that had been administered. 2. Review of resident 3's electronic medical	F 624	1. Resident 3 discharged from facility. 2. All residents at risk for leaving AMA are at risk to be affected by deficient practice. 3. Administrator or designee will provide education to all staff on Against Medical Advice (AMA) discharge policy to include explanation and documentation of discussions of risks for leaving AMA, Assessing resident's competence prior to leaving AMA, and utilization of all available resources to discourage resident from leaving AMA, asking provider if they want to provide verbal order to release medication to the resident at discharge, and document when resident leaves AMA along with instructions given and medications provided. Education will occur no later than 05/05/2025 and those staff not present for education will be educated prior to next worked shift. 4. Administrator or designee will complete weekly audit x4 weeks and monthly x 2 months for all AMA discharges to ensure AMA discharge is	05/05/25

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F 624	Continued From page 7 record (EMR) revealed: *She was admitted on 4/4/25 for rehabilitation services following a left hip replacement. *Three days later she left AMA. *She had signed the provider's AMA form prior to leaving. *A Brief Interview for Mental Status (a tool to determine cognitive function) was not completed prior to her leaving AMA to support if she had been competent enough to make that decision. *There was no documentation to support: -Interventions and other resources had been provided in an attempt to prevent the resident from leaving AMA. -Discharge instructions and medication administration education had not been provided to her ensuring safety after she left AMA. -The resident had been educated on the benefits of remaining in the facility versus the potential risks associated with leaving AMA. 3. Interview on 4/10/25 at 12:30 p.m. with social services (SS) D regarding resident 3 revealed: *She had been informed by director of nursing (DON) B that resident 3 wanted to leave AMA on 4/7/25. *She had notified the resident's physician that resident 3 wanted to leave AMA. *She had attempted to explain to the resident the risks of leaving AMA. *She confirmed she had not documented her conversation with the resident in an attempt to make her say. She agreed she should have. 4. Interview on 4/10/25 at 1:55 p.m. with administrator A, DON B, and regional nurse consultant (RNC) C regarding resident 3 revealed: *Administrator A would have expected the staff to	F 624	completed per facility policy. Administrator or designee will discuss audits in monthly QAPI meeting for further review of progress and discussion of continuation/ discontinuation of audits.	

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F 624	Continued From page 8 have explained the risks of leaving AMA and the benefits of staying in the facility. -That education should have been documented in the resident's EMR to support that it happened. *RNC C stated if a resident left AMA medication and discharge instructions were not provided to the resident prior to leaving the facility. Review of the provider's November 2024 Against Medical Advice (AMA) Discharge revealed: *"Staff shall provide attention and make reasonable effort to prevent a resident from leaving AMA." *"Assess the resident's competence to make the AMA decision (vital signs, mental status examination, including presence or absence of hallucinations and delusions, judgment, reasoning, awareness, and insight)." *"Use all available resources to discourage a resident from leaving AMA. This may include the social worker, nurse, nursing assistant, activity staff, a family member or even a friend." *"Explain and document the discussion(s) of the reason to remain in the facility and all the potential serious risks associated with leaving." *"Explain and document your ongoing concern for the resident and his/her well-being." *"Ask the physician if they want to give a verbal order to release medication to the resident at discharge." *"Document when a resident leaves AMA, along with any instructions given and medications sent with resident."	F 624		
F 658 SS=E	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,	F 658	1. Resident 1 and 2's medication administration unable to rectify past medication administration. Resident 3 discharged.	05/05/25

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F 658	Continued From page 9 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: A. Based on record review, interview, and policy review, the provider failed to follow professional standards by not having ensured two of two sampled residents (1 and 2) had received their PRN (as needed) controlled (medications with risk for abuse and addiction) pain medications as ordered by the physician. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed his medication administration record (MAR) indicated: *He had a physician's order for oxycodone (a controlled pain medication), 5 milligram (mg) tablet, "Give 2 tablet[s] orally every 4 hours as needed for pain." *On 2/17/25, he was given two oxycodone tablets by registered nurse (RN) E at 1:16 a.m., and two oxycodone tablets by licensed practical nurse (LPN) G at 2:12 a.m. -Less than one hour had passed between those administrations. *On 3/20/25, he was given one oxycodone tablet by certified medication aide (CMA) F at 4:37 p.m., and two oxycodone tablets by LPN H at 7:35 p.m. -Less than three hours had passed between those administrations. On 3/21/25, he was given two oxycodone tablets by LPN I at 5:26 p.m., and two oxycodone tablets by RN J by 7:23 p.m. -Less than two hours had passed between those administration. *All of those documented administrations were given before four hours had passed between administrations as ordered.	F 658	2. All residents are at risk to be affected by deficient practice with narcotic medication administration. Implemented new narcotic documentation process with new narcotic books for all residents. All residents are at risk to be affected by deficient practice of not notifying provider and dietitian of significant weight change. 3. DON or Designee will complete education on policy of following physician orders, and weighing the resident, to include Narcotic documentation, 6 rights of medication administration, provider and dietitian notification of significant weight changes. Education will occur no later than 05/05/2025 and those staff not present for education will be educated prior to next worked shift. 4. DON or Designee will complete weekly audits of 5 residents utilizing narcotics on each med cart x 4 weeks, then monthly x 2 months. DON or designee to audit 5 residents weekly x4 weeks then monthly x2 months for significant weight changes and notifications. DON or designee will discuss audits in monthly QAPI meeting for further review of progress and discussion of continuation/ discontinuation of audits.	

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2. Review of resident 2's EMR revealed her January 2025 MAR indicated:
*She had a physician's order for oxycodone, 5 milligram (mg) tablet. "Give 7.5 mg by mouth every 4 hours as needed for pain."
*On 1/3/25 at 1:28 a.m., RN E documented administering resident 2's PRN oxycodone.
-On 1/3/25 at 1:30 a.m., RN E documented administering her an additional dose of oxycodone.
*On 1/21/25 at 2:01 a.m., RN E documented administering resident 2's PRN oxycodone.
*On 1/21/25 at 5:00 a.m., RN E documented administering her an additional dose of oxycodone.
*All of those documented administrations were given before four hours had passed between administrations as ordered.

3. Interview on 4/9/25 at 2:00 p.m. with director of nursing (DON) B revealed:
*It was his expectation that medications would be administered following the physician's orders.
*He was not sure if there was a policy that would state if and how early a PRN medication could be administered.
*He thought that if a PRN medication was requested early, it should not have been administered more than 30 minutes before the next ordered dose.

4. Review of the provider's October 2024 medication administration-general guidelines policy revealed:
*Medications were to be administered observing "SIX RIGHTS- Right resident, right drug, right dose, right route, right time, and right documentation, are applied for each medication

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being administered."
*"Prior to administration of any medication, the medication and dosage schedule on the resident's medication administration record (MAR) are compared with the medication label."
*" Medications are administered in accordance with written orders of the prescriber."

B. Based on record review, interview, and policy review, the provider failed to follow professional standards by not having ensured one of one sampled resident (3) with a documented weight gain had been re-weighed and that the physician was notified of the resident's weight gain according to their policy. Findings include:

1. Review of resident 3's electronic medical record (EMR) revealed:
*She was admitted on 4/4/25 with a diagnoses of:
-congested heart failure (a condition when the heart is unable to pump blood efficiently and causes fluid buildup), and a left hip replacement.
*On 4/4/25, resident 3 had an admission weight of 215 pounds (lbs).
*On 4/5/25, her documented weight was 221 lbs an increase of six pounds.
-There was no documentation of the resident being re-weighed related to the six-pound weight gain.
*On 4/6/25 her documented weight was 227 lbs an increase of six pounds from the previous day's weight.
*There was no documentation of the charge nurse having acknowledged resident 3's weight gain.
*There was no documentation that the physician had been notified of resident 3's twelve-pound weight gain in two days.

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AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

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F 658	Continued From page 12 Interview on 4/10/25 at 1:55 p.m. with administrator A, director of nursing (DON) B, and regional nurse consultant (RNC) C regarding resident 3' s weights revealed: *RNC C stated that resident 3's weight upon admission of 215 lbs had been her hospital weight and was not obtained upon her admission to the facility. *They agreed that there was no documentation that the physician had been notified of resident 3's weight gain and their policy had not been followed. Review of the provider's February 2024 Weighing the Resident revealed: *"Report significant weight loss/weight gain to the charge nurse who will report to the registered dietitian and physician." *"If weight does not appear correct, re-weigh resident to ensure weight is accurate. Consider re-weighing the resident if there is a 5-pound difference from the resident's last weight."	F 658		