STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA ARROWHEAD	**2500 ARROWHEAD DR , RAPID CITY, South Dakota, 57702**

(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 9/15/26. Areas surveyed included the provision of physician-ordered services and the process for entering physicians' orders. Avantara Arrowhead was found to have past non-compliance at F658 and F776.	F0000		
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: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, and interview, the provider failed to ensure professional standards of nursing were followed regarding physician order entry by one of one contracted travel registered nurse (RN) (D) who entered an incorrect medication order start date for one of sampled resident (2), who was administered three Lovenox (a blood thinning medication) injections that should not have been administered and was transferred to the hospital for evaluation and treatment of diarrhea and bloody stools. 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 8/31/26 SD DOH FRI revealed that during the provider's daily "stand-up" (a clinical interdisciplinary meeting), the residents' new and updated physicians' orders were reviewed. During that meeting, director of nursing (DON) B identified that contracted travel RN D entered a	F0658	"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
Jessica Simon	Interim Administrator	09/28/2026

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F0658 SS = D	Continued from page 1 physician's order for Lovenox injections for resident 2 to be started on 8/26/26 in the electronic medical record (EMR) system. The provider's investigation identified that the start date for that medication should have been 9/4/26. Contracted travel RN D's inaccurate order entry resulted in resident 2 receiving three Lovenox injections before that medication's scheduled start date. Contracted travel RN D, the resident's medical provider, and the resident's representative were notified on 8/31/26 of that medication error. The provider completed an investigation of the incident, determined the root cause of the medication error, and took corrective actions to prevent a recurrence. 2. Review of resident 2's EMR revealed she admitted to the facility on 3/23/26. Her diagnoses included a history of a stroke (blood flow to part of the brain is blocked or a blood vessel in the brain bursts), diabetes, heart disease, and lower extremity leg wounds. Resident 2's 9/1/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated she had no cognitive impairment. Resident 2's July 2026 and August 2026 medication administration records (MAR) indicated that she had a leg wound infection that was treated with clindamycin (an antibiotic) from 7/28/26 through 8/4/26 and with amoxicillin (an antibiotic) from 8/12/26 through 8/23/26. There was an 8/19/26 PRN (as needed) physician's order for loperamide to treat the resident's diarrhea. Resident 2 was administered 75 mg (milligrams) Plavix (an antiplatelet used to prevent blood clots) daily and 5 mg Apixaban (an anticoagulant/blood thinner) two times daily related to her stroke history. Contracted travel RN D added orders into the resident's MAR with an 8/26/26 start date that indicated, “Inject 80 mg [of] Lovenox under the skin every 12 hours for 7 doses." Resident 2 was administered the first injection on the evening of 8/26/26, a second injection the morning of 8/27/26, and a third injection the morning of 8/29/26. An 8/27/26 progress note indicated that resident 2 had diarrhea and possible blood in her stool. The resident's physician was notified and ordered lab work to be completed. The physician ordered the staff to stop administering her blood-thinning medications. An 8/29/26 progress note indicated that resident 2 was transferred to a local emergency department related to having diarrhea and bloody stools. She remained hospitalized until 8/31/26.	F0658		

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F0658 SS = D	Continued from page 2 An 8/31/26 hospital discharge summary revealed that resident 2 was treated for clostridium difficile (bacterium that causes severe diarrhea and inflammation of the colon. Using antibiotics can kill good bacteria in the gut, allowing clostridium difficile to grow). A gastroenterology consultation was completed during resident 2's hospital stay, and the gastroenterologist recommended an outpatient colonoscopy (a medical procedure used to examine the inside of the large intestine). The resident's Plavix and Apixaban medications were included in the resident's hospital discharge orders. There was no Lovenox ordered ordered by the hospital physician. A 9/4/26 post-hospital physician progress note revealed that resident 2 had a bowel movement on 9/1/26 with no noted blood in that stool. Follow-up labwork was ordered to be drawn for resident 2 on 9/9/26, and resident 2's hemoglobin (a protein in red blood cells) was being monitored. 3. Interview and 8/26/26 pharmacy fax review on 9/15/26 at 1:30 p.m. with contracted travel RN D revealed that she frequently worked at the nursing home during the past eight months or so. She confirmed that the orientation training from the provider included the process for entering physicians' orders into the resident's EMR. She entered a Lovenox order with a start date of 8/26/26 for resident 2 based on an 8/26/26 pharmacy fax. The 8/26/26 pharmacy fax had the words “Order entered” written on the bottom of it, and contract travel RN D's initials were below that. Contract travel RN D confirmed that those initials were hers and that indicated she had acknowledged and entered the information from the fax as though it was a physician’s order into resident 2's EMR. She stated that the fax was not a physician's order. She was aware that order entry error resulted in resident 2 receiving Lovenox injections before the physician's order intended them to be given, and that error could have caused harm or negatively impacted resident 2. 4. Record review and interview on 9/15/26 at 2:20 p.m. with assistant administrator A, DON B, and regional nurse consultant C revealed that resident 2 had a cardiac procedure that was scheduled to be completed on 9/8/26 at a local heart and vascular center. Resident 2's medication orders for that procedure indicated that she was to be given an injection of 80 mg of Lovenox in the morning and in the evenings on 9/4/26, 9/5/26, and 9/6/26, and one 80 mg Lovenox injection on the morning of	F0658		

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F0658 SS = D	Continued from page 3 9/7/26. Those Lovenox injections should have been entered into resident 2's EMR to be given according to that physician-ordered administration schedule, not the order that contracted travel RN D entered on 8/26/26. 5. The provider's implemented actions to mitigate the likelihood of the deficient practice from recurring were verified on 9/15/26 after record review and interview with assistant administrator A, DON B, and RNC C revealed that the facility had followed its Quality Assurance and Performance Improvement (QAPI) process by immediately discontinuing resident 2's 8/26/26 Lovenox order and entering the correct physician's order for Lovenox, educating all the nurses, included contracted travel RN D, regarding the provider's Following Physician's Order policy, and continuing to audit residents' physicians' orders during the daily stand-up meetings. Audit data is presented to the provider's QAPI team for their input and recommendations. 6. Based on the above information, non-compliance at F658 occurred on 8/26/26, and based on the provider's corrective action plans that were initiated on 8/31/26 and implemented for the deficient practice confirmed on 9/15/26, the non-compliance is considered past non-compliance.	F0658		
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 South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, and interview, the provider failed to ensure diagnostic services were completed as ordered for	F0776	"Past Noncompliance - no plan of correction required"	

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F0776 SS = D	Continued from page 4 one of one sampled resident (1) whose physician-ordered X-rays to be completed on 7/2/26, were not completed until five days later on 7/7/26. That placed the resident at risk for a potential delay in receiving medical treatment. 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 7/7/26 SD DOH FRI revealed that resident 1 had an unwitnessed fall on 6/30/26 with no known injury. On 7/1/26, resident 1 complained of lower right rib pain, and she had a small bruise in that area. A physician evaluated the resident on 7/2/2026, and referred her to an urgent care clinic or local emergency department (ED) for a chest and right-sided rib X-rays. Former scheduler F was made aware of that physician's referral on 7/2/26 by director of nursing (DON) B. It was his responsibility to coordinate resident 1's transportation to a medical facility that was able to complete those X-rays on 7/2/26. Resident 1's X-rays were not completed until 7/7/26, after she fell again on 7/6/26. 2. Review of resident 1's electronic medical record (EMR) revealed that she admitted to the nursing home on 4/21/26 after she fell and was hospitalized. Her diagnoses included a traumatic brain injury (a brain injury that results from a violent blow or jolt to the head), Alzheimer's dementia (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), and a history of falling. Her 7/9/26 Brief Interview for Mental Status (BIMS) assessment score was 11, which indicated her cognition was moderately impaired. A 6/30/26 progress note stated that resident 1 slipped out of her wheelchair in her room and onto the floor. She got back into her wheelchair and reported the fall to the staff. The resident's vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) and neuros (assessment of nerve function, reflexes, coordination, motor skills, sensation, and mental status) were checked with no abnormal findings. The resident reported no pain. A 7/1/26 progress note indicated that resident 1 complained of pain in her lower right rib area, and had a small bruise to that area. She was not short of	F0776		

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F0776 SS = D	Continued from page 5 breath. A 7/2/26 progress note indicated that after evaluating resident 1, her physician ordered scheduled administration of Tylenol for the resident's pain, and referred the resident to an urgent care or local hospital for chest and rib X-rays. 3. Interview on 9/15/26 at 8:10 a.m. with scheduler E revealed that she transported residents to their medical appointments. She assumed that position after former scheduler F ended his employment at the nursing home about ten days earlier. Scheduler E stated that the residents were taken to a nearby urgent care to have their post-fall diagnostic tests completed. The urgent care required a physician’s order to complete an X-ray. The local hospital imaging department was an option for same-day diagnostic testing with a physician’s order, and the local ED was an option for emergency diagnostic testing. Scheduler E stated that if she could not accommodate an unexpected or unplanned resident appointment, there were additional facility staff able to assist with residents' appointments to ensure they were completed on time. If there were transportation concerns, the facility's sister facilities were contacted to assist. If necessary, a non-emergent ambulance transport was arranged. Scheduler E communicated any potential appointment barriers to DON B. 4. Interview on 9/15/26 at 8:50 a.m. with regional nurse consultant (RNC) C revealed that physicians’ orders were printed twice daily and reviewed by the nurse managers to ensure that residents' appointments were added to a computer-based appointment calendar by scheduler E. Resident appointment information was also discussed during the daily morning "stand-up" (an interdisciplinary clinical meeting) for any potential barriers that would prevent the timely completion of a resident's appointment. The purpose of those processes was to decrease the risk of a resident missing an appointment. 5. Observation and interview on 9/15/26 at 11:15 a.m. with resident 1 revealed that she used her feet to propel her wheelchair forward down the hallway. She stated that for years she had problems with her balance. Resident 1 then stood up from her wheelchair without first locking her wheelchair brakes. She stated she was supposed to lock her	F0776		

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F0776 SS = D	Continued from page 6 brakes when she stood up from the wheelchair, but sometimes she forgot to do that. She also knew she was supposed to use her call light when she transferred from her bed to her wheelchair or her wheelchair to her bed, but she sometimes forgot to do that too. 6. The provider's implemented actions to mitigate the likelihood of the deficient practice from recurring were verified on 9/15/26 after record review, resident and caregiver interviews, and interviews with assistant administrator A, DON B, and RNC C revealed that the facility had followed its Quality Assurance and Performance Improvement (QAPI) process and educated DON B regarding her responsibility to ensure that after providing former scheduler F with resident 1's physician's order for X-rays, that she confirmed with scheduler F his plan for ensuring the X-rays were completed on 7/2/26. Former scheduler F was educated regarding the expectation that physician-ordered, post-fall diagnostic tests were completed on the day they were ordered. If that was not possible, it was his responsibility to ensure he notified a nurse manager immediately. Scheduler E was educated by the management staff regarding the responsibilities of her job role. The management staff was educated regarding their responsibility to ensure that physician-ordered, post-fall diagnostic tests were monitored each day to ensure they were completed on the day they were ordered. Resident 1's fall prevention and intervention care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was reviewed and updated by the provider. All staff were educated regarding those care plan changes and updates. Audits were initiated to verify that physician orders for post-fall procedures were promptly provided to the scheduler, and that those procedures were completed on the day they were ordered. That audit data was reported and reviewed at QAPI, and process revisions were made as needed. 7. Based on the above information, non-compliance at F776 occurred on 7/2/26, and based on the provider's corrective action plans that were initiated on 7/7/26 and implemented for the deficient practice confirmed on 9/15/26, the non-compliance is considered past non-compliance.	F0776		