

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

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/22/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA ARROWHEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 ARROWHEAD DR , RAPID CITY, South Dakota, 57702	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/16/26 through 6/18/26, and on 6/22/26. Avantara Arrowhead was found not in compliance with the following requirements: F554, F688, F695, F867, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/16/26 through 6/18/26, and on 6/22/26. Areas surveyed included an elopement, a burn injury, discharge planning, incontinence care, medication errors, the physician's order entry process, medical appointment management, nurse assessment documentation, fall prevention and interventions, and potential resident abuse. Avantara Arrowhead was found to have past non-compliance at F550, F600, F658, and F684.	F0000		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: A. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, record review, and policy review, the provider failed to ensure physician's orders were entered in one of one resident's (57) electronic medical record (EMR) and implemented to mitigate that resident's risk for hospitalization.	F0684	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Jessica Simon

TITLE

Administrator

(X6) DATE

7/20/2026

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F0684 SS = G	Continued from page 1 This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's 3/16/26 submitted SD DOH FRI final report regarding resident 57 revealed that physician HH's 3/6/26 orders were "noted" (acknowledged as being read, understood, and entered in resident 57's EMR) by assistant director of nursing (ADON) P on that same date. The orders were not cross-checked by a second nurse per the provider's revised 11/18/25 Following Physician Orders policy. The provider's investigation confirmed that ADON P only noted and entered physician HH's 3/6/26 medication orders for resident 57 and not physician HH's 3/6/26 orders for a head CT and laboratory tests. 2. Review of resident 57's EMR revealed physician HH's 3/16/26 Nursing Home Attending Physician Visit progress note stated that on 3/6/26, "I [physician HH] ordered laboratory tests [for resident 57]. I [physician HH] also ordered a head CT scan because she [resident 57] had fallen the week before and hit her head. She [resident 57] is on anticoagulation [a blood-thinning medication]. Unfortunately, these orders were not entered at the nursing facility." After physician HH's examination of resident 57 on 3/16/26, the physician ordered the resident's transfer to the local emergency department related to her general decline: loose stools, hallucinations (a false sensory perception that feels real), lethargy (severe physical and mental sluggishness), and malaise (a vague feeling of being unwell). She was hospitalized from 3/16/26 through 3/24/26 for new diagnoses that included acute kidney injury and metabolic acidosis (a condition where the body produces too much acid, or the kidneys are not removing enough of it). An additional diagnosis of paroxysmal atrial fibrillation (episodes of irregular, rapid heartbeats start suddenly) was noted. Resident HH had a cardiac history. 3. Interview on 6/17/26 at 4:15 p.m. with resident 57 regarding her March 2026 hospitalization revealed that she had not felt well for some time before that hospitalization. She was having loose stools, losing weight, and feeling weak. She stated that on 3/16/26, the nursing staff were aware that her symptoms had not improved. The resident's condition was discussed with resident 57's representative, who came to the facility to see the	F0684		

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F0684 SS = G	Continued from page 2 resident. The resident's representative asked that physician HH be contacted to see resident 57 that day, which physician HH did. The resident was transferred to the local emergency department then hospitalized. 4. Interview on 6/17/26 at 5:30 p.m. with ADON P revealed that the above incident investigation and EMR findings were correct. The provider had "a check and balance system" to ensure accurate physician order entry occurred, but it was not followed by ADON P or the night shift nursing staff on 3/6/26 for resident 57's orders. 5. Interview and record review on 6/22/26 at 3:50 p.m. with regional nurse consultant (RNC) C revealed that the provider's failure to fully implement physician HH's 3/6/26 orders for resident 57 prevented the provider from having an accurate clinical picture of the resident's condition, which could have mitigated the resident's need for emergency care on 3/16/26. 6. The disciplinary action, education, interviews, and audits referenced in the provider's 3/16/26 submitted SD DOH FRI were completed and documented. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 6/22/26 after record review revealed the facility had followed their quality assurance process, and on 3/17/26 a quality assurance and performance improvement (QAPI) meeting was held related to this FRI. Former director of nursing (DON) BB completed a corrective action plan with ADON P regarding the incident. Nurse leadership and nursing staff were educated regarding the expectations concerning a resident's change in condition, 24-hour chart checks, follow-up on registered dietitian recommendations, requesting and scheduling resident appointments and entering labs in the EMR. Education regarding pertinent policies and flow sheets accompanied this training. Audits of physician HH's residents' charts were reviewed to ensure that all of the orders the provider had received from the physician in the prior three months were acted upon. All other physicians' orders were also reviewed to verify that their orders were completed and implemented. There were audits of physician progress notes during the provider's daily clinical meeting to ensure any new physician's orders were entered in the EMR and any order follow-up was completed. There were audits to ensure the night shift had signed off on 24-hour chart checks, verified that all new physician's orders	F0684		

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F0684 SS = G	Continued from page 3 were implemented and followed up on, and that there were two nurse signatures to verify new physician order entries. Based on the above information, non-compliance at F684 occurred on 3/6/26, and based on the provider's implemented corrective actions initiated on 3/16/26, for the deficient practice confirmed on 3/6/26, the non-compliance is considered past non-compliance. B. Based on SD DOH FRI, interview, and record review, the provider failed to ensure an outpatient wound care appointment occurred in a timely manner for one of one resident (47) who had a worsening lower extremity wound. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's 3/18/26 submitted SD DOH FRI final report regarding resident 47 revealed that on 3/17/26, physician's assistant (PA) DD was notified by nursing staff that resident 47's foot wound had worsened. Resident 47's 3/12/26 OPWC appointment was canceled due to the provider having transportation issues. The appointment was rescheduled to 3/27/26. PA DD asked the provider to reschedule the appointment to a date earlier than 3/27/26. When PA DD contacted the OPWC clinic, she was told that an earlier appointment for resident 47 was offered to the facility, but it was declined. Former DON BB advised PA DD that there were "not enough transport drivers to accommodate all residents' appointments." That prevented resident 47 from being seen in the OPWC clinic any sooner than 3/27/26. Resident 47's OPWC appointment was rescheduled to 3/20/26. 2. Review of resident 47's EMR revealed her diagnoses included diabetes, Charcot arthropathy (a progressive, degenerative condition affecting bones and joints) of the right foot and ankle, prior right foot and bilateral toe amputations, chronic osteomyelitis (a bone or bone marrow infection), obesity, heart disease, and cirrhosis (progressive, irreversible liver disease). She had regularly scheduled OPWC appointments			F0684			

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F0684 SS = G	Continued from page 4 and attended the scheduled May 2026 and June 2026 appointments. 3. Interview on 6/16/26 at 1:15 p.m. with resident 47 revealed she had no current care concerns and no issues regarding her medical appointments. The resident kept herself informed and educated regarding her medical care needs. 4. Interview on 6/16/26 at 2:30 p.m. with registered nurse (RN) T regarding resident appointments revealed the provider's updated appointment process facilitated communication between physicians, facility nursing staff, and the facility's appointment scheduler. The updated process ensured residents' medical appointments were kept and were not unnecessarily canceled. 5. Interview on 6/16/26 at 3:05 p.m. with transportation coordinator EE regarding resident appointments revealed the provider's updated appointment process facilitated communication between physicians, facility nursing staff, and transportation coordinator EE to ensure residents' medical appointments were kept and are not unnecessarily canceled. He was able to collaborate with the drivers in three other sister facilities to accommodate resident appointments if needed. Any medical appointment scheduling barriers were reported to a member of the facility's management team for guidance and resolution. 6. Interview and record review on 6/17/26 at 11:15 a.m. with RNC C revealed the disciplinary action, education, interviews, and audits referenced in the provider's 3/18/26 submitted SD DOH FRI were completed and documented. 7. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 6/17/26 after record review revealed the facility had followed their quality assurance process, and a Quality Assurance and Performance Improvement (QAPI) meeting was held to identify the root cause for the provider's system failure related to resident appointments. Former DON BB, medical records coordinator LL, and former transportation coordinator CC, nurse management staff, and nursing staff were educated regarding the expectations for managing resident appointments, resident appointment communication, and notifications regarding resident appointment changes. All residents with OPWC appointments were audited to ensure they were not unnecessarily postponed	F0684			

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F0684 SS = G	Continued from page 5 and were rescheduled in a timely manner when indicated. Resident appointments were reviewed during the provider's morning interdisciplinary team meetings to ensure Appointment Request Forms were completed for resident appointments by nursing staff, and provided to transportation coordinator EE to schedule transport for those resident appointments. The resident appointment calendar form was reviewed and compared to the Daily Transportation Log form to ensure that appointments were completed as scheduled. There was documentation to support a rational reason why any appointment was canceled or rescheduled, and that canceled appointments were appropriately rescheduled. Based on the above information, non-compliance at F684 occurred on 3/12/26, and based on the provider's implemented corrective actions initiated on 3/17/26, for the deficient practice confirmed on 3/17/26, the non-compliance is considered past non-compliance. C. Based on SD DOH FRI, interview, record review, and policy review, the provider failed to ensure one of one resident (55) received prompt incontinence (involuntary urine or bowel leakage) care from one of one CNA (II). This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's 3/27/26 FRI revealed that on 3/27/26 at 3:50 p.m. former transportation coordinator CC reported to facility management staff via secure facility email that resident 55 had possibly not been provided incontinence care since earlier that morning. The afternoon of 3/27/26, CNA/registered medication aide (RMA) E was in the resident's room to manage his oxygen tank when she observed resident 55 sitting in his wheelchair. His left pant leg was wet from his groin to his knee. There was a smell of urine in the room. CNA II was responsible for resident 55's care that day and was suspended from working pending an incident investigation. The provider's investigation revealed that resident 55's incontinence brief was last changed on 3/27/26 at approximately noon by CNA II. CNA II stated she was not able to return after that time to check the resident's brief again because she was busy with other residents' care.	F0684		

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F0684 SS = G	Continued from page 6 Resident 55's brief was expected to be checked for incontinence and changed, if needed, every 2 hours according to the provider's Check and Change policy. That had not occurred. 2. CNA/RMA E was scheduled to work on 6/22/26, but called out sick and was not able to be interviewed. She was not scheduled to work again until after the survey ended. CNA II has not worked at the facility since 4/2/26. Resident 55 has severe cognitive impairment and was not able to be interviewed. 3. Random observations made of resident 55 throughout the survey on 6/16/26, 6/17/26, 6/18/26, and 6/22/26 in the dining room and in the resident's room revealed that the resident's clothing was dry and there was no smell of urine. 4. Interview on 6/22/26 at 12:30 p.m. with RNC C revealed caregivers are encouraged and expected to ask for assistance from other caregivers if they are not able to meet residents' care needs. The provider was adequately staffed on 3/27/26 for that to occur. 5. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 6/22/26 after record review revealed the facility had followed their quality assurance process, and former transportation coordinator CC and CNA/RMA E were educated regarding notifying a facility manager of a reportable event (unexpected or adverse events) during regular business hours instead of communicating that information via secured electronic mail. All caregivers were educated on the provider's Abuse/Neglect policy at the 4/14/26 All Staff meeting. Five residents were observed each week for four weeks to ensure their incontinence care needs were met in a timely manner. Ten applicable residents were asked if they were checked for incontinence every two hours and assisted with their toileting needs. 6. Based on the above information, non-compliance at F684 occurred on 3/27/26, and based on the provider's implemented corrective actions initiated on 3/27/26, for the deficient practice confirmed on 3/27/26, the non-compliance is considered past non-compliance.	F0684		
F0867 SS = F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring.	F0867	1.Regional Nurse Consultant (RNC), Assistant Administrator, and Director of Nursing (DON) conducted a review of all Facility Reported Incidents (FRIs) from 3/1/2026 through 6/30/2026 to determine any trend with incontinence care, determine if current audits are sufficient	8/4/2026

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F0867 SS = F	Continued from page 7 A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to	F0867	and need to be updated or continued and returned to QAPI for review. All residents have the potential to be affected by an ineffective Quality Assurance and Performance Improvement (QAPI) program that tracks and measures performance, systematically analyzes underlying causes of systemic quality deficiency, develops and implements corrective actions or performance improvement activities, and evaluates the effectiveness of the corrective actions and revise as needed. 2.The Vice President of Regulatory Affairs will conduct training with Interdisciplinary Team (IDT) on QAPI on 7/15/2026. The Assistant Administrator created a master list for all audits and education for reportable events for completion tracking. The log will include who is assigned to the audit and ensure the person completes the audit, conducts the audit accurately, and documents the findings appropriately. 3.The Regional Nurse Consultant (RNC) or designee will complete an audit of assigned audits to ensure the findings are documented accurately and the audit is assigned to an appropriate individual. Audits will be weekly for 4 weeks then monthly for 2 months. The Vice President of Operations or RNC will attend QAPI for the next 3 months to ensure tracking and trending of reportable events is occurring, data collection is reflective of current facility trends, and root cause is being determined. 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.	

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F0867 SS = F	Continued from page 8 determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F0867		

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F0867 SS = F	Continued from page 9 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI), record review, and interview, the provider failed to ensure an effective, comprehensive quality assurance and performance improvement (QAPI) program was implemented to track and measure performance; systematically analyze underlying causes of a systemic quality deficiency; develop and implement corrective actions or performance improvement activities; and evaluate the effectiveness of the corrective actions, and to revise those actions as needed. Findings include: 1. Review of a 3/20/26 SD DOH FRI revealed that the incident investigation substantiated neglect occurred when the facility failed to provide resident 56 incontinence care. 2. Review of a 3/27/26 SD DOH FRI revealed that the incident investigation substantiated that the facility failed to provide resident 55 incontinence care. 3. Review of a 4/19/26 SD DOH FRI revealed that the incident investigation substantiated that the facility failed to provide resident 37 incontinence care. 4. The provider's corrective action plan for the above FRIs included staff disciplinary action, staff education, and auditing of residents' incontinence care. The same audit tool was used for each of the above FRIs. Five random residents were selected each week. They were observed for incontinence, if their care plan was followed regarding incontinence care, and if the resident reported concerns with their incontinence care. Every audit was marked "yes" in response to the resident reporting incontinence concerns, but there was no information related to those resident concerns. The Summary of Findings section on each audit was blank.			F0867			

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F0867 SS = F	Continued from page 10 5. Review of a 6/12/26 SD DOH FRI revealed that the incident investigation substantiated that resident 62's preference to use a bedpan was not accommodated by staff, and the resident was instructed to urinate in her incontinence brief. 6. Review of the above FRIs and interview on 6/18/26 at 12:15 p.m. with regional nurse consultant (RNC) C revealed she thought that the "yes" response to the audit question regarding whether the resident reported concerns with their incontinence care was answered incorrectly and should have been marked "no". RNC C confirmed that the provider failed to, but should have used information from the above FRIs to identify or rule out potential causes for the incontinence care and to provide education to the staff. 7. Review of the provider's April 2026 and May 2026 Quality Assurance and Performance Improvement (QAPI) meeting minutes revealed that the provider initiated a plan to work on specific areas to improve their quality of care, regulatory compliance, and staff morale. The Systems Review section of the minutes included "Incident Investigations (State Reported [FRIs] and Internal)." Instructions were to "Include data analysis, RCA [root cause analysis] [a structured problem-solving process used to identify the underlying reasons behind an issue], and need for PIP [performance improvement plan] [a structured, data-driven framework used to address identified quality concerns or adverse events]/Action Plan." Neither the April 2026 nor the May 2026 QAPI minutes included a data analysis, RCA, or PIP/Action plan information related to the above FRIs. 8. Review of the April 2026 and May 2026 QAPI meeting minutes and interview on 6/22/2026 at 5:30 p.m. with RNC C and assistant administrator B revealed that the minutes failed to identify who was responsible for completing the Incident Investigations portion of the Systems Review Section. There was no documented RCA that identified the underlying cause(s) for the ongoing incidents of untimely and improper incontinence care. QAPI meeting minutes failed to reflect whether the provider's interventions (audits, staff education, and staff disciplinary actions) in response to the above FRIs were monitored or measured to determine their impact on residents' incontinence care or if alternate interventions were warranted. There was no PIP/Action plan related to incontinence care. RNC C and assistant administrator B stated that a QAPI committee should have been formed several months ago to more effectively and efficiently address the incontinence care issue. 9. Review of the provider's undated QAPI Plan revealed the provider "will use data at	F0867		

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F0867 SS = F	Continued from page 11 every QAPI Committee to ensure performance measures are meeting QAPI goals." Regarding the section labeled, Feedback, Data Systems, and Monitoring: The primary sources for data collection included incident/event reports (FRIs). "Data and its sources will be continuously monitored for accuracy and applicability to performance improvement. It is the responsibility of the QAPI Steering Committee to determine the relevance of data for performance improvement and to examine data for any gaps or discrepancies." Regarding the section labeled, Systemic Analysis and Systematic Action: "The Plan-Do-Study-Act (PDSA) process and Root Cause Analysis (RCA) will be used to identify improvement opportunities and to understand how to improve them. The QAPI Steering Committee monitors progress to ensure that interventions or actions are implemented and effective in making and sustaining improvements."	F0867		
F0554 SS = E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure: *Resident's medication self-administration assessment was completed, and a physician's order was obtained for two of two sampled resident (63 and 43) who was not assessed to determine her ability to safely self-administer her medications or had a physician's order to self-administer those medications. *Resident's medication were not stored in a bedside lockbox for two of two sampled residents (10 and 43) per facility policy and self-administration evaluations. Findings included: 1. Observation and interview on 6/16/26 at 10:30 a.m. with resident 63 in her room revealed she had a small plastic cup containing five pills sitting on her nightstand. Resident 63 stated she was unsure what the medications were for and reported they had been sitting on her nightstand all morning, as she had an	F0554	1. Resident 63's room was checked on 6/18/2026 by RNC and no medication noted at bedside. Resident 43 had a self-administration assessment completed on 7/7/2026 and her ability to self-administer medication was determined not to be safe therefore all medications were removed from room. Resident 43 orders and care plan updated on 7/7/2026. Resident 10's room was checked on 7/7/2026 and his medications were in the lock box, a self-administration assessment completed, and care plan reviewed with no changes. All residents are at risk for this deficient practice. All resident rooms were audited by DON or designee for medications at bedside by 7/16/2026. All residents who request medications at bedside were assessed to determine if they are safe to have medications stored at bedside, orders obtained as needed, and care plans updated. 2. The DON or designee will educate all licensed nurses and medication aides on facility Self-Administration of Medications policy, including observing residents take their medications and staff will not leave the medications for residents to self-administer at bedside without an order. All staff will be educated on what to do if they observe medication unsecured at bedside. Education will occur no later than August 4, 2026. Those not at the education session will be educated prior to their first shift worked.	8/4/2026

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F0554 SS = E	Continued from page 12 upset stomach and had not yet taken her medications. 2. Review of Resident 63's electronic medical record (EMR) revealed she admitted to the facility on 6/4/26. Her diagnosis included dementia (a group of symptoms affecting memory, thinking and social abilities). Her Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. There was no medication self-administration assessment completed to determine whether she could safely self-administer her medications. There was no physician's order that indicated resident 63 was able to self-administer the medications. 3. Interview on 6/18/26 at 10:09 a.m. with licensed practical nurse (LPN) V, revealed she was in training with registered nurse (RN) T on 6/16/26. She stated she left resident 63's medications on the resident's nightstand on 6/16/26 and reported RN T had told her that, due to resident 63's behaviors in the morning, it was acceptable to leave her medications on her nightstand. LPN V stated she did return to resident 63's room to ensure the medications had been taken but was unsure of the time she returned. She was unaware whether resident 63 had completed a self-administration assessment that would permit medications to be left on her nightstand. 4. Interview on 6/18/26 at 10:23 a.m. with RN T revealed she was training LPN V on 6/16/26. She stated that LPN V was passing medications, and she had told LPN V that resident 63 can "be moody" in the morning and to be mindful of her approach with the resident. RN T stated she did not tell LPN V to leave the medication on resident 63's nightstand and was unaware the medications had been left there. RN T stated that LPN V did not inform her that resident 63 had not taken her medications, and RN T was not present when LPN V went into resident 63's room to administer them. 5. Interview on 6/18/26 at 10:33 a.m. with regional nurse consultant (RNC) C regarding resident 63's medications revealed she stated that during LPN V's training RN T should have been with LPN V while LPN V was administering medications to the residents. She stated if a resident wants to self-administer medications, staff are expected to	F0554	3. The DON or designee will audit 10 random resident rooms for medication at bedside to ensure residents have self-administration orders in place, a medication self-administration evaluation in the last quarter and medications are securely stored. The audit will be weekly for 4 weeks then monthly for 2 months. DON or designee will audit 10 random resident medication passes to ensure nurse observes resident take their medications. 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 QAPI meeting with IDT and Medical Director for analysis, recommendation for continuation/discontinuation/revision of audits based on findings.	

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F0554 SS = E	Continued from page 13 follow the provider's policy. 6. Review of the provider's November 2025 Self-Administration of Medications policy revealed "The interdisciplinary team will complete an evaluation of the resident's cognitive, physical and visual ability to carry out this responsibility. The facility may require that drug be administered by the nurse until the care planning team has the opportunity to obtain information necessary to make a determination on resident's ability to complete the task." "Nursing is to get an order from the clinician for self-administration of medications." 7. Observation and interview on 6/16/26 at 8:47 a.m. in resident 43's room revealed that she had a tube of bacitracin (an antibiotic ointment), a bottle of nystatin powder (an antifungal powder), minoxidil hair spray (for hair growth), ciclopirox nail polish (an antifungal nail polish), and two saltshakers on her nightstand. Resident 43 stated that one of the saltshakers was filled with Gold Bond powder (used to absorb excess moisture) and the other saltshaker was filled with nystatin powder. She used the powders at least twice per day and they were easier to use in the saltshakers. She stated that the nursing staff would apply the nail polish for her every night. Review of resident 43's EMR revealed that she had a 4/10/26 BIMS assessment score of 15, meaning that her cognition was intact. She had a 10/14/25 self-administration of medication evaluation that revealed that she was allowed to self-administer the ciclopirox nail polish. The Gold Bond powder, nystatin powder, minoxidil hair spray, and bacitracin ointment were not listed on her self-administration evaluation. The end of her evaluation stated that resident 43 "stores them in her lockbox." Resident 43's 10/15/25 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) included a focus of "I have an order for self-medication administration" with interventions of "confirm and document the medications administered," "I will inform the nurse when I need the medication re-ordered," "medications will be stored in a lockbox in her room," and "medications will be removed from	F0554		

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

FORM APPROVED

OMB NO. 0938-0391

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F0554 SS = E	Continued from page 14 [resident 43]'s room if the order is discontinued by [the] physician." Resident 43's June 2026 electronic medication administration record (eMAR) revealed no documented administrations of the nystatin powder. The eMAR listed the Gold Bond as administered daily. There were no physicians' orders for the bacitracin ointment or the minoxidil hair spray. 8. Observation on 6/22/26 at 12:16 p.m. in resident 10's room revealed a fluticasone inhaler (a corticosteroid used for daily maintenance of lung problems like asthma) on his bedside table. Resident 10 was not in his room, and his roommate was sleeping on his bed. Review of resident 10's EMR revealed that he had a 6/9/26 BIMS assessment score of 15, meaning that his cognition was intact. He had a 1/14/26 self-administration of medication evaluation that revealed that he was allowed to self-administer the fluticasone inhaler once daily. Resident 10's 10/15/26 care plan included a focus of "I requested and was assessed as able to safely self-medicate and keep at the bedside in a lockbox." 9. Interview on 6/22/26 at 12:32 p.m. with registered nurse (RN) AA revealed that residents were not allowed to have medications at the bedside and he was not sure if any residents had lockboxes in their rooms to store medications. 10. Interview on 6/22/26 at 3:25 p.m. with regional nurse consultant C revealed that some residents were allowed to keep medications in their rooms if they were stored in a clear box with a combination lock. No medications were allowed to be kept at the bedside. She expected any non-nursing staff to alert nursing staff if they saw medications in a resident's room that were not locked up. 11. Review of the provider's November 2025 Self-Administration of Medications policy revealed that "if the resident is deemed capable to self-administer medications, then the drugs will be stored in a locked box in the resident's room." The nursing staff was expected to ask the resident if	F0554					

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F0554 SS = E	Continued from page 15 PRN (as needed) medications were taken as ordered by the physician and recorded on the eMAR at the end of each shift.	F0554		
F0600 SS = E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §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. §483.12(a) The facility must- §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), observation, interview, and record review, the provider failed to ensure one of one resident (56) was provided timely incontinence (involuntary urine or bowel leakage) care by one of one certified nurse aide (CNA) (KK). This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's 3/20/26 submitted SD DOH FRI final report revealed that on 3/20/26 at 2:45 p.m. at resident 56's medical appointment, it was identified that the resident's incontinence brief "was saturated." The appointment was not completed. CNA KK was responsible for resident 56's care that day. The resident required staff to check and change his incontinence brief. According to the SD DOH FRI, resident 56's incontinence brief was last checked at 8:00 a.m. by CNA KK, and the brief was dry. Former medical records coordinator LL transported	F0600	"Past Noncompliance - no plan of correction required"	

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F0600 SS = E	Continued from page 16 resident 56 to the above medical appointment. She asked CNA KK to check and change resident 56's incontinence brief before she transported him to his scheduled appointment that afternoon. CNA KK attempted to check resident 56's incontinence brief before the appointment, but he was eating lunch at the time, and the resident declined to be assisted. Instead, he wanted to wait to have his brief changed until after he had eaten. CNA KK did not return after he had eaten to change his brief before he was transported to his appointment that afternoon. Resident 56 was provided prompt incontinence care after he returned to the facility on 3/20/26. Camera footage on 3/20/26 was reviewed by the provider during their investigation, and the above incident was substantiated. 2. Review of resident 56's electronic medical record (EMR) revealed that the nursing staff completed a skin evaluation after the 3/20/26 incident each day after that for 72 hours. No skin concerns were identified related to the 3/20/26 incident. 3. Observation and interview on 6/16/26 at 1:30 p.m. with resident 56 revealed that his appearance was neat and clean. He was unable to recall the 3/20/26 incident. He reported no concerns with the care that was provided to him by the staff. 4. Interview and record review on 6/18/26 at 3:15 p.m. with regional nurse consultant (RNC) C revealed that the disciplinary action, interviews, and audits referenced in the provider's 3/20/26 submitted SD DOH FRI were completed and documented. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 6/18/26 after record review revealed the facility had followed their quality assurance process, and all residents CNA KK was assigned to on 3/20/26 were checked for incontinence issues, and incontinence care was provided as needed. CNA KK was terminated from employment on 3/21/26. Beginning on 3/20/26, all caregivers were educated regarding the provider's Abuse/Neglect policy and resident incontinence care and toileting expectations. Ten random residents were interviewed by the provider on 3/23/26 regarding other potential abuse or neglect concerns. Five random residents were observed each week for approximately six weeks to ensure their incontinence care needs were appropriately met.	F0600		

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F0600 SS = E	Continued from page 17 5. Based on the above information, non-compliance at F600 occurred on 3/20/26, and based on the provider's implemented corrective actions on 3/20/26, for the deficient practice confirmed on 6/18/26, the non-compliance is considered past non-compliance. B. Based on SD DOH FRI, observation, interview, and record review, the provider failed to ensure one of one resident (37) was provided timely incontinence care by one of one CNA (F). This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's 4/19/26 submitted SD DOH FRI final report revealed that before lunch on 4/19/26, CNA/registered medication aide (RMA) E transported resident 37 in her wheelchair to her room. CNA/RMA E observed at that time that resident 37 required assistance with incontinence care. The resident required the assistance of two staff caregivers to complete that care. CNA/RMA E was not able to assist resident 37 with that care because she was responsible for administering medications to the residents on the opposite hall (west hall). CNA/RMA E activated resident 37's call light. CNA/RMA E left the resident's room before the call light was answered. She presumed that CNA F, who was responsible for resident 37's care that day, would answer the call light and assist resident 37. At 6:30 p.m. on 4/19/26, CNA/RMA E and registered nurse (RN) D observed resident 37 in her room. The resident's pants were "saturated in urine." CNA/RMA E and RN D provided incontinence care. Resident 37 has severe cognitive impairment, and she was not able to provide any information to the staff regarding her incontinence care. RN D was not able to find CNA F after she and CNA/RMA E provided resident 37's incontinence care to discuss the incident. CNA F failed to respond to attempts by the provider to participate in the incident investigation. CNA F was suspended from working on 4/19/26 pending the outcome of the incident investigation and then terminated from employment. Resident	F0600			

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F0600 SS = E	Continued from page 18 neglect was substantiated by the provider based on their incident investigation. 2. Interview on 6/18/26 at 10:20 a.m. with CNA/RMA E regarding the 4/19/26 incident revealed that she confirmed the information in the above FRI. 3. Interview on 6/18/26 at 10:30 a.m. with CNA G revealed that on 4/19/26, she and CNA F were assigned to provide care to the east hall residents. The staff assignment sheet indicated that CNA F was assigned to resident 37's care that day. Both CNA F and CNA G were expected to communicate with each other throughout their work shift, so if a resident required the assistance of two staff for their ADL care, the second CNA could help. CNA G did not recall CNA F asking for her assistance to provide resident 37's incontinence care during their day shift together on 4/19/26. 4. Interview and record review on 6/18/26 at 3:15 p.m. with RNC C revealed that the disciplinary action, interviews, and audits referenced in the provider's 4/19/26 submitted SD DOH FRI were completed and documented. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 6/18/26 after record review revealed the facility had followed their quality assurance process and suspended, then terminated CNA F based on their investigation findings. Resident 37's skin was assessed by nursing staff on 4/19/26. No new skin findings related to the resident's lack of incontinence care on 4/19/26 were identified. Incontinence care audits were initiated the week of 4/16/26 and continued through the week of 5/9/26 to identify any potential systemic issues related to residents' incontinence care. 5. Based on the above information, non-compliance at F600 occurred on 4/19/26, and based on the provider's implemented corrective actions on 4/19/26, for the deficient practice confirmed on 4/19/26, the non-compliance is considered past non-compliance.	F0600		
F0658 SS = E	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-	F0658	"Past Noncompliance - no plan of correction required"	

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F0658 SS = E	Continued from page 19 (i) Meet professional standards of quality. 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 adhere to professional nursing standards of practice to ensure one of one resident's (99) pain medication was administered according to the physician's order by one of one licensed practical nurse (LPN) (H). This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's 5/4/26 SD DOH FRI revealed that during the provider's investigation of a separate, unsubstantiated neglect allegation that involved LPN H, a medication error was identified that occurred on 4/30/26. It was determined that LPN H administered an incorrect dose of pain medication to resident 99. The provider submitted a FRI regarding this incident to the SD DOH because LPN H alleged that insufficient staffing contributed to her making that medication error. 2. Review of resident 99's electronic medical record (EMR) revealed her admission date was 4/30/26 and her discharge date was 5/15/26. The resident's April 2026 medication administration record (MAR) included a physician's order for the resident to receive two hydrocodone-acetaminophen tablets (brand name/Norco, an opioid pain medication) every six hours as needed for pain. LPN H documented on 4/30/26 that she administered resident 99 two Norco tablets as ordered. Each day at the change-of-shifts, the oncoming and off-going nursing staff accounted for the quantity of resident 99's Norco because it was a controlled substance (a medication with a high potential for abuse and severe dependence). LPN H documented on resident 99's 4/30/26 Norco accounting sheet that she administered three Norco tablets to resident 99 and not the two Norco tablets that were prescribed by the resident's physician. During the provider's incident investigation, LPN H confirmed she administered three Norco tablets to resident 99.	F0658		

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F0658 SS = E	Continued from page 20 There was no documentation to support that resident 99 incurred any adverse consequences after she was administered the incorrect pain medication dose on 4/30/26. 3. Review of the provider's posted staffing information for 6/16/26 and 6/17/26 revealed that the staffing ratio aligned with the provider's Facility Assessment (an annual evaluation of the facility's resident population that identifies the needed resources to provide the care and services required by those residents) and facility census of 59 residents. 4. Interview on 6/16/26 at 4:40 p.m. with registered nurse (RN) T revealed that she verbalized no concern with sufficient nurse staffing. The provider maintained a monthly nurse on-call schedule that was posted at the nurses' station. For each day of the month, there was a manager's name and contact number listed. RN T stated that the schedule was referred to as needed for manager support in addressing issues such as staff call-outs. 5. Interview and record review on 6/17/26 at 1:45 p.m. with regional nurse consultant (RNC) C revealed that the disciplinary action, interviews, and audits referenced in the provider's 5/4/26 submitted SD DOH FRI were completed and documented. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 6/17/26 after record review revealed the facility had followed their quality assurance process and completed an audit to ensure the 5/8/26 staffing ratio was in alignment with the Facility Assessment. Completed random resident interviews to ensure that their care needs were being met by the staff. Completed audits to ensure medications are administered per the physician's order, according to the manufacturer's directions, and according to the six rights of medication administration. Completed an additional audit to ensure proper medication accounting, storage, and disposal practices are followed. LPN H's employment with the provider was terminated on 5/4/26 based on the facility's progressive disciplinary action procedure. Based on the above information, non-compliance at F658 occurred on 4/30/26, and based on the provider's implemented corrective actions on 5/4/26, for the deficient practice confirmed on 5/4/26, the non-compliance is considered past non-compliance.	F0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/22/2026
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F0658 SS = E	Continued from page 21 B. Based on SD DOH FRI review, record review, interview, and provider's protocol review, the provider failed to ensure that one of one RN (T) completed the required post-incident follow-up documentation in the EMR following a choking incident of one of one sampled resident (66). This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's 6/5/26 submitted SD DOH FRI regarding resident 66 revealed that on 6/2/26 resident 66 had aspirated (accidentally inhaling food, liquid, or saliva into the airway or lungs) during the lunch meal. She was served her prescribed mechanical soft diet (individual with chewing or swallowing difficulties) at the assisted dining table with staff supervision. Staff reported that resident 66 began coughing after taking a bite of food. She continued to cough experienced excessive mucus production and noted difficulties spitting out phlegm. Resident 66's provider was notified and the order was given to transport her out to the hospital. Resident 66's power of attorney (POA) was notified of the incident and the order to transport to the hospital, and they declined the hospital transfer. Resident 66 was placed on oxygen, received oral suctioning, and was able to clear the phlegm. She returned to her baseline on 6/2/26. Certified nursing assistant (CNA) U had checked on resident 66 on 6/5/26 at 6:00 p.m. and had found her unresponsive and reported it to RN T. Resident 66 was a do not resuscitate (DNR). The facility's investigation into the incident revealed that RN T was the RN assigned to resident 66 on the day of the incident and then on 6/4/26 and 6/5/26. She had checked resident 66 on 6/5/26 noting the resident appeared fatigued but was able to take her medications from RN T. RN T reported she did not enter any progress notes or assessment documentation into resident 66's EMR for the dates of 6/4/26 or 6/5/26. A review of camera footage identified that the staff obtained vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) of resident 66 multiple times on 6/4/26 and 6/5/26, but those assessments were not documented in her EMR. The facility determined that the staff had followed resident 66's care plan and diet order during the incident.	F0658		

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F0658 SS = E	Continued from page 22 Administrator A educated regional nurse consultant (RNC) C as she was the interim director of nursing (DON) at the time, on ensuring nursing staff were completing 72- hour post incident documentation. The facility educated the nursing leadership on ensuring that the follow-up documentation was occurring per facility protocol for 72-hour monitoring post event. Education was completed for the nurses on Post -Foreign-Body Airway Obstruction checklist, including the 72-hour monitoring. 2. Review of resident 66's EMR confirmed there was no 72-hour post incident documentation per facility's protocol to include the residents vitals on 6/4/26 and 6/5/26. 3. RN T was not available for an interview at time of the survey. 4. Interview on 6/22/26 at 11:29 a.m. with RNC C confirmed she had received education related to ensuring the nursing staff had completed the 72-hour post-incident documentation in the residents EMR. 5. Staff confirmed they received education regarding follow-up documentation per the provider's protocol for 72-hour monitoring post event, and education for nurses on Post Foreign-Body Airway Obstruction checklist, which included 72-hour monitoring. Record review confirmed that staff were educated about the follow-up documentation per the provider's protocol for 72-hour monitoring post-event, and education for Post Foreign-Body Airway Obstruction checklist. 6. Administrator A was not available for an interview at time of the survey. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed onsite on 6/22/26 after record review revealed the facility had followed their quality assurance (QAPI) process regarding 72-hour post incident documentation, education was provided to nursing staff regarding the follow-up documentation per facility protocol, and education on Post Foreign-Body Airway Obstruction checklist. Interviews revealed staff understood the education that was provided regarding those topics, and audits were implemented regarding the 72-hour post-incident documentation and will continue for two months.	F0658		

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F0658 SS = E	Continued from page 23 Based on the above information, non-compliance at F658 occurred on 6/2/26, and based on the provider's implemented corrective actions on 6/17/26, for the deficient practice confirmed on 6/17/26, the non-compliance is considered past non-compliance.	F0658		
F0880 SS = E	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, 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 §483.71 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:	F0880	1. Certified nursing assistant GG was educated on cleaning of equipment after use. Certified nursing assistants L, GG, U, and S were educated on how to use PPE and appropriate hand hygiene when donning and doffing. Certified nursing assistants FF and L were educated on maintaining clean resident personal hygiene items. PPE, including face shield placed in hopper room. A sign indicating how to use hopper with appropriate PPE in place. All residents have the potential to be affected by mechanical lifts not being cleaned between residents, staff not using appropriate hand hygiene during personal protective equipment (PPE) use, staff not understanding how to use PPE, and staff not maintaining clean resident personal hygiene items. An audit of all shared equipment was conducted to ensure disinfectant wipes are available on 7/8/2026. An audit of all rooms with PPE completed to ensure supplies are available on 7/16/2026. An audit of all whirlpool rooms completed to ensure personal hygiene supplies are labeled and kept separately on 7/13/2026. An audit of hopper rooms will be conducted to ensure PPE supplies are available for use by 7/16/2026 2. The DON or designee will educate all staff on Linen and Laundry Handling policy, Transmission Based Precautions policy, Hand Hygiene Policy, and Cleaning and Disinfection of Equipment Policy will occur no later than August 4, 2026. Those not at the education session will be educated prior to their first shift worked. 3. The DON or designee will conduct observational audits of 5 mechanical lift transfers to ensure disinfectant wipes are available on the lift, the lift is not visibly soiled, and the staff are cleaning/disinfecting lift after use weekly for 4 weeks then monthly for 2 months. The DON or designee will conduct observational audits of 10 staff members' PPE use including, hand hygiene, face shield use, donning and doffing per policy weekly for 4 weeks and then monthly for 2 months. Observations will include PPE use while using the hopper. The DON or designee will audit whirlpool tub rooms to ensure personal items are stored and labeled per	8/4/2026

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F0880 SS = E	Continued from page 24 (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 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 observations, interviews, and policy review, the provider failed to ensure one of five certified nurse aide (CNA) (GG) wiped down a mechanical lift after resident use with disinfectant, two of five CNAs (L and GG) performed hand hygiene after resident cares or before putting on personal protective equipment (PPE), three of five CNAs (U, L, and S) had access to and could state how to use PPE per facility policy, and two of five CNAs (FF and L) maintained clean resident personal hygiene items in two of two sampled whirlpool rooms. Findings include: 1. Observation on 6/16/26 at 9:45 a.m. in resident 17's room revealed CNA GG completed a full body lift (a mechanical lift and sling used to lift a person's full body) transfer to weigh resident 17. After the lift was completed, CNA GG moved the	F0880	policy, residents are not using previously opened donated bottles, facility provided soap is being utilized in appropriate containers, and all donated items from staff are sealed and labeled accordingly. Audits will be conducted 3 times weekly for 4 weeks and then weekly for 2 months. 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.	

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F0880 SS = E	Continued from page 25 mechanical lift to the hallway outside of resident 17's door. She did not perform hand hygiene (cleaning hands with alcohol-based hand sanitizer or washing with soap and water), then went into another resident's room. 2. Observation on 6/17/26 at 4:06 p.m. in the West hallway soiled laundry room revealed a hopper (a specialized sink flushing device used to rinse soiled items and linens of body fluids). There was a set of reusable rubber gloves sitting on the counter next to that hopper. No other personal protective equipment (PPE) was available in that room or signage for how to properly use that hopper. 3. Interview on 6/17/26 with certified nurse assistant (CNA) U revealed that the facility had two hoppers, one in each resident hallway. She stated that she had never used goggles or face protection while rinsing resident's soiled linens in the hopper before. 4. Interview on 6/17/26 at 1:34 p.m. with CNA FF in the whirlpool room revealed that the facility used stock products for bathing personal hygiene items like shampoo, conditioner, and body wash. Some residents had their own, and their name was written on the bottle with a marker. She stated that some of the travel staff would donate their old, opened containers of body products, and the residents were welcome to use those if they wanted to. CNA FF also stated that if a resident discharged or passed away and they left behind some personal hygiene items, the staff would bring them into the whirlpool room for other residents to use instead of throwing them away. 5. Observation and interview on 6/18/26 at 9:34 a.m. with CNA L in the East hallway soiled utility room revealed that the hoppers were used to rinse off the resident's linens if there was excessive stool or urine on those linens. They were expected to rinse the linens, spray them with a sanitizer spray, put them in a plastic bag, tie that bag at the top, and put it in the soiled laundry container. CNA L could not find the spray that they were expected to use in the room. She stated that most of the traveling staff just used a pair of gloves when the hopper was used, and she thought that everyone was supposed to wear a gown too. She was not sure whether any kind of face protection was expected to be used. Observation of CNA L after the interview revealed that she left the soiled utility room, applied PPE			F0880			

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F0880 SS = E	Continued from page 26 consisting of a gown and gloves, and went into another resident's room without performing hand hygiene. 6. Further interview on 6/22/26 at 12:18 p.m. with CNA L revealed that sometimes staff would offer to run to the store to pick up specific personal hygiene items to be used in the whirlpool rooms, and some of the products were donated. If those bottles of product belonged to a specific resident, then staff would label the bottles with a marker. The facility used Procure Complete Bath as the stock shampoo and body wash. She used a smaller bottle with a pump top for all of the residents who did not have specific hygiene products. When the bottle was empty, she rinsed it out "because it gets gross", then refilled it with the Procure Complete Bath. 7. Interview on 6/22/26 at 2:53 p.m. with CNA S revealed that the facility did offer a face mask for staff to use while rinsing soiled linens in the hopper, but she did not believe it was mandatory for staff to use face or eye protection. She thought that wearing a gown was mandatory. She stated that lifts were expected to be wiped down with sanitizer after each use. 8. Interview on 6/22/26 at 3:04 p.m. with regional nurse consultant (RNC) C revealed that staff were expected to perform hand hygiene before and after performing care for residents and using any PPE. She expected common use equipment, such as a mechanical lift, would be sanitized after every resident use. She expected staff to wear PPE, including a face shield, while performing duties that may splash, including rinsing linens in the hopper sink. She expected that the staff would use a new bottle of the stock Procure Complete Bath when the old one was out, that it would be cleaned between residents, and that no opened and unlabeled bottles would be used on residents during their baths. 9. Review of the provider's January 2026 Linen and Laundry Handling policy revealed that staff were expected to don (put on) goggles or a face shield, a mask, a gown, and gloves when there is a possibility of splashing or soiling their clothing. In the "protecting employees during [the] sorting process" section of the policy. "PPE including fluid-resistant gowns or aprons, gloves, and masks/face protection, and hand hygiene facilities shall be made available to personnel who sort laundry/work with	F0880		

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F0880 SS = E	Continued from page 27 soiled laundry. PPE should be worn when handling laundry."	F0880		
F0550 SS = D	10. Review of the provider's January 2026 Transmission Based Precautions policy revealed that common equipment items "should be adequately cleaned and/or disinfected immediately after use" and hand hygiene should be completed prior to the don and after the doff (take off) of PPE. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal	F0550	"Past Noncompliance - no plan of correction required"	

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F0550 SS = D	Continued from page 28 from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, and record review, the provider failed to ensure that one of one resident's (62) preference for incontinence care was observed by one of one certified nurse aide (CNA) (Y). This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's 6/12/26 submitted SD DOH FRI final report regarding resident 62 revealed that on 6/12/26 at 10:15 p.m., resident 62 advised CNA Z that she needed to use a bedpan to urinate in. Resident 62 stated that earlier that same evening, CNA Y refused to accommodate the resident's request to use a bedpan and was told by CNA Y to urinate in her incontinence brief instead. CNA Z provided resident 62 a bedpan to use per the resident's request. When CNA Z returned to resident 62's room a short time later to check on her, CNA Y was in the resident's room. Resident 62 identified CNA Y as the CNA who, earlier that same evening, denied the resident's request to use a bedpan. CNA Z completed resident 62's continence care. Outside of resident 62's room, CNA Z asked CNA Y about the above incident. CNA Y confirmed that she had not provided resident 62 a bedpan as the resident requested and stated, "she [resident 62] should wet her brief" instead. CNA Y was suspended on 6/12/26 pending an investigation of the incident. She was terminated from employment on 6/13/26. 2. Review of resident 62's electronic medical record (EMR) revealed that a Skin Evaluation was completed after the above incident occurred. The resident had no new skin concerns. Resident 62's care plan reflected her need for staff to provide a bedpan for her to use when she requested it "to preserve her dignity." 3. Interview on 6/17/26 at 2:30 p.m. with resident 62 revealed she voiced no concerns regarding her	F0550		

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F0550 SS = D	Continued from page 29 continence care. 4. Interview and record review on 6/22/26 at 3:15 p.m. with regional nurse consultant C revealed the disciplinary action, education, and interviews referenced in the provider's 6/12/26 submitted SD DOH FRI were completed and documented. 5. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 6/22/26 after record review revealed the facility had followed their quality assurance process and educated all caregivers regarding the expectation that all residents will receive necessary staff assistance to ensure their toileting needs are met. Residents are not expected to wet or soil their briefs if the resident has a preference for or uses a specific toileting method, such as a bedpan, urinal, or toilet chair. 6. Based on the above information, non-compliance at F550 occurred on 6/12/26, and based on the provider's implemented corrective actions on 6/12/26, for the deficient practice confirmed on 6/12/26, the non-compliance is considered past non-compliance.	F0550		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review,	F0688	1. An order was obtained for occupational therapy evaluations for hand contracture for Resident 37 on 6/25/2026 and Resident is currently being seen by occupational therapy for evaluation and treatment of contracture. Resident 37's care plan was updated to reflect current occupational therapy plan and goals. All residents are at risk and will be audited for contractures by DON or designee no later than August 4, 2026. Any resident identified with contractures will be referred to therapy for evaluation as indicated and a restorative plan developed and implemented. 2. The DON or designee will educate all nursing staff on what a contracture is, what to do if they notice a resident with a contracture, including, who to notify of concerns. Additional education will be provided to the restorative aide on program and process expectations for restorative rehabilitation. Education will occur no later than August 4, 2026. Those not at the education session will be educated prior to their first shift worked. 3. The DON or designee will conduct 5 observation audits of residents to determine if they have contractures, if the contracture has been evaluated by therapy and a restorative plan created weekly for 4 weeks then monthly for 2 months. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with IDT and	8/4/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/22/2026
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F0688 SS = D	Continued from page 30 the provider failed to ensure that services were provided to improve or maintain the range of motion for one of three sampled residents (37), who developed a contracture (a permanent tightening or shortening of muscles, tendons, skin, or other tissues that causes joints to become stiff) of her left hand while residing in the facility, did not receive therapy services in the past 12 months, a physician's order was in place for staff to follow regarding resident 37's brace management and use, and the care plan included goals and interventions to address resident 37's left-hand contracture and brace use. Findings include: 1. Observation on 6/17/26 at 2:57 p.m. of resident 37 in her room revealed she was awake in bed, nonverbal, but followed with her eyes and smiled. She partially extended her left arm from her side and reached out her hand. This surveyor gently shook her hand and explained why she was there. She was noted to have a left-hand contracture; no brace or washcloth roll was applied to her left hand. 2. Review of resident 37's electronic medical record (EMR) revealed she was admitted to the facility on 4/22/08. Her 4/2/26 Brief Interview for Mental Status (BIMS) assessment was not completed because she rarely understood others or made herself understood, and a staff interview was conducted, which indicated her cognition was severely impaired. Her diagnoses included moderate intellectual disability, unspecified pain, and left-hand contracture that developed while at the facility. Review of resident 37's current physician orders revealed that there were no active orders for her left-hand brace, including the management or use of the brace, to include wear schedule, cleaning, tolerance, and monitoring, and showed no physical, occupational, or restorative therapy treatment orders related to her range of motion and contracture of her left-hand and brace use. Review of resident 37's therapy records showed that resident 37's most recent therapy rehabilitation referral screening was conducted on 12/24/25, and her most recent restorative program evaluation was conducted on 1/25/23. The 12/24/25 referral documented that resident 37 was not appropriate for therapy intervention, as resident 37 had shown no change since her last therapy. Review of resident 37's June 2026 treatment	F0688	Medical Director for analysis, recommendation for continuation/discontinuation/revision of audits based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/22/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA ARROWHEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 ARROWHEAD DR , RAPID CITY, South Dakota, 57702	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0688 SS = D	Continued from page 31 administration record (TAR) revealed that daily documentation had been completed by nursing staff to clean and apply resident 37's left-hand brace each morning and remove the brace at bedtime. Review of resident 37's 4/2/26 Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) dated 4/2/26 showed that resident 37 was coded "0" for assistance with a brace or splint, indicating that resident 37 did not receive any restorative nursing brace assistance for at least 15 minutes a day during that 7-day look-back period. This did not match the revised care plan dated 3/19/26, which indicated "resident 37 has a palm protector brace that she wore on her left hand due to her hand contracture." Review of resident 37's revised 3/19/26 care plan showed that she wore a palm protector brace on her left hand due to her hand contracture; however, the care plan did not include goals and interventions to maintain her current range of motion or prevent further decline. The care plan did not include resident 37's brace use and management, including wear schedule, cleaning, brace tolerance, or monitoring, and did not include therapy involvement, range-of-motion interventions, skin monitoring, or positioning specific to resident 37's left-hand contracture and brace. The care plan did not reflect the need for a physician's order for brace use or a plan to monitor effectiveness. 3. Interview on 6/16/26 at 2:54 p.m. with physical therapist assistant (PTA) M revealed that there was no restorative program for residents at the facility, and she was unsure when the last active restorative program was in place. 4. Observation on 6/17/26 at 9:09 a.m. in resident 37's room revealed that staff had just completed her morning care. She was dressed and sitting in her wheelchair, and she did not have a brace on her left hand. 5. Interview on 6/18/26 at 10:45 a.m. with PTA N revealed that a restorative program for the facility was in progress, and training was being completed for a newly hired employee who will serve as the restorative aide. The facility and therapy departments hoped to start the restorative program the following week, after finalization. PTA N was unable to recall how long the facility had been without a restorative program for the residents and stated, "It has been quite a long time." She acknowledged that resident	F0688		

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

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/22/2026	
NAME OF PROVIDER OR SUPPLIER AVANTARA ARROWHEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 ARROWHEAD DR , RAPID CITY, South Dakota, 57702		
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F0688 SS = D	Continued from page 32 37 was not receiving physical or occupational therapy and did not know when she had last received those services. 6. Interview on 6/18/26 at 10:49 a.m. with interim director of nursing (IDON) O revealed that she had been at the facility since 6/8/26 and was assisting and coordinating with the therapy department to get the new restorative program up and running by the end of next week. She stated that she was made aware that the facility had no current restorative program when she started, but that a plan was in place. She acknowledged that resident 37 and other residents in the facility could benefit from the restorative program. She was unsure how long the facility had been without a restorative program for the residents. 7. Interview on 6/18/26 at 10:58 a.m. with assistant director of nursing (ADON) P. She revealed she had been employed at the facility since 1/6/26 and stated there had been no restorative program during her time there. She did not know when the facility last offered a restorative program for the residents. 8. Interview on 6/22/26 at 3:09 p.m. with occupational therapist (OT) R revealed that she worked as needed (PRN) in the facility's therapy department and was unsure about resident 37's current therapy service. She stated that she was unaware of resident 37's left-hand contracture, brace use, or management. 9. Observation on 6/22/26 at 3:10 p.m. of resident 37 in her room revealed that she was lying in bed looking at a book, and she did not have a brace on her left hand. 10. Interview on 6/22/26 at 3:28 p.m. with contracted certified nursing assistant (CNA) S revealed that she had been employed by the facility since 4/24/26 as PRN through a staffing agency. She stated, "It was not an everyday thing to apply the brace, but we are asked to apply it." She acknowledged that some nurses ask CNAs to apply resident 37's brace in the mornings and that resident 37 is encouraged to wear it and keep it on. Contracted CNA S said that resident 37 allowed staff to apply her brace in the mornings, but at times during the day she would remove it. Staff was to remove the brace at bedtime.	F0688			

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F0688 SS = D	Continued from page 33 11. Interview on 6/22/26 at 3:40 p.m. with physical therapist (PT) Q revealed that resident 37 was not currently on any therapy services with Physical, occupational, or restorative therapy services related to her left-hand contracture and brace use. She said that resident 37 last received speech therapy on 11/28/25, and that she could not find any current evaluation, plan, or order for physical, occupational, or restorative therapy services for resident 37 in the past 12 months. She acknowledged that resident 37 and other residents in the facility could benefit from a restorative program and was unsure why resident 37 had not been receiving therapy services for her left-hand contracture and brace use to maintain or improve mobility for so long. She stated that the referral and screening process for nurses was unclear and could be improved through better communication between the therapy department and facility leadership, along with clear procedural guidelines. 12. Interview on 6/22/26 at 4:06 p.m. with regional nurse consultant (RNC) C revealed that the facility was currently working on getting a restorative program implemented within the next week to ten days. She stated that a new employee had been hired and was being trained for the restorative aide position, and that the final plans were nearly complete between the therapy departments and leadership. RNC C was unsure when the facility last had a restorative program. She stated that the referral and screening process for therapy services, completed by the facility nurses, was an area needing improvement. She said that the facility identified areas of concern in March 2026 and began discussing them during its morning clinical meetings. She acknowledged that therapy referrals and screenings by the facility nurses had not been identified back in March 2026 as an identified area of concern and had not been addressed during the morning clinical meetings to date. RNC C acknowledged that resident 37 did not have a current physician's order in place for staff to follow regarding her left-hand brace, its management, and use. Resident 37 did not have therapy services provided in the past 12 months to provide range of motion with the contracture that developed while she resided in the facility, and her care plan did not include goals and interventions to address her	F0688		

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NAME OF PROVIDER OR SUPPLIER AVANTARA ARROWHEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 ARROWHEAD DR , RAPID CITY, South Dakota, 57702	
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F0688 SS = D	Continued from page 34 left-hand contracture and brace use. RNC C expected the facility to have all those areas in place for resident 37 to help maintain her range of motion and prevent an unnecessary decline 13. Interviews on 6/22/26 at 6:20 p.m. with CNAs K and L in the east hall revealed that neither CNA was aware that resident 37 had a brace for her left-hand contracture, nor were they aware that some staff were applying the brace in the mornings and removing it at bedtime. CNA K stated that she had been employed as PRN since 8/1/25 and had never seen a brace for resident 37, nor had she applied or removed a brace for her since she began working at the facility. CNA L said she has never seen resident 37 with a brace on her left hand and has never applied or removed one for her. 14. Unable to interview resident 37 due to her cognitive ability and being nonverbal. 15. Administrator A was unavailable for an interview during the survey. 16. The facility was unable to provide an updated therapy services policy, a brace-and-splint use policy, or a range-of-motion policy for review, as requested on 6/22/26 at 4:06 p.m.	F0688		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, policy review, and manufacturer's user guide review, the provider failed to ensure infection control practices were followed for the cleaning of a continuous positive airway pressure (CPAP) machine for one of one sampled resident (34). Findings included: 1.Observation and interview on 6/16/26 at 10:46	F0695	1.Resident 34's CPAP was cleaned on 6/16/2026. Orders for resident 34 were updated for clarification on 6/17/2026. All residents who use CPAP/BiPAP equipment are at risk for improper cleaning and storage of the equipment. An audit of all residents who have CPAPs was conducted by 7/16/2026 to ensure their CPAP is cleaned daily and appropriate filters in stock and orders to change are in place. 2.The DON or designee will educate all nursing staff regarding CPAP and BiPAP Cleaning policy. All licensed nurses will be educated on Following Physician Orders policy. Education will occur no later than August 4, 2026. Those not at the education session will be educated prior to their first shift worked. 3.The DON or designee will audit 5 residents on CPAP or BiPAP therapy weekly for cleaning and storage of equipment. The audits 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 QAPI meeting with IDT and Medical Director for analysis, recommendation for continuation/discontinuation/revision of audits based on findings.	8/4/2026

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NAME OF PROVIDER OR SUPPLIER AVANTARA ARROWHEAD				STREET ADDRESS, CITY, STATE, ZIP CODE 2500 ARROWHEAD DR , RAPID CITY, South Dakota, 57702			
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F0695 SS = D	Continued from page 35 a.m. of resident 34 in his room revealed there was a CPAP machine on top of his nightstand. The water chamber remained connected to the CPAP machine and contained water. After removing the water chamber, a dried white film was visible on the interior and exterior sides and the back area where the water chamber connects to the CPAP machine. The CPAP housing where the water chamber inserts into it had brown spots and dried white film on the bottom and a portion of the sides. The filter located at the back of the CPAP machine was dark brown. Resident 34 stated the staff were not cleaning the CPAP machine or water chamber daily or weekly. He also stated the staff had not changed the filter in the back of the CPAP. 2. Review of resident 34's electronic medical record (EMR) revealed he admitted to the facility on 3/6/26. His diagnosis was obstructive sleep apnea (where the throat muscles relax during sleep, blocking the airway and causing pauses in breathing). His Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated his cognition was moderately impaired. He had a 4/13/26 physician's order for, "CPAP: Clean CPAP tubing and water reservoir with warm and mild soap weekly and allow to dry everyday shift for CPAP cleaning" and a 4/14/26 physician's order for, "Clean CPAP weekly every evening shift every 7 day(s) for Apnea". The treatment administration record (TAR) showed staff had been documenting they had been cleaning the CPAP machine and water chamber daily and every seven days. 3. Interview on 6/16/26 at 3:45 p.m. with certified nursing assistant (CNA) W revealed she did not clean resident 34's CPAP machine. She stated she was the CNA that was responsible for getting resident 34 up in the mornings and believed night-shift staff were responsible for cleaning the CPAP machine. She agreed the CPAP machine and the water chamber did not appear clean. She was unaware there was a filter located at the back of the CPAP machine that needed to be cleaned. 4. Interviewed on 6/16/26 at 3:55 regional nurse consultant (RNC) C, revealed she agreed the CPAP machine and water chamber were not cleaned. She was unaware of the filter located at the back of the CPAP machine. Her expectation was for the staff to follow the provider's policy for CPAP machine			F0695			

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F0695 SS = D	Continued from page 36 cleaning and maintenance. 5. Review of the provider's revised January 2026 CPAP and BiPAP Cleaning policy revealed "After each use, the mask/reservoir will be wiped with warm soapy water per manufacturer's instructions, rinsed and placed upside down to dry on a paper towel/clean dry hand towel." "The machine should be wiped/cleaned with a disinfectant on at least a weekly basis and as needed." 6. Review of the manufacturer's user guide revealed "Daily: Empty the humidifier tub [water chamber] and wipe it thoroughly with a clean disposable cloth. Allow it to dry out of direct sunlight." "Weekly: Humidifier tub-in warm water using a mild dishwashing liquid."		F0695				

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E0000	Initial Comments 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 6/16/26. Avantara Arrowhead was found in compliance.	E0000			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Jessica Simon

TITLE

Administrator

(X6) DATE

7/16/2026

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

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435051		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 06/16/2026	
NAME OF PROVIDER OR SUPPLIER AVANTARA ARROWHEAD				STREET ADDRESS, CITY, STATE, ZIP CODE 2500 ARROWHEAD DR , RAPID CITY, South Dakota, 57702			
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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 6/16/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Arrowhead was found in compliance.			K0000			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jessica Simon</i>		TITLE Administrator	(X6) DATE 7/16/2026
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10668	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/22/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA ARROWHEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 ARROWHEAD DR RAPID CITY, SD 57702		
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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 on on 6/16/26 through 6/18/26, and on 6/22/26. Avanatara Arrowhead was found in compliance.	S 000		

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

Jessica Simon

TITLE

Administrator

(X6) DATE

7/16/2026