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	12/10/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interviews, and record review, the provider failed to ensure two of two registered nurses (RN) (D and E) had reported allegations of suspected abuse for two of two sampled residents (1 and 2). 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 the provider's SD DOH FRI submitted on 12/1/25 at 6:52 p.m. revealed that resident 1 had informed RN E that he had felt the care that was provided by agency-certified nursing assistant (CNA) K was rough. Resident 1 commented to his son, over the phone, about the care that was provided. Administrator A and social services director L had interviewed the resident, and he reported to them that he had pain with the care provided by agency CNA K. RN E had talked to agency CNA K and instructed her to be more careful with resident 1 during his care. Agency CNA K was blocked from picking up any shifts during the investigation. RN E was educated on the reporting of allegations of suspected abuse and neglect. For resident 1's pain control, his provider increased his Tylenol 500 mg to three times a day and increased his hydrocodone-acetaminophen 5-325 mg to twice a day and prn (as needed). 2. Review of resident 1's electronic medical record (EMR) revealed he was admitted on [DATE]. His diagnoses included Parkinson's disease (disorder of the central nervous system), hypertension (high blood pressure), spinal stenosis (narrowing of the spaces within the spine), radiculopathy (pinching of the nerves), low back pain, and a history of falling. His Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated he was moderately cognitively impaired. His care plan revealed he was dependent on bathing, dressing, personal hygiene, oral hygiene, bed mobility and transfers, initiated on 6/14/25.A skin evaluation was completed on 12/1/25 at 6:15 p.m., indicating left dorsal [back] hand dry skin, raised, left forearm dry skin, raised 1 cm [centimeter] x 0.8 cm, left lat [lateral] calf scabbing 2.3 cm x 0.3 cm, left lat shin scab [scabbing] 1cm x0.9, right mid [middle] lat shin yellow bruise 2.1 cm x 1.8 cm, right side nose scab 0.6 cm x 0.2 cm, right upper medial calf yellow bruise 1.3 cm x 1.3 cm. Additional Skin/Treatment Note: Bruising consistent with sit/stand lift when legs rub against shin guard on lift. Scabbing to BLE [bilateral lower extremity] (r/t [related to] scratching. Resident [1] states my skin is dry and itchy3. Interview on 12/9/25 at 4:27 p.m. with resident 1 revealed that he thought agency CNA K was angry and handled him roughly while turning him to his right side. Resident 1 stated that during the turn, he struck the inside of his right ankle against the wall. He said agency CNA K did not talk to him during the care.4. Review of agency CNA K's personnel file revealed her professional certifications or license were current, and her pre-employment background checks identified no areas of concern. She completed abuse and neglect training and resident rights on 3/25/25. She completed training for the turning and repositioning of residents on 11/25/25. 5. Interview on 12/10/25 at 2:06 p.m. with RN E regarding resident 1 revealed that she had gone into his room to give him his morning medication, and he responded to her with that woman. RN E was able to figure out that it was agency CNA K that he was referring to, and he informed her that she was rough during his care. RN E informed resident 1 that she would speak with agency CNA K, and he thanked her and returned to sleep. RN E said she approached agency CNA K regarding allegations of being rough during care with resident 1. Agency CNA K denied the allegations of being rough during care but agreed to go more slowly and be more careful with him during care. RN E confirmed that she did not report the allegations of suspected abuse, but acknowledged she should have reported to management about the suspected abuse towards resident 1. 6. Interview on 12/10/25 at 2:32 p.m. with administrator A revealed she had received a call from resident 1's son stating that resident 1 had commented to him that he was not happy about the care he received from a CNA. Administrator A and social worker director (SSD) L interviewed resident 1, and he stated the CNA seemed angry and was working too fast. Administrator A interviewed agency CNA K, and she denied the allegations of being rough during care. Agency CNA K was blocked from picking up any shift at the facility during the investigation, but has now been unblocked and will have education and training to be completed before her first shift back at the facility.The provider implemented actions to ensure the deficient practice would not recur was confirmed after record review revealed the facility had followed their quality assurance process, 1:1 education was provided to RN E for not reporting suspected abuse and review of the abuse and neglect policy. They had provided education to all the staff on reporting suspected abuse and reviewed the abuse and neglect policy. Resident interviews were conducted, and asked if they felt safe in the facility. Based on

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, and record review, the provider failed to ensure:*One of one agency certified nursing assistant (CNA) (O) followed the care plan regarding cares in pairs for one of one sampled resident (3).*One of one CNA (G) followed the care plan regarding the correct transfer device for one of one sampled resident (4), which resulted in a fall. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include:Review of the provider's SD DOH FRI submitted on 11/14/25 at 7:30 a.m. revealed that resident 3 indicated she was touched inappropriately by agency CNA O earlier that morning on 11/14/25. Assistant director of nursing (ADON) P assessed resident 3 following the allegation. Review of resident 3's care plan (personalized plan that addresses a resident's care needs, goals, and interventions) showed she was cares in pairs due to embellishing/fabricating stories. Resident 3 also has a pear emblem on her name plate to alert staff she was a cares in pairs resident. Resident 3's care sheet (a report of the resident's care needs and interventions) was reviewed, and it indicated she was cares in pairs (needs two staff members present). Immediately following the allegation agency CNA O was blocked from picking up future shifts at the facility. Staff were educated on cares in pairs procedures, and random audits were initiated to ensure compliance. The facility did not send resident 3 to the emergency department for a sexual assault evaluation; instead, a UA (urinalysis) was ordered and returned normal. A monitoring order was implemented to address resident 3's psychosocial needs. She was currently seen by a Mental Health Provider every two weeks. 2. Review of resident 3's electronic medical record (EMR) revealed she was admitted on [DATE]. Her diagnoses included ataxic cerebral palsy (affecting balance and coordination, causing unsteady, jerky movements, wide-legged walking, and difficulty with fine motor skills due to damage to the cerebellum), delusional disorder, major depressive disorder, and epilepsy (a brain disorder causing recurrent seizures). Her Brief Interview for Mental Status (BIMS) assessment score was 15, indicating she was cognitively intact. A skin evaluation progress note on 11/14/25 indicated, No concerns noted to any area. Physical exam completed with another CNA. Resident gave permission. Completed by Nurse supervisor/LPN N. Skin evaluations completed on 11/15/25, 11/22/25, 11/29/25, and 12/5/29 indicated no skin concerns. Review of resident 3's 12/2/25 care plan indicated she was cares in pairs. for oral care, toileting hygiene, transfer, bathing, personal hygiene, and bed mobility, which was initiated on 6/17/2025. 3. The care sheet dated 11/13/25 indicated resident 3 was cares in pairs. 4. Interview on 12/9/25 at 2:15 p.m. with resident 3 revealed that she stated agency CNA O had touched her on her bottom. Resident 3 stated that she was aware that agency CNA O would not be returning to the facility, and that she had felt safe in the facility since that night of the incident. 5. Review of agency CNA O's personnel file revealed his professional certifications or license were current, and his pre-employment background checks identified no areas of concern. He completed trainings on abuse and neglect on 4/2/25 and resident rights on 4/3/25. He completed proper repositioning training and Cares in Pairs training on 11/12/25. 6. Interview on 12/9/25 at 2:25 p.m. with DON C revealed she had seen resident 3 approximately two hours later, after the allegation was made, to obtain the urine specimen. She reported that she had not observed any bruising on resident 3, and the resident did not report any pain. 7. Interview on 12/9/25 at 3:35 p.m. with administrator A revealed she reviewed the camera footage from the night of 11/14/25. She observed agency CNA O working in the hallway and entering and exiting multiple resident rooms while providing care. Administrator A indicated that nothing unusual was noted on the footage and that agency CNA O did not spend any additional or unusual amount of time in resident 3's room. Administrator A confirmed that resident 3 was cares with pairs and agency CNA O should have had another staff member present when providing cares for resident 3. 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, audits were started to monitor her cares with pairs and updated her care plan to reflect the audits. A monitoring order has been put in place for resident 3 for psychosocial issues. Staff and residents were interviewed and asked if they had any issues and if they felt safe. Education was provided to all staff on cares with pairs. and education will be continued with all staff on how to follow a resident's care plan and care sheets.Based on the above information, non-compliance at F684 was determined to occur on 11/14/25, and the provider implemented 12/1/25 corrective actions for the deficient practice confirmed on 12/9/25; the non-compliance is considered past

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the South Dakota Department of Health (SD DOH) facility-reported incident (FRI), complaint intake form, interview, record review, and policy review, the provider failed to ensure adequate pain management for one of one sampled resident (5) who consistently voiced concerns regarding unmanaged pain and the lack of staff response to her request for pain medication. 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 the provider's SD DOH FRI submitted on 11/21/25 revealed that resident 5 reported staff members had not assisted her throughout their shift. Resident 5 stated licensed practical nurse (LPN) F refused to assist her with her needs. Resident 5 stated she had long call light wait times. CNA H reported that resident 5's main request was for pain medication, and was upset the staff had not answered her call light immediately. LPN F informed the CNAs to use pairs with care with resident 5 due to her behaviors. Resident 5 continued to be aggressive and have escalated behaviors, and LPN F informed staff to steer clear of resident. LPN F was suspended pending investigation due to inaccurate and subjective charting and not following up on resident concerns. Resident left AMA (against medical advice) on 11/21/25. Other residents were interviewed and asked if they felt safe in the facility, and education was started with LPN F on inaccurate and subjective charting and instructing staff to stop giving care to a resident. 2. Review of the SD DOH complaint intake form revealed that resident 5 stated she did not remain at the facility for 24 hours. She went to the facility for care related to a C2 neck fracture. Resident 5 reported she had not received any pain medications because the medication dispensing machine was not functioning. Resident 5 stated LPN F was outside for more than an hour assisting with someone's car. 3. Review of resident 5's electronic medical record (EMR) revealed she was admitted on [DATE]. Her diagnoses included fracture of C2 vertebra, alcohol abuse, depression, anxiety disorder, insomnia (a common sleep disorder marked by persistent difficulty falling asleep, staying asleep, or getting quality rest, leading to daytime fatigue, irritability, poor concentration, and mood issues), and chronic pain syndrome. A progress note dated 11/20/25 at 3:27 p.m. indicated, At approx. [approximately] 1430 resident arrived to [the] facility via facility transportation in wheelchair from [local hospital]. A&O [alert and orientate] x3, able to make needs known. [Resident 5 was] X2 assist from wheelchair to bed. In stable condition. Has c/o [complaints of] pain and discomfort. Awaiting Rx [prescription] to be sent to pharmacy to get prn [as needed] pain medication from e-kit [emergency kit]. Does yell out ow ow ow when attempting to reposition. When asking what wrong or what pain is she is having, just continue to yell louder.A progress note dated 11/21/25 at 5:45 a.m. indicated, Resident has been rude as well as verbally abusive to all staff tonight, at one point she was yelling from her room after quiet time, we were able to hear her at [the] nurses station. Numerous attempts have been made to accommodate resident [5] even while being verbally battered and threatened by her. Staff has continued to assist or respond to resident in pairs at a minimum, resident [5] just called down to nurses station and this nurse [LPN F] answered, the conversation began with resident [5] raising her voice and threatening me of loosing [losing] my job I asked resident [5] what it is she needed from me and she responded with unclear answers and continued to assume me of doing something wrong yet never did tell me what it was that I have done to upset her. Resident [5] did state she has been waiting for 6 hours. The CNA [H] just reported to this nurse [LPN F] that resident [5] has now taken her neck brace off. I did advice the aide to leave resident [5] to herself at this point, we have been unable to accommodate her, this nurse believes it to be in the best interest of staff currently working to steer clear of resident [5] for safety of all, resident [5] continues to threaten staff.A progress note dated 11/21/25 at 8:46 a.m. indicated, spoke with pharmacy re:[regarding] oxycodone and lyrica, states just received script and will get it sent to facility on this date. This writer [nurse supervisor/LPN N] asks for medications to be stat delivery. Pharmacist states understanding. Pharmacist entered code in e-kit for staff to pull x1 oxycodone 5mg [milligrams] to administer to resident. This writer pulled oxycodone 5mg from e-kit and gave it to the floor nurse for administration.A progress note dated 11/21/25 at 9:00 a.m. indicated, oxycodone HCl oral Tablet 5Mg Give 1 tablet by mouth every 4 hours as needed for pain for 3 days.A progress note dated 11/21/25 at 1:32 p.m. indicated discharge summary, SSD [social services director [L] met with resident this morning after being told by the floor nurse that resident [5] was requesting to leave AMA. SSD [L] spoke to resident [5] and she would not go into detail or explain why she wanted to leave but was still wanting help packing and preparing to leave AMA. Resident [5] was educated by SSD [L]