| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435051 | A. Building<br>B. Wing | 03/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avantara Arrowhead | 2500 Arrowhead Dr<br>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.

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47780<br><br>Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, observation, record review, and interview, the provider failed to protect the residents' right to be free from neglect by two of two certified nursing assistants (CNA) (C and D) who failed to provide prompt incontinence care for two of two sampled residents (1 and 2) with continence assistance needs. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented immediately following the incident. Findings include:<br><br>1. Review of the provider's SD DOH FRI submitted on 3/25/25 at 8:49 a.m. revealed:<br><br>*Residents 1 had stated CNA D failed to provide incontinence care during her day shift and he had reported it to the night CNA who changed his soiled brief.<br><br>*Resident 2 was found soiled by the night CNA and resident 2 stated CNA C failed to change her during her day shift.<br><br>*The provider reported it as an neglect by the two CNAs.<br><br>2. Observation and interview on 3/25/25 at 12:31 p.m. in resident 1's room revealed:<br><br>*He was sitting in his wheelchair.<br><br>*He stated he had a doctor's appointment later that afternoon and was waiting for his lunch.<br><br>*On Saturday 3/22/25, he was in bed, and around 11:00 a.m., he became incontinent and put on his call light for the CNA to assist him.<br><br>-He knew she was a CNA by the color of scrubs she wore but he was unsure who the CNA was.<br><br>*The CNA came in and turned the call light off and told him she would be right back.<br><br>*He stated she never came back.<br><br>*He put the call light on again, she again came in, turned the call light off and told him she would be back in a moment; and never returned.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | *He stated it was a night shift CNA, who came on shift after the other CNA left, who changed his wet and soiled brief.<br><br>3. Review of resident 1's electronic medical record (EMR) revealed:<br><br>*He was admitted on [DATE] and his diagnoses included pneumonia, chronic obstructive pulmonary disease (COPD), stable burst fracture of T5-T6 vertebra, and paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs).<br><br>*His Brief Interview for Mental Status (BIMS) assessment score was a 15, which indicated he was cognitively intact.<br><br>*A skin assessment completed on 3/15/25 at 4:14 a.m. indicated Resident has redness in groin area. Area cleansed, dried, and barrier cram applied.<br><br>*A skin assessment completed on 3/21/25 at 10:13 p.m. indicated resident has groin redness, skin is intact, barrier cream applied, resident refused feet and he was not compliant with my request completely, so i was unable to thoroughly inspect skin but did get a quick look over<br><br>*A skin assessment completed on 3/24/25 at 2:50 p.m. indicated groin, penis,left lower ab fold: very red and inflamed<br><br>*No further skin assessments completed to indicate further issues since the incident.<br><br>4. Observation on 3/26/25 at 10:25 a.m. in resident 2's room revealed:<br><br>*Her room was dark, and she was sleeping in her bed with a blanket over her.<br><br>*Her bedside table was placed next to her right side.<br><br>*Her call light was placed on her bed within her reach.<br><br>5. Review of resident 2's EMR revealed:<br><br>*She was admitted on [DATE] and her diagnoses included ataxic cerebral palsy (it affects balance, coordination, and depth perception), muscle weakness, depressive disorder, and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures).<br><br>*Her Brief Interview for Mental Status (BIMS) assessment score was a 10, which indicated she had moderate cognitive impairment.<br><br>*A skin assessment completed on 3/24/25 at 2:10 p.m. indicating Skin pink, warm, dry, intact except to R [right] upper buttock has polka dot type impression that measures 3 cm [centimeters] x 3 cm [centimeters], no redness noted to the area. No redness or open areas noted during assessment. Repositioned every 2 hours, barrier cream applied. NO other skin issues noted.<br><br>*No further skin assessments completed to indicate further issues since the incident.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 6. Interview on 3/26/25 at 10:39 a.m. with assistant director of nursing (ADON) B revealed:<br><br>*On 3/22/25 the night CNA reported to the night nurse that resident 1 had stated the CNA D had not changed his wet and soiled brief all day.<br><br>*On 3/23/25, CNA H reported to the night nurse that resident 2 was still in the same brief she had marked morning of 3/23/24 when she had worked.<br><br>*CNA H had reported that resident 2 was soaked in urine, and that she had offered the resident a bath.<br><br>*She stated that looking through the schedule it was CNA C that was on day shift of 3/23/25 when resident 2 stated she did not get prompt incontinence care.<br><br>*She had interviewed CNA D and she had stated she had provided resident 1 incontinence care before her shift ended at 6:00 p.m. on 3/22/25.<br><br>7. Interview on 3/26/25 at 11:54 a.m. with administrator A revealed:<br><br>*She stated that CNA C was an agency staff member and would not return to the facility, and CNA D was a facility employee and was suspended pending investigation.<br><br>The provider implemented actions to ensure the deficient practice does not recur was confirmed after record review revealed the facility had followed their quality assurance process, education was provided to all staff regarding abuse, neglect and the reporting time frame, staff and resident interviews revealed staff understood the education provided and residents' needs were being met. Audits had been initiated for resident satisfaction with staff response time to call lights. The provider is continuing their investigation to determine the need, if any, for further auditing and monitoring.<br><br>Based on the above information, non-compliance at F600 was determined on 3/22/25 and the provider's implemented 3/25/25 corrective actions for the deficient practice confirmed on 3/26/25, the non-compliance is considered past non-compliance. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47780<br><br>Based on South Dakota Department of Health (SD DOH) complaint review, record review, interview, and policy review, the provider failed to ensure one of one sampled severely cognitively impaired resident (3) who developed a skin rash had:<br><br>*Been provided adequate scheduled bathing.<br><br>*Physician's orders for prompt treatment of the resident's skin rash.<br><br>Findings include:<br><br>1. Review of the 3/19/25 SD DOH complaint intake form regarding resident 3 revealed:<br><br>*The complainant would like to remain anonymous.<br><br>*They had concerns regarding the care resident 3 was receiving at the facility.<br><br>-They stated resident 3 was not getting bathed as scheduled and staff had not been putting lotion on the resident's dry skin.<br><br>Review of resident 3's electronic medical record (EMR) revealed:<br><br>*He was admitted on [DATE], and his diagnoses included sepsis, urinary tract infection (UTI), chronic obstructive pulmonary disease (COPD), depression, dementia, and diabetes.<br><br>*His Brief Interview for Mental Status (BIMS) assessment score was 2, which indicated he was severely cognitively impaired.<br><br>*A progress note on 1/13/25 at 6:01 a.m., Resident has red scabby rash on LUE and has a 1x1 [one by one] cm [centimeter] scab on [his] face. Resident was picking at [a] scab and reopened it. Scant bleeding noted. No signs of infection, no other open areas noted. Area cleansed with soap and water. Resident tolerated well, no complaints of pain or discomfort to [the] area. Provider notified via fax. DON [director of nursing] notified via fax. Will pass on to day shift nurse to notify POA [power of attorney].<br><br>*A skin assessment on 1/20/25 at 4:52 a.m., Resident has numerous scabbing BUE [bilateral upper extremities/both arms], from [his] shoulders down to [his] hands, some or possibly all of which is due to resident scratching [those area]. Bilateral [both] hips have scratch marks, and [his] LLE [lower left extremity/legs] on upper thigh has a few abrasions. Skin protectant applied to all areas.<br><br>*A skin assessment on 1/27/25 at 3:56 a.m., Resident has scabs on upper arms and chest and back due to scratching and picking. No infections noted, open areas.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | *A progress note on 1/29/25 at 00:00, [midnight] [Resident 3] is a [resident's age] year old male who is seen today at the request of the nursing staff for A&D ointment. He has redness and discomfort in [his] groin area and skin folds. Verbal order was given on day of appt [appointment] for A&D ointment [to be] applied prn [as needed] to reddened, irritated skin prn.<br><br>*A skin assessment on 2/2/25 at 7:42 p.m. small, dry, faint red/brown scabs on [his] upper shoulders. bilateral [both] feet: dry and scant flaking noted. redness noted to bottoms of feet and interior right foot red by great toe. groin: no redness noted. abdominal fold: faint blue bruising noted to abdominal area from insulin injections.<br><br>*He was discharged to an assisted living center (ALC) on 2/3/25.<br><br>Review of resident 3's bath scheduled revealed:<br><br>*In December 2024, he received no baths from his admission on 12/13/25 through the end of the month.<br><br>*In January 2025, he received four baths.<br><br>-There was a two-week period between those four baths which he did not receive a bath.<br><br>*In February 2025, he received one bath before he was discharged on [DATE].<br><br>Interview on 3/26/25 at 9:37 a.m. with certified nursing assistant (CNA)/bath aide E revealed:<br><br>*She was unsure why resident 3 did not receive a bath in December 2024.<br><br>*She stated that when a resident admitted to the facility, the bath aides would write the resident's name on the bottom of the bath sheet, she had thought they forgot to add resident 3 to the bath sheet.<br><br>*She was unsure why he did not receive a bath for two weeks in January 2025.<br><br>*In January 2025, she remembered she had bathed him two times.<br><br>-She stated she had noticed the scabs from his scratching had worsened from the first time she bathed him to the last time she bathed him in January 2025.<br><br>Interview on 3/26/25 at 9:54 a.m. with agency CNA F revealed:<br><br>*She was assigned to care for resident 3's when he resided in the facility.<br><br>*She stated she had noticed the scabs on his skin from his scratching had worsened from the first time she had assisted him with morning ADLs [activities of daily living] to one of the last times she assisted him prior to his discharge.<br><br>Interview on 3/26/25 at 10:10 a.m. with licensed practical nurse (LPN) unit manager G revealed:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | *She stated a registered nurse (RN) resident 3 had a rash on 1/16/25.<br><br>*On 1/22/25, the RN asked the physician in HUCU (electronic communication system) for an anti-itch cream for resident 3.<br><br>-She stated the physician did not respond to the order request for the anti-itch cream.<br><br>*On 1/27/25, LPN/unit manager G requested an order for a topical ointment for resident 3 in HUCU.<br><br>*She stated that on 1/27/25, the physician's assistant (PA) had given a verbal order for the topical ointment for the resident's skin.<br><br>-The topical ointment was started on January 28, 2025.<br><br>-The TAR (treatment administration record) has shown it was documented in January 2025 and February 2025 that he was receiving those topical ointment treatments.<br><br>*She had been responsible for the residents' bath schedule since January 2025.<br><br>*She was unsure why resident 3 did not receive a bath for two weeks in January 2025.<br><br>*She stated that when a resident would refuse bathing, bath aides were to document the refusal in their charting.<br><br>Interview on 3/26/25 at 11:35 a.m. with administrator A revealed:<br><br>*She knew staff was had tried to get the topical ointment for resident 3.<br><br>*She was aware the bath schedule was an issue for getting resident bathed timely.<br><br>-They have discussed the bathing schedule in QAPI and have opened a PIP (performance improvement project) in January 2025.<br><br>Review of the provider's revised 9/11/24 Skin and Pressure Injury Prevention Program policy revealed:<br><br>General Guidelines<br><br>*5. The facility should have a system/procedure to ensure assessments are timely and accurately and changes in condition are recognized, evaluated and reported to the physician.<br><br>Review of the provider's reviewed 9/30/24 Bathing policy revealed:<br><br>Procedure<br><br>*-Document bathing activity or refusal of bathing activity. If resident refuses bathing, reapproach resident at a later time or offer another day to bathe the resident. |