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	05/15/2024

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 40788 Based on observation, interview, record review and policy review, the provided failed to ensure the following: *One of one registered nurse (RN) L had appropriately administered and documented medication administration for one of three sampled residents (31). *One of one licensed practical nurse (LPN) N had appropriately documented medication administration for one of one sampled resident (36). *Accurate and complete documentation of nutritional formula and water flushes for one of two sampled residents (50) who had a feeding tube. Findings include: 1. Observation on 5/15/24 at 8:00 a.m. of RN L: *She mixed the resident 31's pills with applesauce in a medication cup and poured her nutritional supplement and Mirilax (a laxative) mixed with water into two separate plastic drinking cups. *RN L placed those two plastic drinking cups on the dining room table where the resident was eating her breakfast and administered her pills to her. *RN L left the dining room without ensuring resident 31 drank her nutritional supplement and Mirilax. -RN L then documented on resident 31's Medication Administration Record (MAR) that her pills and Mirilax were administered. Continued observation at 8:15 a.m. revealed: *The resident exited the dining room with staff assistance. *About half of the Mirilax and the nutritional supplement remained in the cups on the table. Interview on 5/15/24 at 8:20 a.m. with RN L regarding resident 31's morning medication administration revealed: (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*It was her process to have left the Mirilax and nutritional supplement cups on the table, return to check the amount the resident had consumed of both after the meal, and then document the medication administered. *At 8:25 a.m. RN L entered the dining room and returned to the medication cart. -She stated the resident drank all her Mirilax and most of the nutritional supplement. *After she was asked to re-look at the Mirilax cup again she confirmed the resident had not consumed all of the Mirilax. *Her MAR documentation regarding the Mirilax administration was not accurate. 2. Review of resident 36's April 2024 controlled drug record revealed she was given 0.5 milliliters (ml) of lorazepam (anti-anxiety medication) and 0.25 ml of morphine on 4/26/24 by licensed practical nurse (LPN) N. Review of resident 36's April 2024 Medication Administration Record (MAR) revealed no documentation the lorazepam or morphine was given on 4/26/24. Interview on 5/15/24 at 3:00 p.m. with LPN N regarding medication administration documentation revealed: *She failed to document having administered resident 36's 4/26/24 lorazepam and morphine doses on the resident's MAR. -She was expected to document those administrations at the same time she documented their administration in the controlled drug record. *She recalled administering those medications prior to changing the resident's Foley catheter. -Her 4/26/24 progress note in the resident's electronic medical record (EMR) supported that. 3. Review of resident 50's May 2024 MAR revealed: *A tube feeding (nutritional formula) order based on the amount of food the resident had eaten at her three daily mealtimes and a scheduled tube feeding at night. -If resident eats greater than 75% of her meal, hold the tube feeding. -If resident eats between 50-75% of her meal, give 150 ml of the tube feeding. -If resident eats less than 50% of her meal, give 300 ml of the tube feeding. -Always give full tube feeding at night (300 ml). -Flush the feeding tube with 75 ml water before and after each feeding. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of the May 2024 MAR tube feeding documentation revealed: *There was only documentation from 5/7/24 through 5/14/24 because the resident was hospitalized at the beginning of the month. *The MAR was set-up to capture the following documentation: -The percentage of the morning, mid-day, and evening meals consumed. -The ml of tube feeding administered at those times based on the percentage of the meal consumed. -The ml administered at the scheduled nighttime tube feeding. *On 5/10/24, 5/11/24, and 5/12/24 there was 0 ml tube feeding formula documented as having been administered for the nighttime administration. -The resident should have received 300 ml according to the medical provider's order. *On 5/13/24 the resident had eaten 100% of her evening meal so her tube feeding should have been held. -240 ml was documented as administered. *On 5/8/24, 5/9/24, and 5/13/24 450 ml was documented as administered with the nighttime scheduled feeding. -It was unknown if the 450 reflected the scheduled tube feeding amount (300 ml) plus the pre and post tube feeding water flushes (150 ml). *No other ml documentation was found for the pre and post feeding water flushes. -There was no separate space on the MAR to have documented the water flushes. Interview on 5/15/24 at 12:05 p.m. with director of nursing B regarding medication administration documentation revealed: *Staff were expected to observe residents during medication administration to ensure medications were taken by the resident before documenting they had taken the medications. *Medication administration documentation was expected to have been completed at the time it occurred. *The ordered water flushes for resident 50 were not accounted for on her MAR but should have been. Interview on 5/15/24 at 12:30 p.m. with registered nurse (RN) M regarding her 5/10/24 tube feeding documentation for resident 50 revealed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She administered that nighttime tube feeding but had not known why she failed to have documented it. *Her ml documentation included only the mls of tube feeding administered. -There was no documentation the resident's water flushes were given as ordered by the medical provider. Review of the September 2018 Medication Administration policy revealed: *Medication Administration: -1. Medications are administered in accordance with written orders of the prescriber. If necessary, the nurse contacts the prescriber for (order) clarification. 20. The resident is always observed after administration to ensure that the dose was completely ingested. *Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42558 Based on observation, record review, interview, and policy review, the provider failed to ensure: *A bowel management program was monitored for one of one sampled resident (9) who had multiple diarrhea consistency stools and unintentional weight loss. *Appropriate and necessary notification of resident 9's physician assistant (PA) H and registered dietician (RD) I about the consistency and amount of her stools. Findings include: 1. Observation on 5/13/24 from 5:30 p.m. to 6:00 p.m. of resident 9 while in the dining room during the evening meal revealed: *She was sitting in a wheelchair and had a small, frail, bony appearance. *She was eating a meal from a fast-food restaurant. Interview on 5/14/24 at 9:30 a.m. with resident 9 revealed: *She felt she was losing weight because she poops all the time and everything goes right through me. -She stated she was having a watery bowel movement (BM) with every toileting and often had incontinent (uncontrolled) BMs. -She stated, I have had water poop for a long time. I think it is those pills they give me. Review of resident 9's electronic medical record (EMR) revealed: *She was admitted on [DATE] with the primary diagnosis of ataxic (impaired coordination) cerebral palsy. *Her weight on admission was 115.8 pounds. *On 2/6/24 the resident weighed 99.7 pounds. -On 5/7/24 her weight was 93.6 pounds. -That was a 6.12% weight loss within a three month time period. *She was not on a physician prescribed weight loss program. *She was eating between 50 and 100 percent of her meals and also accepted a snack most evenings. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	*Her medication administration record (MAR) revealed she was drinking 100% of Liquacel dietary supplement, one ounce, twice a day, and a 2.0 calorie supplement drink, four ounces, three times a day. *Her 4/12/24 Brief Interview of Mental Status (BIMS) score was 14, indicating she was cognitively intact. Review of resident 9's Point Click Care (PCC) BM record from 4/14/24 to 5/14/24 revealed: *Resident 9 had 48 BMs in a 30-day period. -33 of those stools were documented as diarrhea loose. -8 stools were putty like and 7 were formed stools. Further review of resident 9's April and May 2024 MARs revealed the following: *A 7/19/23 physician's order for a MiraLax (a laxative)17 gram oral packet to have been mixed with fluid daily in the morning. *A 11/25/21 physician's order for docusate sodium (stool softener)100 milligram tablet to be given daily in the morning. *The MiraLax was refused by the resident seven times on 4/5, 4/7, 4/8, 4/10, 5/11, 5/13, and 5/14. -There was no documentation found that indicated staff had held her laxative or stool softener due to diarrhea (loose) stools. Further review of resident 9's EMR revealed: *There was no documentation found that indicated the physician had been notified of her frequent loose stools. *Her 4/12/24 quarterly Minimum Data Set (MDS) assessment's section H revealed she was occasionally incontinent of BM. *Her 4/12/24 Braden skin assessment revealed a score of 18, indicating she was at high risk for skin breakdown. Interview on 5/14/24 at 3:38 p.m. with certified nursing assistant (CNA) G regarding resident 9 revealed: *She was aware the resident was having frequent loose stools. -She stated the CNA's charted the consistency of the BMs in PCC for the nurses to use as a reference. Interview on 5/14/24 at 3:42 p.m. with registered nurse (RN) F revealed she: (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	*Stated since PCC was updated, she was unable to view CNA charting on BM consistency. *Was aware resident 9 had loose stools and stated that was normal for her. -Was unable to explain why the resident was taking both a laxative and a stool softener every day if she was having loose stools. *Was unsure if the physician had been notified of the resident's loose stools. Interview on 5/14/24 at 4:05 p.m. with MDS coordinator E revealed: *She was aware resident 9 was having loose stools. -Stated resident 9's loose stools were sporadic and she expected the nurses to have held the laxative medication when her stools were loose. *Stated the nurses were able to view a resident's BM consistency in PCC. -It was located under a separate tab in the bowel documentation area. *She was unaware if the physician had been notified of the resident's loose stools. 2. Interview on 5/15/24 at 8:30 a.m. with resident 9's physician assistant (PA) H regarding weight loss and loose stools revealed: *She was not aware the resident was having multiple loose, diarrhea consistency stools. -It was her expectation for staff to have notified her about that issue. -She stated that during her monthly visits with the resident, she had never complained of having loose stools. *She confirmed multiple diarrhea stools could be a factor in the resident's weight loss. Interview on 5/15/24 at 9:40 a.m. with administrator A, director of nursing (DON) B, and nurse supervisor D regarding resident 9's weight loss and loose stools revealed: *They stated it was the resident's normal to have loose stools on occasion, but were unaware of how frequently it was occurring. *They were aware of the resident's weight loss despite nutritional interventions. -They had attributed the weight loss to her progression of cerebral palsy disease and mental decline. *Their expectation was for the aides to communicate to the nurses when the resident was having loose, diarrhea stools. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Interview on 5/15/24 at 10:54 a.m. with consulting dietitian I regarding resident 9 revealed: *She had worked as the provider's dietitian on a consultant basis for at least 2 years. *She reviewed the resident's charts remotely and performed an on-site visit with the residents and the interdisciplinary team once a month. *She was aware the resident had been losing weight and was monitoring her as a nutritionally high-risk resident. *She was able to view a resident's BM frequency in PCC, but had not known how to view the BM's consistency. *Staff had not informed her of the resident's loose stools. -She depended on staff to notify her of changes in a resident's condition. Review of the provider's 8/23/23 Notification of Change of Condition policy revealed: *1. The facility must immediately inform the resident; consult with the resident's medical provider; and notify, consistent with his or her authority, the resident representative(s) when: -c. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or . Review of the provider's 12/1/19 CNA and RN job description and the March 2021 Toileting and Incontinence policy revealed: *There was no mention of reporting frequent loose stools to the nurse or the physician. *There was no mention of holding laxatives or stool softeners during episodes of loose stools.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40788 Based on record review, observation, interview, and policy review, the provider failed to ensure medications were administered as ordered for two of nine sampled residents (14 and 32). Findings include: 1. Review of resident 14's 4/9/24 through 5/14/24 controlled drug records for his clonazepam (anti-seizure) medications revealed: *Two drug record logs for resident 14's clonazepam. -One accounted for his 0.25 milligram (mg) morning dose administrations and the second for his 0.5 mg evening dose administrations. *The morning dose log documentation revealed on 4/11/24, 4/12/24, 4/21/24, 4/25/24, 5/3/24, 5/4/24, and 5/8/24 the resident was given the 0.25 mg clonzepam dose in the evening instead of the 0.5 mg dose that was ordered. -A count of the number of clonazepam tablets in the morning and evening medication blister packs (med cards) supported the documentation referred to above. Review of resident 14's April 2024 and May 2024 Medication Administration Records (MARs) revealed the 0.5 mg evening clonazepam dose was documented as having been given on 4/11/24, 4/12/24, 4/21/24, 4/25/24, 5/3/24, 5/4/24, and 5/8/24 when it was the 0.25 mg dose that was administered. 2. Observation and interview on 5/15/24 at 8:05 a.m. with registered nurse (RN) L during resident 32's morning medication pass revealed: *The pharmacy label on the resident's lisinopril (blood pressure medication) blister pack included instructions to Hold [do not administer] if systolic [blood pressure reading] < [less than] 90. *The May 2024 MAR order for that lisinopril did not include the instruction for holding the medication. -RN L confirmed the medical provider's original lisinopril order had included that instruction but it was not included when the order was entered on the MAR. *RN L administered resident 32's morning lisinopril without first: -Reconciling the discrepancy between the blister pack label and the MAR order. -Ensuring the resident's blood pressure reading was taken before administering the lisinopril. Interview on 5/14/24 at 3:00 p.m. with director of nursing B revealed: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Medication errors occurred when staff administered resident 14's morning dose of clonazepam instead of his ordered evening dose of clonezepam on 4/11/24, 4/12/24, 4/21/24, 4/25/24, 5/3/24, 5/4/24, and 5/8/24. *A medication error occurred when RN L administered resident 32's lisinopril without first taking her blood pressure as ordered. -No medication error reports were completed, investigated, or followed-up on for the errors referred to above. *Staff authorized to administer resident medications were expected to compare each blister pack label to the MAR order for all medications and to reconcile any discrepancies between the two before administering a medication. Review of the September 2018 Medication Administration policy revealed: *Medication Preparation: 3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage on the schedule on the resident's MAR with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule. Apply a 'direction change' sticker to label if directions have changed from the current label. *Medication Administration: 2. Obtaine and record any vital signs as necessary prior to medication administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40788 Based on record review, observation, interview, and policy review, the provider failed to ensure: *Two of nine sampled residents (14 and 32) had prescription medications that were accurately labeled. *One of one certified medication aide (CMA) (J) had not altered one of one sampled resident's (14) prescription medication label. Findings include: 1. Review of resident 14's May 2024 Medication Administration Record (MAR) revealed: *A 3/31/24 medical provider's order for 0.25 mg clonazepam (anti-seizure medication) scheduled for daily administration in the morning. Observation of the prescription label on the medication blister pack (med card) of clonazepam read: Give 0.5 tablet by mouth every morning as needed (1/2 tab=0.25 mg [milligram]). Interview on 5/14/24 at 3:00 p.m. with director of nursing (DON) B, assistant DON C, and certified medication aide (CMA) J revealed: *They confirmed that prescription label had not matched the order on the May 2024 MAR for that medication. -The frequency of the morning dose read as needed on the blister pack but the MAR instructed daily administration. 2. Observation on 5/15/24 at 2:45 p.m. of resident 14's morning clonazepam blister pack revealed a line drawn through the words as needed on that prescription label. Interview on 5/15/24 at 3:00 p.m. with DON B and CMA J regarding that altered medication label revealed: *CMA J had covered the medication frequency instructions, as needed, with a black permanent marker. -Only the pharmacy provider was authorized to have made alterations to medication labels. 3. Observation and interview on 5/15/24 at 8:05 a.m. with registered nurse (RN) L during resident 32's morning medication pass revealed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*RN L administered the resident's lisinopril (a blood pressure medication) during morning medication pass. *The pharmacy label on the lisinopril blister pack included instruction to Hold [do not administer] if systolic [blood pressure reading],<[less than] 90. *The resident's May 2024 MAR order did not include the instruction for holding the medication. Interview on 5/15/24 at 3:00 p.m. with DON B revealed all staff authorized to have administered resident medications were expected to compare each blister pack label to the MAR order for all medications and to reconcile any discrepancies between the two before administering a medication. Review of the September 2018 Medication Administration policy revealed: *Medication Preparation: 3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage on the schedule on the resident's MAR with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule. Apply a 'direction change' sticker to label if directions have changed from the current label. Review of the May 2016 Medications and Medication Labels policy revealed 6. Medication labels are not altered, modified, or marked in any way by nursing personnel.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40788 Based on observation, interview, and policy review, the provider failed to ensure proper infection control practices were followed for the following: *Hand hygiene and glove use by one of one occupational therapist (OT) (K) during personal care for one of one sampled resident (50). *Hand hygiene by one of one assistant director of nursing (ADON) (C) during personal care for one of one observed resident (209). Findings include: 1. Observation on 5/13/24 at 1:50 p.m. of resident 50 revealed: *Enhanced barrier precaution (EBP) signage outside of her room. *Inside her room OT K was preparing to transport the resident to therapy. *After putting on a gown and gloves, OT K assisted the resident to her wheelchair. -She used her gloved hands to move each metal footplate on the wheelchair to a downward position and to physically assist the resident's feet onto the footplates. *Without removing her gloves, performing hand hygiene, and putting on a clean pair of gloves, OT K used those same unclean gloves to adjust the resident's oxygen tubing underneath her nose. *Then she removed a Kleenex from a Kleenex box with those same gloves to wipe saliva from the resident's mouth. *OT K removed her gown and gloves and without performing hand hygiene exited the room pushing the resident in her wheelchair. Interview on 5/13/24 at 2:50 p.m. with OT K regarding the above observations revealed she confirmed: *Her unclean gloves handled the resident's oxygen tubing and the Kleenex used to wipe the resident's mouth. *She should have performed hand hygiene after glove removal. 2. Observation on 5/13/24 at 2:05 p.m. of ADON C and certified nursing assistant (CNA) O while assisting resident 209 with toileting revealed: *After transferring the resident from her wheelchair to the toilet ADON C removed her gloves and washed her hands in the bathroom sink. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She used her wet washed hands to turn the faucet handle off before drying her hands with a paper towel. *ADON C put on a clean pair of gloves and used disinfectant wipes to clean spots of urine off the floor. -After discarding the wipes, she removed her gloves, and washed her hands in the bathroom sink. -She used her wet hands to adjust the faucet handle, completed her hand washing, and turned the faucet handle off with a paper towel. Interview on 5/13/24 at 2:15 p.m. with ADON C regarding the above observations revealed she confirmed: *Her wet hands should not have touched the faucet handle at any time during her hand washing. -A clean paper towel should have been used to turn the faucet handle off or adjust it. Review of the revised 2/20/24 Hand Hygiene policy revealed: *Hand hygiene should be completed 7) j. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident, *9) The use of gloves does not replace hand hygiene. Hand hygiene must be completed prior to and after removal of gloves. *Washing Hands: 13) Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel.