| 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 03/09/2023 |

| 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 |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 3/7/23 through 3/9/23. Avantara Arrowhead was found not in compliance with the following requirement: F658.<br><br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 3/7/23 through 3/9/23. Areas surveyed included quality of care and infection control. Avantara Arrowhead was found in compliance. | F 000 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the provider failed to ensure procedural techniques were followed for:<br>*Proper hand hygiene by one of two unlicensed medication aides (UMA) (E) prior to medication administration for three of four observed residents (3, 9, and 30).<br>*Correct and accurate medication preparation by one of two UMAs (E) for two of four observed residents (30 and 9).<br>Findings include:<br><br>1. Observation and interview on 3/9/23 between | F 658 | 1. No immediate corrective action could be taken for unlicensed medication aid (UMA) (E) failing to perform proper hand hygiene prior to medication administration. No immediate corrective action could be taken for UME E failing to complete correct and accurate medication preparation.<br><br>2. All residents are at risk for adverse effects resulting from the failure to ensure proper hand hygiene is performed prior to medication administration. All residents are at risk for adverse effects resulting from the failure to complete correct and accurate medication preperation.<br><br>3. The Director of Nursing (DON) or designee will educate all nurses and UMA's, to include UMA E, on the Hand Hygiene and Medication Administration policies to ensure proper hand hygiene is being performed during medication administration and to ensure correct and accurate | 04/24/2023 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Ashley Malys

TITLE
Administrator

(X6) DATE
03/24/2023

| 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 03/09/2023 |

| 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 |
|---|---|---|---|---|
| F 658 | Continued From page 1<br>7:30 a.m. and 8:05 a.m. with UMA E revealed he:<br>*Administered residents 3, 30, and 9s' morning medications.<br>*Failed to perform hand hygiene prior to preparing each of their medications for administration.<br>*Usually carried his own hand sanitizer but had not had any hand sanitizer with him today.<br>-There was no hand sanitizer available on the medication cart.<br>-He could have used the wall mounted hand sanitizers but had not done so.<br><br>2. Observation of UMA E at 7:40 a.m. preparing resident 30's medications for administration revealed he:<br>*Reviewed her medication administration record (MAR) for the resident's name, the medication name, dosage information, administration time, and by what route (orally) the medication was to have been given.<br>*Compared that information to the labels on each medication blister pack containing the same medications expected to have been given and then laid those medication blister packs on top of the medication cart.<br>-That same check and balance was performed again prior to "popping" the medication out of each blister pack and into the medication cup.<br>*Placed one 5 milligram (mg) midodrine HCl tablet (blood pressure medication) into the medication cup along with resident 30's other medications to have been administered.<br>*Locked the medication cart, took the medication cup, and prepared to administer the medications.<br><br>Review and interview of resident 30's MAR and the midodrine HCl blister pack label with UMA E prior to the medication administration revealed: | F 658 | medication preparation is being performed. Education will occur no later than April 14, 2023. Those not in attendance at education sessions due to vacations, sick leave, or casual work status will be educated prior to their first shift worked. The DON or designee will complete a Hand Hygiene and Medication Administration competency with all nurses and UMA's, to include UMA E, no later than April 14th, 2023.<br><br>4. The DON or designee will audit 5 medication administrations, to include UMA E, to ensure proper hand hygiene is being performed prior to administering medications to residents and to ensure correct and accurate medication preparation prior to administration. Audits will be weekly for four weeks, then monthly for two months. Results of the audits will be discussed by the DON or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting with IDT and Medical Director for analysis, recommendatioin for continuation/discontinuation/revision of audits based on audit findings. | |

| 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 03/09/2023 |

| 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 |
|---|---|---|---|---|
| F 658 | Continued From page 2<br>*Instructions on the MAR for midodrine HCl: "Midodrine HCl tablet 5 mg. Give 15 mg by mouth every 8 hr [hours] for LBP [low blood pressure]. 3 tablets=15 mg."<br>*Instructions on the blister pack label for midodrine HCl: "5 mg. 3 tabs every 8 hr."<br>*He had not correctly looked beyond the "5 mg" instructions on both the MAR and the blister pack label to have known he should have placed three tablets and not one midodrine tablet in the medication cup for administration.<br>-Placed the two additional ordered midodrine tablets into the medication cup prior to administering her medications after it had been brought to his attention.<br>*He agreed that would have been a medication error if he had only administered one midodrine HCl tablet as he had planned.<br>-Was uncertain what possible consequences to the resident that might have occurred as a result of that potential medication error.<br><br>3. Continued observation and interview with UMA E preparing resident 9's medications for administration revealed:<br>*He used the same process referred to above to prepare resident 9's medications.<br>*All her medications were tablets with the exception of the levetiracetam (anti-seizure medication) which was a liquid medication.<br>-Instructions for use of that medication were for 15 milliliter (ml) to be administered orally every 12 hours.<br>*He used a separate medication cup with measurement marks to pour that medication into the cup by holding the medication cup in front of his face with one hand and using the other hand to pour the medication into the cup.<br>*The surveyor asked UMA E to place the | F 658 | | |

| 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 03/09/2023 |

| 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 |
|---|---|---|---|---|
| F 658 | Continued From page 3 | F 658 | | |

medication cup on top of the medication cart and recheck the amount of medication he had prepared.
-He had poured 20 ml which was 5 ml more than what had been prescribed.
*He agreed that would have been a medication error if the levetiracetam had been administered as he had planned.
-Was uncertain what possible consequences to the resident might have occurred as a result of that potential medication error.
*He had been a UMA for "over 20 years."

Interview on 3/8/23 at 10:25 a.m. with director of nursing B regarding the above observed medication administration revealed:
*She expected hand hygiene to have been performed prior to and following medication administration.
*UMA E's "check and balance" system for ensuring medication administration accuracy had failed.
-If he had thoroughly compared the MAR instructions against the blister card label for resident 30 there would not have been a potential medication error.
*She expected medication cups were placed on a level surface to ensure a liquid medication measurement was precise prior to the administration of that medication.
*UMA E had completed a medication administration competency in April 2022.

Review of the revised 1/24/23 Hand Hygiene policy revealed:
*Hand hygiene supplies were expected to have been "readily accessible and convenient for staff use to encourage compliance with hand hygiene policies."

| 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 03/09/2023 |

| 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 |
|---|---|---|---|---|
| F 658 | Continued From page 4<br>*If hands were not visibly soiled an alcohol based hand sanitizer was expected to have been used "before preparing or handling medications."<br><br>Review of the January 2021 Medication Administration General Guidelines revealed:<br>*Medication Preparation:<br>-"7. When administering potent medications in liquid form or those requiring precise measurement, such as phenytoin [anti-seizure medication], devices provided by the manufacturer or obtained from a supplier, (e.g., oral syringes) are used to allow accurate measurement of doses."<br>*Medication Administration:<br>-"9. Verify medication is correct three (3) times before administering the medication.<br>a. When pulling medication package from med cart.<br>b. When dose is prepared.<br>c. Before dose is administered." | F 658 | | |

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 _____ | 03/09/2023 |

| 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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>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 from 3/7/23 through 3/9/23. Avantara Arrowhead was found in compliance. | E 000 | | |

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

Ashley Malys | Administrator | 03/27/23

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.

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<br>B. WING _____ | 03/07/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA ARROWHEAD | 2500 ARROWHEAD DR<br>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 000 | INITIAL COMMENTS<br><br>A recertification survey for compliance with the life safety code (LSC) (2012 existing health care occupancy) was conducted on 3/7/23. Avantara Arrowhead was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.<br><br>The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Ashley Malys

TITLE

Administrator

(X6) DATE

03/2/27/23

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.

RECEIVED
MAR 27 2022
SD DOH-OLC

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 435051 | MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING | DATE SURVEY COMPLETE: **3/7/2023** |
|---|---|---|---|

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

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| **K 712** | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>A. Based on observation and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (checking the door for the fire location and procedures). Findings include:<br><br>1. Observation on 3/7/23 at 9:55 a.m. revealed the fire alarm was sounded to initiate a drill for a simulated fire in resident room 40 in the west hall.<br><br>Only staff person responding to the fire drill location did not perform an acceptable closed door check for heat (used the front of her hand and opened the door without checking the metal handle for heat). She then proceeded to enter the room without a backup responder in accompaniment. The remainder of staff gathered at the nurses' station and some staff were overheard questioning what to do next.<br><br>B. Based on record review and interview, the provider failed to ensure fire drills were held at varying times). Findings include:<br><br>1. Record review on 3/7/23 at 8:15 a.m. revealed fire drills were documented on a quarterly basis (one drill per shift per quarter) from 2/24/22 through 2/24/23. A shift had a drill every third month. The first shift had drills as follows:<br>*7/19/22 at 11:07 a.m.<br>*10/27/22 at 11:23 a.m.<br>*1/20/23 at 11:00 a.m.<br><br>Interview with the maintenance supervisor at the time of the observation confirmed those findings.<br><br>The deficiency had the potential to affect 100% of the occupants. |

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

The above isolated deficiencies pose no actual harm to the residents

South Dakota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10668 | A. BUILDING: _____ B. WING _____ | 03/09/2023 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | Compliance/Noncompliance Statement<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/7/23 through 3/9/23. Avantara Arrowhead was found in compliance. | S 000 | | |

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

Ashley Malys | Administrator | 3/27/23