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	06/22/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, and record review, the provider failed to ensure that one of one resident's (62) preference for incontinence care was observed by one of one certified nurse aide (CNA) (Y).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 6/12/26 submitted SD DOH FRI final report regarding resident 62 revealed that on 6/12/26 at 10:15 p.m., resident 62 advised CNA Z that she needed to use a bedpan to urinate in. Resident 62 stated that earlier that same evening, CNA Y refused to accommodate the resident's request to use a bedpan and was told by CNA Y to urinate in her incontinence brief instead.CNA Z provided resident 62 a bedpan to use per the resident's request. When CNA Z returned to resident 62's room a short time later to check on her, CNA Y was in the resident's room. Resident 62 identified CNA Y as the CNA who, earlier that same evening, denied the resident's request to use a bedpan. CNA Z completed resident 62's continence care. Outside of resident 62's room, CNA Z asked CNA Y about the above incident. CNA Y confirmed that she had not provided resident 62 a bedpan as the resident requested and stated, she [resident 62] should wet her brief instead.CNA Y was suspended on 6/12/26 pending an investigation of the incident. She was terminated from employment on 6/13/26. 2. Review of resident 62's electronic medical record (EMR) revealed that a Skin Evaluation was completed after the above incident occurred. The resident had no new skin concerns. Resident 62's care plan reflected her need for staff to provide a bedpan for her to use when she requested it to preserve her dignity.3. Interview on 6/17/26 at 2:30 p.m. with resident 62 revealed she voiced no concerns regarding her continence care. 4. Interview and record review on 6/22/26 at 3:15 p.m. with regional nurse consultant C revealed the disciplinary action, education, and interviews referenced in the provider's 6/12/26 submitted SD DOH FRI were completed and documented. 5. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 6/22/26 after record review revealed the facility had followed their quality assurance process and educated all caregivers regarding the expectation that all residents will receive necessary staff assistance to ensure their toileting needs are met. Residents are not expected to wet or soil their briefs if the resident has a preference for or uses a specific toileting method, such as a bedpan, urinal, or toilet chair. 6. Based on the above information, non-compliance at F550 occurred on 6/12/26, and based on the provider's implemented corrective actions on 6/12/26, for the deficient practice confirmed on 6/12/26, the non-compliance is considered past non-compliance.

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
	435051	A. Building B. Wing	06/22/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. A. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, and record review, the provider failed to ensure one of one resident (56) was provided timely incontinence (involuntary urine or bowel leakage) care by one of one certified nurse aide (CNA) (KK). 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 3/20/26 submitted SD DOH FRI final report revealed that on 3/20/26 at 2:45 p.m. at resident 56's medical appointment, it was identified that the resident's incontinence brief was saturated. The appointment was not completed.CNA KK was responsible for resident 56's care that day. The resident required staff to check and change his incontinence brief. According to the SD DOH FRI, resident 56's incontinence brief was last checked at 8:00 a.m. by CNA KK, and the brief was dry.Former medical records coordinator LL transported resident 56 to the above medical appointment. She asked CNA KK to check and change resident 56's incontinence brief before she transported him to his scheduled appointment that afternoon.CNA KK attempted to check resident 56's incontinence brief before the appointment, but he was eating lunch at the time, and the resident declined to be assisted. Instead, he wanted to wait to have his brief changed until after he had eaten. CNA KK did not return after he had eaten to change his brief before he was transported to his appointment that afternoon. Resident 56 was provided prompt incontinence care after he returned to the facility on 3/20/26. Camera footage on 3/20/26 was reviewed by the provider during their investigation, and the above incident was substantiated. 2. Review of resident 56's electronic medical record (EMR) revealed that the nursing staff completed a skin evaluation after the 3/20/26 incident each day after that for 72 hours. No skin concerns were identified related to the 3/20/26 incident. 3. Observation and interview on 6/16/26 at 1:30 p.m. with resident 56 revealed that his appearance was neat and clean. He was unable to recall the 3/20/26 incident. He reported no concerns with the care that was provided to him by the staff.4. Interview and record review on 6/18/26 at 3:15 p.m. with regional nurse consultant (RNC) C revealed that the disciplinary action, interviews, and audits referenced in the provider's 3/20/26 submitted SD DOH FRI were completed and documented. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 6/18/26 after record review revealed the facility had followed their quality assurance process, and all residents CNA KK was assigned to on 3/20/26 were checked for incontinence issues, and incontinence care was provided as needed. CNA KK was terminated from employment on 3/21/26. Beginning on 3/20/26, all caregivers were educated regarding the provider's Abuse/Neglect policy and resident incontinence care and toileting expectations. Ten random residents were interviewed by the provider on 3/23/26 regarding other potential abuse or neglect concerns. Five random residents were observed each week for approximately six weeks to ensure their incontinence care needs were appropriately met. 5. Based on the above information, non-compliance at F600 occurred on 3/20/26, and based on the provider's implemented corrective actions on 3/20/26, for the deficient practice confirmed on 6/18/26, the non-compliance is considered past non-compliance.B. Based on SD DOH FRI, observation, interview, and record review, the provider failed to ensure one of one resident (37) was provided timely incontinence care by one of one CNA (F). 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 4/19/26 submitted SD DOH FRI final report revealed that before lunch on 4/19/26, CNA/registered medication aide (RMA) E transported resident 37 in her wheelchair to her room. CNA/RMA E observed at that time that resident 37 required assistance with incontinence care. The resident required the assistance of two staff caregivers to complete that care.CNA/RMA E was not able to assist resident 37 with that care because she was responsible for administering medications to the residents on the opposite hall (west hall). CNA/RMA E activated resident 37's call (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 B. Wing	06/22/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	light. CNA/RMA E left the resident's room before the call light was answered. She presumed that CNA F, who was responsible for resident 37's care that day, would answer the call light and assist resident 37.At 6:30 p.m. on 4/19/26, CNA/RMA E and registered nurse (RN) D observed resident 37 in her room. The resident's pants were saturated in urine. CNA/RMA E and RN D provided incontinence care. Resident 37 has severe cognitive impairment, and she was not able to provide any information to the staff regarding her incontinence care.RN D was not able to find CNA F after she and CNA/RMA E provided resident 37's incontinence care to discuss the incident. CNA F failed to respond to attempts by the provider to participate in the incident investigation.CNA F was suspended from working on 4/19/26 pending the outcome of the incident investigation and then terminated from employment. Resident neglect was substantiated by the provider based on their incident investigation. 2. Interview on 6/18/26 at 10:20 a.m. with CNA/RMA E regarding the 4/19/26 incident revealed that she confirmed the information in the above FRI. 3. Interview on 6/18/26 at 10:30 a.m. with CNA G revealed that on 4/19/26, she and CNA F were assigned to provide care to the east hall residents. The staff assignment sheet indicated that CNA F was assigned to resident 37's care that day. Both CNA F and CNA G were expected to communicate with each other throughout their work shift, so if a resident required the assistance of two staff for their ADL care, the second CNA could help. CNA G did not recall CNA F asking for her assistance to provide resident 37's incontinence care during their day shift together on 4/19/26. 4. Interview and record review on 6/18/26 at 3:15 p.m. with RNC C revealed that the disciplinary action, interviews, and audits referenced in the provider's 4/19/26 submitted SD DOH FRI were completed and documented. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 6/18/26 after record review revealed the facility had followed their quality assurance process and suspended, then terminated CNA F based on their investigation findings. Resident 37's skin was assessed by nursing staff on 4/19/26. No new skin findings related to the resident's lack of incontinence care on 4/19/26 were identified. Incontinence care audits were initiated the week of 4/16/26 and continued through the week of 5/9/26 to identify any potential systemic issues related to residents' incontinence care.5. Based on the above information, non-compliance at F600 occurred on 4/19/26, and based on the provider's implemented corrective actions on 4/19/26, for the deficient practice confirmed on 4/19/26, the non-compliance is considered past non-compliance.

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	06/22/2026

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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. A. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, and interview, the provider failed to adhere to professional nursing standards of practice to ensure one of one resident's (99) pain medication was administered according to the physician's order by one of one licensed practical nurse (LPN) (H).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 5/4/26 SD DOH FRI revealed that during the provider's investigation of a separate, unsubstantiated neglect allegation that involved LPN H, a medication error was identified that occurred on 4/30/26. It was determined that LPN H administered an incorrect dose of pain medication to resident 99. The provider submitted a FRI regarding this incident to the SD DOH because LPN H alleged that insufficient staffing contributed to her making that medication error. 2. Review of resident 99's electronic medical record (EMR) revealed her admission date was 4/30/26 and her discharge date was 5/15/26. The resident's April 2026 medication administration record (MAR) included a physician's order for the resident to receive two hydrocodone-acetaminophen tablets (brand name/Norco, an opioid pain medication) every six hours as needed for pain. LPN H documented on 4/30/26 that she administered resident 99 two Norco tablets as ordered. Each day at the change-of-shifts, the oncoming and off-going nursing staff accounted for the quantity of resident 99's Norco because it was a controlled substance (a medication with a high potential for abuse and severe dependence). LPN H documented on resident 99's 4/30/26 Norco accounting sheet that she administered three Norco tablets to resident 99 and not the two Norco tablets that were prescribed by the resident's physician. During the provider's incident investigation, LPN H confirmed she administered three Norco tablets to resident 99. There was no documentation to support that resident 99 incurred any adverse consequences after she was administered the incorrect pain medication dose on 4/30/26. 3. Review of the provider's posted staffing information for 6/16/26 and 6/17/26 revealed that the staffing ratio aligned with the provider's Facility Assessment (an annual evaluation of the facility's resident population that identifies the needed resources to provide the care and services required by those residents) and facility census of 59 residents. 4. Interview on 6/16/26 at 4:40 p.m. with registered nurse (RN) T revealed that she verbalized no concern with sufficient nurse staffing. The provider maintained a monthly nurse on-call schedule that was posted at the nurses' station. For each day of the month, there was a manager's name and contact number listed. RN T stated that the schedule was referred to as needed for manager support in addressing issues such as staff call-outs. 5. Interview and record review on 6/17/26 at 1:45 p.m. with regional nurse consultant (RNC) C revealed that the disciplinary action, interviews, and audits referenced in the provider's 5/4/26 submitted SD DOH FRI were completed and documented. The provider's implemented actions to ensure the deficient practice does not recur were confirmed (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 B. Wing	06/22/2026

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 - Some	onsite on 6/17/26 after record review revealed the facility had followed their quality assurance process and completed an audit to ensure the 5/8/26 staffing ratio was in alignment with the Facility Assessment. Completed random resident interviews to ensure that their care needs were being met by the staff. Completed audits to ensure medications are administered per the physician's order, according to the manufacturer's directions, and according to the six rights of medication administration. Completed an additional audit to ensure proper medication accounting, storage, and disposal practices are followed. LPN H's employment with the provider was terminated on 5/4/26 based on the facility's progressive disciplinary action procedure. Based on the above information, non-compliance at F658 occurred on 4/30/26, and based on the provider's implemented corrective actions on 5/4/26, for the deficient practice confirmed on 5/4/26, the non-compliance is considered past non-compliance. B. Based on SD DOH FRI review, record review, interview, and provider's protocol review, the provider failed to ensure that one of one RN (T) completed the required post-incident follow-up documentation in the EMR following a choking incident of one of one sampled resident (66). 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 6/5/26 submitted SD DOH FRI regarding resident 66 revealed that on 6/2/26 resident 66 had aspirated (accidentally inhaling food, liquid, or saliva into the airway or lungs) during the lunch meal. She was served her prescribed mechanical soft diet (individual with chewing or swallowing difficulties) at the assisted dining table with staff supervision. Staff reported that resident 66 began coughing after taking a bite of food. She continued to cough experienced excessive mucus production and noted difficulties spitting out phlegm. Resident 66's provider was notified and the order was given to transport her out to the hospital. Resident 66's power of attorney (POA) was notified of the incident and the order to transport to the hospital, and they declined the hospital transfer. Resident 66 was placed on oxygen, received oral suctioning, and was able to clear the phlegm. She returned to her baseline on 6/2/26. Certified nursing assistant (CNA) U had checked on resident 66 on 6/5/26 at 6:00 p.m. and had found her unresponsive and reported it to RN T. Resident 66 was a do not resuscitate (DNR). The facility's investigation into the incident revealed that RN T was the RN assigned to resident 66 on the day of the incident and then on 6/4/26 and 6/5/26. She had checked resident 66 on 6/5/26 noting the resident appeared fatigued but was able to take her medications from RN T. RN T reported she did not enter any progress notes or assessment documentation into resident 66's EMR for the dates of 6/4/26 or 6/5/26. A review of camera footage identified that the staff obtained vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) of resident 66 multiple times on 6/4/26 and 6/5/26, but those assessments were not documented in her EMR. The facility determined that the staff had followed resident 66's care plan and diet order during the incident. Administrator A educated regional nurse consultant (RNC) C as she was the interim director of nursing (DON) at the time, on ensuring nursing staff were completing 72- hour post incident (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 B. Wing	06/22/2026

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 - Some	documentation. The facility educated the nursing leadership on ensuring that the follow-up documentation was occurring per facility protocol for 72-hour monitoring post event. Education was completed for the nurses on Post -Foreign-Body Airway Obstruction checklist, including the 72-hour monitoring. 2. Review of resident 66's EMR confirmed there was no 72-hour post incident documentation per facility's protocol to include the residents vitals on 6/4/26 and 6/5/26. 3. RN T was not available for an interview at time of the survey. 4. Interview on 6/22/26 at 11:29 a.m. with RNC C confirmed she had received education related to ensuring the nursing staff had completed the 72-hour post-incident documentation in the residents EMR. 5. Staff confirmed they received education regarding follow-up documentation per the provider's protocol for 72-hour monitoring post event, and education for nurses on Post Foreign-Body Airway Obstruction checklist, which included 72-hour monitoring. Record review confirmed that staff were educated about the follow-up documentation per the provider's protocol for 72-hour monitoring post-event, and education for Post Foreign-Body Airway Obstruction checklist. 6. Administrator A was not available for an interview at time of the survey. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed onsite on 6/22/26 after record review revealed the facility had followed their quality assurance (QAPI) process regarding 72-hour post incident documentation, education was provided to nursing staff regarding the follow-up documentation per facility protocol, and education on Post Foreign-Body Airway Obstruction checklist. Interviews revealed staff understood the education that was provided regarding those topics, and audits were implemented regarding the 72-hour post-incident documentation and will continue for two months. Based on the above information, non-compliance at F658 occurred on 6/2/26, and based on the provider's implemented corrective actions on 6/17/26, for the deficient practice confirmed on 6/17/26, the non-compliance is considered past non-compliance.

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	06/22/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, record review, and policy review, the provider failed to ensure physician's orders were entered in one of one resident's (57) electronic medical record (EMR) and implemented to mitigate that resident's risk for hospitalization. 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 3/16/26 submitted SD DOH FRI final report regarding resident 57 revealed that physician HH's 3/6/26 orders were noted (acknowledged as being read, understood, and entered in resident 57's EMR) by assistant director of nursing (ADON) P on that same date. The orders were not cross-checked by a second nurse per the provider's revised 11/18/25 Following Physician Orders policy. The provider's investigation confirmed that ADON P only noted and entered physician HH's 3/6/26 medication orders for resident 57 and not physician HH's 3/6/26 orders for a head CT and laboratory tests.2. Review of resident 57's EMR revealed physician HH's 3/16/26 Nursing Home Attending Physician Visit progress note stated that on 3/6/26, I [physician HH] ordered laboratory tests [for resident 57]. I [physician HH] also ordered a head CT scan because she [resident 57] had fallen the week before and hit her head. She [resident 57] is on anticoagulation [a blood-thinning medication]. Unfortunately, these orders were not entered at the nursing facility.After physician HH's examination of resident 57 on 3/16/26, the physician ordered the resident's transfer to the local emergency department related to her general decline: loose stools, hallucinations (a false sensory perception that feels real), lethargy (severe physical and mental sluggishness), and malaise (a vague feeling of being unwell). She was hospitalized from [DATE] through 3/24/26 for new diagnoses that included acute kidney injury and metabolic acidosis (a condition where the body produces too much acid, or the kidneys are not removing enough of it). An additional diagnosis of paroxysmal atrial fibrillation (episodes of irregular, rapid heartbeats start suddenly) was noted. Resident HH had a cardiac history. 3. Interview on 6/17/26 at 4:15 p.m. with resident 57 regarding her March 2026 hospitalization revealed that she had not felt well for some time before that hospitalization. She was having loose stools, losing weight, and feeling weak. She stated that on 3/16/26, the nursing staff were aware that her symptoms had not improved. The resident's condition was discussed with resident 57's representative, who came to the facility to see the resident. The resident's representative asked that physician HH be contacted to see resident 57 that day, which physician HH did. The resident was transferred to the local emergency department then hospitalized . 4. Interview on 6/17/26 at 5:30 p.m. with ADON P revealed that the above incident investigation and EMR findings were correct. The provider had a check and balance system to ensure accurate physician order entry occurred, but it was not followed by ADON P or the night shift nursing staff on 3/6/26 for resident 57's orders. 5. Interview and record review on 6/22/26 at 3:50 p.m. with regional nurse consultant (RNC) C revealed that the provider's failure to fully implement physician HH's 3/6/26 orders for resident 57 prevented the provider from having an accurate clinical picture of the resident's condition, which could have mitigated the resident's need for emergency care on 3/16/26.6. The disciplinary action, education, interviews, and audits referenced in the provider's 3/16/26 submitted SD DOH FRI were completed and documented. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 6/22/26 after record review revealed the facility had followed their quality assurance process, and on 3/17/26 a quality assurance and performance improvement (QAPI) meeting was held related to this FRI. Former director of nursing (DON) BB completed a corrective action plan with ADON P regarding the incident. Nurse leadership and nursing staff were educated regarding the expectations concerning a resident's change in condition, 24-hour chart checks, follow-up on registered dietitian recommendations, requesting and scheduling resident appointments and entering labs in the EMR. Education regarding pertinent policies and flow sheets accompanied this training. Audits of physician (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 B. Wing	06/22/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	HH's residents' charts were reviewed to ensure that all of the orders the provider had received from the physician in the prior three months were acted upon. All other physicians' orders were also reviewed to verify that their orders were completed and implemented. There were audits of physician progress notes during the provider's daily clinical meeting to ensure any new physician's orders were entered in the EMR and any order follow-up was completed. There were audits to ensure the night shift had signed off on 24-hour chart checks, verified that all new physician's orders were implemented and followed up on, and that there were two nurse signatures to verify new physician order entries.Based on the above information, non-compliance at F684 occurred on 3/6/26, and based on the provider's implemented corrective actions initiated on 3/16/26, for the deficient practice confirmed on 3/6/26, the non-compliance is considered past non-compliance.B. Based on SD DOH FRI, interview, and record review, the provider failed to ensure an outpatient wound care appointment occurred in a timely manner for one of one resident (47) who had a worsening lower extremity wound. 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 3/18/26 submitted SD DOH FRI final report regarding resident 47 revealed that on 3/17/26, physician's assistant (PA) DD was notified by nursing staff that resident 47's foot wound had worsened. Resident 47's 3/12/26 OPWC appointment was canceled due to the provider having transportation issues. The appointment was rescheduled to 3/27/26. PA DD asked the provider to reschedule the appointment to a date earlier than 3/27/26. When PA DD contacted the OPWC clinic, she was told that an earlier appointment for resident 47 was offered to the facility, but it was declined. Former DON BB advised PA DD that there were not enough transport drivers to accommodate all residents' appointments. That prevented resident 47 from being seen in the OPWC clinic any sooner than 3/27/26.Resident 47's OPWC appointment was rescheduled to 3/20/26. 2. Review of resident 47's EMR revealed her diagnoses included diabetes, Charcot arthropathy (a progressive, degenerative condition affecting bones and joints) of the right foot and ankle, prior right foot and bilateral toe amputations, chronic osteomyelitis (a bone or bone marrow infection), obesity, heart disease, and cirrhosis (progressive, irreversible liver disease).She had regularly scheduled OPWC appointments and attended the scheduled May 2026 and June 2026 appointments. 3. Interview on 6/16/26 at 1:15 p.m. with resident 47 revealed she had no current care concerns and no issues regarding her medical appointments. The resident kept herself informed and educated regarding her medical care needs. 4. Interview on 6/16/26 at 2:30 p.m. with registered nurse (RN) T regarding resident appointments revealed the provider's updated appointment process facilitated communication between physicians, facility nursing staff, and the facility's appointment scheduler. The updated process ensured residents' medical appointments were kept and were not unnecessarily canceled. 5. Interview on 6/16/26 at 3:05 p.m. with transportation coordinator EE regarding resident appointments revealed the provider's updated appointment process facilitated communication between physicians, facility nursing staff, and transportation coordinator EE to ensure residents' medical appointments were kept and are not unnecessarily canceled. He was able to collaborate with the drivers in three other sister facilities to accommodate resident appointments if needed. Any medical appointment scheduling barriers were reported to a member of the facility's management team for guidance and resolution.6. Interview and record review on 6/17/26 at 11:15 a.m. with RNC C revealed the disciplinary action, education, interviews, and audits referenced in the provider's 3/18/26 submitted SD DOH FRI were completed and documented. 7. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 6/17/26 after record review revealed the facility had followed their quality assurance process, and a Quality Assurance and Performance Improvement (QAPI) meeting was held to identify the root cause for the provider's system failure related to resident appointments. Former DON BB, medical records coordinator LL, and former transportation coordinator CC, nurse management staff, and nursing staff were educated regarding the expectations for managing resident appointments, resident appointment communication, and notifications regarding resident appointment (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 B. Wing	06/22/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	changes.All residents with OPWC appointments were audited to ensure they were not unnecessarily postponed and were rescheduled in a timely manner when indicated. Resident appointments were reviewed during the provider's morning interdisciplinary team meetings to ensure Appointment Request Forms were completed for resident appointments by nursing staff, and provided to transportation coordinator EE to schedule transport for those resident appointments.The resident appointment calendar form was reviewed and compared to the Daily Transportation Log form to ensure that appointments were completed as scheduled. There was documentation to support a rational reason why any appointment was canceled or rescheduled, and that canceled appointments were appropriately rescheduled.Based on the above information, non-compliance at F684 occurred on 3/12/26, and based on the provider's implemented corrective actions initiated on 3/17/26, for the deficient practice confirmed on 3/17/26, the non-compliance is considered past non-compliance.C. Based on SD DOH FRI, interview, record review, and policy review, the provider failed to ensure one of one resident (55) received prompt incontinence (involuntary urine or bowel leakage) care from one of one CNA (II). 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 3/27/26 FRI revealed that on 3/27/26 at 3:50 p.m. former transportation coordinator CC reported to facility management staff via secure facility email that resident 55 had possibly not been provided incontinence care since earlier that morning. The afternoon of 3/27/26, CNA/registered medication aide (RMA) E was in the resident's room to manage his oxygen tank when she observed resident 55 sitting in his wheelchair. His left pant leg was wet from his groin to his knee. There was a smell of urine in the room. CNA II was responsible for resident 55's care that day and was suspended from working pending an incident investigation. The provider's investigation revealed that resident 55's incontinence brief was last changed on 3/27/26 at approximately noon by CNA II. CNA II stated she was not able to return after that time to check the resident's brief again because she was busy with other residents' care. Resident 55's brief was expected to be checked for incontinence and changed, if needed, every 2 hours according to the provider's Check and Change policy. That had not occurred.2. CNA/RMA E was scheduled to work on 6/22/26, but called out sick and was not able to be interviewed. She was not scheduled to work again until after the survey ended. CNA II has not worked at the facility since 4/2/26. Resident 55 has severe cognitive impairment and was not able to be interviewed.3. Random observations made of resident 55 throughout the survey on 6/16/26, 6/17/26, 6/18/26, and 6/22/26 in the dining room and in the resident's room revealed that the resident's clothing was dry and there was no smell of urine.4. Interview on 6/22/26 at 12:30 p.m. with RNC C revealed caregivers are encouraged and expected to ask for assistance from other caregivers if they are not able to meet residents' care needs. The provider was adequately staffed on 3/27/26 for that to occur.5. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 6/22/26 after record review revealed the facility had followed their quality assurance process, and former transportation coordinator CC and CNA/RMA E were educated regarding notifying a facility manager of a reportable event (unexpected or adverse events) during regular business hours instead of communicating that information via secured electronic mail. All caregivers were educated on the provider's Abuse/Neglect policy at the 4/14/26 All Staff meeting. Five residents were observed each week for four weeks to ensure their incontinence care needs were met in a timely manner. Ten applicable residents were asked if they were checked for incontinence every two hours and assisted with their toileting needs.6. Based on the above information, non-compliance at F684 occurred on 3/27/26, and based on the provider's implemented corrective actions initiated on 3/27/26, for the deficient practice confirmed on 3/27/26, the non-compliance is considered past non-compliance.

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	06/22/2026

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI), record review, and interview, the provider failed to ensure an effective, comprehensive quality assurance and performance improvement (QAPI) program was implemented to track and measure performance; systematically analyze underlying causes of a systemic quality deficiency; develop and implement corrective actions or performance improvement activities; and evaluate the effectiveness of the corrective actions, and to revise those actions as needed.Findings include:1. Review of a 3/20/26 SD DOH FRI revealed that the incident investigation substantiated neglect occurred when the facility failed to provide resident 56 incontinence care. 2. Review of a 3/27/26 SD DOH FRI revealed that the incident investigation substantiated that the facility failed to provide resident 55 incontinence care. 3. Review of a 4/19/26 SD DOH FRI revealed that the incident investigation substantiated that the facility failed to provide resident 37 incontinence care. 4. The provider's corrective action plan for the above FRIs included staff disciplinary action, staff education, and auditing of residents' incontinence care. The same audit tool was used for each of the above FRIs. Five random residents were selected each week. They were observed for incontinence, if their care plan was followed regarding incontinence care, and if the resident reported concerns with their incontinence care.Every audit was marked yes in response to the resident reporting incontinence concerns, but there was no information related to those resident concerns. The Summary of Findings section on each audit was blank. 5. Review of a 6/12/26 SD DOH FRI revealed that the incident investigation substantiated that resident 62's preference to use a bedpan was not accommodated by staff, and the resident was instructed to urinate in her incontinence brief. 6. Review of the above FRIs and interview on 6/18/26 at 12:15 p.m. with regional nurse consultant (RNC) C revealed she thought that the yes response to the audit question regarding whether the resident reported concerns with their incontinence care was answered incorrectly and should have been marked no. RNC C confirmed that the provider failed to, but should have used information from the above FRIs to identify or rule out potential causes for the incontinence care and to provide education to the staff. 7. Review of the provider's April 2026 and May 2026 Quality Assurance and Performance Improvement (QAPI) meeting minutes revealed that the provider initiated a plan to work on specific areas to improve their quality of care, regulatory compliance, and staff morale. The Systems Review section of the minutes included Incident Investigations (State Reported [FRIs] and Internal). Instructions were to Include data analysis, RCA [root cause analysis] [a structured problem-solving process used to identify the underlying reasons behind an issue], and need for PIP [performance improvement plan] [a structured, data-driven framework used to address identified quality concerns or adverse events]/Action Plan. Neither the April 2026 nor the May 2026 QAPI minutes included a data analysis, RCA, or PIP/Action plan information related to the above FRIs. 8. Review of the April 2026 and May 2026 QAPI meeting minutes and interview on 6/22/2026 at 5:30 p.m. with RNC C and assistant administrator B revealed that the minutes failed to identify who was responsible for completing the Incident Investigations portion of the Systems Review Section. There was no documented RCA that identified the underlying cause(s) for the ongoing incidents of untimely and improper incontinence care. QAPI meeting minutes failed to reflect whether the provider's interventions (audits, staff education, and staff disciplinary actions) in response to the above FRIs were monitored or measured to determine their impact on residents' incontinence care or if alternate interventions were warranted. There was no PIP/Action plan related to incontinence care. RNC C and assistant administrator B stated that a QAPI committee should have been formed several months ago to more effectively and efficiently address the incontinence care issue. 9. Review of the provider's undated QAPI Plan revealed the provider will use data at every QAPI Committee to ensure performance measures are meeting QAPI goals. Regarding the section labeled, Feedback, Data Systems, and Monitoring: The primary sources for data collection (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 B. Wing	06/22/2026

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	included incident/event reports (FRIs). Data and its sources will be continuously monitored for accuracy and applicability to performance improvement. It is the responsibility of the QAPI Steering Committee to determine the relevance of data for performance improvement and to examine data for any gaps or discrepancies. Regarding the section labeled, Systemic Analysis and Systematic Action: The Plan-Do-Study-Act (PDSA) process and Root Cause Analysis (RCA) will be used to identify improvement opportunities and to understand how to improve them. The QAPI Steering Committee monitors progress to ensure that interventions or actions are implemented and effective in making and sustaining improvements.