STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435051	A. Building B. Wing	03/05/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 40788 Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, interview, record review, observation, and job description review, the provider failed to ensure one of one certified nurse aide (CNA) (J) had followed CNA professional standards and scope of practice by having applied a dressing to one of one sampled resident's (2) newly discovered skin 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. Interview on 3/4/25 at 2:40 p.m. with doctor of nursing (DNP)/registered nurse (RN) B regarding the provider's FRI submitted to the SD DOH on 2/26/25 at 1:30 p.m. revealed: *While performing resident 2's personal cares on 2/20/25, CNA J observed resident 2 had a new skin injury on her buttock. -She described the size of that injury as quarter-size. *CNA J had notified unit manager/licensed practical nurse (LPN)/wound care nurse H and RN E of her observation. -RN E was responsible for resident 2's nursing care on 2/20/25. *After she was notified by CNA J of resident 2's new skin injury RN E failed to: -Complete and document an assessment of resident 2's new skin injury. -Notify resident 2's physician, obtain, and implement the physician's order for treatment of that skin injury. *CNA J had applied a dressing to the resident's buttock. -That task was outside of CNA J's scope of practice. Interview and FRI review on 3/4/25 at 3:00 p.m. with RN E revealed she: *Confirmed CNA J had notified her of resident 2's new skin injury on 2/20/25. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Was busy and failed to complete resident 2's skin assessment or notify the resident's physician of the new skin injury. *RN E had not directed CNA J to have applied a dressing to resident 2's buttock. -CNA J may have asked her for a dressing cover, but RN E did not know CNA J intended to apply it to resident 2's buttock. That was not a task CNA J was to perform as a CNA. CNA J was not available for an interview. Review of the provider's 5/20/22 Certified Nursing Assistant job description revealed: *The CNA was responsible for reporting to the Floor Nurse, Unit Manager, and Staffing Coordinator. *Essential Functions included: -5. Provides care that maintains each Guest's [resident] skin integrity to prevent pressure ulcers, skin tears and other damage by changing incontinent Guest, turning repositioning immobile Guests and by applying moisturizers to fragile skin and other areas. -Independently applying a dressing to a resident's skin injury was not included in those functions. The changes the provider implemented to ensure the above deficient practice did not reoccur were reviewed and confirmed on 3/5/25. Those changes were based on a Root Cause Analysis of the FRI and resulted in the development of multiple improvement plans. The plans and actions included staff interviews regarding their knowledge and understanding of the process and expectations after identification of new resident skin injuries, staff education and re-training related to the care and treatment of residents' skin, and staff-specific disciplinary action. Staff interviews confirmed those actions Based on the above information, non-compliance at F658 occurred on 2/20/25. Based on the provider's implemented corrective actions for the deficient practice confirmed on 3/5/25, the non-compliance is considered past non-compliance.

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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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40788 Based on record review, interview, South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, and policy review, the provider failed to ensure: *One of one registered nurse (RN) (F) had assessed one of one sampled resident (1) for irreversible signs of death after she was found unresponsive. *One of one RN (F) and one of one licensed practical nurse (LPN) (I) had documented one of one sampled resident's (1) change in medical status. These citations are considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of resident 1's closed electronic medical record (EMR) revealed: *She was admitted to the nursing home on [DATE]. Her [DATE] Brief Interview for Mental Status assessment score was 8, which indicated she was moderately cognitively impaired. *She was hospitalized on [DATE] through [DATE]. A pathological (abnormal changes in tissue structure that result from a disease process) lesion in her left proximal humerus (upper arm bone near the shoulder joint) with concerns for malignancy was identified. -Her other diagnoses had included: heart disease, anemia, COPD [a chronic lung disease], chronic peptic ulcer, depression, and alcohol abuse. *Her [DATE] Resuscitation Designation Order form was signed by resident 1 and her physician. It had identified her preference for full code resuscitation status. *Physician progress notes indicated: -On [DATE], a review of the resident's medications was completed. Her blood thinner medication was discontinued and changes to her pain medication (oxycodone) regimen were made. -The [DATE] physician's history and physical revealed there had been no new orders. -On [DATE], the physician had completed a pain recheck. Resident 1 reported the pain medication changes that had been started on [DATE] were helping. Interview on [DATE] at 8:15 a.m. with unlicensed medication aide (UMA) M revealed: *On [DATE] she was preparing medications in the hallway outside of resident 1's room when CNA L called her into the resident's room. -She found resident 1 unresponsive and ice cold to the touch. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*CNA L immediately notified RN F who was the charge nurse. *CMA M stated resident 1 had no carotid (arteries that carry blood to the head and neck) or radial (forearm) pulse. -The resident's arm was stiff and cold when CMA M manipulated it to check for a pulse. *RN F and LPN I had quickly responded to resident 1's room and CMA M had exited the room. *UMA M was not aware of any significant changes resident 1 had since she was admitted to the facility. *All [of the] management staff showed up that day ([DATE]) following the event. There was a de-briefing for all staff who had involvement with resident 1 that morning, and education was provided to all staff within a day or two of the event regarding resident code statuses, and the process for responding to a code [medical emergency]. Interview on [DATE] at 9:00 a.m. with LPN I revealed: *RN F was in resident 1's room when LPN I had entered the room on [DATE]. -LPN I was not sure what, if any, resident assessment he had completed before she had arrived. *When she touched resident 1's skin to take her radial pulse, it was cold and the resident's arm was stiff. -The resident's chest was not expanding which indicated she was not breathing. *She and RN F left resident 1's room. -RN F had gone to the nurses' station to verify the resident's code status and to make phone calls. *RN F had given her no directive to have done anything else at that time. *LPN I retrieved a stethoscope, returned to resident 1's room, and verified she had no heartbeat. -She had noticed the resident's lower extremities (beneath the knees) were mottled (blotchy skin discoloration that can occur due to reduced blood flow. It can be a sign of approaching death.) *LPN I exited the room and reported to the nurses' station. -She was informed by RN F that resident 1 was a full code. He had notified administrator A about resident 1's condition. Administrator A called RN F back and advised him CPR should be initiated for resident 1. *RN F remained at the nurses' station. Then LPN I had gotten help from the manager-on-duty, activities director/LPN N. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The crash cart (a wheeled cart that carried equipment for use in emergency resuscitations) was retrieved and brought to resident 1's room. *LPN I stated she didn't think it was right to perform CPR on resident 1 based on her earlier assessment of the resident. *Before any life-sustaining measures had been started, emergency medical services arrived and took over resident 1's care. *Members of management arrived soon after the event. They met with staff to discuss the event, answer staffs' questions regarding the event, and provided education to the staff. Interview on [DATE] at 9:20 a.m. with assistant director of nursing (ADON) C revealed: *She had been in the facility between 2:00 a.m. and 4:30 a.m. on [DATE] and was the on-call nurse. -She missed RN F's call to her at 8:40 a.m. that morning. *ADON C had assisted other management team members with the post-incident staff de-briefing, education, and investigation. *A review of camera footage revealed that at 10:00 p.m. on [DATE], RN G had administered resident 1 her medication. -During that medication pass, resident 1 had asked RN G to change the television station for her. Resident 1's mentation was at baseline and she had offered no concerns or complaints. Her call light was within reach when RN G had exited her room. *Two other caregivers had been in resident 1's room at 6:09 a.m. and 7:00 a.m. on [DATE]. One staff member checked the bathroom trash and the other staff member administered medications to resident 1's roommate. -Those staff had no interactions with resident 1 during those times. Interview on [DATE] at 10:45 a.m. with doctor of nursing practice (/DNP)/RN B revealed: *Administrator A had called her after talking with RN F on the morning of [DATE]. -Administrator A reported to DNP/RN B that resident 1 was found unresponsive, cold, and without a pulse. -RN F had not reported to administrator A if resident 1 had any signs of irreversible death (standards set forth by the American Heart Association and taught during CPR certification classes that included rigor mortis/postmortem rigidity [stiffening of the limbs] dependent lividity/postmortem lividity/rigor mortis [gravitational pooling of blood to lower dependent area causing red/purple coloration]). (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*If a full code resident had experienced an unwitnessed cardiac or respiratory arrest, CPR was not indicated in the presence of obvious clinical signs of irreversible death. Interviews on [DATE] at 11:40 a.m. and on [DATE] at 8:45 a.m. with administrator A revealed: *During RN F's call to her on [DATE], RN F had reported resident 1 was unresponsive and cold to the touch. She was a full code. -RN F's report to her had not indicated resident 1 had signs of irreversible death. *She called DNP/RN B and relayed RN F's above report to her. -Based on RN F not having reported any signs of irreversible death, CPR was indicated. *Administrator A called RN F back and advised that CPR should be initiated. Interview on [DATE] at 8:45 a.m. with administrator A, DNP/RN B, and regional administrator D regarding the facility's post-event investigation revealed: *Staff who had found resident 1 unresponsive were expected to have radioed a code blue to the resident's room number. -Hearing that code announcement should have prompted a crash cart to have been brought to the room. *RN F failed to: -Direct the code in his role as charge nurse that day. -Communicate to administrator A if his assessment of resident 1 was positive for signs of irreversible death. -Identify resident 1's code status promptly. Computer access was available outside of her room on UMA M's medication cart. RN F had walked to the nurses' station for that information instead. -Call 911 after he had identified resident 1's full code status (sometime between 8:30 a.m. and 8:40 a.m.) 911 was not called until 9:00 a.m. *LPN I failed to document any progress note in resident 1's EMR regarding the [DATE] event. *RN F's [DATE] progress note regarding the [DATE] event: At approximately 0830 (8:30 a.m.) [I] was called urgently to room [room number] for an unresponsive resident. Upon arrival found resident unresponsive and not breathing. She was cold to the touch. At 0900 [9:00 a.m.] cpr [cardiopulmonary resuscitation] was initiated and 911 called. Dr was notified at 0840 [8:40 a.m.]. Attempts to reach next of kin failed as the number listed was disconnected. I also attempted to call her case worker but there was no answer. Ambulance arrived shortly after 0900. Police were first on the scene. At this time we are awaiting for the police to conclude their investigation. CNA L and RN F were not available for interview. Review of the provider's [DATE] Death Documentation policy revealed: *There was a progress note template in the EMR called A deceased Note without CPR that was completed by nursing staff when that situation had occurred. -The RN/LPN should note the absence of vital signs and any other clinical signs of death, if present (i.e., lividity, rigor mortis, etc) on the structured progress note. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The changes the provider implemented to ensure the above deficient practice did not reoccur were reviewed and confirmed on [DATE]. Those changes were based on a Root Cause Analysis of the FRI and resulted in the development of multiple improvement plans. The plans and actions included a staff termination, staff disciplinary action, a review of the code statuses for all residents to ensure their accuracy, re-education for all licensed nurses, and all staff education and re-education regarding the provider's CPR Irreversible Death policy and a review of all resident code statuses. Education content and staff sign-in sheets were reviewed. Caregivers were also educated regarding running a code blue, code status identification, steps for a full code, and crash cart location/maintenance/documentation. Mock code drills had also been initiated. Staff interviews confirmed those actions. Based on the above information, non-compliance at F678 occurred on [DATE]. Based on the provider's implemented corrective actions for the deficient practice confirmed on [DATE], the non-compliance is considered past non-compliance.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 40788 Based on interview, record review, observation, South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, and policy review, the provider failed to ensure an assessment, physician notification, initiation of a skin treatment, and monitoring for one of one sampled resident's (2) newly discovered skin 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. Review of resident 2's electronic medical record (EMR) revealed: *Her admitted was 12/12/23 and her 2/21/25 Brief Interview for Mental Status (BIMS) assessment score was 0 which indicated she was severely cognitively impaired. *Her diagnoses included: hemiplegia, stroke, stage IV chronic kidney disease, diabetes, vascular dementia, and anxiety. She had a suprapubic catheter (tube inserted into the bladder to drain urine) related to acute cystitis (inflammation of the bladder). *She had a change in her medical condition on 2/17/25 and received intravenous (IV) fluids and an IV antibiotic for treatment of a urinary tract infection. *Her 2/7/25 Braden scale (pressure sore risk indicator) score was 18 which indicated she was at high risk for pressure ulcer development. *A 2/27/25 physician's progress note indicated: -Patient [resident] with progressive decline over the past several weeks, now with rapidly progressive ulcer to sacrum [bone at the base of the spine]. Reviewed picture on HUCU, [a type of electronic medical record] dark purple border, rapidly progressive over [the] past week and large necrotic appearing center. In context of poor oral intake, declination in health generally, this certainly appears to be a Kennedy ulcer [a type of skin breakdown that occurs in people who are nearing the end of their life. The cause is unknown but believed to be related to the physiological changes that occur during the dying process]. She is on comfort cares currently, DNH [do not hospitalize]. Review of resident 2's 3/4/25 physician's orders summary revealed: *She had received a twice daily liquid protein supplement ordered on 4/4/24. *A topical wound paste was applied to her buttocks once daily for excoriation and sequelae (a long term residual effect after an initial skin trauma has resolved) was ordered on 5/9/24. *She was laid down between meals to offload her buttocks, initiated on 5/9/24. *She had a pressure-relieving mattress for her bed, initiated on 8/22/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*Weekly skin assessments, initiated on 8/24/24. *Wound care instructions: Cleanse sacrum with NS [normal saline], pat dry, apply hydrogel to wound bed, cover with border foam. Change every other day and PRN [as needed] every day shift every 2 day(s) for wound care, ordered on 2/25/25. Review of resident 2's February 2025 weekly skin assessments revealed: *On 2/15/25: Redness to buttocks with treatment in place. *On 2/22/25: Area on both buttock[s] is still there. *On 2/24/25: A left buttock wound measurement was 5 cm (centimeters) by 5 cm. -That same wound had measured 8.70 cm X 8.30 cm on 2/25/25, and on 3/4/25 the wound had measured 8. 20 cm X 8.00 cm. Observations on 3/4/25 at 2:30 p.m. and again at 4:00 p.m. of resident 2 in her room revealed: *She was sleeping on her back in bed lying on top of a pressure-reducing mattress. *She was wearing protective heel boots. *There was a pressure-reducing cushion on her wheelchair seat. *She remained asleep in her bed, but she had been repositioned. Interview on 3/4/25 at 2:40 p.m. with doctor of nursing practice (DNP)/registered nurse (RN) B regarding the provider's FRI submitted to the SD DOH on 2/26/25 at 1:30 p.m. revealed: *While performing resident 2's personal cares on 2/20/25, certified nurse aide (CNA) J observed resident 2 had a new skin injury on her buttock. -She described the size of that injury as quarter-size. *CNA J had notified unit manager/licensed practical nurse (LPN)/wound care nurse H and RN E of the above observation. -RN E was responsible for resident 2's nursing care on 2/20/25. *After the above notification from CNA J, RN E failed to: -Complete and document an assessment of resident 2's new skin injury. -Notify resident 2's physician, obtain, and implement the physician's order for treatment of that skin injury. -Report to the oncoming shift that resident 2 had a new skin injury. *Resident 2's weekly skin assessment was completed on 2/22/25 by RN F. RN F failed to: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Document a measurement or a description of the new skin injury in his assessment. -Notify the resident's physician, obtain, and implement the physician's order for treatment of that skin injury. *During the evening/overnight shift on 2/22/25 through the morning of 2/23/25 it was reported to RN G that resident 2's buttock dressing was coming off. -She had not known resident 2 had a skin injury to her buttock. *She had completed a skin assessment and measured the skin injury as having been 5 cm (centimeters) by 5 cm. -RN G failed to initiate wound care standing orders (written protocol allowing certain healthcare staff to perform certain tasks without a specific order from a medical provider) for treatment of that skin injury until the resident's physician was able to be reached during regular business hours. *RN G had reported resident 2's skin injury to assistant director of nursing (ADON)/C the morning of 2/24/25. -ADON C and other management team members investigated and identified the root causes for the above process failures then developed and implemented corrective actions to mitigate the likelihood of them reoccurring. Interview on 3/4/25 at 3:00 p.m. with RN E revealed: *She stated she was busy and failed to complete a skin evaluation for resident 2 after it was reported to her by CNA J resident 2 had a new skin injury on her buttock. -She had not asked for assistance from another licensed nurse working that day to have ensured the skin assessment was completed. *RN E had worked on 2/21/25 and had not completed resident 2's skin assessment on that date. Telephone interview on 3/4/25 at 3:30 p.m. with physical therapist (PT)/certified wound therapist (CWT) K revealed: *He was employed by a company specializing in wound care that consulted with the nursing home on their residents' wound care. -He had reviewed the facility's residents who had skin wounds with unit manager/LPN/wound care nurse H on 3/4/25. *After reviewing documentation regarding resident 2's skin injury and observing that injury, he had concurred with the above 2/27/25 physician's progress note that resident 2's skin injury was appropriately classified as a Kennedy terminal ulcer based on its size, appearance, and the rapid development of that ulcer. -He felt the skin injury was unavoidable. The facility had identified resident 2 was at high risk for pressure ulcer development and had implemented appropriate preventative measures to mitigate her risk for pressure ulcer development. Resident 2's current treatment plan was appropriate. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 3/4/25 at 4:15 p.m. with unit manager/LPN/wound care nurse H revealed: *On 2/20/25, CNA J had reported resident 2's new skin injury to her. -She had directed CNA J to notify resident 2's nurse, RN E. *Unit manager/LPN/wound care nurse H confirmed RN E, RN F, and RN G failed to follow the facility's process for the management of resident 2's new skin injury. CNA J, RN F and RN G were not available to interview. Review of the provider's revised 9/11/24 Skin and Pressure Injury Prevention Program revealed: *Section 1: -5. A wound assessment will be completed: A) When a pressure injury is identified: This assessment will include, a) Site, stage, size, appearance of wound bed, undermining, depth, drainage, and status of peri-wound tissue; b) Treatment of the pressure injury, c) A review of the resident's current POC (plan of care) and medical status-any other possible risk factors, impaired healing due to diagnoses; d) Type of skin injury, and provide skin treatment orders. Reassess the wound at least weekly. The changes the provider implemented to ensure the above deficient practices did not reoccur was reviewed and confirmed on 3/5/25. Those changes were based on a Root Cause Analysis of the FRI and resulted in the development of multiple improvement plans. The plans and actions included resident interviews regarding staff compliance with their repositioning schedules, staff interviews regarding their knowledge and understanding of the process and expectations after identification of new resident skin injuries, staff education and re-training related to the care and treatment of residents' skin, audits of all residents' skin, and staff-specific disciplinary action. Staff interviews confirmed those actions. Based on the above information, non-compliance at F686 occurred on 2/22/25. Based on the provider's implemented corrective actions for the deficient practice confirmed on 3/5/25, the non-compliance is considered past non-compliance.