| 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 | 06/18/2025 |

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

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|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to ensure the physician was notified that prescribed medication had not been given to one of one sampled resident (2).<br><br>Findings include:<br><br>1. Review of the provider's 5/13/25 SD DOH FRI revealed:<br><br>*Resident 2 had inappropriate contact with resident 3.<br><br>*As part of the investigation the facility staff reviewed resident 2's medication and was found that his monthly Depo-Provera [medication that may control sexually inappropriate behaviors] injections had not been administered for April 2025, and the medication was unavailable for his May 2025 dose.<br><br>2. Review of resident 2's electronic medical record (EMR) revealed:<br><br>*He was admitted on [DATE] and his diagnoses included intracranial (within the [NAME]) injury with loss of consciousness, hemiplegia and hemiparesis (weakness or parial paralysis) affecting the left side, dysphagia (difficulty speaking), dementia, depressive disorder, seizures, and traumatic brain injury.<br><br>*His Brief Interview for Mental Status (BIMS) assessment score was 9, which indicated he was moderately cognitively impaired.<br><br>*A discontinued 10/26/23 order date, indicated Depo-Provera intramuscular Suspension 150 MG/ML [milligram/milliliter] (Medroxyprogesterone Acetate (Contraceptive))<br><br>Directions: Inject 1ml intramuscularly at bedtime every 30 day (s) for neoplasm (an abnormal tissue growth that occurs when cells divide and grow more than normal) of uncertain behavior.<br><br>*A new order on 6/5/25 indicated Depo-Provera Intramuscular Suspension 150 MG/ML (Medroxyprogesterone Acetate (Contraceptive))<br><br>Directions: Inject 1 ml intramuscularly every day shift every 30 day (s) for neoplasm of uncertain behavior.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | *Review of resident 2's medication administration record (MAR) revealed they had not administered his monthly Depo-Provera injections for 10/20/24, 12/19/24, 2/17/24 and 4/18/25.<br><br>*A progress note on 5/18/25 at 10:51 p.m. indicated the Depo-Provera medication was not available<br><br>refill request sent.<br><br>*A progress note on 2/17/25 at 6:37 p.m. indicated the Depo-Provera<br><br>Medication [is] not available. Order sent to pharmacy.<br><br>*A progress note on 12/18/24 11:23 p.m. indicated the Depo-Provera Medication [is]not available. Order placed with pharmacy.<br><br>*A progress note on 10/20/24 at 10:28 p.m. indicated the Depo-Provera Medication is not available, ordered from pharmacy.<br><br>*There was no documentation of resident 2's Depo-Provera missed dose on 4/18/25.<br><br>*There was no documentation that the physician was notified that resident 2 had not received his Depo-Provera doses on 10/20/24, 12/19/24 and 2/17/25.<br><br>3. Review of resident 2's medication error report on 6/17/25 revealed:<br><br>*A medication error report was completed for 4/18/25 and 5/19/25, and indicated the physician was notified that the resident had not received those ordered monthly Depo-Provera injections.<br><br>*There was no medication error report completed to have notified the physician that resident 2 had not received his ordered monthly Depo-Provera doses on 10/20/24, 12/19/24 and 2/17/25.<br><br>4. Interview on 6/18/25 at 12:59 p.m. with director of nursing (DON) B revealed:<br><br>*They reviewed the progress notes daily and should have noticed the progress notes that indicated resident 2 had not received his ordered monthly Depo-Provera injections.<br><br>*She confirmed there was no documentation that the physician was notified that resident 2 had not received his ordered Depo-Provera injections on 10/20/24, 12/19/24 and 2/17/25.<br><br>5. Review of the provider's updated 9/30/24 Following Physician Orders policy revealed:<br><br>Procedure:<br><br>9. The physician should be notified when an order is not followed for any reason (omission, medication not in stock, resident refusals, etc). |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** A. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, and interview, the provider failed to protect the resident's right to be free from potential physical abuse by one of one certified nursing assistant (CNA) F while providing morning cares for one of one sampled resident (1).<br><br>Findings include:<br><br>1. Review of the provider's SD DOH FRI submitted on 6/14/25 at 10:45 a.m. revealed:<br><br>*Resident 1 informed CNA D that he had been mistreated by CNA F during his morning care routine.<br><br>*Resident 1 had told qualified medication aide (QMA) G that he had injured his ankle during a bed transfer, and reported a pain level six out of ten.<br><br>*Resident 1 received his scheduled Tylenol as well as PRN (as needed) hydrocodone for the ankle pain.<br><br>*LPN E conducted an assessment of the resident and noted skin abrasions on both the left and right shins of the resident.<br><br>*Resident had a bruise on his right eye from a previous fall.<br><br>*CNA F was suspended from working pending the outcome of the provider's investigation.<br><br>2. Review of resident 1's electronic medical record (EMR) revealed:<br><br>*He was admitted on [DATE], and his diagnoses included Parkinson's disease (disorder of the central nervous system), hypertension (high blood pressure), weakness, spinal stenosis (narrowing of the spaces within the spine), radiculopathy (pinching of the nerves), low back pain, and a history of falling.<br><br>*His Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated he was cognitively intact.<br><br>*A progress note on 6/10/25 at 5:57 p.m. indicated Resident has a small bruise to R [right] eye that is yellow and purple in color. Resident states it is from his previous fall. Resident usually wears his cap and wasn't wearing it at dinner this evening and staff noticed the bruise. Denies c/o [complains of] pain or discomfort. MD [doctor of medicine] notified, management notified, family notified.<br><br>*Skin evaluations completed on 6/3/25, 6/9/25, and 6/17/25, indicated no skin concerns.<br><br>*A skin alteration evaluation was completed on 6/10/25 at 6:30 p.m., indicating a facility-acquired Bruising length 1.0, width 1.0, depth 0, stage N/A [not applicable]. R eye.<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 - Some | *A handwritten note dated 6/14/25 from LPN E after the incident from CNA F indicated Bruise [to his] R [right] eye dark purple/blue and yellow Abrasion L [left] shin R [right] shin-abrasion c/o [complaint of] pain [in his] ankle joints L [left] wrist scab.<br><br>3. Review of CNA F's personnel file revealed:<br><br>*Her professional certifications or licenses were current, and her pre-employment background checks identified no areas of concern.<br><br>*She completed mechanical and total lift training, one-person assist transfer training, turning and repositioning of resident training, on 9/27/24.<br><br>*She completed abuse and neglect training on 3/27/25.<br><br>4. Interview on 6/18/25 at 3:07 p.m. with resident 1 revealed he stated:<br><br>*He had felt CNA F was upset with him.<br><br>*CNA F made him feel like he was not moving fast enough for her during his morning care routine on 6/14/25.<br><br>*He had injured his ankle when she was moving him in bed.<br><br>*He had injured his shins as she was transferring him out of his bed to his wheelchair.<br><br>*His ankle had not been hurting for the past couple of days.<br><br>5. Phone interview on 6/18/25 at 3:47 p.m. with CNA D regarding the 6/14/25 FRI involving resident 1 revealed she stated:<br><br>*Resident 1 had reported to her that CNA F was upset with him and was rough during his morning care routine that day.<br><br>*Resident 1 had mentioned to CNA D during his morning care, CNA F had bent his foot, which caused him discomfort to his ankle.<br><br>*She had informed administrator A about the resident's concerns.<br><br>6. Interview on 6/18/25 at 4:05 p.m. with QMA G regarding the 6/14/25 FRI involving resident 1 revealed:<br><br>*She noticed esident 1's voice was shaky and crackly that morning which was unlike him.<br><br>*He had informed her that his ankle was injured during his morning care routine on 6/14/25 with CNA F, and he reported that he had a pain level of six out of ten.<br><br>*Resident 1 had wanted something stronger than his regular scheduled Tylenol for his pain.<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 - Some | 7. Interview on 6/18/25 at 4:57 p.m. with administrator A regarding the 6/14/25 FRI for resident 1 revealed:<br><br>*She had gotten a call from CNA D who stated that resident 1 had reported to CNA D that CNA F had roughed him up during his morning care routine that day, and that his ankle was hurt in the process.<br><br>*Administrator A and social worker director (SSD) K interviewed resident 1 and he stated to them that CNA F had roughed him up during his morning care routine.<br><br>*Administrator A had interviewed CNA F who stated resident 1 was stiff that morning and in pain during his morning care routine. He had shouted out in pain, but he was fine once he was in his wheelchair.<br><br>*Administrator A had interviewed QMA G who reported resident 1 had mentioned CNA F had mistreated him and he had informed QMA G that his ankle was in pain after his morning care routine.<br><br>*Administrator A stated CNA F was suspended pending an investigation.<br><br>*Administrator A stated SSD K had completed resident interviews to determine if they feeling safe in the facility, they have not finished their final investigation yet to determine all education to be completed and audits to be completed.<br><br>B. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, and interview, the provider failed to protect the resident's right to be free from sexual abuse by one of one sampled resident (2) who made unsolicited sexual advances towards one of four sampled residents (3).<br><br>Findings include:<br><br>1. Review of the provider's 5/13/25 SD DOH FRI revealed:<br><br>*Registered nurse (RN) J reported to the assistant director of nursing (ADON) C that she had witnessed resident 2 with one of his hands inside the top of resident 3's shirt.<br><br>*Resident 2 was immediately put on 1:1 (one staff to one resident) supervision during the investigation.<br><br>*ADON C reviewed the camera footage, and it showed CNA I had brought resident 3 to the nurses' station, resident 2 then propelled his wheelchair towards resident 3 backed up his wheelchair which positioned him next to resident 3.<br><br>*Resident 2 was then seen on the camera footage attempting to lift resident 3's shirt when laundry aide H walked by, and he immediately removed his hand.<br><br>*After laundry aide H walked by, resident 2 slid the back of his hand into her V-neck shirt and placed it against her chest area, for approximately 20 seconds before RN J intervened.<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 - Some | *The facility reviewed resident 2's medication, and identified that his monthly Depo-Provera [medication which may control sexually inappropriate behaviors] injection had not been administered for April 2025, and the medication was unavailable for administration in May 2025.<br><br>*A medication review led to a recommendation to change resident 2's psychiatric medication, as the current medication may have contributed to an increase in the resident's sexual drive. That change was approved during his psychiatric appointment on 5/28/25.<br><br>*All staff members were educated on medication errors, and instructions were given that resident 2 should not be near female residents without direct supervision staff<br><br>*To prevent future issues, resident 2's Depo-Provera injections had now been scheduled to be administered during the day shift instead of at night to ensure better oversight of the administration.<br><br>2. Review of resident 2's electronic medical record (EMR) revealed:<br><br>*He was admitted on [DATE] and his diagnoses included intracranial (within the skull) injury with loss of consciousness, hemiplegia and hemiparesis (muslce weakness and partial paralysis) affecting the left side, dysphagia (difficulty speaking), dementia, depressive disorder, seizures, and traumatic brain injury.<br><br>*His Brief Interview for Mental Status (BIMS) assessment score was 9, which indicated he was moderately cognitively impaired.<br><br>*A discontinued 10/26/23 order date, indicated Depo-Provera intramuscular Suspension 150 MG/ML [milligram/milliliter] (Medroxyprogesterone Acetate (Contraceptive))<br><br>Directions: Inject 1ml intramuscularly at bedtime every 30 day (s) for neoplasm (an abnormal tissue growth that occurs when cells divide and grow more than normal) of uncertain behavior.<br><br>*A new 6/5/25 order date, indicated Depo-Provera Intramuscular Suspension 150 MG/ML (Medroxyprogesterone Acetate (Contraceptive))<br><br>Directions: Inject 1 ml intramuscularly every day shift every 30 day (s) for neoplasm of uncertain behavior.<br><br>*A progress note on 5/24/25 at 7:07 a.m. indicated Attempted to notify POA [power of attorney] of [resident 2] ([resident 2]'s POA @ 0633, resident 2's POA @ 0634 and [resident 3]'s POA @ 637) Action: no answer.<br><br>*A progress note on 5/24/25 at 3:07 p.m. indicated Contact was made with [resident 2's POA] to report [an] incident that occurred with female [a] resident. Action: n/a [not applicable] Response: Aware of investigation, no other concerns verbalized.<br><br>3. Interview on 6/18/25 at 1:16 p.m. with assistant director of nursing (ADON) C regarding the 5/13/25 FRI involving resident 2 revealed:<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 - Some | *She had received a call from RN J who informed her that resident 2 had made inappropriate sexual contact with resident 3.<br><br>*She reviewed the camera footage, and it was observed that CNA I had placed resident 3 near the nurses' station earlier that morning, approximately nine feet away from resident 2. Resident 2 was then seen moving in his wheelchair over to resident 3 and then backed up his wheelchair positioned next to resident 3.<br><br>*The camera footage showed that resident 2 attempted to reach into resident 3's shirt. At that moment, laundry aide H walked by, and resident 2 retracted his arm. After laundry aide H had walked by, resident 2 used the back of his left hand to reach into resident 3's V-neck shirt. His thumb was visibly sticking out of her shirt, and he appeared to rub his hand inside her shirt.<br><br>*The inappropriate contact lasted approximately twenty seconds before RN J intervened and immediately separated the residents. Resident 2 was placed on 1:1 supervision to ensure the safety of all the residents during the investigation.<br><br>4. Phone interview on 6/18/25 at 1:25 p.m. with RN J regarding the 5/13/25 FRI for resident 2 revealed she:<br><br>*Returned to the nurses' station after passing medications, and observed resident 2 with his hand inside resident 3's shirt.<br><br>*Immediately intervened and redirected resident 2 to the dining room.<br><br>*Stated resident 2 was placed on 1:1 supervision after that.<br><br>*Stated her shift had ended right after the incident, and she had reported the incident to the next nurse during the shift report.<br><br>5. Interview on 6/18/25 at 1:41 p.m. with director of nursing (DON) B regarding the 5/13/25 FRI involving resident 2 revealed:<br><br>*She stated resident 2 was placed on 1:1 supervision during the investigation of the incident<br><br>*During the medication review, it was discovered that resident 2's scheduled April and May 2025 monthly Depo-Provera injections were not administered.<br><br>*Following a consultation, the pharmacist and psychologist agreed to change one of his psychiatric medications.<br><br>*They had placed an additional dose of Depo-Provera injection in their electronic emergency kit (E-kit) to ensure the medication would be available in the facility.<br><br>*The administration team later confirmed that resident 2 had received a Depo-Provera injection later in May, and no further behavioral episodes or attempts to inappropriately touch other residents had been reported. As a result, the 1:1 supervision was discontinued.<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 - Some | *Resident 3 had a psychologist appointment and an integrated behavioral health appointment after the 5/13/25 incident and it was determinted resident 3 was back to her baseline.<br><br>*Staff was educated regarding resident 2 was not to be near any femal resident without direct supervision of staff.<br><br>*Audit after the 5/13/25 incident revealed another resident that received a 90-day Depo-Provera injection had not received his scheduled dose in May 2025 but later recieved the injection in June 2025. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, record review, and policy review, the provider failed to ensure medication was administered as ordered by the physician for two of two sampled residents (2 and 4). Findings include:<br><br>1. Review of the 3/21/25 SD DOH FRI revealed:<br><br>*49 capsules of 400 milligram (mg) Gabapentin (a non-narcotic medication used to treat pain) that should have been available to be administered to resident 4 were missing.<br><br>-The provider's investigation of the above missing medications revealed they were unable to identify when or how those capsules had gone missing.<br><br>*The FRI stated on 3/19/25 resident 4's 10:00 p.m. scheduled Gabapentin dose was not administered because it was not available to administer at that time.<br><br>-There was no indication on that FRI resident 4 had missed any other scheduled Gabapentin administrations related to the Gabapentin not being available to administer.<br><br>2. Interview on 6/16/25 at 3:30 p.m. with qualified medication aide (QMA) L regarding the medication reordering process revealed:<br><br>*A reorder sticker was affixed to each residents' medication card. The date on that sticker indicated the soonest that medication would be able to be refilled by pharmacy.<br><br>-That date was based on the amount of medication that was delivered when it was last filled and how much of that medication should remain available to be administered.<br><br>*Medications were reordered when a resident had seven doses or seven days of a medication that remained available to administer.<br><br>-The overflow medication cart (a medication cart used to store extra medication cards) was checked for any unused medication cards before a medication was reordered from the pharmacy.<br><br>*Medications were reordered through a resident's electronic medical record (EMR) in their medication administration record (MAR).<br><br>-The needed medication was selected and the reorder option button was clicked. That action sent an electronic communication to the pharmacy notifying them that a medication refill had been requested.<br><br>*The reorder sticker was removed from the medication card after a medication was reordered. That communicated to the other licensed nurses and QMAs that the medication had been reordered.<br><br>3. Interview on 6/16/25 at 3:35 p.m. with registered nurse (RN) M regarding medication delivery by the pharmacy revealed:<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | *The pharmacy had scheduled medication delivery times twice daily on weekdays and one time daily on Saturdays. There were no scheduled Sunday deliveries.<br><br>-The pharmacy had an on-call number to arrange for medication deliveries at times other than the scheduled delivery times, if needed.<br><br>*RN M stated if a medication was not available to administer from either the medication cart or the overflow medication cart, the medication may have been available to administer from the facility's Emergency Kit (E-Kit).<br><br>-The E-Kit was a secured electronic medication dispensing system that was located in the medication room. It was stocked with commonly used resident medications.<br><br>*RN M confirmed that both 100 mg and 400 mg capsules of Gabapentin were available for administration from the E-Kit.<br><br>4. Interview on 6/18/25 at 2:50 p.m. with director of nursing (DON) B and review of resident 4's March 2025 MAR, March 2025 medication administration progress notes, and the March 2025 pharmacy provider's manifest logs (a record that lists and describes the medication delivered to the facility) revealed:<br><br>*A 2/22/25 physician's order for resident 4's Gabapentin that indicated:<br><br>-one, 400 mg capsule was scheduled to have been administered three times each day (at 9:00 a.m., 2:00 p.m., and 10:00 p.m.) for his diagnosis of radiculopathy (a pinching of nerves which sometimes causes pain, weakness, and numbness).<br><br>*On 3/5/25, the manifest log indicated the pharmacy had delivered a 30-day supply of 400 mg Gabapentin for resident 4.<br><br>*On 3/17/25 and 3/19/25, staff had requested the pharmacy refill the resident's Gabapentin, but it was too soon to have been refilled based on the amount of Gabapentin that should have been available for administration at facility.<br><br>*On 3/19/25, the manifest log indicated there were ten, 100 mg Gabapentin capsules in the E-Kit.<br><br>-On that same day, four Gabapentin capsules had been removed and administered to resident 4 for his 2:00 p.m. scheduled 400 mg dose.<br><br>-Four Gabapentin capsules had also been removed on that day and administered to another resident.<br><br>*On 3/19/25, resident 4 was not administered his 10:00 p.m. Gabapentin dose. Medication not available[,] on order, med not in med box [E-Kit] according to the medication administration progress note.<br><br>*On 3/20/25, the resident was not administered his 9:00 a.m. Gabapentin dose. Medication not available according to the medication administration progress note.<br><br>(continued on next page) |

| 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 | 06/18/2025 |

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

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -DON B confirmed there was no documentation to support the pharmacy had been contacted about refilling the Gabapentin in the E-Kit so resident 4 could have been administered his 9:00 a.m.dose.<br><br>*On 3/20/25 at 12:52 p.m., ten, 100 mg Gabapentin capsules were delivered by the pharmacy and placed in the E-Kit for replacements.<br><br>-Those ten capsules remained in the E-Kit from the time they were delivered until 3/24/25.<br><br>*On 3/20/25, resident 4 was not administered his 2:00 p.m. and 10:00 p.m. doses of Gabapentin due to Medication not available according to the medication administration progress note.<br><br>-DON B confirmed Gabapentin was available in the E-Kit to administer the resident's 2:00 p.m. and 10:00 p. m. doses that day.<br><br>-Nursing staff and a QMA failed to check the E-Kit for the available Gabapentin. Those staff had assumed the medication was not delivered and was not available for administration.<br><br>*On 3/21/25, the resident was not administered his 9:00 a.m. dose of Gabapentin. Medication not available, spoke w/ [with] pharm [pharmacy], medication to be sent later today according to the medication administration progress note.<br><br>-DON B confirmed Gabapentin had remained available in the E-Kit to have administered resident 4's 9:00 a. m. dose that day.<br><br>-Nursing staff failed to check the E-Kit. They had assumed the medication was not delivered and was not available to for administration.<br><br>*On 3/21/25, the pharmacy manifest log had indicated 90, 400 mg Gabapentin capsules were delivered to the facility for resident 4.<br><br>-Resident 4's Gabapentin administration schedule resumed as ordered with his 3/21/25 2:00 p.m. dose that day.<br><br>*DON B confirmed the above missed medication administrations were medication errors.<br><br>5. Review of resident 4's March 2025 MAR revealed:<br><br>*He had an as-needed (PRN) order for acetaminophen 325, two tabs for pain.<br><br>-He was administered that medication periodically throughout the month.<br><br>-His reported pain levels prior to having been administered that PRN medication had varied.<br><br>*There was no apparent correlation between resident 4 having not been administered his scheduled Gabapentin and his need for PRN acetaminophen related to pain.<br><br>*Resident 4's May 2025 MAR and June 1, 2025 through June 17, 2025 MAR revealed no further missed Gabapentin medication administrations had been documented.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 6. Review of the 3/21/25 Medication Error Report related to the above medication errors revealed:<br><br>*Identified 3/19 [2025] that resident was out of gabapentin. Gabapentin available again 3/21 [2025].<br><br>-That Medication Error Report was completed and signed by DON B on 6/16/25.<br><br>7. Review of the provider's 5/13/25 SD DOH FRI revealed:<br><br>*Resident 2 had inappropriate contact with resident 3.<br><br>*As part of the investigation the facility staff reviewed resident 2's medication and it was found that his monthly Depo-Provera [medication that may control sexually inappropriate behaviors] injections had not been administered for April 2025, and the medication was unavailable for his May 2025 dose.<br><br>8. Review of resident 2's electronic medical record (EMR) revealed:<br><br>*He was admitted on [DATE] and his diagnoses included intracranial (within the skull) injury with loss of consciousness, hemiplegia and hemiparesis (muslce weakness and partial paralysis) affecting the left side, dysphagia (difficulty speaking), dementia, depressive disorder, seizures, and traumatic brain injury.<br><br>*His Brief Interview for Mental Status (BIMS) assessment score was 9, which indicated he was moderately cognitively impaired.<br><br>*A discontinued 10/26/23 order date, indicated Depo-Provera intramuscular Suspension 150 MG/ML [milligram/milliliter] (Medroxyprogesterone Acetate (Contraceptive))<br><br>Directions: Inject 1ml intramuscularly at bedtime every 30 day (s) for neoplasm (an abnormal tissue growth that occurs when cells divide and grow more than normal) of uncertain behavior.<br><br>*A new 6/5/25 order date, indicated Depo-Provera Intramuscular Suspension 150 MG/ML (Medroxyprogesterone Acetate (Contraceptive))<br><br>Directions: Inject 1 ml intramuscularly every day shift every 30 day (s) for neoplasm of uncertain behavior.<br><br>*A progress note on 5/18/25 at 10:51 p.m. indicated the Depo-Provera not available refill request sent.<br><br>*A progress note on 2/17/25 at 6:37 p.m. indicated the Depo-Provera Medication not available. Order sent to pharmacy.<br><br>*A progress note on 12/18/24 11:23 p.m. indicated the Depo-Provera Medication not available. Order placed with pharmacy.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | *A progress note on 10/20/24 at 10:28 p.m. indicated the Depo-Provera Medication is not available, ordered from pharmacy.<br><br>*There was no documentation of resident 2's Depo-Provera missed dose for 4/18/25.<br><br>9. Review of resident 2's medication error report on 6/17/25 revealed:<br><br>*A medication error report was completed for 4/18/25 and 5/19/25, which indicated the medication was not available on the date it was due and was not administered on 4/18/25. The medication was not available on the date it was due on 5/19/25 but was later administered on 5/24/25.<br><br>*There was no documentation that a medication error was completed report for resident 2's ordered monthly Depo-Provera injections that were not administered on 10/20/24, 12/19/24 and 2/17/25.<br><br>10. Review of resident 2's medication administration record (MAR) revealed he had not been administered his ordered monthly Depo-Provera injections on 10/20/24, 12/19/24, 2/17/25 and 4/18/25.<br><br>11. Interview on 6/18/25 at 8:01 a.m. with licensed practical nurse (LPN) E revealed:<br><br>*When a medicine suppy was running low, she would select the re-order button in the MAR system, which would order more from the pharmacy, as she was administering the current dose.<br><br>*She stated there was a medication re-order reminder option within the MAR that staff could use, and it could be customized for different hours depending on when the medication was expected to arrive from the pharmacy.<br><br>*She stated if there was a delay in receiving medication from the pharmacy, those medication orders could be put on hold and then resumed once the medication supply arrived from the pharmacy.<br><br>12. Interview on 6/18/25 at 11:36 a.m. with director of nursing (DON) B revealed:<br><br>*They reviewed the progress notes daily and should have noticed the progress notes regarding resident 2's monthly Depo-Provera injections that were not administered as ordered<br><br>*She confirmed there was no documentation that medication error reports were completed for Depo-Provera injections not administered as ordered on 10/20/24, 12/19/24 and 2/17/25.<br><br>*She confirmed staff could set re-order reminders within the MAR system for different hours if the same nurse would be working that next shift for consistency.<br><br>*She expected the staff who administered medications to report to the next shift when they had ordered residentsmedications from the pharmacy.<br><br>*She agreed that the staff did not follow their policy for medication errors.<br><br>Review of the provider's updated 2/20/24 Medication Errors policy revealed:<br><br>Policy:<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | To ensure medication errors are identified to prevent adverse resident effects. Errors will be documented, investigated, reported, and reviewed for need of interventions and to prevent recurrence.<br><br>Procedures<br><br>1. Each medication error discovered will be documented on the Medication Error Report form. The person discovering the error will complete Part 1 of the Form.<br><br>2. Each medication error will be reported to the resident's physician/designee and respond noted. Documentation of the notification will be completed on Part 2 of the Form by the person contacting the physician/designee. The family will also be notified, and documentation will show who was notified, date and time.<br><br>3. Part 3 of the Form will address how this error occurred and can be prevented in the future. This section will be completed by the nurse/medication aide most closely responsible for the error.<br><br>4. The Director of Nursing or designee will complete Part 4 of the Form which indicates the classification of the medication error and what steps have been taken to prevent a future error.<br><br>5. The entire Medication Error Report will then be reviewed by the DON or designee to determine any further steps needed such as counseling, suspension, DOH reporting, etc. The DON or designee will document actions on the Summary portion of the Form.<br><br>6. Medication errors will be reviewed by the Medical Director and Consultant Pharmacist. The review may be done via telephone, during routine visits or during QAPI [Quality Assurance and Performance Improvement] discussion.<br><br>7. The medication error will be entered into the Risk Management section of PCC [point click care] for trending and tracking purposes. |