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	11/06/2025

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 0689 Level of Harm - 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** Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) reviews, interviews, record review, and policy review, the provider failed to ensure the safety of three of eight sampled residents (1, 2, and 3) who had incidents of falls related to equipment use between 9/11/25 and 11/5/25. The manufacturer's instructions and policies for safe use of the resident care equipment had not been followed by the staff. Findings include: 1. Review of a 10/24/25 SD DOH FRI revealed that resident 1 had fallen out of a bath chair in the bathing room. The root cause identified for that fall was certified nurse aide (CNA) C failing to secure the bath chair's safety belt around the resident's waist while the resident was seated in that chair. After bathing the resident, CNA C moved the unsecured resident who was sitting in the bath chair out of the whirlpool bathtub. The resident leaned forward in the bath chair, causing her to fall forward out of the chair and onto the bathing room floor. Resident 1 was transported by emergency medical personnel to the emergency room (ER) for evaluation of her injuries that resulted from that fall. CNA C was suspended from employment during the FRI investigation and then terminated from employment after the investigation was completed for failing to use the bath chair's safety belt to secure resident 1 in the bath chair. 2. Review of CNA C's 10/31/25 witness statement regarding resident 1's 10/24/25 fall revealed: [Resident 1] was not seat belted in [the bath chair]. I was not aware we are suppose to seat belt her in. 3. Review of the provider's 10/21/25 clinical all staff meeting agenda revealed bath aides and certified nurse aides were educated on the following topics related to recent resident falls: *Equipment/device use: per manufacturer's instructions. *Buckle all buckles, strap all straps, hook all hooks. *Always ask questions if something is unclear, always use two people if indicated. Short cuts can hurt the resident as well as the staff member. CNA C had signed the education sign-in sheet confirming that she had received the above education on 10/21/25. That education was three days prior to resident 1's fall on 10/24/25. (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	4. Interview on 11/4/25 at 2:15 p.m. with registered nurse (RN) D and director of nursing (DON) B regarding resident 1's 10/24/25 fall revealed RN D stated that after CNA C was heard calling for help on 10/24/25 from the bathing room, RN D entered the bathing room and observed resident 1 face down on the floor with her head turned to one side. The amount of blood she observed and the resident's position on the floor made RN D suspect that resident 1 may have sustained a head injury after falling. Resident 1 was making no sound and was not responding. RN E was already in the bathing room when RN D arrived. RN D said that RN E had instructed her to retrieve the vital signs cart. Before RN D exited the bathing room to get the cart, RN D told RN E to stabilize resident 1's head and neck before she was turned onto her back. Resident 1 was on her back when RN D returned to the bathing room with the vitals cart. RN D observed a bleeding laceration on resident 1's forehead. RN D said she had told RN E to complete a neurological evaluation (assessment of nerve function, reflexes, coordination, motor skills, sensation, reflexes, and mental status) of resident 1 in addition to taking her vital signs. RN E then instructed RN D to bring a Hoyer lift (a mechanical lift and sling used to lift a person's full body) to the bathing room. With the uncertainty of the extent of resident 1's injuries, RN D thought the resident should have remained on the floor until emergency medical services (EMS) arrived, but since RN E was managing the accident, she followed RN E's instructions. 5. Telephone interview on 11/4/25 at 2:50 p.m. with RN E on speaker phone and DON B listening regarding resident 1's 10/24/25 fall revealed that upon arrival to the bathing room after the resident's fall, RN E observed resident 1 face down on the floor with her head turned to the side. RN E noticed blood on the floor near the resident's face. She had not known at that time where the blood was coming from. She had not suspected that resident 1 may have injured her head. When RN D entered the bathing room, RN E stated that she asked RN D if a neck brace or a backboard should be used to roll resident 1 onto her back. RN D reportedly told her to use a Hoyer lift to move the resident. After RN E and CNA C rolled resident 1, RN E observed the laceration on the resident's forehead, a bruise to the resident's shoulder, and the resident's nose was bleeding. RN E stated that she suspected resident 1 may have had a head injury at that time. She said RN D shined a light into resident 1's eyes (an evaluation used during a neurological assessment) to determine how or if the resident's eyes had reacted to the light. RN E said RN D conducted this evaluation in both the bathing room and later in the resident's room. RN E said that resident 1 was responding to simple questions and commands at that time. Resident 1 was lifted off the bathing room floor with a Hoyer lift to her wheelchair, then transported to her room until EMS arrived. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	6. Review of resident 1's electronic medical record (EMR) revealed a 10/24/25 emergency department After Visit Summary that indicated CT scans (non-invasive medical imaging procedure) of resident 1's head, chest, and back were negative for any acute abnormalities or fractures. A CT scan of her cervical spine (upper portion of the spinal column, consisting of the first seven bones located in her neck) showed C1 and C2 [the first two cervical vertebrae (bones), located at the base of the skull] cervical fractures. Resident 1 returned to the facility on [DATE] after her hospital evaluation. Her discharge instructions indicated she was to wear a neck collar for 12 weeks and follow up in the neurological trauma clinic in about three months with a repeat cervical spine CT scan. 7. Interviews on 11/4/25 at 3:00 p.m. and on 11/5/25 at 4:15 p.m. with DON B regarding resident 1's 10/24/25 fall revealed she agreed: There were significant discrepancies between RN D and RN E's versions of that fall that should have been, but were not, reconciled and followed up on. The above interviews and fall-related documentation failed to support whether resident 1 was appropriately repositioned onto her back by RN E and CNA C. She expected resident 1 to have been made as comfortable as possible by the nursing staff until EMS arrived and the resident should not have been moved out of the bathing room to mitigate the possibility of further injury. Resident 1's cervical fractures had likely occurred when she struck the bathing room floor during the fall, but those injuries could have been made worse by RN E and CNA C repositioning and then transferring the resident with the Hoyer lift into a wheelchair. A copy of resident 1's 10/24/25 neurological evaluation was requested from DON B on 11/4/25 at 3:00 p.m. On 11/5/25 at 4:15 p.m., DON B confirmed there was no documented neurological evaluation completed by nursing staff after resident 1's fall, but there should have been. Review of the provider's undated Fall Check List revealed: Do not move resident if major or life-threatening injury is suspected. Complete [a] neurological assessment (if fall was unwitnessed or [the resident] hit head). All assessment findings must be on paper neuros [neurological forms] and in PCC [Point, Click, Care]. (A type of electronic medical record). Complete [the paper neuros] end of shift. Review of the provider's January 2020 Neurological Evaluation policy revealed neurological evaluations were indicated c. following a fall or other accident/injury involving head trauma; Review of the provider's 2/20/24 Falls Management policy revealed: 7. Perform neurological checks (neuro-checks) per policy for any unwitnessed fall or any fall with evidence of injury to head. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	8. Review of a 10/24/25 SD DOH FRI revealed that resident 2 had fallen while he was being transferred in the provider's sit to stand lift (a mechanical lift to help people who have some strength but need assistance to get from a seated position to a standing position) by CNA G. The root cause of the fall was determined to be a failure by the staff to use the leg straps on the sit to stand lift during the resident's transfer. The report indicated that the resident let go of the hand bars while in the lift and slid to the floor. The resident reported hip and leg pain after the fall and was transferred to the hospital for evaluation. 9. Review of resident 2's EMR revealed that he had an x-ray (a noninvasive medical image to check for broken bones) at the hospital that did not show any fractures after the 10/24/25 fall from the sit to stand lift. His 12/30/24 care plan had a focus of I am at risk for falls with the intervention ensure proper use of [the] sit to stand lift. This intervention was resolved and updated on 10/24/25 to I use a total body mechanical lift transfer. 10. Review of the undated CNA G's sit to stand training education revealed that he was watched while performing a lift with the sit to stand mechanical lift. The answer no was checked on the section if sit to stand has straps, affix straps across legs. The action taken section of the training form stated that education was performed with CNA G to clip the leg strap in place with resident transfers in the sit to stand lift. 11. Review of the provider's 2/20/2024 Mechanical Lifts policy revealed staff was to lock the wheels on any device that will receive the patient. They were expected to keep all clips, latches, and hangar bars securely fastened during operation. 12. Interview on 11/5/25 at 11:58 a.m. with DON B revealed she would expect all staff to perform transfers and lifts with the safety straps on and according to the manufacturer's instructions. She had followed CNA G on his first shift working in the facility on 10/22/25 and confirmed that he performed lifts using the sit to stand lift correctly. 13. Review of a 9/12/2025 SD DOH FRI revealed that resident 3 had fallen out of the bath chair in his room on 9/10/25. CNA F had transported resident 3 from the bathing room to his room in the bath chair. She put the call bell on for assistance then left the resident's room to get a mechanical lift from the hallway. Resident 3 was on the floor in front of the bath chair when CNA F returned to his room. The facility investigation determined resident 3 likely leaned forward in the chair causing the fall. He did not have the bath chair seatbelt in place, or the wheels locked. 14. Interview on 11/5/2025 at 2:14 p.m. with CNA F regarding resident 3's fall from the bath chair on 9/10/25 revealed that she was aware that the seatbelt should have been secured in place and the breaks on the lift should have been locked while the resident was sitting in the chair for safety. She had taken the seatbelt off when dressing resident 3 and had not replaced it before she left the room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	15. Interview with assistant DON H revealed that a morning meeting was done Monday through Friday with members of the provider's leadership team. They discussed any new falls including the investigation, root cause, and new interventions that needed to be added to the resident's care plan. She agreed that the care plan for resident 3 was not updated after his 9/10/25 fall as she would have expected. 16. Review of resident 3's EMR revealed that he got a skin tear to the left side of his head when he fell from the bath chair on 9/10/25. Review of the provider's 2/20/2024 Mechanical Lifts policy revealed staff was to lock the wheels on any device that will receive the patient. They were expected to keep all clips, latches, and hangar bars securely fastened during operation. Review of the revised G 10-16-2020 [NAME] Bathing, Safe Operation and Maintenance Manual revealed 9. All residents must always be securely safety belted at the waist when using any of the [NAME] Lift Systems (page 7). Review of the provider's 12/1/19 CNA job description revealed that they were to follow established safety precautions when performing tasks and using equipment and supplies.