DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435051	A. BUILDING _____ B. WING _____	C 05/15/2024

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

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/13/24 through 5/15/24. Avantara Arrowhead was found not in compliance with the following requirements: F658, F690, F760, F761, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/13/24 through 5/15/24. Areas surveyed included resident rights and pharmaceutical services. Avantara Arrowhead was found in compliance.	F 000		
F 658 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 observation, interview, record review and policy review, the provided failed to ensure the following: *One of one registered nurse (RN) L had appropriately administered and documented medication administration for one of three sampled residents (31). *One of one licensed practical nurse (LPN) N had appropriately documented medication administration for one of one sampled resident (36). *Accurate and complete documentation of nutritional formula and water flushes for one of	F 658	1. No immediate correction could be made for the failure to appropriately administer and document medication administration to resident 31, appropriately documenting medication administration to resident 36, and ensuring accurate and complete documentation of nutritional formula and water flushes for resident 50. Resident 50 has a separate space on the MAR to document water flushes. 2. All residents are risk for the failure to appropriately administer and document medication administrations. All residents receiving enteral tube feedings are at risk for the failure to ensure accurate and complete documentation of nutritional formula and water flushes. 3. The Director of Nursing (DON) or designee will educate all licensed nurses, to include licensed practical nurse (LPN) N, and certified medication aides (CMA) on the Medication Administration policy to ensure appropriate administration and documentation of medication administrations. Registered nurse (RN) L no longer works at the facility effective May 25, 2024.	6/13/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/07/24

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 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.

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F 658	Continued From page 1 two sampled residents (50) who had a feeding tube. Findings include: 1. Observation on 5/15/24 at 8:00 a.m. of RN L. *She mixed the resident 31's pills with applesauce in a medication cup and poured her nutritional supplement and Mirilax (a laxative) mixed with water into two separate plastic drinking cups. *RN L placed those two plastic drinking cups on the dining room table where the resident was eating her breakfast and administered her pills to her. *RN L left the dining room without ensuring resident 31 drank her nutritional supplement and Mirilax. -RN L then documented on resident 31's Medication Administration Record (MAR) that her pills and Mirilax were administered. Continued observation at 8:15 a.m. revealed: *The resident exited the dining room with staff assistance. *About half of the Mirilax and the nutritional supplement remained in the cups on the table. Interview on 5/15/24 at 8:20 a.m. with RN L regarding resident 31's morning medication administration revealed: *It was her process to have left the Mirilax and nutritional supplement cups on the table, return to check the amount the resident had consumed of both after the meal, and then document the medication administered. *At 8:25 a.m. RN L entered the dining room and returned to the medication cart. -She stated the resident drank all her Mirilax and most of the nutritional supplement.	F 658	Additionally, the licensed nurses will receive education on ensuring accurate and complete documentation of nutritional formula and water flushes for residents requiring enteral tube feedings. The education will occur no later than June 13, 2024. Those licensed nurses and CMAs not in attendance at the education session due to vacation, illness or casual work status will be educated prior to their first shift worked. 4. The DON or designee will audit 5 licensed nurses and/or CMAs to ensure appropriate administration and documentation of medication administrations. The DON or designee will audit 5 licensed nurses during enteral tube feedings to ensure accurate and complete documentation of nutritional formula and water flushes. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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*After she was asked to re-look at the Mirilax cup again she confirmed the resident had not consumed all of the Mirilax.
*Her MAR documentation regarding the Mirilax administration was not accurate.

2. Review of resident 36's April 2024 controlled drug record revealed she was given 0.5 milliliters (ml) of lorazepam (anti-anxiety medication) and 0.25 ml of morphine on 4/26/24 by licensed practical nurse (LPN) N.

Review of resident 36's April 2024 Medication Administration Record (MAR) revealed no documentation the lorazepam or morphine was given on 4/26/24.

Interview on 5/15/24 at 3:00 p.m. with LPN N regarding medication administration documentation revealed:
*She failed to document having administered resident 36's 4/26/24 lorazepam and morphine doses on the resident's MAR.
-She was expected to document those administrations at the same time she documented their administration in the controlled drug record.
*She recalled administering those medications prior to changing the resident's Foley catheter.
-Her 4/26/24 progress note in the resident's electronic medical record (EMR) supported that.

3. Review of resident 50's May 2024 MAR revealed:
*A tube feeding (nutritional formula) order based on the amount of food the resident had eaten at her three daily mealtimes and a scheduled tube feeding at night.
-If resident eats greater than 75% of her meal,

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hold the tube feeding.
-If resident eats between 50-75% of her meal, give 150 ml of the tube feeding.
-If resident eats less than 50% of her meal, give 300 ml of the tube feeding.
-Always give full tube feeding at night (300 ml).
-Flush the feeding tube with 75 ml water before and after each feeding.

Continued review of the May 2024 MAR tube feeding documentation revealed:
*There was only documentation from 5/7/24 through 5/14/24 because the resident was hospitalized at the beginning of the month.
*The MAR was set-up to capture the following documentation:
-The percentage of the morning, mid-day, and evening meals consumed.
-The ml of tube feeding administered at those times based on the percentage of the meal consumed.
-The ml administered at the scheduled nighttime tube feeding.
*On 5/10/24, 5/11/24, and 5/12/24 there was "0" ml tube feeding formula documented as having been administered for the nighttime administration.
-The resident should have received 300 ml according to the medical provider's order.
*On 5/13/24 the resident had eaten "100%" of her evening meal so her tube feeding should have been held.
-"240 ml" was documented as administered.
*On 5/8/24, 5/9/24, and 5/13/24 "450 ml" was documented as administered with the nighttime scheduled feeding.
-It was unknown if the "450" reflected the scheduled tube feeding amount (300 ml) plus the pre and post tube feeding water flushes (150 ml).

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*No other "ml" documentation was found for the pre and post feeding water flushes.
-There was no separate space on the MAR to have documented the water flushes.

Interview on 5/15/24 at 12:05 p.m. with director of nursing B regarding medication administration documentation revealed:
*Staff were expected to observe residents during medication administration to ensure medications were taken by the resident before documenting they had taken the medications.
*Medication administration documentation was expected to have been completed at the time it occurred.
*The ordered water flushes for resident 50 were not accounted for on her MAR but should have been.

Interview on 5/15/24 at 12:30 p.m. with registered nurse (RN) M regarding her 5/10/24 tube feeding documentation for resident 50 revealed:
*She administered that nighttime tube feeding but had not known why she failed to have documented it.
*Her "ml" documentation included only the mls of tube feeding administered.
-There was no documentation the resident's water flushes were given as ordered by the medical provider.

Review of the September 2018 Medication Administration policy revealed:
*Medication Administration:
-"1. Medications are administered in accordance with written orders of the prescriber." "If necessary, the nurse contacts the prescriber for (order) clarification."
"20. The resident is always observed after

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F 658	Continued From page 5 administration to ensure that the dose was completely ingested." *Documentation: "1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given."	F 658		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690	1. Provider reviewed resident 9's bowel regimen upon discovery of loose stools on May 15, 2024, and made an adjustment to her laxative medication. Registered dietician (RD) was notified of resident 9's multiple diarrhea consistency stools upon discovery on May 15, 2024. 2. All residents are risk for their bowel management program not being monitored to identify multiple diarrhea consistency stools resulting in unintentional weight loss and failure to notify their provider and the RD. 3. Administrator, DON, and interdisciplinary team (IDT) in collaboration with the medical director did review the Toileting and Incontinence and Notification of Change of Condition policies. A new clinical alert was developed in PointClickCare (PCC) clinical software to provide an alert on the dashboard if a resident had 2 loose stools in 2 days. The clinical alerts on the dashboard will be reviewed by IDT during the morning clinical meeting 5 days per week to identify residents that have had 2 loose stools in 2 days and ensure bowel management programs are being monitored. The DON or designee will educate the licensed nurses on how to access the dashboard to review the clinical alerts to identify residents that have had 2 loose stools in 2 days to ensure their bowel management program is being monitored, as well as provide education to all nursing staff on the Notification of Change of Condition policy	6/13/2024

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F 690	Continued From page 6 comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure: *A bowel management program was monitored for one of one sampled resident (9) who had multiple diarrhea consistency stools and unintentional weight loss. *Appropriate and necessary notification of resident 9's physician assistant (PA) H and registered dietician (RD) I about the consistency and amount of her stools. Findings include: 1. Observation on 5/13/24 from 5:30 p.m. to 6:00 p.m. of resident 9 while in the dining room during the evening meal revealed: *She was sitting in a wheelchair and had a small, frail, bony appearance. *She was eating a meal from a fast-food restaurant. Interview on 5/14/24 at 9:30 a.m. with resident 9 revealed: *She felt she was losing weight because she "poops all the time and everything goes right through me." -She stated she was having a watery bowel movement (BM) with every toileting and often had incontinent (uncontrolled) BMs. -She stated, "I have had water poop for a long time. I think it is those pills they give me." Review of resident 9's electronic medical record	F 690	to ensure appropriate notifications are made when a resident has diarrhea consistency stools and unintentional weight loss. The education will occur no later than June 13, 2024. Those licensed nurses not in attendance at the education session due to vacation, illness or casual work status will be educated prior to their first shift worked. 4. The DON or designee will audit 5 residents' bowel records to identify if resident has had loose stools that their bowel medication regimen was addressed, and the provider and RD were notified of the consistency and amount of stools when necessary. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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(EMR) revealed:
*She was admitted on 5/9/17 with the primary diagnosis of ataxic (impaired coordination) cerebral palsy.
*Her weight on admission was 115.8 pounds.
*On 2/6/24 the resident weighed 99.7 pounds.
-On 5/7/24 her weight was 93.6 pounds.
-That was a 6.12% weight loss within a three month time period.
*She was not on a physician prescribed weight loss program.
*She was eating between 50 and 100 percent of her meals and also accepted a snack most evenings.
*Her medication administration record (MAR) revealed she was drinking 100% of Liquacel dietary supplement, one ounce, twice a day, and a 2.0 calorie supplement drink, four ounces, three times a day.
*Her 4/12/24 Brief Interview of Mental Status (BIMS) score was 14, indicating she was cognitively intact.

Review of resident 9's Point Click Care (PCC) BM record from 4/14/24 to 5/14/24 revealed:
*Resident 9 had 48 BMs in a 30-day period.
-33 of those stools were documented as "diarrhea loose."
-8 stools were "putty like" and 7 were "formed" stools.

Further review of resident 9's April and May 2024 MARs revealed the following:
*A 7/19/23 physician's order for a MiraLax (a laxative)17 gram oral packet to have been mixed with fluid daily in the morning.
*A 11/25/21 physician's order for docusate sodium (stool softener)100 milligram tablet to be given daily in the morning.

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*The MiraLax was refused by the resident seven times on 4/5, 4/7, 4/8, 4/10, 5/11, 5/13, and 5/14.
-There was no documentation found that indicated staff had held her laxative or stool softener due to diarrhea (loose) stools.

Further review of resident 9's EMR revealed:
*There was no documentation found that indicated the physician had been notified of her frequent loose stools.
*Her 4/12/24 quarterly Minimum Data Set (MDS) assessment's section H revealed she was occasionally incontinent of BM.
*Her 4/12/24 Braden skin assessment revealed a score of 18, indicating she was at high risk for skin breakdown.

Interview on 5/14/24 at 3:38 p.m. with certified nursing assistant (CNA) G regarding resident 9 revealed:
*She was aware the resident was having frequent loose stools.
-She stated the CNA's charted the consistency of the BMs in PCC for the nurses to use as a reference.

Interview on 5/14/24 at 3:42 p.m. with registered nurse (RN) F revealed she:
*Stated since PCC was updated, she was unable to view CNA charting on BM consistency.
*Was aware resident 9 had loose stools and stated that was "normal for her."
-Was unable to explain why the resident was taking both a laxative and a stool softener every day if she was having loose stools.
*Was unsure if the physician had been notified of the resident's loose stools.

Interview on 5/14/24 at 4:05 p.m. with MDS

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coordinator E revealed:
*She was aware resident 9 was having loose stools.
-Stated resident 9's loose stools were "sporadic" and she expected the nurses to have held the laxative medication when her stools were loose.
*Stated the nurses were able to view a resident's BM consistency in PCC.
-It was located under a separate tab in the bowel documentation area.
*She was unaware if the physician had been notified of the resident's loose stools.

2. Interview on 5/15/24 at 8:30 a.m. with resident 9's physician assistant (PA) H regarding weight loss and loose stools revealed:
*She was not aware the resident was having multiple loose, diarrhea consistency stools.
-It was her expectation for staff to have notified her about that issue.
-She stated that during her monthly visits with the resident, she had never complained of having loose stools.
*She confirmed multiple diarrhea stools could be a factor in the resident's weight loss.

Interview on 5/15/24 at 9:40 a.m. with administrator A, director of nursing (DON) B, and nurse supervisor D regarding resident 9's weight loss and loose stools revealed:
*They stated it was the resident's "normal" to have loose stools on occasion, but were unaware of how frequently it was occurring.
*They were aware of the resident's weight loss despite nutritional interventions.
-They had attributed the weight loss to her progression of cerebral palsy disease and mental decline.
*Their expectation was for the aides to

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communicate to the nurses when the resident was having loose, diarrhea stools.

Interview on 5/15/24 at 10:54 a.m. with consulting dietitian I regarding resident 9 revealed:
*She had worked as the provider's dietitian on a consultant basis for at least 2 years.
*She reviewed the resident's charts remotely and performed an on-site visit with the residents and the interdisciplinary team once a month.
*She was aware the resident had been losing weight and was monitoring her as a nutritionally high-risk resident.
*She was able to view a resident's BM frequency in PCC, but had not known how to view the BM's consistency.
*Staff had not informed her of the resident's loose stools.
-She depended on staff to notify her of changes in a resident's condition.

Review of the provider's 8/23/23 Notification of Change of Condition policy revealed:
*"1. The facility must immediately inform the resident; consult with the resident's medical provider; and notify, consistent with his or her authority, the resident representative(s) when:"
-"c. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or..."

Review of the provider's 12/1/19 CNA and RN job description and the March 2021 Toileting and Incontinence policy revealed:
*There was no mention of reporting frequent loose stools to the nurse or the physician.
*There was no mention of holding laxatives or stool softeners during episodes of loose stools.

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F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview, and policy review, the provider failed to ensure medications were administered as ordered for two of nine sampled residents (14 and 32). Findings include: 1. Review of resident 14's 4/9/24 through 5/14/24 controlled drug records for his clonazepam (anti-seizure) medications revealed: *Two drug record logs for resident 14's clonazepam. -One accounted for his 0.25 milligram (mg) morning dose administrations and the second for his 0.5 mg evening dose administrations. *The morning dose log documentation revealed on 4/11/24, 4/12/24, 4/21/24, 4/25/24, 5/3/24, 5/4/24, and 5/8/24 the resident was given the 0.25 mg clonzepam dose in the evening instead of the 0.5 mg dose that was ordered. -A count of the number of clonazepam tablets in the morning and evening medication blister packs (med cards) supported the documentation referred to above. Review of resident 14's April 2024 and May 2024 Medication Administration Records (MARs) revealed the 0.5 mg evening clonazepam dose was documented as having been given on 4/11/24, 4/12/24, 4/21/24, 4/25/24, 5/3/24, 5/4/24, and 5/8/24 when it was the 0.25 mg dose that was administered.	F 760	1. No immediate corrective action could be made for the failure to ensure medications were administered as ordered for residents' 14 and 32. A medication error report has been completed for the medication errors identified for resident's 14 and 32. 2. All residents are risk for failure to ensure medications are administered as ordered. 3. The DON or designee will educate all licensed nurses and CMAs on the Medication Administration policy to ensure residents are administered medications as ordered. RN L no longer works at the facility effective May 25, 2024. Additionally, the DON or designee will complete a medication administration competency with all licensed nurses and CMAs to ensure residents are administered medications as ordered. The education and competencies will occur no later than June 13, 2024. Those licensed nurses and CMAs not in attendance at the education session due to vacation, illness or casual work status will be educated prior to their first shift worked. 4. The DON or designee will audit 5 licensed nurses and/or CMAs while administering medications to ensure the resident is administered medications as ordered. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	6/13/2024

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	435051	A. BUILDING _____ B. WING _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 12	F 760		

2. Observation and interview on 5/15/24 at 8:05 a.m. with registered nurse (RN) L during resident 32's morning medication pass revealed:
*The pharmacy label on the resident's lisinopril (blood pressure medication) blister pack included instructions to "Hold [do not administer] if systolic [blood pressure reading] < [less than] 90".
*The May 2024 MAR order for that lisinopril did not include the instruction for holding the medication.
-RN L confirmed the medical provider's original lisinopril order had included that instruction but it was not included when the order was entered on the MAR.
*RN L administered resident 32's morning lisinopril without first:
-Reconciling the discrepancy between the blister pack label and the MAR order.
-Ensuring the resident's blood pressure reading was taken before administering the lisinopril.

Interview on 5/14/24 at 3:00 p.m. with director of nursing B revealed:
*Medication errors occurred when staff administered resident 14's morning dose of clonazepam instead of his ordered evening dose of clonezepam on 4/11/24, 4/12/24, 4/21/24, 4/25/24, 5/3/24, 5/4/24, and 5/8/24.
*A medication error occurred when RN L administered resident 32's lisinopril without first taking her blood pressure as ordered.
-No medication error reports were completed, investigated, or followed-up on for the errors referred to above.
*Staff authorized to administer resident medications were expected to compare each blister pack label to the MAR order for all medications and to reconcile any discrepancies between the two before administering a

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F 760	Continued From page 13 medication. Review of the September 2018 Medication Administration policy revealed: *Medication Preparation: "3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage on the schedule on the resident's MAR with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule. Apply a 'direction change' sticker to label if directions have changed from the current label." *Medication Administration: "2. Obtaine and record any vital signs as necessary prior to medication administration."	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761	1. Provider for resident 14 was contacted to request clarification of clonazepam 0.25mg at the time of discovery on May 15, 2024, with new orders received from provider on May 16, 2024. The order for lisinopril for resident 32 was updated to include hold if systolic is <90 with supplemental documentation added to document the results upon discovery on May 15, 2024. CMA J was educated that only the pharmacy provider is authorized to make alterations to a pharmacy label upon discovery on May 15, 2024. 2. All residents are risk for failure to ensure prescription medications were accurately labeled and for improper altering of a resident's prescription label. DON or designee will	6/13/2024

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F 761	Continued From page 14	F 761		

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation, interview, and policy review, the provider failed to ensure:
*Two of nine sampled residents (14 and 32) had prescription medications that were accurately labeled.
*One of one certified medication aide (CMA) (J) had not altered one of one sampled resident's (14) prescription medication label.
Findings include:

1. Review of resident 14's May 2024 Medication Administration Record (MAR) revealed:
*A 3/31/24 medical provider's order for 0.25 mg clonazepam (anti-seizure medication) scheduled for daily administration in the morning.

Observation of the prescription label on the medication blister pack (med card) of clonazepam read: "Give 0.5 tablet by mouth every morning as needed (1/2 tab=0.25 mg [milligram])."

Interview on 5/14/24 at 3:00 p.m. with director of nursing (DON) B, assistant DON C, and certified medication aide (CMA) J revealed:
*They confirmed that prescription label had not matched the order on the May 2024 MAR for that

complete a full house audit of all residents' prescription labels to ensure they match the provider's order and to ensure no alterations have been made to a prescription label by an unauthorized individual.

3. The DON or designee will educate all licensed nurses and CMAs on the Medications and Medication Labels policy to ensure prescription labels are accurately labeled and to ensure that only pharmacy providers are authorized to make alterations to medication labels. Additionally, the DON or designee will complete a medication administration competency with all licensed nurses and CMAs to ensure prescription labels are accurately labeled and that only pharmacy providers have altered a prescription medication label if required. The education and competencies will occur no later than June 13, 2024. Those licensed nurses and CMAs not in attendance at the education session due to vacation, illness or casual work status will be educated prior to their first shift worked.

4. The DON or designee will audit 5 licensed nurses and/or CMAs while administering medications to ensure the prescription medication labels are accurately labeled and only pharmacy providers have made alterations to a prescription medical label if required. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings

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F 761	Continued From page 15	F 761		

medication.
-The frequency of the morning dose read "as needed" on the blister pack but the MAR instructed daily" administration.

2. Observation on 5/15/24 at 2:45 p.m. of resident 14's morning clonazepam blister pack revealed a line drawn through the words "as needed" on that prescription label.

Interview on 5/15/24 at 3:00 p.m. with DON B and CMA J regarding that altered medication label revealed:
*CMA J had covered the medication frequency instructions, "as needed", with a black permanent marker.
-Only the pharmacy provider was authorized to have made alterations to medication labels.

3. Observation and interview on 5/15/24 at 8:05 a.m. with registered nurse (RN) L during resident 32's morning medication pass revealed:
*RN L administered the resident's lisinopril (a blood pressure medication) during morning medication pass.
*The pharmacy label on the lisinopril blister pack included instruction to "Hold [do not administer] if systolic [blood pressure reading],<[less than] 90."
*The resident's May 2024 MAR order did not include the instruction for holding the medication.

Interview on 5/15/24 at 3:00 p.m. with DON B revealed all staff authorized to have administered resident medications were expected to compare each blister pack label to the MAR order for all medications and to reconcile any discrepancies between the two before administering a medication.

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F 761	Continued From page 16 Review of the September 2018 Medication Administration policy revealed: *Medication Preparation: "3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage on the schedule on the resident's MAR with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule. Apply a 'direction change' sticker to label if directions have changed from the current label." Review of the May 2016 Medications and Medication Labels policy revealed "6. Medication labels are not altered, modified, or marked in any way by nursing personnel."	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880	1. No immediate corrective action could be made for the failure to ensure proper hand hygiene and glove use by one occupational therapist (OT) K during personal care for resident 50 and failure to ensure proper hand hygiene by one assistant director of nursing (ADON) C during personal care for resident 209. 2. All residents are risk for failure to ensure proper hand hygiene and glove use to prevent the spread of infection. 3. The DON or designee will educate all staff, to include OT K and ADON C, on the Hand Hygiene policy that includes glove use to ensure proper hand hygiene and glove use during personal cares to prevent the spread of infection.	6/13/2024

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F 880	Continued From page 17 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880	Additionally, the DON or designee will complete a hand hygiene competency with all staff. The education and competencies will occur no later than June 13, 2024. Those employees not in attendance at the education session due to vacation, illness or casual work status will be educated prior to their first shift worked. 4. The DON or designee will audit 5 employees while performing personal cares with residents to ensure proper hand hygiene and glove use to prevent the spread of infection. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 880	Continued From page 18	F 880		

corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and policy review, the provider failed to ensure proper infection control practices were followed for the following:
*Hand hygiene and glove use by one of one occupational therapist (OT) (K) during personal care for one of one sampled resident (50).
*Hand hygiene by one of one assistant director of nursing (ADON) (C) during personal care for one of one observed resident (209).
Findings include:

1. Observation on 5/13/24 at 1:50 p.m. of resident 50 revealed:
*Enhanced barrier precaution (EBP) signage outside of her room.
*Inside her room OT K was preparing to transport the resident to therapy.
*After putting on a gown and gloves, OT K assisted the resident to her wheelchair.
-She used her gloved hands to move each metal footplate on the wheelchair to a downward position and to physically assist the resident's feet onto the footplates.
*Without removing her gloves, performing hand hygiene, and putting on a clean pair of gloves, OT K used those same unclean gloves to adjust the

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F 880	Continued From page 19	F 880		

resident's oxygen tubing underneath her nose.
*Then she removed a Kleenex from a Kleenex box with those same gloves to wipe saliva from the resident's mouth.
*OT K removed her gown and gloves and without performing hand hygiene exited the room pushing the resident in her wheelchair.

Interview on 5/13/24 at 2:50 p.m. with OT K regarding the above observations revealed she confirmed:
*Her unclean gloves handled the resident's oxygen tubing and the Kleenex used to wipe the resident's mouth.
*She should have performed hand hygiene after glove removal.

2. Observation on 5/13/24 at 2:05 p.m. of ADON C and certified nursing assistant (CNA) O while assisting resident 209 with toileting revealed:
*After transferring the resident from her wheelchair to the toilet ADON C removed her gloves and washed her hands in the bathroom sink.
-She used her wet washed hands to turn the faucet handle off before drying her hands with a paper towel.
*ADON C put on a clean pair of gloves and used disinfectant wipes to clean spots of urine off the floor.
-After discarding the wipes, she removed her gloves, and washed her hands in the bathroom sink.
-She used her wet hands to adjust the faucet handle, completed her hand washing, and turned the faucet handle off with a paper towel.

Interview on 5/13/24 at 2:15 p.m. with ADON C regarding the above observations revealed she

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F 880	Continued From page 20	F 880		

confirmed:
*Her wet hands should not have touched the faucet handle at any time during her hand washing.
-A clean paper towel should have been used to turn the faucet handle off or adjust it.

Review of the revised 2/20/24 Hand Hygiene policy revealed:
*Hand hygiene should be completed "7) j. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident,"
*"9) The use of gloves does not replace hand hygiene. Hand hygiene must be completed prior to and after removal of gloves."
*Washing Hands: "13) Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 000	Initial Comments	E 000		6/13/2024

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 5/13/24. Avantara Arrowhead was found in compliance.

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6/07/24

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 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.

South Dakota Department of Health

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	10668	A. BUILDING: _____ B. WING _____	05/15/2024

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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 5/13/24 through 5/15/24. Avantara Arrowhead was found not in compliance with the following requirement: S430.	S 000		
S 430	44:73:12:27(1-3) Ventilating Systems The ventilating systems shall maintain temperatures, minimum air changes of outdoor air an hour, minimum total air changes, and relative humidities as follows: (1) All occupied areas of the building shall maintain a minimum humidity level of 15% relative humidity provided through the building central ventilation system; (2) Beauty shops shall provide a minimum of 15 air changes per hour of exhaust ventilation when the room is in use; and (3) Toilet and bathing rooms shall provide a minimum of 10 air changes per hour of exhaust ventilation. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to install exhaust ventilation for the salon. Findings include: 1. Observation on 5/13/24 at 2:15 p.m. revealed the salon room was not equipped with any ventilation. The salon was required to have a minimum of 15 air changes per hour exhaust ventilation. Interview with the maintenance supervisor on 5/13/24 at the time of the above observation confirmed that condition. He stated it appeared	S 430	1. All residents are at risk. The exhaust ventilation for the beauty shop will be installed by June 13, 2024. 2. The administrator will in-service maintenance director to ensure all exhaust ventilation systems are functioning in all rooms in the facility as of June 13, 2024. 3. The administrator or designee will complete monthly audits 4 times weekly to ensure exhaust ventilation systems are working in accordance with the Administrative Rule of South Dakota. Results of monthly audits will be reported by administrator or designee to monthly QAPI meeting for further review and recommendation and/or continuance of audits. 4. June 13, 2024.	6/13/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 6/07/24

South Dakota Department of Health

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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) COMPLETE DATE
S 430	Continued From page 1 the room had never had any ventilation installed.	S 430		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 5/13/24 through 5/15/24. Avantara Arrowhead was found in compliance.	S 000		6/13/24

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435051	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/13/2024

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K 000	INITIAL COMMENTS A recertification survey for compliance with the life safety code (LSC) (2012 existing health care occupancy) was conducted on 5/13/24. Avantara Arrowhead was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K222 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are	K 222	1. All residents are at risk. The maintenance director will have the front door egress door set as one of the seven egress door locations. Egress Signage on the front door was removed on May 13, 2024, until the new mag locks are applied to the front door. 2. Administrator will in-service maintenance director to ensure the facility follows the egress door guidance of proper signage and delay times in accordance with Delayed-Egress Locking Arrangements for the front door by June 13, 2024. 3. The Administrator or designee will complete monthly audits 4 times weekly to ensure all facility egress doors are in complying with the Delayed-Egress Locking Arrangements. Results of audits will be reported by administrator or designee to monthly QAPI meeting for further review and recommendation	6/13/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/07/24

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 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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435051	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA ARROWHEAD	**2500 ARROWHEAD DR** **RAPID CITY, SD 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
K 222	Continued From page 1 being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and testing, the	K 222	and/or continuance/discontinuance of audits. 4. June 13, 2024.	

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	435051	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/13/2024

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K 222	Continued From page 2 provider failed to provide egress doors as required at one of seven exit door locations (main entrance). Findings include: 1. Observation and interview with the administrator on 5/13/24 at 3:15 p.m. revealed the main entrance vestibule had two sets of double exit doors that were each equipped with magnetic locks. The administrator stated the magnetic locks for the double doors at the exterior of the vestibule could be activated to prevent entrance. a. Testing of the exterior set of magnetically locked doors by applying force in the direction of the path of egress revealed that action would not initiate an irreversible process to unlock the magnet and release the doors. That indicated the magnetically locked doors were not functioning as delayed egress locked doors. b. Testing of the interior set of magnetically locked doors by applying force in the direction of the path of egress revealed that action would initiate an irreversible process to unlock the magnet and release the doors. That indicated the magnetically locked doors were functioning as delayed egress locked doors. These doors also had the correct signage indicating they were delayed egress with a 15-second delay. Further interview at the time of the above observation on 5/13/24 with the administrator confirmed that condition. She stated the magnetic locks had been on the doors since the provider acquired the facility in 2019. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the building	K 222		