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 11/06/2025

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 from 11/4/25 through 11/6/25. Areas surveyed included potential neglect, physical environment, and quality of care related to fall prevention interventions and post-fall management. Avantara Arrowhead was found not in compliance with the following requirement: F689.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) reviews, interviews, record review, and policy review, the provider failed to ensure the safety of three of eight sampled residents (1, 2, and 3) who had incidents of falls related to equipment use between 9/11/25 and 11/5/25. The manufacturer's instructions and policies for safe use of the resident care equipment had not been followed by the staff. Findings include: 1. Review of a 10/24/25 SD DOH FRI revealed that resident 1 had fallen out of a bath chair in the bathing room. The root cause identified for that fall was certified nurse aide (CNA) C failing to secure the bath chair's safety belt around the resident's waist while the resident was seated in that chair. After bathing the resident, CNA C moved the unsecured resident who was sitting in the bath chair out of the	F0689	1. Resident 1 was transported to hospital on 10/24/25 for treatment and Certified Nursing Assistant (CNA) C was terminated from employment as stated in the citation. Resident 1 is in the facility and continues to wear her Miami-J collar and without noted concerns. RN D was provided one on one education on 11/24/2025 by Director of Nursing (DON) on Falls Management Policy and expectations of nurse leadership during management of situations/incidents. RN E, an agency nurse, is no longer completing shifts at the facility. CNA G was observed, educated, and competency completed for mechanical lift transfer on 10/24/2025 by Regional Nurse Consultant. Resident 3's care plan was reviewed and updated on 11/21/2025. All residents are at risk for failure to secure safety belt on bath chair and all nursing staff were educated on belt use after the fall. All residents who fall are at risk for further injury for failure to follow the Falls Management Policy and Neurological Evaluation Policy. All falls are reviewed by a nurse manager on-call manager after the incident to ensure the policies post fall were followed.	12/06/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sharon Martin	Administrator	11/24/2025

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 11/06/2025

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
F0689 SS = G	Continued from page 1 whirlpool bathtub. The resident leaned forward in the bath chair, causing her to fall forward out of the chair and onto the bathing room floor. Resident 1 was transported by emergency medical personnel to the emergency room (ER) for evaluation of her injuries that resulted from that fall. CNA C was suspended from employment during the FRI investigation and then terminated from employment after the investigation was completed for failing to use the bath chair's safety belt to secure resident 1 in the bath chair. 2. Review of CNA C's 10/31/25 witness statement regarding resident 1's 10/24/25 fall revealed: "[Resident 1] was not seat belted in [the bath chair]. I was not aware we are suppose to seat belt her in." 3. Review of the provider's 10/21/25 clinical all staff meeting agenda revealed bath aides and certified nurse aides were educated on the following topics related to recent resident falls: *"Equipment/device use: per manufacturer's instructions. *Buckle all buckles, strap all straps, hook all hooks. *Always ask questions if something is unclear, always use two people if indicated. Short cuts can hurt the resident as well as the staff member." CNA C had signed the education sign-in sheet confirming that she had received the above education on 10/21/25. That education was three days prior to resident 1's fall on 10/24/25. 4. Interview on 11/4/25 at 2:15 p.m. with registered nurse (RN) D and director of nursing (DON) B regarding resident 1's 10/24/25 fall revealed RN D stated that after CNA C was heard calling for help on 10/24/25 from the bathing room, RN D entered the bathing room and observed resident 1 face down on the floor with her head turned to one side. The amount of blood she observed and the resident's position on the floor made RN D suspect that resident 1 may have sustained a head injury after falling. Resident 1 was "making no sound" and was "not responding". RN E was already in the bathing room when RN D arrived. RN D said that RN E had instructed her to retrieve the	F0689	2. The Administrator, DON, Social Services Director, Assistant Director of Nursing, Unit Manager, and Activities Director in collaboration with the Medical Director, reviewed the Falls Management, Bathing Policy, and Neurological Evaluation policies that address fall prevention and post-fall management processes. The policies address appropriate response to and assessment of head injuries to prevent further injury and related risks, safe use of equipment including bathing chairs/lifts, safe transfers, review/revision of residents' care planned fall prevention interventions as needed after a falling incident, and implementation of those interventions. DON or designee will provide education to all staff on proper response to a fall, not moving residents if head or spinal injury is suspected, and the falls management policy. CNAs and Nurses will be educated on fall prevention, bathing policy, safety during bathing, and where to find safety information. Nurses will be educated on Neurological Evaluation Policy and post fall check list. Competencies of staff knowledge and implementation of all aspects of the education provided will be obtained after the education is completed. All nurses will complete neurological check competencies. Education/Competencies will be completed no later than December 6, 2025. Those not at the education session will be educated prior to their first shift worked. 3. The DON or designee will audit all residents falls weekly for completion of fall scene investigation, new interventions on care plan, verification of interventions in place, fall risk UDA and Neuro check UDA complete. The audits will be weekly for 4 weeks then 10 random falls monthly for 2 months. The DON or designee will conduct 10 random observations of baths each week for 4 weeks, then 10 random baths each month for 2 months on safety belt use on	

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 11/06/2025

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
F0689 SS = G	Continued from page 2 vital signs cart. Before RN D exited the bathing room to get the cart, RN D told RN E to stabilize resident 1's head and neck before she was turned onto her back. Resident 1 was on her back when RN D returned to the bathing room with the vitals cart. RN D observed a bleeding laceration on resident 1's forehead. RN D said she had told RN E to complete a neurological evaluation (assessment of nerve function, reflexes, coordination, motor skills, sensation, reflexes, and mental status) of resident 1 in addition to taking her vital signs. RN E then instructed RN D to bring a Hoyer lift (a mechanical lift and sling used to lift a person's full body) to the bathing room. With the uncertainty of the extent of resident 1's injuries, RN D thought the resident should have remained on the floor until emergency medical services (EMS) arrived, but since RN E was managing the accident, she followed RN E's instructions. 5. Telephone interview on 11/4/25 at 2:50 p.m. with RN E on speaker phone and DON B listening regarding resident 1's 10/24/25 fall revealed that upon arrival to the bathing room after the resident's fall, RN E observed resident 1 face down on the floor with her head turned to the side. RN E noticed blood on the floor near the resident's face. She had not known at that time where the blood was coming from. She had not suspected that resident 1 may have injured her head. When RN D entered the bathing room, RN E stated that she asked RN D if a neck brace or a backboard should be used to roll resident 1 onto her back. RN D reportedly told her to use a Hoyer lift to move the resident. After RN E and CNA C rolled resident 1, RN E observed the laceration on the resident's forehead, a bruise to the resident's shoulder, and the resident's nose was bleeding. RN E stated that she suspected resident 1 may have had a head injury at that time. She said RN D shined a light into resident 1's eyes (an evaluation used during a neurological assessment) to determine how or if the resident's eyes had reacted to the light. RN E said RN D conducted this evaluation in both the bathing room and later in the resident's room. RN E said that resident 1 was responding to simple questions and commands at that time. Resident 1 was lifted off the bathing room floor with a Hoyer lift to her wheelchair, then transported to her room until EMS arrived.	F0689	residents in bath chair during transport to the bath house and while in the bath house. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with IDT and Medical Director for analysis, recommendation for continuation/ discontinuation/revision of audits based on findings. 4. 12/06/2025.	

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 11/06/2025

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
F0689 SS = G	Continued from page 3 6. Review of resident 1's electronic medical record (EMR) revealed a 10/24/25 emergency department After Visit Summary that indicated CT scans (non-invasive medical imaging procedure) of resident 1's head, chest, and back were negative for any acute abnormalities or fractures. A CT scan of her cervical spine (upper portion of the spinal column, consisting of the first seven bones located in her neck) showed "C1 and C2 [the first two cervical vertebrae (bones), located at the base of the skull] cervical fractures." Resident 1 returned to the facility on 10/24/25 after her hospital evaluation. Her discharge instructions indicated she was to wear a neck collar for 12 weeks and follow up in the neurological trauma clinic in about three months with a repeat cervical spine CT scan. 7. Interviews on 11/4/25 at 3:00 p.m. and on 11/5/25 at 4:15 p.m. with DON B regarding resident 1's 10/24/25 fall revealed she agreed: There were significant discrepancies between RN D and RN E's versions of that fall that should have been, but were not, reconciled and followed up on. The above interviews and fall-related documentation failed to support whether resident 1 was appropriately repositioned onto her back by RN E and CNA C. She expected resident 1 to have been made as comfortable as possible by the nursing staff until EMS arrived and the resident should not have been moved out of the bathing room to mitigate the possibility of further injury. Resident 1's cervical fractures had likely occurred when she struck the bathing room floor during the fall, but those injuries could have been made worse by RN E and CNA C repositioning and then transferring the resident with the Hoyer lift into a wheelchair. A copy of resident 1's 10/24/25 neurological evaluation was requested from DON B on 11/4/25 at 3:00 p.m. On 11/5/25 at 4:15 p.m., DON B confirmed there was no documented neurological evaluation completed by nursing staff after resident 1's fall, but there should have been. Review of the provider's undated Fall Check List revealed: "Do not move resident if major or life-threatening injury is suspected." "Complete [a] neurological assessment (if fall was	F0689		

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 11/06/2025

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
F0689 SS = G	Continued from page 4 unwitnessed or [the resident] hit head)." "All assessment findings must be on paper neuros [neurological forms] and in PCC [Point, Click, Care]. (A type of electronic medical record). Complete [the paper neuros] end of shift." Review of the provider's January 2020 Neurological Evaluation policy revealed neurological evaluations were indicated "c. following a fall or other accident/injury involving head trauma;" Review of the provider's 2/20/24 Falls Management policy revealed: "7. Perform neurological checks (neuro-checks) per policy for any unwitnessed fall or any fall with evidence of injury to head." 8. Review of a 10/24/25 SD DOH FRI revealed that resident 2 had fallen while he was being transferred in the provider's sit to stand lift (a mechanical lift to help people who have some strength but need assistance to get from a seated position to a standing position) by CNA G. The root cause of the fall was determined to be a failure by the staff to use the leg straps on the sit to stand lift during the resident's transfer. The report indicated that the resident let go of the hand bars while in the lift and slid to the floor. The resident reported hip and leg pain after the fall and was transferred to the hospital for evaluation. 9. Review of resident 2's EMR revealed that he had an x-ray (a noninvasive medical image to check for broken bones) at the hospital that did not show any fractures after the 10/24/25 fall from the sit to stand lift. His 12/30/24 care plan had a focus of "I am at risk for falls" with the intervention "ensure proper use of [the] sit to stand lift". This intervention was resolved and updated on 10/24/25 to "I use a total body mechanical lift transfer". 10. Review of the undated CNA G's sit to stand training education revealed that he was watched while performing a lift with the sit to stand mechanical lift. The answer "no" was checked on the section "if sit to stand has straps, affix straps across legs". The "action taken" section of the training form stated that education was performed with CNA G to clip the leg strap in place with resident transfers in the sit to stand lift. 11. Review of the provider's 2/20/2024 Mechanical Lifts policy revealed staff was to "lock the wheels on any	F0689		

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 11/06/2025

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
F0689 SS = G	Continued from page 5 device that will receive the patient". They were expected to "keep all clips, latches, and hangar bars securely fastened during operation". 12. Interview on 11/5/25 at 11:58 a.m. with DON B revealed she would expect all staff to perform transfers and lifts with the safety straps on and according to the manufacturer's instructions. She had followed CNA G on his first shift working in the facility on 10/22/25 and confirmed that he performed lifts using the sit to stand lift correctly. 13. Review of a 9/12/2025 SD DOH FRI revealed that resident 3 had fallen out of the bath chair in his room on 9/10/25. CNA F had transported resident 3 from the bathing room to his room in the bath chair. She put the call bell on for assistance then left the resident's room to get a mechanical lift from the hallway. Resident 3 was on the floor in front of the bath chair when CNA F returned to his room. The facility investigation determined resident 3 likely leaned forward in the chair causing the fall. He did not have the bath chair seatbelt in place, or the wheels locked. 14. Interview on 11/5/2025 at 2:14 p.m. with CNA F regarding resident 3's fall from the bath chair on 9/10/25 revealed that she was aware that the seatbelt should have been secured in place and the breaks on the lift should have been locked while the resident was sitting in the chair for safety. She had taken the seatbelt off when dressing resident 3 and had not replaced it before she left the room. 15. Interview with assistant DON H revealed that a morning meeting was done Monday through Friday with members of the provider's leadership team. They discussed any new falls including the investigation, root cause, and new interventions that needed to be added to the resident's care plan. She agreed that the care plan for resident 3 was not updated after his 9/10/25 fall as she would have expected. 16. Review of resident 3's EMR revealed that he got a skin tear to the left side of his head when he fell from the bath chair on 9/10/25. Review of the provider's 2/20/2024 Mechanical Lifts policy revealed staff was to "lock the wheels on any device that will receive the patient". They were expected to "keep all clips, latches, and hangar bars securely fastened during operation". Review of the revised G 10-16-2020 Penner Bathing, Safe Operation and Maintenance Manual revealed "9. All	F0689		

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 11/06/2025

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
F0689 SS = G	Continued from page 6 residents must always be securely safety belted at the waist when using any of the Penner Lift Systems" (page 7). Review of the provider's 12/1/19 CNA job description revealed that they were to "follow established safety precautions when performing tasks and using equipment and supplies".	F0689		