

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

PRINTED: 07/07/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2025
NAME OF PROVIDER OR SUPPLIER AVANTARA ARROWHEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 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 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 6/16/25 through 6/18/25. Areas surveyed included medication administration, medication errors, medical provider notification related to changes in a resident's medical condition, and potential staff to resident abuse. Avantara Arrowhead was found not in compliance with the following requirements: F580, F600, and F760.	F 000			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580	1. No immediate correction could occur for resident 2's missing Depo-Provera for 10/20/24, 12/19/24, 2/17/25, and 4/18/25. Resident 2 was provided with his May dose on 5/24/25. No further corrective action could be taken for resident 2 as he was discharged on 7/2/2025. All residents who take medications have the potential to be affected. The DON or designee will review progress notes for the last 30 days to determine if all unavailable medications were reported to the provider and all follow-up completed. 2. The DON or designee will educate all nurses in facility on Notification of Change of Condition Policy, Medication Error Policy, Following Physician Orders to ensure nurses know the expectations of what to do when a medication is not available and how to obtain the medication, and documentation required when a medication is not administered per physician order.	7/18/25	

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

TITLE

(X6) DATE

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 580	<p>Continued From page 1</p> <p>physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to ensure the physician was notified that prescribed medication had not been given to one of one sampled resident (2).</p> <p>Findings include:</p> <p>1. Review of the provider's 5/13/25 SD DOH FRI revealed:</p> <p>*Resident 2 had inappropriate contact with resident 3.</p> <p>*As part of the investigation the facility staff reviewed resident 2's medication and was found</p>	F 580	<p>The DON or designee will review nurses' documentation each working day to monitor for medications documented as unavailable and follow up to ensure medication administration procedures were followed and medication obtained. Education will occur no later than July 30, 2025. Those not at the education session will be educated prior to their first shift worked.</p> <p>3. The DON or designee will audit 5 random resident's medication administration records per week to verify medications were given as prescribed and without medication error from omission and appropriate medical provider notification was completed timely per policy. The audit will be weekly for 4 weeks then monthly for 2 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, recommendation for continuation/discontinuation/revision of audits based on findings.</p> <p>4. 7/30/2025</p>		

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F 580	<p>Continued From page 2</p> <p>that his monthly Depo-Provera [medication that may control sexually inappropriate behaviors] injections had not been administered for April 2025, and the medication was unavailable for his May 2025 dose.</p> <p>2. Review of resident 2's electronic medical record (EMR) revealed:</p> <p>*He was admitted on 5/21/21 and his diagnoses included intracranial (within the skull) injury with loss of consciousness, hemiplegia and hemiparesis (weakness or partial paralysis) affecting the left side, dysphagia (difficulty speaking), dementia, depressive disorder, seizures, and traumatic brain injury.</p> <p>*His Brief Interview for Mental Status (BIMS) assessment score was 9, which indicated he was moderately cognitively impaired.</p> <p>*A discontinued 10/26/23 order date, indicated "Depo-Provera intramuscular Suspension 150 MG/ML [milligram/milliliter] (Medroxyprogesterone Acetate (Contraceptive))"</p> <p>Directions: "Inject 1ml intramuscularly at bedtime every 30 day (s) for neoplasm (an abnormal tissue growth that occurs when cells divide and grow more than normal) of uncertain behavior."</p> <p>*A new order on 6/5/25 indicated "Depo-Provera Intramuscular Suspension 150 MG/ML (Medroxyprogesterone Acetate (Contraceptive))"</p> <p>Directions: "Inject 1 ml intramuscularly every day shift every 30 day (s) for neoplasm of uncertain behavior."</p> <p>*Review of resident 2's medication administration record (MAR) revealed they had not administered his monthly Depo-Provera injections for 10/20/24, 12/19/24, 2/17/24 and 4/18/25.</p> <p>*A progress note on 5/18/25 at 10:51 p.m. indicated "the Depo-Provera medication was not available</p>	F 580			

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F 580	<p>Continued From page 3</p> <p>refill request sent".</p> <p>*A progress note on 2/17/25 at 6:37 p.m. indicated " the Depo-Provera Medication [is] not available. Order sent to pharmacy".</p> <p>*A progress note on 12/18/24 11:23 p.m. indicated "the Depo-Provera Medication [is]not available. Order placed with pharmacy."</p> <p>*A progress note on 10/20/24 at 10:28 p.m. indicated "the Depo-Provera Medication is not available, ordered from pharmacy".</p> <p>*There was no documentation of resident 2's Depo-Provera missed dose on 4/18/25.</p> <p>*There was no documentation that the physician was notified that resident 2 had not received his Depo-Provera doses on 10/20/24, 12/19/24 and 2/17/25.</p> <p>3. Review of resident 2's medication error report on 6/17/25 revealed:</p> <p>*A medication error report was completed for 4/18/25 and 5/19/25, and indicated the physician was notified that the resident had not received those ordered monthly Depo-Provera injections.</p> <p>*There was no medication error report completed to have notified the physician that resident 2 had not received his ordered monthly Depo-Provera doses on 10/20/24, 12/19/24 and 2/17/25.</p> <p>4. Interview on 6/18/25 at 12:59 p.m. with director of nursing (DON) B revealed:</p> <p>*They reviewed the progress notes daily and should have noticed the progress notes that indicated resident 2 had not received his ordered monthly Depo-Provera injections.</p> <p>*She confirmed there was no documentation that the physician was notified that resident 2 had not received his ordered Depo-Provera injections on 10/20/24, 12/19/24 and 2/17/25.</p>	F 580			

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F 600 SS=E	<p>5. Review of the provider's updated 9/30/24 Following Physician Orders policy revealed: Procedure: "9. The physician should be notified when an order is not followed for any reason (omission, medication not in stock, resident refusals, etc)."</p> <p>Free from Abuse and Neglect CFR(s): 483.12(a)(1)</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: A. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, and interview, the provider failed to protect the resident's right to be free from potential physical abuse by one of one certified nursing assistant (CNA) F while providing morning cares for one of one sampled resident (1). Findings include:</p> <p>1. Review of the provider's SD DOH FRI</p>	F 600	<p>1. Certified Nurse Assistant F is no longer employed at Avantara Arrowhead as a result of Resident 1's allegations of abuse and no further immediate action can be taken at this time. No further corrective action could be taken for resident 2 as he was discharged on 7/2/2025. No further corrective action could be taken for resident number 3 as she was discharged on 7/3/2025. All residents have the potential to be affected, and the Social Service Designee will interview all residents who are able to be interviewed in the facility no later than July 16, 2025, to determine if they have concerns regarding abuse in the facility.</p> <p>2. Nursing Home Administrator or Designee completed education with all staff on the Abuse and Neglect Policy and if resident to resident abuse is witnessed, staff is to separate the residents and notify charge nurse immediately. Education will occur no later than July 30, 2025. Those not at the education session will be educated prior to their first shift worked.</p>	7/18/25	

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F 600	<p>Continued From page 5</p> <p>submitted on 6/14/25 at 10:45 a.m. revealed:</p> <p>*Resident 1 informed CNA D that he had been mistreated by CNA F during his morning care routine.</p> <p>*Resident 1 had told qualified medication aide (QMA) G that he had injured his ankle during a bed transfer, and reported a pain level six out of ten.</p> <p>*Resident 1 received his scheduled Tylenol as well as PRN (as needed) hydrocodone for the ankle pain.</p> <p>*LPN E conducted an assessment of the resident and noted skin abrasions on both the left and right shins of the resident.</p> <p>*Resident had a bruise on his right eye from a previous fall.</p> <p>*CNA F was suspended from working pending the outcome of the provider's investigation.</p> <p>2. Review of resident 1's electronic medical record (EMR) revealed:</p> <p>*He was admitted on 12/2/24, and his diagnoses included Parkinson's disease (disorder of the central nervous system), hypertension (high blood pressure), weakness, spinal stenosis (narrowing of the spaces within the spine), radiculopathy (pinching of the nerves), low back pain, and a history of falling.</p> <p>*His Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated he was cognitively intact.</p> <p>*A progress note on 6/10/25 at 5:57 p.m. indicated "Resident has a small bruise to R [right] eye that is yellow and purple in color. Resident states it is from his previous fall. Resident usually wears his cap and wasn't wearing it at dinner this evening and staff noticed the bruise. Denies c/o [complains of] pain or discomfort. MD [doctor of medicine] notified, management notified, family</p>	F 600	<p>3. Nursing Home Administrator or Designee will conduct 10 random interviews with residents weekly to determine if the resident has any concerns with abuse in the facility. Results of the audits will be discussed by the Administrator or designee at the monthly QAPI meeting with IDT and Medical Director for analysis, recommendation for continuation/discontinuation/revision of audits based on findings.</p> <p>4. 7/30/2025</p>		

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F 600	<p>Continued From page 6 notified."</p> <p>*Skin evaluations completed on 6/3/25, 6/9/25, and 6/17/25, indicated no skin concerns.</p> <p>*A skin alteration evaluation was completed on 6/10/25 at 6:30 p.m., indicating "a facility-acquired Bruising length 1.0, width 1.0, depth 0, stage N/ A [not applicable]. R eye".</p> <p>*A handwritten note dated 6/14/25 from LPN E after the incident from CNA F indicated "Bruise [to his] R [right] eye dark purple/blue and yellow Abrasion L [left] shin R [right] shin-abrasion c/o [complaint of] pain [in his] ankle joints L [left] wrist scab".</p> <p>3. Review of CNA F's personnel file revealed: *Her professional certifications or licenses were current, and her pre-employment background checks identified no areas of concern. *She completed mechanical and total lift training, one-person assist transfer training, turning and repositioning of resident training, on 9/27/24. *She completed abuse and neglect training on 3/27/25.</p> <p>4. Interview on 6/18/25 at 3:07 p.m. with resident 1 revealed he stated: *He had felt CNA F was upset with him. *CNA F made him feel like he was not moving fast enough for her during his morning care routine on 6/14/25. *He had injured his ankle when she was moving him in bed. *He had injured his shins as she was transferring him out of his bed to his wheelchair. *His ankle had not been hurting for the past couple of days.</p> <p>5. Phone interview on 6/18/25 at 3:47 p.m. with CNA D regarding the 6/14/25 FRI involving</p>	F 600			

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F 600	<p>Continued From page 7</p> <p>resident 1 revealed she stated:</p> <p>*Resident 1 had reported to her that CNA F was upset with him and was "rough" during his morning care routine that day.</p> <p>*Resident 1 had mentioned to CNA D during his morning care, CNA F had bent his foot, which caused him discomfort to his ankle.</p> <p>*She had informed administrator A about the resident's concerns.</p> <p>6. Interview on 6/18/25 at 4:05 p.m. with QMAG regarding the 6/14/25 FRI involving resident 1 revealed:</p> <p>*She noticed resident 1's voice was shaky and crackly that morning which was unlike him.</p> <p>*He had informed her that his ankle was injured during his morning care routine on 6/14/25 with CNA F, and he reported that he had a pain level of six out of ten.</p> <p>*Resident 1 had wanted something stronger than his regular scheduled Tylenol for his pain.</p> <p>7. Interview on 6/18/25 at 4:57 p.m. with administrator A regarding the 6/14/25 FRI for resident 1 revealed:</p> <p>*She had gotten a call from CNA D who stated that resident 1 had reported to CNA D that CNA F had "roughed" him up during his morning care routine that day, and that his ankle was hurt in the process.</p> <p>*Administrator A and social worker director (SSD) K interviewed resident 1 and he stated to them that CNA F had "roughed" him up during his morning care routine.</p> <p>*Administrator A had interviewed CNA F who stated resident 1 was stiff that morning and in pain during his morning care routine. He had shouted out in pain, but he was fine once he was in his wheelchair.</p>	F 600			

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F 600	<p>Continued From page 8</p> <p>*Administrator A had interviewed QMA G who reported resident 1 had mentioned CNA F had mistreated him and he had informed QMA G that his ankle was in pain after his morning care routine.</p> <p>*Administrator A stated CNA F was suspended pending an investigation.</p> <p>*Administrator A stated SSD K had completed resident interviews to determine if they feeling safe in the facility, they have not finished their final investigation yet to determine all education to be completed and audits to be completed.</p> <p>B. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, and interview, the provider failed to protect the resident's right to be free from sexual abuse by one of one sampled resident (2) who made unsolicited sexual advances towards one of four sampled residents (3). Findings include:</p> <p>1. Review of the provider's 5/13/25 SD DOH FRI revealed:</p> <p>*Registered nurse (RN) J reported to the assistant director of nursing (ADON) C that she had witnessed resident 2 with one of his hands inside the top of resident 3's shirt.</p> <p>*Resident 2 was immediately put on 1:1 (one staff to one resident) supervision during the investigation.</p> <p>*ADON C reviewed the camera footage, and it showed CNA I had brought resident 3 to the nurses' station, resident 2 then propelled his wheelchair towards resident 3 backed up his wheelchair which positioned him next to resident 3.</p> <p>*Resident 2 was then seen on the camera footage attempting to lift resident 3's shirt when</p>	F 600			

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F 600	<p>Continued From page 9</p> <p>laundry aide H walked by, and he immediately removed his hand.</p> <p>*After laundry aide H walked by, resident 2 slid the back of his hand into her V-neck shirt and placed it against her chest area, for approximately 20 seconds before RN J intervened.</p> <p>*The facility reviewed resident 2's medication, and identified that his monthly Depo-Provera [medication which may control sexually inappropriate behaviors] injection had not been administered for April 2025, and the medication was unavailable for administration in May 2025.</p> <p>*A medication review led to a recommendation to change resident 2's psychiatric medication, as the current medication may have contributed to an increase in the resident's sexual drive. That change was approved during his psychiatric appointment on 5/28/25.</p> <p>*All staff members were educated on medication errors, and instructions were given that resident 2 should not be near female residents without direct supervision staff</p> <p>*To prevent future issues, resident 2's Depo-Provera injections had now been scheduled to be administered during the day shift instead of at night to ensure better oversight of the administration.</p> <p>2. Review of resident 2's electronic medical record (EMR) revealed:</p> <p>*He was admitted on 5/21/21 and his diagnoses included intracranial (within the skull) injury with loss of consciousness, hemiplegia and hemiparesis (muscle weakness and partial paralysis) affecting the left side, dysphagia (difficulty speaking), dementia, depressive disorder, seizures, and traumatic brain injury.</p> <p>*His Brief Interview for Mental Status (BIMS)</p>	F 600			

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NAME OF PROVIDER OR SUPPLIER AVANTARA ARROWHEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 ARROWHEAD DR RAPID CITY, SD 57702		
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F 600	<p>Continued From page 10</p> <p>assessment score was 9, which indicated he was moderately cognitively impaired.</p> <p>*A discontinued 10/26/23 order date, indicated "Depo-Provera intramuscular Suspension 150 MG/ML [milligram/milliliter] (Medroxyprogesterone Acetate (Contraceptive))"</p> <p>Directions: "Inject 1ml intramuscularly at bedtime every 30 day (s) for neoplasm (an abnormal tissue growth that occurs when cells divide and grow more than normal) of uncertain behavior."</p> <p>*A new 6/5/25 order date, indicated "Depo-Provera Intramuscular Suspension 150 MG/ML (Medroxyprogesterone Acetate (Contraceptive))"</p> <p>Directions: "Inject 1 ml intramuscularly every day shift every 30 day (s) for neoplasm of uncertain behavior."</p> <p>*A progress note on 5/24/25 at 7:07 a.m. indicated "Attempted to notify POA [power of attorney] of [resident 2] ([resident 2]'s POA @ 0633, resident 2's POA @ 0634 and [resident 3]'s POA @ 637) Action: no answer".</p> <p>*A progress note on 5/24/25 at 3:07 p.m. indicated "Contact was made with [resident 2's POA] to report [an] incident that occurred with female [a] resident. Action: n/a [not applicable] Response: Aware of investigation, no other concerns verbalized."</p> <p>3. Interview on 6/18/25 at 1:16 p.m. with assistant director of nursing (ADON) C regarding the 5/13/25 FRI involving resident 2 revealed:</p> <p>*She had received a call from RN J who informed her that resident 2 had made inappropriate sexual contact with resident 3.</p> <p>*She reviewed the camera footage, and it was observed that CNA I had placed resident 3 near the nurses' station earlier that morning, approximately nine feet away from resident 2.</p>	F 600			

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F 600	<p>Continued From page 11</p> <p>Resident 2 was then seen moving in his wheelchair over to resident 3 and then backed up his wheelchair positioned next to resident 3.</p> <p>*The camera footage showed that resident 2 attempted to reach into resident 3's shirt. At that moment, laundry aide H walked by, and resident 2 retracted his arm. After laundry aide H had walked by, resident 2 used the back of his left hand to reach into resident 3's V-neck shirt. His thumb was visibly sticking out of her shirt, and he appeared to rub his hand inside her shirt.</p> <p>*The inappropriate contact lasted approximately twenty seconds before RN J intervened and immediately separated the residents. Resident 2 was placed on 1:1 supervision to ensure the safety of all the residents during the investigation.</p> <p>4. Phone interview on 6/18/25 at 1:25 p.m. with RN J regarding the 5/13/25 FRI for resident 2 revealed she:</p> <p>*Returned to the nurses' station after passing medications, and observed resident 2 with his hand inside resident 3's shirt.</p> <p>*Immediately intervened and redirected resident 2 to the dining room.</p> <p>*Stated resident 2 was placed on 1:1 supervision after that.</p> <p>*Stated her shift had ended right after the incident, and she had reported the incident to the next nurse during the shift report.</p> <p>5. Interview on 6/18/25 at 1:41 p.m. with director of nursing (DON) B regarding the 5/13/25 FRI involving resident 2 revealed:</p> <p>*She stated resident 2 was placed on 1:1 supervision during the investigation of the incident</p> <p>*During the medication review, it was discovered that resident 2's scheduled April and May 2025 monthly Depo-Provera injections were not</p>	F 600			

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F 600	Continued From page 12 administered. *Following a consultation, the pharmacist and psychologist agreed to change one of his psychiatric medications. *They had placed an additional dose of Depo-Provera injection in their electronic emergency kit (E-kit) to ensure the medication would be available in the facility. *The administration team later confirmed that resident 2 had received a Depo-Provera injection later in May, and no further behavioral episodes or attempts to inappropriately touch other residents had been reported. As a result, the 1:1 supervision was discontinued. *Resident 3 had a psychologist appointment and an integrated behavioral health appointment after the 5/13/25 incident and it was determined resident 3 was back to her baseline. *Staff was educated regarding resident 2 was not to be near any female resident without direct supervision of staff. *Audit after the 5/13/25 incident revealed another resident that received a 90-day Depo-Provera injection had not received his scheduled dose in May 2025 but later received the injection in June 2025.	F 600			
F 760 SS=E	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 South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, record review, and policy review, the provider failed to ensure medication was	F 760	1. No immediate correction could occur for resident 4 missing gabapentin from 3/19/2025. Resident 4 missing gabapentin available in facility on 3/21/25. No immediate correction could occur for resident 2' s missing Dep-Provera for 10/20/24, 12/19/24, 2/17/25, and 4/18/25. Resident 2 was provided with his May dose on 5/24/25. No further corrective action could be taken for resident 2 as he was discharged on 7/2/2025.	7/18/25	

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F 760	<p>Continued From page 13</p> <p>administered as ordered by the physician for two of two sampled residents (2 and 4). Findings include:</p> <p>1. Review of the 3/21/25 SD DOH FRI revealed: *49 capsules of 400 milligram (mg) Gabapentin (a non-narcotic medication used to treat pain) that should have been available to be administered to resident 4 were missing. -The provider's investigation of the above missing medications revealed they were unable to identify when or how those capsules had gone missing. *The FRI stated on 3/19/25 resident 4's 10:00 p.m. scheduled Gabapentin dose was not administered because it was not available to administer at that time. -There was no indication on that FRI resident 4 had missed any other scheduled Gabapentin administrations related to the Gabapentin not being available to administer.</p> <p>2. Interview on 6/16/25 at 3:30 p.m. with qualified medication aide (QMA) L regarding the medication reordering process revealed: *A reorder sticker was affixed to each residents' medication card. The date on that sticker indicated the soonest that medication would be able to be refilled by pharmacy. -That date was based on the amount of medication that was delivered when it was last filled and how much of that medication should remain available to be administered. *Medications were reordered when a resident had seven doses or seven days of a medication that remained available to administer. -The overflow medication cart (a medication cart used to store extra medication cards) was checked for any unused medication cards before a medication was reordered from the pharmacy.</p>	F 760	<p>All residents who take medication are at risk and a complete audit of all resident's medication list to current medications in cart to verify all medications were in facility and available for resident use was completed on July 16, 2025.</p> <p>2. The DON or designee will educate all nurses in facility on Reordering of Medication protocol and Following Physician Orders to ensure nurses know the expectations of what to do when a medication is not available and how to obtain the medication. The DON or designee will review nurses' documentation each working day to monitor for medications documented as unavailable and follow up to ensure medication administration procedures were followed and medication obtained. Education will occur no later than July 30, 2025. Those not at the education session will be educated prior to their first shift worked. Additionally, an RXNow audit was conducted on July 8, 2025 to determine that all facility users have access to the emergency medication supply and education on medication unavailability was added to new nurse orientation.</p> <p>3. The DON or designee will audit 5 random residents per week to verify their medications in cart match the current medication list. The audit will be weekly for 4 weeks then monthly for 2 months.</p>	7/18/25	

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F 760	<p>Continued From page 14</p> <p>*Medications were reordered through a resident's electronic medical record (EMR) in their medication administration record (MAR). -The needed medication was selected and the "reorder" option button was clicked. That action sent an electronic communication to the pharmacy notifying them that a medication refill had been requested. *The reorder sticker was removed from the medication card after a medication was reordered. That communicated to the other licensed nurses and QMAs that the medication had been reordered.</p> <p>3. Interview on 6/16/25 at 3:35 p.m. with registered nurse (RN) M regarding medication delivery by the pharmacy revealed: *The pharmacy had scheduled medication delivery times twice daily on weekdays and one time daily on Saturdays. There were no scheduled Sunday deliveries. -The pharmacy had an on-call number to arrange for medication deliveries at times other than the scheduled delivery times, if needed. *RN M stated if a medication was not available to administer from either the medication cart or the overflow medication cart, the medication may have been available to administer from the facility's Emergency Kit (E-Kit). -The E-Kit was a secured electronic medication dispensing system that was located in the medication room. It was stocked with commonly used resident medications. *RN M confirmed that both 100 mg and 400 mg capsules of Gabapentin were available for administration from the E-Kit.</p> <p>4. Interview on 6/18/25 at 2:50 p.m. with director of nursing (DON) B and review of resident 4's</p>	F 760	<p>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. 7/30/2025</p>		

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F 760	<p>Continued From page 15</p> <p>March 2025 MAR, March 2025 medication administration progress notes, and the March 2025 pharmacy provider's manifest logs (a record that lists and describes the medication delivered to the facility) revealed:</p> <p>*A 2/22/25 physician's order for resident 4's Gabapentin that indicated:</p> <ul style="list-style-type: none"> -one, 400 mg capsule was scheduled to have been administered three times each day (at 9:00 a.m., 2:00 p.m., and 10:00 p.m.) for his diagnosis of radiculopathy (a pinching of nerves which sometimes causes pain, weakness, and numbness). <p>*On 3/5/25, the manifest log indicated the pharmacy had delivered a 30-day supply of 400 mg Gabapentin for resident 4.</p> <p>*On 3/17/25 and 3/19/25, staff had requested the pharmacy refill the resident's Gabapentin, but it was too soon to have been refilled based on the amount of Gabapentin that should have been available for administration at facility.</p> <p>*On 3/19/25, the manifest log indicated there were ten, 100 mg Gabapentin capsules in the E-Kit.</p> <ul style="list-style-type: none"> -On that same day, four Gabapentin capsules had been removed and administered to resident 4 for his 2:00 p.m. scheduled 400 mg dose. -Four Gabapentin capsules had also been removed on that day and administered to another resident. <p>*On 3/19/25, resident 4 was not administered his 10:00 p.m. Gabapentin dose. "Medication not available[,] on order, med not in med box [E-Kit]" according to the medication administration progress note.</p> <p>*On 3/20/25, the resident was not administered his 9:00 a.m. Gabapentin dose. "Medication not available" according to the medication administration progress note.</p>	F 760			

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F 760	<p>Continued From page 16</p> <p>-DON B confirmed there was no documentation to support the pharmacy had been contacted about refilling the Gabapentin in the E-Kit so resident 4 could have been administered his 9:00 a.m.dose.</p> <p>*On 3/20/25 at 12:52 p.m., ten, 100 mg Gabapentin capsules were delivered by the pharmacy and placed in the E-Kit for replacements.</p> <p>-Those ten capsules remained in the E-Kit from the time they were delivered until 3/24/25.</p> <p>*On 3/20/25, resident 4 was not administered his 2:00 p.m. and 10:00 p.m. doses of Gabapentin due to "Medication not available" according to the medication administration progress note.</p> <p>-DON B confirmed Gabapentin was available in the E-Kit to administer the resident's 2:00 p.m. and 10:00 p.m. doses that day.</p> <p>-Nursing staff and a QMA failed to check the E-Kit for the available Gabapentin. Those staff had assumed the medication was not delivered and was not available for administration.</p> <p>*On 3/21/25, the resident was not administered his 9:00 a.m. dose of Gabapentin. "Medication not available, spoke w/ [with] pharm [pharmacy], medication to be sent later today" according to the medication administration progress note.</p> <p>-DON B confirmed Gabapentin had remained available in the E-Kit to have administered resident 4's 9:00 a.m. dose that day.</p> <p>-Nursing staff failed to check the E-Kit. They had assumed the medication was not delivered and was not available to for administration.</p> <p>*On 3/21/25, the pharmacy manifest log had indicated 90, 400 mg Gabapentin capsules were delivered to the facility for resident 4.</p> <p>-Resident 4's Gabapentin administration schedule resumed as ordered with his 3/21/25 2:00 p.m. dose that day.</p>	F 760			

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F 760	<p>Continued From page 17</p> <p>*DON B confirmed the above missed medication administrations were medication errors.</p> <p>5. Review of resident 4's March 2025 MAR revealed: *He had an as-needed (PRN) order for acetaminophen 325, two tabs for pain. -He was administered that medication periodically throughout the month. -His reported pain levels prior to having been administered that PRN medication had varied. *There was no apparent correlation between resident 4 having not been administered his scheduled Gabapentin and his need for PRN acetaminophen related to pain. *Resident 4's May 2025 MAR and June 1, 2025 through June 17, 2025 MAR revealed no further missed Gabapentin medication administrations had been documented.</p> <p>6. Review of the 3/21/25 Medication Error Report related to the above medication errors revealed: *"Identified 3/19 [2025] that resident was out of gabapentin. Gabapentin available again 3/21 [2025]." -That Medication Error Report was completed and signed by DON B on 6/16/25.</p> <p>7. Review of the provider's 5/13/25 SD DOH FRI revealed: *Resident 2 had inappropriate contact with resident 3. *As part of the investigation the facility staff reviewed resident 2's medication and it was found that his monthly Depo-Provera [medication that may control sexually inappropriate behaviors] injections had not been administered for April 2025, and the medication was unavailable for his</p>	F 760			

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F 760	<p>Continued From page 18 May 2025 dose.</p> <p>8. Review of resident 2's electronic medical record (EMR) revealed: *He was admitted on 5/21/21 and his diagnoses included intracranial (within the skull) injury with loss of consciousness, hemiplegia and hemiparesis (muscle weakness and partial paralysis) affecting the left side, dysphagia (difficulty speaking), dementia, depressive disorder, seizures, and traumatic brain injury. *His Brief Interview for Mental Status (BIMS) assessment score was 9, which indicated he was moderately cognitively impaired. *A discontinued 10/26/23 order date, indicated "Depo-Provera intramuscular Suspension 150 MG/ML (milligram/milliliter) (Medroxyprogesterone Acetate (Contraceptive))" Directions: "Inject 1 ml intramuscularly at bedtime every 30 day (s) for neoplasm (an abnormal tissue growth that occurs when cells divide and grow more than normal) of uncertain behavior." *A new 6/5/25 order date, indicated "Depo-Provera Intramuscular Suspension 150 MG/ML (Medroxyprogesterone Acetate (Contraceptive))" Directions: "Inject 1 ml intramuscularly every day shift every 30 day (s) for neoplasm of uncertain behavior." *A progress note on 5/18/25 at 10:51 p.m. indicated "the Depo-Provera not available refill request sent". *A progress note on 2/17/25 at 6:37 p.m. indicated "the Depo-Provera Medication not available. Order sent to pharmacy". *A progress note on 12/18/24 11:23 p.m. indicated "the Depo-Provera Medication not available. Order placed with pharmacy." *A progress note on 10/20/24 at 10:28 p.m.</p>	F 760			

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F 760	<p>Continued From page 19</p> <p>indicated "the Depo-Provera Medication is not available, ordered from pharmacy".</p> <p>*There was no documentation of resident 2's Depo-Provera missed dose for 4/18/25.</p> <p>9. Review of resident 2's medication error report on 6/17/25 revealed:</p> <p>*A medication error report was completed for 4/18/25 and 5/19/25, which indicated the medication was not available on the date it was due and was not administered on 4/18/25. The medication was not available on the date it was due on 5/19/25 but was later administered on 5/24/25.</p> <p>*There was no documentation that a medication error was completed report for resident 2's ordered monthly Depo-Provera injections that were not administered on 10/20/24, 12/19/24 and 2/17/25.</p> <p>10. Review of resident 2's medication administration record (MAR) revealed he had not been administered his ordered monthly Depo-Provera injections on 10/20/24, 12/19/24, 2/17/25 and 4/18/25.</p> <p>11. Interview on 6/18/25 at 8:01 a.m. with licensed practical nurse (LPN) E revealed:</p> <p>*When a medicine supply was running low, she would select the re-order button in the MAR system, which would order more from the pharmacy, as she was administering the current dose.</p> <p>*She stated there was a medication re-order reminder option within the MAR that staff could use, and it could be customized for different hours depending on when the medication was expected to arrive from the pharmacy.</p> <p>*She stated if there was a delay in receiving</p>	F 760			

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F 760	<p>Continued From page 20</p> <p>medication from the pharmacy, those medication orders could be put on hold and then resumed once the medication supply arrived from the pharmacy.</p> <p>12. Interview on 6/18/25 at 11:36 a.m. with director of nursing (DON) B revealed:</p> <p>*They reviewed the progress notes daily and should have noticed the progress notes regarding resident 2's monthly Depo-Provera injections that were not administered as ordered</p> <p>*She confirmed there was no documentation that medication error reports were completed for Depo-Provera injections not administered as ordered on 10/20/24, 12/19/24 and 2/17/25.</p> <p>*She confirmed staff could set re-order reminders within the MAR system for different hours if the same nurse would be working that next shift for consistency.</p> <p>*She expected the staff who administered medications to report to the next shift when they had ordered residents medications from the pharmacy.</p> <p>*She agreed that the staff did not follow their policy for medication errors.</p> <p>Review of the provider's updated 2/20/24 Medication Errors policy revealed: Policy: "To ensure medication errors are identified to prevent adverse resident effects. Errors will be documented, investigated, reported, and reviewed for need of interventions and to prevent recurrence." Procedures "1. Each medication error discovered will be documented on the Medication Error Report form. The person discovering the error will complete Part 1 of the Form."</p>	F 760			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2025
NAME OF PROVIDER OR SUPPLIER AVANTARA ARROWHEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 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 760	Continued From page 21 "2. Each medication error will be reported to the resident's physician/designee and respond noted. Documentation of the notification will be completed on Part 2 of the Form by the person contacting the physician/designee. The family will also be notified, and documentation will show who was notified, date and time." "3. Part 3 of the Form will address how this error occurred and can be prevented in the future. This section will be completed by the nurse/medication aide most closely responsible for the error." "4. The Director of Nursing or designee will complete Part 4 of the Form which indicates the classification of the medication error and what steps have been taken to prevent a future error." "5. The entire Medication Error Report will then be reviewed by the DON or designee to determine any further steps needed such as counseling, suspension, DOH reporting, etc. The DON or designee will document actions on the Summary portion of the Form." "6. Medication errors will be reviewed by the Medical Director and Consultant Pharmacist. The review may be done via telephone, during routine visits or during QAPI [Quality Assurance and Performance Improvement] discussion." "7. The medication error will be entered into the Risk Management section of PCC [point click care] for trending and tracking purposes."	F 760			