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	08/06/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47780 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, and record review, the provider failed to ensure proper supervision for one of one sampled resident (1) who fell and received and injury when the resident was outside. Findings include: 1. Review of the SD DOH FRI revealed: *On 7/11/24 resident 1 walked outside and sat on a bench when a transportation staff member held the door open for him. *The transportation staff member had not notified any facility staff members. *Resident 1 had a fall while he was outside, which caused an abrasion on his forehead and his right knee. *Resident 1 was sent to the Emergency Department (ED). Review of resident 1's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *He had a Brief Interview for Mental Status (BIMS) of 9 which indicated moderate cognitive impairment. *His diagnoses included of cerebral aneurysm, fall 2/13/24, anxiety, vascular dementia, and major depressive disorder. Review of resident 1's 7/08/24 care plan revealed: *An initiated focus on 5/9/24, that indicated he had extensive care needs and required the support/services of the long-term care (LTC) setting. His stay was planned for long term. -The goal for this focus was that his care needs would be provided during his stay at the facility. (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The interventions for this goal included: Take me outside when the weather permits, but I may wonder off so stay with me. Interview on 8/6/24 at 12:30 p.m. with administrator A revealed: *She was unaware the above reviewed initiated focus on 5/9/24 was in resident 1's care plan. -The staff member who initiated the above reviewed focus was not at the facility. *Before resident 1 fell , she had been watching him sitting on the bench and stated when he was ready to come back inside, he would ring the bell at the front door and staff would let him in. -He was in her eyesight, as the bench was outside her window. *She said resident 1 was not an elopement risk. -His last elopement assessment was completed on 6/6/24, indicated he was not an elopement risk. Interview on 8/6/24 at 1:53 p.m. with certified nursing assistant (CNA) E revealed: *She had been employed with the facility since 5/5/23. *Resident 1 was to have someone with him when he was outside before he fell . -Even when he was seated on the bench, he was to have someone with him. -She stated he was a wanderer. *She stated resident 1 did not use an assisted device. *She had seen activities and resident 1 walk outside. Interview on 8/6/24 at 1:59 p.m. with restorative/activities director D revealed: *She had been employed with the facility since 11/3/21. *Resident 1 had been on a restorative program since 8/2/23. *One of the programs was to go outside and walk around the facility. *He was not safe to be outside by himself even before he fell . -She stated resident 1 would get tired easily. -He could get disoriented and possibly wander off. Interview on 8/6/24 at 3:00 p.m. with licensed practical nurse F revealed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She had been employed with the facility since 10/3/23. *Resident 1 should have had someone with him when he was outside even before he fell due to his wandering. *She stated even when he was seated on the bench, he should have someone with him. Interview on 8/6/24 at 3:20 p.m. with administrator A regarding the above interviews revealed she stated she was not going to disagree with her staff.