STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435051	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Arrowhead	2500 Arrowhead Dr Rapid City, SD 57702

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47416 Based on record review, interview, and policy review, the provider failed to ensure the physician and family had been notified for a change in condition for one of one sampled resident (1) following a laceration to her left leg. Findings include: 1. Review of resident 1's medical record revealed: *She had been admitted on [DATE]. *Her (Brief Interview for Mental Status (BIMS) was 11 which indicated her cognition was moderately impaired. *Her diagnoses included paroxysmal atrial fibrillation, abrasion left lower leg, secondary malignant neoplasm of bone marrow, acute kidney failure, malignant neoplasm of unspecified site of left female breast and congestive heart failure. * She received a skin tear to her left lower leg on 6/21/24. *The on-call care provider was notified of her left leg laceration and agreed it could be addressed in the facility. *Resident 1's son was informed of her left leg laceration and provider's recommendation. *A physician's notes on 6/21/24 stating Staff called Friday 6/21 10 p.m. Staff stated she had abrasion/skin tear to leg from catching it on wheel chair. Verbal order for steri-strips and bandage. Will monitor close. Staff agreed with plan. *A progress note on 06/22/24: Call from RN L on Sat 6/21 at 1 p.m. Nurse stated wound was bleeding and with blood thinners was weeping. She recommended she can do pressure dressing. Verbal order for pressure dressing to stop bleeding and monitor close. Discussion with nurse-she was on blood thinners. Pt has severe hx [history] of PAD [peripheral artery disease] and CAD [coronary artery disease]- medical discussion making considered and elected to not stop blood thinner due to PAD. Discussed with nurse to continue to monitor close and continue pressure dressing. If worse can consider sending to ED. Will f/u this week for eval. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	*A progress note on 06/22/24 at 14:24: Resident has skin tear to LLE [left lower extremity] that is bleeding. Skin has been approximated, putting pressure dressings on and change dressing when resident bleeds through the dressing. Dressing has been changed x2 [two times] so far. [NAME] notified and stated to keep putting pressure dressing on. *A wound note on 06/23/24 at 12:00 a.m.: This RN changed residents dressing on L calf. Bandage was saturated in blood. No steri-strips available at this time. *A wound note on 06/23/24 at 4:11 a.m.: This RN changed dressing on L calf. Bandage was saturated with blood. No steri-strips available at this time. *A wound note on 06/23/24 at 1:51 p.m.: Skin tear to LLE still bleeding but has lessened. This nurse has changed the dressing x2. There are blood clots present. Monitor. *A wound note on 06/24/24 at 4:29 a.m.: Resident dressing on L calf was saturated in blood, observed blood clots within the saturated bandage. Removed, cleaned the area gently and applied new sterile dressing. *A wound note on 06/24/24 at 8:33 a.m. Was notified at arrival to facility of wound to her left pretibial surface. Pictures obtained with size documented. Pressure bandage reapplied. Will do dressing change later this morning. Follow up on wound care orders. Patient expressed that she was not in pain. She is on Eliquis. *No wound care notated for residents left lower leg skin tear in treatment administration record (TAR). *She passed away on 6/24/24 at 10:45 a.m. 2. Interview on 0709/24 at 10:20 a.m. with certified nursing assistant (CNA) H revealed: *She was not working during the time resident 1 received the skin tear to her left leg. *She stated when residents have accidents CNAs know to let the nursing staff know and they will advise on what the next step is. *Staff had training monthly on how to deal with different issues that may arise. 3. Interview on 06/10/24 at 7:32 a.m. with CNA J regarding resident 1 revealed: *She was in resident 1's room assisting her roommate. *on 6/21/24 she saw resident 1 slipping out of her wheelchair, stopped her from falling, and assisted her to her bed. *She stated that resident 1 had cut her left lower leg on her wheelchair at which point she notified the nurse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	*She checked on resident 1 twice throughout the night between 8:00 p.m. and 5:00 a.m. on 6/22/24 and had to change dressing twice due to it being soaked. *She had to change resident 1's bedding before leaving due to the bedding being soaked in blood. 4. Interview on 06/10/24 at 10:00 a.m. with Licensed Practical Nurse (LPN) F revealed: *She did not work the weekend of resident 1's injury but had heard about it. *She stated that when a resident would have an injury the CNAs would inform the nurses who would then evaluate the injury and inform the provider, management and family if needed. *The nurse would measure skin tears and inform the wound nurse. *She would have pushed for resident 1 to be sent to the emergency room if she had seen the injury. 5. Interview on 06/10/24 at 10:53 a.m. with RN L revealed: *She was working the weekend that resident 1 cut her left lower leg on her wheelchair. *The resident's family, management, and physician's assistant (PA) K were notified of the injury. *PA K never mentioned taking resident 1 to the emergency department. *PA K advised there was not much to be done about the injury and to keep putting a pressure dressing on it. *She applied non-adherent ABD (abdominal) pads and Coban (self-adherent wrap) to the wound. *She changed resident 1's dressing four times from Friday 06/21/24 to Saturday 06/22/24 and twice from Saturday 06/22/24 to Sunday 06/23/24. *The bleeding had lessened on 06/23/24. *If the bleeding had not lessened, she would have called PA K back. *She would not have done anything differently and that there was not much you could have done for that skin tear. 6. Interview on 06/10/24 at 4:06 p.m. with RN M revealed: *She was working the weekend resident 1 cut her left lower leg on her wheelchair. *She was informed of resident 1's skin tear then called on-call provider PA K. *She was told by PA K that resident 1 did not need to go to the emergency department and was told to call her son. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	*On 06/22/24 the skin tear was still bleeding, and she did not have any steri-strips. *She called management who advised that the wound nurse would be in on Sunday 06/23/24 to look at the wound. She was not sure if the wound nurse came in that Sunday. *She called the provider again, but no one directed to send the resident out to the emergency department. *She did not think sutures, staples or going to the emergency department would have helped the resident. *She was upset that she did not have the right supplies to assist the resident. 7. Interview on 06/10/24 at 3:12 p.m. with CNA I revealed: *He worked the weekend resident 1 cut her left lower leg. *He was informed that she had a small abrasion on her left leg at the shift change meeting. *He stated when he checked on resident 1 the dressing was soaked through and there was a pool of blood in the resident's bed. *He notified RN L every hour that the dressing needed to be changed. *He asked RN L multiple times if resident 1 would be sent to the emergency department and did not get an answer from her. *When he came back to work on Sunday 06/23/24 resident 1's wound looked the same to him as it had on 06/22/24. * He watched the resident go from vibrant on 06/22/24 to pale and quiet on 06/23/24. 8. Interview on 06/10/24 at 1:51 p.m. with assistant director of nursing (ADON) D revealed: *She was the nurse on-call on the weekend resident 1 cut her left lower leg. *She stated she had made notes for this incident to keep her thoughts straight. *She provided a color picture of the wound and stated that the blood in the picture was moderate and called the wound an abrasion. *She stated that she did not believe anything was done incorrectly and she trusted her nurses. *She was never contacted about not having enough steri-strips for the wound. *She stated in hindsight the family could have been notified again and been asked to have made the decision to send to the emergency department or the provider could have been contacted to come and look at the wound. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	*She stated that the incident was not reported to the Department of Health (DOH) due to it not being an unknown injury and she did not think that it needed to be reported, even though it did not stop bleeding for three days. 9. Interview on 06/10/24 at 4:07 p.m. with Administrator A revealed: *She did not think anything had been done incorrectly. *She stated due to having advanced cancer she did not think sending the resident to the emergency department would have been beneficial. *She stated that in hindsight she would not have done anything differently. *She stated that she expected her staff to treat the resident, notify the provider and the family and to monitor the situation. 10. Review of provider's February 2024 Abuse and Neglect policy revealed: *Neglect -Neglect is the failure to provide necessary and adequate (medical, personal, or psychological) care. Neglect is the failure to are for a person in a manner, which would avoid harm and pain, or the failure to react to a situation which may be harmful. Staff may be aware or should have been aware of the service the resident requires but fails to provide that service. 11. Review of provider's June 2024 Wound Care Protocol by Wound Type revealed: *Cleanse with normal saline. -Reapproximate skin over wound when possible. -Xeroform or Vaseline gauze to skin tear. -Silicone border dressing, when possible ,otherwise ABD and roll gauze to secure dressing. -Change dressing every 3 days and as needed until resolved to keep dressing clean, dry, and intact. Do not remove to shower, cover to bathe. Do not soak. Change dressing if it becomes saturated with drainage, shower water or becomes compromised.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50015 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to assess, and implement preventative pressure injury interventions for one of one sampled resident (2) who was identified as at risk for pressure injuries and developed a pressure injury. Failure to assess and implement pressure injury prevention interventions potentially contributed to resident 2's development of a pressure injury. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. A review of facility reported event (FRI) for resident 2 revealed: *He admitted to facility on 6/5/24. *He was at risk for skin breakdown at admission. *He should have been turned and repositioned every two hours. *Only intervention in place at admit was heel lift boots for skin integrity. 2. A review of resident 2's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *He had diagnoses of: -Cerebral infarction (stroke). -Hypertensive emergency. -Acute respiratory failure. -Epilepsy (seizure disorder). -Spinal stenosis. *His 6/5/24 Braden scale (assessment for predicting pressure injury risk) score indicated he was at high risk for developing pressure ulcers. *His care plan dated 6/6/24 revealed: -He was to turn and reposition every two hours and as needed (PRN). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-He needed total staff assistance with activities of daily living (ADLS) including bed mobility, dressing, hygiene, and locomotion. -Staff were to use a full-body mechanical lift with the assistance of two staff. -Staff were to apply a moisture barrier product to his peri-area after incontinent episodes. *On 6/7/24 a request was made for a bariatric air mattress and wheelchair cushion for skin integrity as he cannot move independently. *On 6/9/24 his family and provider were notified he had a blister on his coccyx (tailbone). *On 6/9/24, the provider ordered a foam border dressing and barrier cream to be applied to his coccyx. *On 6/11/24 orders were received for: -Bariatric air mattress. -Pressure redistribution wheelchair cushion. -Wound care referral for new wound on coccyx -Reposition every two hours (was a verbal order). *On 6/13/24 his Braden scale score indicated his risk had increased to being at very high risk for developing pressure ulcers. *His weekly skin assessments dated 6/10/24, 6/17/24, and 6/24/24 were signed off as being completed, but were not completed. 3. Review of provider's wound report dated 5/1/24 to 7/9/24 revealed resident 2 had a Stage one Pressure/Ulceration wound to the right outer rim of his ear identified on 6/14/24. 4. Interview on 7/9/24 at 1:05 p.m. with Administrator A regarding weekly skin assessments revealed: *Resident 2's skin assessments 6/10/24 and 6/17/24 had not been completed, but were signed off as completed. *His skin assessment dated [DATE] was signed off, but the resident was admitted to the hospital on 6/18/24 and then discharged . *An audit was completed on 6/21/24 for wound/skin documentation and follow-up. 5. Interview on 7/9/24 at 1:12 p.m. with certified nursing assistant (CNA) G revealed: *Skin alterations were documented under the skin task in the EMR system. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*She would report those to the nurse. *Red skin would be observed and placed on the wound watch list. 6. Interview on 7/9/24 at 1:16 p.m. with licensed practical nurse (LPN) F revealed: *She would check skin notes first to see if something was documented. *A risk management report would be completed for all skin areas/concerns. *She would then contact the resident's family and provider. *Wound nurses would do rounds on Tuesdays. *Floor nurses were responsible for doing the weekly skin assessments on residents. *She would notify the on-call RN for management, of any immediate concerns/problems. 7. Interview on 7/9/24 at 1:28 p.m. with CNA H revealed: *Skin issues were reported to the charge nurse. *She documented them in the skin task in the EMR system. *Nurses assessed the area and took over from there. 8. Interview on 7/9/24 at 2:13 p.m. with assistant director of nursing (ADON) B revealed: *When resident 2 came to the facility she had just started her position. *There was a lesion/blister found on his coccyx over the weekend. *A silicone barrier was placed per standing orders. *On 6/11/24 on wound rounds she and ADON C had removed the old dressing. -Another blister under the adhesive had occurred. -When the dressing was removed the blister popped. -They cleaned the area and replaced the dressing. *She was unaware why every two-hour repositioning was not initiated per his care plan. *On-call was also notified of skin issues. *Weekly wound rounds are done every Tuesday. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*Management meeting's were on Wednesdays, and they discussed patients who were at risk for skin breakdown. 9. Interview on 7/10/24 at 12:36 p.m. with Minimum Data Set (MDS) coordinator E revealed: *She completed the care plans for all residents. *She opened the sections for completion by other disciplines. *The floor nurses completed the user-defined assessments on admission. *She put every two-hour repositioning for resident 2 in his care plan dated 6/6/24. *Based on diagnosis and history and physical data on admission. *ADON C would have put in the treatment administration record order for every two-hour repositioning. -She was unsure of the date of that order. 10. Follow-up interview on 7/10/24 at 12:43 p.m. with ADON C revealed: *She had entered the every two-hour repositioning order in resident 2's chart on 6/11/24 most likely due to observations during wound rounds. *She would have expected the nurse's to verify the repositioning was being completed by the CNA's. *MDS coordinator E would have put the task in the system for CNAs to complete the repositioning. 11. Follow-up interview on 7/10/24 at 12:58 p.m. with MDS coordinator E revealed: *She thought it was, a miscommunication on who was doing what. *For resident 2 It was not in the CNAs tasks (to reposition). *The order for nurses to sign off on the repositioning was initiated on 6/11/24. *She was no longer able to access any tasks for resident 2 because, he had discharged from the facility. 12. Interview on 7/10/24 at 4:02 p.m. with Administrator A revealed: *The standard of care would be something that should be followed, the task are just extra items for the CNA's and that would be that they checked on and reposition every two hours. 13. Review of providers Skin and Pressure Injury Prevention Program policy last reviewed on 3/23/23 revealed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*To ensure a resident who enters the facility without pressure injuries does not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable. *To provide care and services to prevent pressure injury development and to promote the healing of pressure injuries/wounds that are present. *A plan of care will be put in place for residents that are identified with actual skin breakdown or at-risk for skin breakdown. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 6/24/24 after: record review and staff interviews revealed the facility had followed their quality assurance process, education was provided to all nursing care staff regarding wound/skin documentation and follow-up, and staff were aware of the provider's procedure for assessing, monitoring, implementing interventions, and documentation of interventions provided to prevent the development of pressure injuries. Based on the above information, non-compliance at F686 occurred on 6/9/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 7/9/24, the non-compliance is considered past non-compliance.