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	09/11/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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 0554 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 observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (31) observed with medications at her bedside were securely stored, had a physician's order for self-administration, and were not outdated according to the provider's policy.Findings include:1. Observation and interview on 9/9/25 at 9:51 a.m. and 3:24 p.m. with resident 31 in her room revealed:*Resident 31 had a Lubrifresh P.M. eye ointment (a medication used to treat the inflammation that results from dry eyes) box and a bottle of saline nasal spray (a medication used to moisturize and clear nasal passages) on her over-the-bed table.*She stated she self-administered those medications.*The saline nasal spray had a hospital label on it that stated it was issued on 8/23/25.*Resident 31 stated she used the saline nasal spray as needed for a dry nose.*The Lubrifresh P.M. box contained, -A tube of Lubrifresh P.M eye ointment, which did not have a pharmacy label on it to indicate how the medication was to be administered, and it outdated in July 2020.-A tube of Stye (a red, painful, eyelid bump) sterile lubricant ointment (a medication used to relieve burning, stinging, and itching related to a Stye), which did not have a pharmacy label on it to indicate how the medication was to be administered.-A bottle of Refresh Liquid Gel eye drops (for dry eyes), which did not have a pharmacy label on it to indicate how the medication was to be administered, and it outdated in July 2024.*Resident 31 stated she self-administered the Lubrifresh P.M. eye ointment every night and the Refresh Liquid Gel eye drops as needed for her dry eyes.-She stated the last time she had self-administered both the Lubrifresh eye ointment, and the Refresh Liquid Gel eye drops had been the evening of 9/8/25.-She stated she self-administered the Stye sterile lubricant ointment and the Lubrifresh P.M. eye ointment interchangeably.*There was a unit dose of albuterol sulfate 2.5 mg (milligram) /3 ml (milliliter) (a medication used to treat shortness of breath related to conditions such as asthma or chronic obstructive lung diseases). *There was no nebulizer machine (device that converts liquid medication into an inhalable mist) in resident 31's room.*Resident 31 stated she had not been administered a nebulizer medication in a long time.2. Review of resident 31's electronic medical record (EMR) revealed:*She was admitted on [DATE].*She had a 7/24/25 Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated her cognition was intact.*She had a 9/2/25 physician's order for Artificial Tears Opthalmic Ointment 83-15 % (White Petrolatum-Mineral Oil) Instill 1 application in both eyes at bedtime for dry eyes BOTH EYES and Carboxymethylcellulose Sodium Opthalamic Solution (Carboxymethylcellulose Sodium (Opthth)) Instill 1 drop in both eyes four times a day for dry eyes.*There was no physician's order for the albuterol sulfate nebulizer solution, the saline nasal spray, the Stye sterile lubricant, or the Refresh Liquid Gel eye drops. *Resident 31's 8/12/25 Medication Self-Administration Evaluation did not include, the Lubrifresh P.M. eye ointment, Stye sterile lubricant, Refresh Liquid Gel eye drops, saline nasal spray, or the albuterol nebulizer solution as medications resident 31 had been assessed to safely self-administer.*Resident 31's 8/12/25 Medication Self-Administration Evaluation indicated:-There was no physician's order to keep her medications at bedside.-Her medications were to be stored in the medication cart.3. Interview on 9/10/25 at 1:37 p.m. with certified medication aide (CMA) O revealed he:*Knew which residents were assessed to self-administer medications by a list that was in a binder on the medication cart.*Reviewed the list and stated resident 31 was not on the list.*Did not know who was responsible for updating the list or when it was last updated.*Did not know that resident 31 had medications on her over-the-bed table that she was self-administering.4. Interview on 9/11/25 at 9:58 a.m. with licensed practical nurse (LPN) K revealed:*There were no residents in the facility who had a physician's order to store medications in their room.*If she found a medication in a resident room, she would talk to the resident about the safety risk of keeping medication unsecured in their room due to wandering residents and then remove the medication from the resident's room.*A physician's order was required prior to the administration of a medication to a resident.*She knew which residents were able to self-administer their own medications, after being set up by the nursing staff, because it was indicated on the resident's care plan.*Medications that were outdated were to be destroyed and could not be administered to residents.5. Interview on 9/11/25 at 4:46 p.m. with director of nursing (DON) B revealed:*After a resident expressed interest in self-administering medication the care team would determine if the resident had the mental capacity to self-administer medication. If the resident was found to have the mental capacity to self-administer medications an assessment would be completed to determine if it was safe for the resident to self-administer medications.*Once that assessment was completed and the resident

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the provider failed to ensure one of one sampled resident's (8) advance directive wishes after he returned to the facility following a hospital stay was accurately identified and documented to ensure the resident's directives were followed if an event that may have prompted life-sustaining measures occurred. Findings include:1. Record review of resident 8's electronic medical record (EMR) revealed:*His code status (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop) was entered on [DATE] as Intubate (a tube inserted into the lungs to control breathing) Only in the EMR.*He had two signed documents that were checked Do Not Resuscitate (no life-sustaining measures) (DNR) in his EMR and in his paper chart.-One DNR was signed by resident 8 on [DATE].-The other DNR was signed by him on [DATE].-Those two documents had a provider's signature and a signature of the facility's authorized agent.*His care plan included a focus area of I have elected DNR status. CPR (cardiopulmonary resuscitation; an emergency procedure used to restart a person's heartbeat) measures ARE NOT to be performed.-The goal for that focus area stated, staff will respect my decisions to be DNR.2. Interview on [DATE] at 11:38 a.m. with resident 8 revealed:*He thought his code status was DNR. *He had to be intubated once during a surgical procedure and stated, I never want to go through that again. 3. Interview on [DATE] at 2:55 p.m. with licensed practical nurse (LPN) E revealed:*The resident's code status was kept in the paper chart on orange paper so it stands out easily.*She confirmed that resident 8's code status in his paper chart was a DNR and his code status in his EMR was Intubate Only.*She looked at his Intubate Only code status in the EMR and identified it was changed by nurse supervisor LPN M on [DATE].*She stated that if the resident code (stop breathing or if his heart stop beating) then she would have to follow the highest level of care that was listed in his records which was to intubate only.4. Interview with nurse supervisor LPN M on [DATE] at 3:06 p.m. revealed:*The residents receive admission paperwork when they arrive at the facility, which included code status wishes for the resident to fill out and sign.-The code status was to be signed by the provider and a witness from the facility.*Resident 8 was admitted to the hospital on [DATE] and returned to the facility on [DATE].-She noticed his code status changed to Intubate Only when he was in the hospital. She updated his EMR with that new code status after he returned to the facility on [DATE].-She confirmed that she did not discuss that code change with the resident before she updated his code status in the EMR.5. Interview with director of nursing (DON) B on [DATE] at 4:46 p.m. revealed:*She would expect that if there was a question about a code status change after a resident's hospitalization, the facility would need to confirm the resident's code statis wishes with the resident. *Code status were to be reviewed at the residents' care conferences.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and policy review, the provider failed to ensure one of one sampled resident's (12) protected health information in the resident's electronic medical record (EMR) was secured and was not displayed and accessible to other residents and staff in the west hall by one of one observed licensed practical nurse (LPN) (K).Findings include:1. Observation and interview on 9/11/25 at 1:13 p.m. with licensed practical nurse (LPN) K in the west hall revealed:*LPN K was away from the medication cart, administering medications to resident 12.*The computer screen on the medication cart was unlocked and displayed resident 12's EMR information.*Multiple staff members and residents were in the west hall and walked past that unlocked computer screen that displayed resident 12's EMR information.*LPN K agreed that the computer screen should have been locked. 2. Interview on 9/11/25 at 1:36 p.m. with director of nursing (DON) B revealed:*The EMR system used by the provider had a lock screen feature to secure the residents' EMR information from being viewed.*She would expect the screen to be locked anytime a staff member walked away from it. 3. Review of the provider's 12/20/19 HIPAA [Health Insurance Portability and Accountability Act] Fundamentals policy revealed:* HIPAA is a federal regulation comprised, in part, of the Privacy Rule, Security Rule, Enforcement Rule, and Breach Notification Rule. As an employee of a healthcare facility, you are required to comply with HIPAA regulations in performing your job duties to protect the integrity and privacy of residents' Protected Health Information (PHI). PHI is any individually identifiable information that the facility creates, receives or maintains related to the treatment of residents or payment for residents' care. PHI can be in any form or media, whether electronic, paper, or oral.* HIPAA Do:-Log off of computers/terminals when not in use.* HIPAA Don't:-Leave charts or paper PHI in areas accessible by the public.* HIPAA Breaches-A breach is an unauthorized use or disclosure of PHI that compromises the integrity of a resident's PHI.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities (continued on next page)

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F 0645 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 observation, interview, record review, and policy review, the provider failed to ensure one of two sampled residents resident (8 and 31) with diagnosed post-traumatic stress disorder had a Preadmission Screening and Resident Review (PASRR) reviewed for accuracy to ensure the resident was evaluated for mental health care needs.Findings include:1. Review of resident 8's electronic medical record (EMR) revealed:*He was admitted to the facility on [DATE].*His care plan dated 4/3/24 had a focus area of I am at risk for altered thought process due to history of alcohol abuse, PTSD, depression, and anxiety.*He had a Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated his cognition was intact.*Resident 8's diagnoses included: insomnia (trouble falling and staying asleep), alcohol abuse, major depressive disorder, anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), post-traumatic stress disorder, depression, adjustment disorder(a mental health reaction to stressful life events or changes that are considered a maladaptive response to a psychosocial stressor), and hallucinations (to see, hear, smell, taste, or touch something that is not there).*He had a PASRR that was screened at Level 1 (one).- PASRR question box does the individual have a condition of, or is there any presenting evidence that may indicate the individual may have mental illness? was marked no.2. Observation and interview on 9/10/25 at 11:38 a.m. with resident 8 in his room revealed he:*Resided in a private room. He was sitting in his bed with his laptop on the table in front of him. He was wearing a hospital gown.*Did not usually go to the facility's activities and preferred to stay in his room.*Was a veteran of the United States armed forces.*Had worked in underground [NAME] part-time while he was going to college. He would have to climb up and down a height of 150 feet on ladders. He sometimes had to carry dynamite up and down that ladder.*Said, I didn't know they [the facility] knew about that when he was asked about his diagnosis of post-traumatic stress disorder (PTSD; a mental health condition that can develop after exposure to a traumatic event).*Stated he had a hard time knowing what could trigger him. *Has not been offered any services for his PTSD that he can remember since being in the facility. 3. Interview on 9/10/25 at 1:52 p.m. with social services designee (SSD) D revealed:*She had been in her SSD role at the facility for about a year.*She received resident 8's PASRR from a branch of the United States Department of Veterans Affairs (VA).*She reviewed resident 8's PASRR and agreed it was completed incorrectly.*She agreed that a Level II PASARR would have been accurate for resident 8.4. Interview with administrator A on 9/11/25 at 5:31 p.m. revealed:*She would expect each resident's PASRR to be completed and accurate.5. Review of the provider's 5/14/25 Preadmission Screening and Resident Review (PASRR) policy revealed:*The Preadmission Screening and Resident Review (PASRR) is a federal requirement to ensure [the] nursing facility residents with serious mental illness (MI) or intellectual and developmental disability (ID/DD) are:-Identified and evaluated;-Placed in the most appropriate and least restrictive setting available;-Transitioned to an appropriate community setting when they no longer meet criteria for nursing facility placement;-Provided with the MI/ID/DD services they need, including specialized services.*A negative Level 1 screen permits admission to proceed and ends the pre-screening process unless possible serious mental disorder or intellectual disability arises later. A positive Level 1 screen necessitates an in-depth evaluation of the individual, by the state-designated authority, known as Level II [two] PASRR, which must be conducted prior to admission to the facility.*Failure to pre-screen residents prior to admission to the facility may result in the failure to identify residents who have or may have MD, ID, or a related condition. A record of the prescreening should be retained in the resident's medical record.*Individuals who have or are suspected to have MD, ID, or a related condition (as indicated by a positive Level 1 screen) may not be admitted to a Medicaid-certified nursing facility unless approved based on Level II [two] PASRR evaluation and determination. Exemptions to this requirement are specified in S483.20 (k)(2) and may be exercised at the discretion of the State, as specified in the State's PASRR process.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review the provider failed to review and revise the resident's care plan for two of two sampled residents' (8 and 31) care needs related to trauma exposure, and how to manage those needs according to the provider's policy.Findings include:1. Review of resident 8’s electronic medial record (EMR) revealed: *He was admitted to the facility on [DATE]. *He had a Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated his cognition was intact. *Resident 8’s diagnoses included: insomnia (trouble falling and staying asleep), alcohol abuse, major depressive disorder, anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), post-traumatic stress disorder, depression, adjustment disorder(a mental health reaction to stressful life events or changes that are considered a maladaptive response to a psychosocial stressor), and hallucinations (to see, hear, smell, taste, or touch something that is not there). 2. Observation and interview on 9/10/25 at 11:38 a.m. with resident 8 in his room revealed he: *Resided in a private room. He was sitting in his bed with his laptop on the table in front of him. He was wearing a hospital gown. *Does not usually go to the facility’s activities and preferred to stay in his room. *Was a veteran of the United States armed forces. *Had worked in underground [NAME] as while he was going to college. He would have to climb up and down a height of 150 feet on ladders. *Said, “I didn’t know they [the facility] knew about that” when he was asked about his diagnosis of post-traumatic stress disorder (PTSD; a mental health condition that can develop after exposure to a traumatic event). *Had a hard time knowing what would trigger him. *Had not been offered any services for his PTSD that he can remember since being in the facility. 3. Review of resident 8’s care plan revealed: *He had a focus area of “I am at risk for altered thought process due to history of alcohol abuse, PTSD, depression, and anxiety”. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Interventions listed for this focus area included “Call provider for any changes in cognitive functioning and/or any changes in behavior. Give medications as ordered. Keep the environment uncluttered. Make sure the resident wears eyeglasses and hearing aids, if applicable. Offer cues, direction, and redirection as needed”. -The interventions did not include what would potentially trigger resident 8’s PTSD or what the staff could do to prevent re-triggering the resident’s trauma. -The interventions did not tell staff what kind of behaviors they would need to monitor him for. -The care plan interventions for resident 8 were not specific to what staff would need to do when he would have an altered thought process. 4. Observation and interview on 9/10/25 at 9:01 a.m. with resident 31 in her room revealed: *The room was dark with the only light source coming from the outside window. *She had multiple items situated around her on her over-the-bed tables. *She did not move her legs when she attempted to reposition herself in bed with the use of her side rails (bars attached to the bed). *She stated she used the side rails to reposition herself, but her legs sometimes got “tangled up”. *Resident 31 stated she was a veteran of the armed forces. *Since her admission to the facility, she had not spoken to a staff member about her past traumas or experiences that have been difficult for her. *She felt like she was “talked around” instead of spoken to. *She did not remember if she was offered counseling services since her admission. *Resident 31 stated she had received counseling through the VA (Veterans Affairs) but did not have a good experience. 5. Review of resident 31’s EMR revealed: *She was admitted on [DATE]. *She had a 7/24/25 Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated her cognition was intact. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Resident 31’s diagnoses included adjustment disorder (a mental health reaction to stressful life events or changes that are considered a maladaptive response to a psychosocial stressor), borderline personality disorder (a mental disorder characterized by unstable moods, behavior, and relationships), major depressive disorder, PTSD, nightmare disorder (repeated intense nightmares), and anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). *She had a 9/2/25 physician’s orders for, “Bupropion HCL ER (XL) Tablet Extended Release 24 Hour [and anti-depressant medication]150 MG [milligrams] Give 1 tablet by mouth one time a day for depression”, and a 9/2/25 physician’s order for “DULoxetine HCL Capsule Delayed Release Particles [an anti-depressant medication] 30 MG Give 3 capsules by mouth at bedtime for depression”. *She was a veteran of the armed forces. *She was involved in a motor vehicle crash which resulted in paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs). *She had a physician’s orders for, “Bupropion HCL ER (XL) Tablet Extended Release 24 Hour [and anti-depressant medication]150 MG [milligrams] Give 1 tablet by mouth one time a day for depression”, and “DULoxetine HCL Capsule Delayed Release Particles [an anti-depressant medication] 30 MG Give 3 capsules by mouth at bedtime for depression”. *An 8/31/25 Summary of Episode Note by qualified mental health practitioner (QMHP) U stated, “In addition to addressing the patient’s medical needs, behavioral health concerns were identified, including moderately severe depression symptoms and severe anxiety symptoms. Conducted a brief behavioral health assessment to further evaluate the patient’s needs. Provided brief interventions and counseling to address immediate concerns and promote coping strategies.” *A 9/5/25 progress note stated, Resident 31 “expressed experiencing hallucinations since readmission [from the hospital]. Per resident and POA [power of attorney]. Physician notified.” 6. Review of resident 31’s 9/10/25 care plan revealed: *She had a focus area of “I am at risk for experiencing Hallucinations [to see, hear, smell, taste or touch something that is not there]”. -Interventions identified for that focus area were, “I will be provided a safe environment at all times. I will demonstrate reality-based thought process in verbal communication, and I will learn ways to refrain from responding to hallucinations.” -Resident 31’s care plan did not identify what types of hallucinations she experienced or how they affected her. -Resident 31’s care plan did not include her potential hallucination triggers or resident-specific interventions for her hallucinations. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She had a focus area of “I receive Psychoactive medications [drugs that affect brain activities associated with mental processes and behavior] d/t [due to] Adjustment disorder, Personality Disorder, Depression, PTSD, [and] Nightmare disorder”. -Interventions identified for that focus area were, “Administer the medications as ordered, Monitor behavior while on medication, Monitor for adverse or allergic reaction; Call MD [medical doctor] for any changes in condition, Monitor for ill effects related to medication, Monitor labs as ordered by MD, Verbal/Written consent for Psychotropic medication/s obtained from the resident”. -Resident 31’s care plan did not identify resident 31’s triggers, coping mechanisms, or resident specific interventions related to her experience as a veteran and surviving a MVC which resulted in her paraplegia and how that relates to her PTSD, personality disorder, depression, nightmare disorder, and adjustment disorder. -Resident 31’s care plan did not identify interventions for how her emotional and psychosocial needs were to be met to promote optimal quality of life. 7. Interview on 9/11/25 at 9:49 a.m. with certified nursing assistant (CNA) Q revealed she referred to the residents’ care plans to determine the care the resident required when she cared for a new or unfamiliar resident. 8. Interview on 9/11/25 at 9:58 a.m. with licensed practical nurse (LPN) K revealed she referred to the residents’ care plans to determine how they would transfer, if they had a specialized diet, if they received wound care, and their identified behaviors and what the interventions for those behaviors were. 9. Interview on 9/11/25 at 4:46 p.m. with director of nursing (DON) B revealed: *The responsibility for the updating residents' care plans was “segmented” between the interdisciplinary team of social services, nursing, activities, and dietary, and depended on the situation and the residents' current care plans. *She stated that when the Minimum Data Set (MDS) nurse was on-site at the facility, she was relied on to keep the care plans up to date. *She expected the care plans to be updated anytime there was a change in a resident’s care needs. *Upon the review of the care plans for resident 8 and 31, she verified trauma-informed care (a compassionate approach to healing that addresses the root cause of mental health struggles) was not addressed within those residents' care plans. *She stated the information gathered during the trauma-informed care process should be included in the care plan because it could affect how and what cares needed to be provided for the resident. *DON B stated the triggers, behaviors, and interventions would vary between residents who have experienced trauma because their past trauma exposure may have been different. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. Review of the provider’s 9/30/24 Care Plans policy revealed: *“Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident’s stay to promote optimal quality of life while in residence. In doing so, the following considerations are made: -1. Each resident is an individual. The personal history, habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical/diagnosis-based care considerations.” *“Data/Problems/Needs/Concerns are a culmination of resident social and medical history, assessment results and interpretation, ancillary service tracking, pattern identification, and personal information forming the foundation of the care plan.” *“Interventions act as the means to meet the individual’s needs. The ‘recipe’ for care requires active problem solving and creative thinking to attain, and clearly delineate who, what, where, when, and how the individual goals are being addressed and met. Assessment tools are used to help formulate the interventions (they are not THE intervention).” Review of the provider’s 9/30/24 Mental Health Adjustment Difficulties Related to Trauma, PTSD or Other Mental Health issues policy revealed: *“To ensure appropriate treatment and services are provided to all residents with adjustment difficulties to achieve the highest practicable mental and psychosocial well-being. ‘Appropriate’ means based upon assessment and care plan, should be person-centered, and the facility must make attempts to provide the services or assist residents with accessing such services.” *“Adjustment Difficulties: -…Are characterized by distress that is out of proportion to the severity or intensity of the stressor, taking into account external context and cultural factors, and/or a significant impairment in social, occupational, or other important areas of functioning. -May be related to a single event or involve multiple stressors and may be recurrent or continuous. -May cause a depressed mood, anxiety, and/or aggression.” *“History of Trauma: -Involves psychological distress, following a traumatic or stressful event, that is often variable. -May be connected to feelings of anxiety and/or fear. -Often involves expressions of anger or aggressiveness. -Some individuals who experience trauma will develop PTSD.” *“PTSD: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Involves the development of symptoms following exposure to one or more traumatic, life-threatening events. -…Symptoms may include, but are not limited to, the re-experiencing or re-living of the stressful event (e.g. flashbacks or disturbing dreams), emotional and behavioral expressions of distress (e.g. outbursts of anger, irritability, or hostility), extreme discontentment or inability to experience pleasure, as well as dissociation (e.g. detachment from reality, avoidance, or social withdrawal), hyperarousal (e.g. increased startle response or difficulty sleeping).” *“Moving from the community into a long-term care facility can be a very difficult transition and cause worsening or reemergence of symptoms for an individual with a history of trauma or PTSD.” *“Assess the resident to determine if services are needed.” *“[The resident’s] Care Plan should address the individualized emotional and psychosocial needs of the resident.” *“Staff must consistently implement the care approaches identified in the Care Plan. [The resident’s] Care Plan must be reviewed and revised if interventions are not effective or [the] resident has had a change in condition.”

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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 - 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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure quality care by not promptly implementing physician-ordered treatments for one of one sampled resident (69) with a physician-ordered negative pressure wound (NPWT) and antibiotic medication treatment. Findings include: 1. Review of resident 69's electronic medical record (EMR) revealed:*Her admission date was 3/25/25.*Her 3/31/25, 7/1/25, and 7/29/25 Brief Interview of Mental Status assessment scores were a 15, which indicated her cognition was intact.*She was hospitalized from [DATE] through 7/23/25 and again from 8/7/25 through 8/22/25.*Hospice (a program for terminally ill individuals that focuses on comfort and symptom management) care was initiated on 8/23/25.*She passed away at the facility on 8/24/25. *Her 3/25/25 admission diagnoses included hemiplegia and hemiparesis (partial paralysis affecting one side of the body) following cerebral infarction (brain tissue death caused by a severe and prolonged lack of blood flow) affecting her left non-dominant side, muscle wasting (the loss of muscle tissue), and atrophy (loss of muscle mass), acute respiratory failure with hypoxia (a serious medical condition where the lungs are unable to adequately exchange oxygen and carbon dioxide, leading to low levels of oxygen in the blood), transient ischemic attack (stroke), cerebral infarction without residual deficits (no lasting impacts), other malaise (a general feeling of discomfort, uneasiness, or lack of well-being), lymphedema (swelling, typically in the arms or legs caused by lymphatic system blockage), neuropathy (a condition that damages nerve function), obstructive sleep apnea (repeated episodes of partial or complete airway collapse during sleep, causing breathing to stop or decrease significantly), peripheral vascular disease (a slow and progressive circulation disorder of narrowing or blocked arteries and veins), chronic kidney disease, (a condition in which the kidneys gradually lose their ability to filter waste products and excess fluid from the blood), type 2 diabetes mellitus (a condition involving disruptions in how the body regulates blood sugar) with hyperglycemia (low blood sugar level), hypothyroidism (the thyroid gland does not produce enough thyroid hormone, which is essential for regulating many bodily functions), morbid (severe) obesity (excessive weight that significantly impacts health and well-being) due to excess calories.*Diagnoses added after her admission included:-On 4/8/25 a venous ulcer of her right lower leg and varicose veins.-On 5/23/25 venous insufficiency (a condition where the veins in the legs do not function properly, leading to poor blood flow back to the heart).-On 7/1/25 a non-pressure chronic ulcer (skin injury) of her left calf with unspecified severity.-On 7/23/25 restless leg syndrome (a common sleep disorder characterized by an irresistible urge to move the legs, often accompanied by uncomfortable sensations such as tingling, crawling, or pulling), and necrosis of muscle (muscle tissue death).*Her 3/25/25 Braden Scale (a tool used to assess the risk of developing pressure ulcers) score was eleven, which indicated she was at high risk for the development of pressure ulcers (skin wounds caused by prolonged pressure). Resident 69's 3/25/25 nursing admission assessment indicated:*Her ability to walk [was] severely limited or non-existant [non-existent]. [She] Cannot bear [her] own weight and/or must be assisted into [a] chair or wheelchair.*[Her mobility was] Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.*[She required] moderate to maximum [staff] assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction. Resident 69's nurse progress notes indicated:*On 3/25/25, she was admitted to the facility. Her left leg was very weak. She had non-pitting edema [observable swelling of body tissues caused by an accumulation of excess fluid] in her bilateral (both) lower legs. There was an open area to the calf of her right leg.*On 3/31/25, a note that included she required total assistance from a staff member for her oral hygiene, toileting, dressing, bed mobility, transfers, and personal hygiene. She was always incontinent (involuntary urine or bowel leakage) of her bladder and bowels. She had a skin treatment on her posterior [back] right leg . Resident 69's 5/7/25 monthly nursing summary indicated the area to document if she had edema was marked Yes and BLE (bilateral lower extremity). There were no other monthly nursing summaries documented in her EMR. A 5/20/25 nurse progress note included, During weekly wound assessment, states has a scratch to left leg. Upon assessment, open area, measuring 3.8cm [centimeter] x [by] 2.3cm. Depth unknow d/t [due to] slough [dead tissue]. Foul odor noted. Scant serosanguineous [wound drainage that is a mixture of clear, watery fluid and blood] drainage noted. Has left sided weakness. Uses sit stand lift [a mechanical lift used to assist

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review the provider failed to identify and implement pressure ulcer (skin and/or underlying tissue injury due to prolonged pressure) preventative interventions for residents identified at risk for developing pressure ulcers for:*One of one sampled resident (31) who developed a pressure ulcer to her right heel, left upper buttocks, and left foot.*One of one sampled resident (11) who developed a pressure ulcer to his left lower and left upper buttocks.Findings include:1. Observation and interview on 9/9/25 at 9:22 a.m. with resident 31 in her room revealed:*There was a sign on resident 31's door that indicated she was on enhanced barrier precautions (personal protective equipment, such as gloves and a gown was to be worn with all close contact resident care) (EBP).*She had an air mattress on her bed.*She was lying in bed on her left side.*She had two Prevalon boots (a cushioned boot that floats the heel off the surface of the mattress, to help reduce pressure) on the counter in her room.*Her feet were not elevated off the mattress with the use of pillows or other devices.*She had foam dressings on both of her feet. *When she was admitted to the facility, she had an abrasion on her buttocks that worsened until a wound vac (a medical device used to promote wound healing by applying negative pressure) was used for wound treatment.*She no longer had a wound vac because it became dislodged frequently.*She was able to reposition herself somewhat in bed with the use of her side rails (bar/bars attached to the bed) but often required assistance from staff for complete repositioning.*She stated she often waits a long time for staff to answer her call light when she needed assistance with repositioning.Observation and interview on 9/10/25 at 8:40 a.m. with resident 31 in her room revealed:*She was lying in bed on her left side.*The Prevalon boots were in the same location on her counter as they were on 9/9/25.*Her feet were not elevated off the mattress with the use of pillows or other devices.*She thought her Prevalon boots were missing a part and that was why staff did not put them on her.*There was a gel cushion in her wheelchair.*Resident 31 stated she did not get out of bed as often as she would like to and felt that was due to the staff being busy.*She had difficulty moving her legs when she was in bed because they often got tangled up.Review of resident 31's electronic medical record (EMR) revealed:*She was admitted on [DATE].*She had a 7/24/25 Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated her cognition was intact.*She was involved in a motor vehicle crash which resulted in paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs).*She was admitted with pressure ulcers on her left foot and right sacrum (the base of the spine that forms the back wall of the pelvis).*She had pressure ulcers on her right heel, and left buttock area that developed after she was admitted to the facility on [DATE].*Resident 31's 11/5/24 Braden Scale (a tool used to assess the risk of developing pressure ulcers) assessment score was 7, which indicated she was at high risk for developing a pressure ulcer.*The pressure ulcer to her right heel was identified on 12/25/24 as a deep tissue pressure injury (a localized area of tissue damage that occurs when prolonged pressure or shear forces damage the skin and underlying soft tissues) that measured 1.4 centimeters (cm)in length by 1.5 cm in width.*The pressure ulcer to her left buttock area was identified on 1/21/25 as a stage III (3; open wound with full-thickness skin loss. Fatty tissue may be visible) pressure ulcer that measured 4.4 cm in length by 4.5 cm in width by 0.1cm in depth.-On 7/22/25 the pressure ulcer was documented as a stage IV (4; open wound with full-thickness skin and tissue loss. Bone, tendon, or muscle may be visible) pressure ulcer that measured 2.7 cm in width by 3.4 cm in length by 0.6cm in depth.*Review of resident 31's 11/5/25 baseline care plan revealed, a focus area of, I am at risk for impairment to skin integrity r/t [related to] impaired mobility and paraplegia -open wound to.-Resident-specific interventions for that focus area were, Air mattress to bed and w/c [wheelchair] cushion in place and HIGH RISK- skin check every shift. Report abnormalities to the nurse.*Review of resident 31's 9/10/25 care plan revealed a focus area of, I am at risk for impairment to skin integrity r/t impaired mobility and paraplegia -open wound to left medial dorsal [inner top of the] foot -left upper buttocks stage 3 -unstageable to the sacrum -SDTI [suspected deep tissue injury] right plantar aspect [bottom of foot] -SDTI right posterior heel.-Interventions identified related to that focus area in addition to the baseline care plan interventions were:--On 1/7/25 left foot and ankle, two layer wrap in place.--On 1/21/25 I will often refuse to offload [reposition to relieve pressure] and my wound care.--On 3/4/25 Turn and reposition q [every] 2hrs [two hours] per my request -I often refused repositioning when offered -I often request a pillow placed under one side or the other, which doesn't fully offload me.--There were no identified approaches or interventions identified if resident 31 refused repositioning, offloading, or

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview, record review, and policy review, the provider failed to ensure: Interventions were implemented or updated to mitigate falling incidents for one of one sampled resident (14) identified at risk for falling who fell and sustained facial bruising and to have completed and documented a thorough investigation of that fall.Findings include:1. Observation on 9/9/25 at 8:46 a.m. of resident 14 in her room revealed she was lying on her side in bed. There was purple colored bruising beneath and above her right eye, extending to her forehead hairline. The resident stated she had fallen but was not sure how that had occurred. Her bed was low to the floor. Her call light was held inside the top closed drawer of a three-drawer plastic storage container near the head of her bed. A fall mat was folded against the wall on her roommate's side of the room. A walker and a wheelchair were also by that wall. Observation and interview on 9/9/25 at 11:35 a.m. with occupational therapist (OT) X in resident 14's room revealed she was encouraging the resident to reach towards the walker in front of her and pull herself to a standing position. OT X stated resident 14 took a couple falls when she was recently sick. Observation on 9/9/25 at 3:30 p.m. revealed resident 14 was asleep in bed. Her call light remained positioned in the above manner inside the plastic storage container. The above fall mat, walker, and wheelchair remained near or against the wall. Review of resident 14's electronic medical record (EMR) revealed her diagnoses included Alzheimer's, anxiety, depression, and high blood pressure. Resident 14's 9/2/25 revised fall care plan included the following fall prevention interventions: Ensure that [resident 14's] FWW (front wheeled walker) is within her reach when she is in bed. Initiated on 5/24/23.Fall mat at bedside while in bed to prevent injury. Initiated on 9/2/25.Keep call light within reach when in bedroom and bathroom. Initiated on 4/18/22.Sign in room to remind resident to ask for assist with transfers. Initiated on 6/14/23.Signs in room to remind resident to lock wheelchair. Initiated on 8/4/22. Observation on 9/10/25 at 7:50 a.m. revealed resident 14 was asleep in bed. Her call light was inside the drawer of the plastic storage container. A wheelchair and one end of an over-the-bed table were positioned in front of the exit side of her bed. The fall mat was folded against the wall on her roommate's side of the room. Interview on 9/10/25 at 8:55 a.m. with certified nurse aide (CNA) T regarding the positioning of the above equipment in front of resident 14's bed revealed that it was done to create a clutter-free path for resident 14's roommate. Observation and interview on 9/10/25 at 3:50 p.m. with resident 14 revealed that she sat in her wheelchair in her room. Her call light remained inside the drawer of the plastic storage container. When she was shown the call light, she was able to explain that its purpose was to bring help to her. There was no fall prevention signage posted on resident 6's side of the room. Review of the 9/1/25 Fall Scene Investigation (FSI) Report revealed that at 4:00 a.m. that morning, resident 14 was found on the floor of her room after an unwitnessed fall. Per the report, the resident had stated she was going through cards in her three-drawer plastic storage container and fell out of her wheelchair. She had refused the staff's assistance to get into her bed. She had been agitated and confused before that fall had occurred. She was last assisted to use the bathroom at 2:00 a.m. The section in the above report used to identify the root cause of the fall was blank. The section on that same report used to identify interventions to prevent future falls was blank. The checkbox to indicate if the resident's care plan had been updated was unchecked. The space for the nurse who had completed the form to sign and date it was blank.The last section of the above report was titled Falls Team Meeting Notes and it included the following meeting summary: Resident [14] anxious and exhibiting behaviors. Staff checked on resident at 0355 [3:55 a.m.] and resident was medicated for anxiety. Placed floor mat to prevent injury.There was no indication if the fall prevention interventions that were identified in resident 14's care plan were implemented at the time of her fall. There was no indication whether those same fall prevention interventions were reviewed to determine if they remained appropriate after she fell on 9/1/25.Observation and interview on 9/11/25 at 11:05 a.m. with director of nursing (DON) B in resident 14's room revealed the cause of the resident's facial bruising was a result of her 9/1/25 fall. The resident had tested positive for COVID-19 at the end of August 2025 and was expected to isolate in her room until her isolation precautions were lifted on 9/4/25. Resident 14's anxiety and restlessness had increased during that isolation period. She had not understood why she was expected to stay in her room. Resident 14 had no fewer than three falls during that isolation period.Regarding resident 14's fall care plan interventions, DON B confirmed that having a walker in reach when the resident was in bed was no longer indicated due to a decline in the resident's physical abilities. A fall mat was still expected to have been placed on the floor at the exit side of her bed when the resident was in her bed. That intervention should have been added to the

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure the respiratory treatment equipment for five of five sampled residents (40, 56, 57, 58, and 67) who used oxygen and one of one sampled resident (58) who used a continuous positive airway pressure (CPAP) machine (a machine used to keep a person's airway open while they sleep) was cleaned and stored according to the manufacturer's instructions and the provider's policies.Findings include: 1. Observation and interview on 9/9/25 at 9:06 a.m. with resident 67 in his room revealed: *He was on oxygen, and the flow rate on the oxygen concentrator (a device that filters room air into purified oxygen) was set to four liters per minute (4L/min). *The oxygen concentrator had a label on it that had another person’s name on it. * There was a thick, fuzzy layer of gray dust caked on the filter of the concentrator. *The nasal cannula (flexible tubing with prongs that delivers oxygen through the nose) attached to the concentrator was not dated. *A wheelchair in his room had a portable oxygen tank on the back of it, with another nasal cannula tubing attached to the tank. -That nasal cannula was hanging over the back of the wheelchair, touching the wheels of the wheelchair, and was also undated. Observation on 9/9/25 at 4:23 p.m. in resident 67’s room revealed: *The flow rate on the concentrator remained at 4L/min. *The nasal cannula attached to the portable tank was lying on the floor. Observation on 9/10/25 at 9:46 a.m. in resident 67’s room revealed: *The flow rate on the concentrator was set to 2L/min. *Both nasal cannulas were labeled with the date “9/7.” *The label with another person’s name on it had been removed from the concentrator. *The filter remained dusty. *The nasal cannula on the portable tank was in a pocket on the wheelchair. Review of resident 67’s electronic medical record (EMR) revealed: *He was admitted on [DATE]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*He had 9/3/25 orders for: -“Oxygen continuous [at all times] [at] 2L/min via nasal cannula.” -“Concentrator Filter Cleaning” weekly, every Saturday. -Change oxygen tubing every Saturday, and as needed. 2. Observation and interview on 9/9/25 at 9:30 a.m. with resident 56 in her room revealed: *She used oxygen at night. *There was an oxygen concentrator near her bed. It had a nasal cannula attached to it that was hanging over a bedrail, tucked between the mattress and the bedrail. -That nasal cannula was dated “8/23.” 3. Observation and interview on 9/9/25 at 9:40 a.m. with resident 40 in his room revealed: *He was on oxygen, and there was a portable oxygen tank on the back of his wheelchair that was set to 3L/min. *That nasal cannula was dated “8/23/25.” Review of resident 40’s EMR revealed: *He had 12/21/24 orders for: -“Oxygen continuous 3L/min via nasal cannula.” -Change oxygen tubing every Saturday, and as needed. 4. Observation on 9/9/25 at 9:23 a.m. of resident 57’s room revealed: *There was a nasal cannula draped over a bed. *The nasal cannula was attached to an oxygen concentrator that was running. *There was no place for the nasal cannula to be stored to prevent potential contamination of the nasal cannula. *There was dust coating the outside of the oxygen concentrator. *The oxygen concentrator had a brown waxy oil on the vents of the filter cover. *The tab to release the cover over the filter was missing. *The filter in the oxygen concentrator was covered with gray dust particles. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 9/10/25 at 9:42 a.m. with resident 57 in her room revealed: *Resident 57 was sitting on the side of her bed. Her nasal cannula was draped on the bed beside her, and the oxygen concentrator was running. *She stated she wore the oxygen when she slept. *She stated she did not know if someone had replaced her nasal cannula or cleaned her oxygen concentrator. Review of resident 57’s electronic medical record (EMR) revealed she: *Was admitted on [DATE]. *Had a Brief Interview of Mental Status (BIMS) assessment score of 15, which indicated her cognition was intact. *Had diagnoses of respiratory failure (not enough oxygen passes from the lungs to the body), and thromboembolic pulmonary hypertension (a rare condition where blood clots in the lungs persist and cause high blood pressure in the artery that carries blood from the heart to the lungs, which results in damage to the heart and lungs). *She had a 1/3/25 physician’s order for, “Oxygen continuous 2L/min [liters per minute] via nasal cannula”. Review of resident 57’s August 2025 treatment administration record (TAR) revealed: *She was scheduled on Saturday night shifts to have her nasal cannula replaced and her concentrator filter cleaned. -There was no documentation that was completed on 8/9/25 or 8/30/25 as scheduled. 5. Observation on 9/9/25 at 9:26 a.m. of resident 58’s room revealed: *He was sitting in his wheelchair with his nasal cannula on. *His nasal cannula was attached to an oxygen concentrator, which was running. *The oxygen concentrator was covered in white flakes and dust particles. *The vent cover over the oxygen concentrator’s filter was covered in dust. *There was an assembled mask and tubing attached to a continuous positive airway pressure (CPAP) machine (a machine used to keep a person’s airway open while they sleep) on resident 58’s bedside table. Observation and interview on 9/10/25 at 9:39 a.m. with resident 58 in his room revealed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*He was sitting in his wheelchair with his nasal cannula on. *His nasal cannula was attached to the oxygen concentrator. *There was another nasal cannula draped over the handles on the back of his wheelchair was attached to a portable oxygen cylinder. *There was no place for the nasal cannula to be stored to prevent potential contamination of the nasal cannula. *The filter of the oxygen concentrator had a coating of gray dust on it, and the compartment surrounding the filter was dusty. *Resident 58 stated he wore oxygen all the time. *The CPAP mask and tubing remained assembled on his bedside table. *Resident 58 stated he wore the CPAP at night. *Resident 58 shrugged his shoulders when he was asked if someone cleaned his CPAP mask and tubing, or his oxygen concentrator. Review of resident 58’s EMR revealed he: *Was admitted on [DATE]. *Had a BIMS assessment score of 3, which indicated he had severe cognitive impairment. *Had diagnosis of chronic respiratory failure with hypoxia (low oxygen in the blood) and obstructive sleep apnea (a sleep disorder where the airway repeatedly collapses during sleep, leading to pauses in breathing). *Had a 12/16/24 physician’s order for “Oxygen 3LPM [liters per minute] via nasal cannula” and “CPAP Setting 11 with 2L [liters] o2 [oxygen] bleed in every evening shift for CPAP usage **Assist with placement at bedtime**”. Review of resident 58’s August 2025 treatment administration record (TAR) revealed: *He was scheduled on Saturday night shifts to have his nasal cannula replaced. -There was no documentation that was completed on 8/9/25 or 8/30/25 as scheduled. *Cleaning of the oxygen concentrator filter was not scheduled on the TAR to be completed. *Cleaning of the CPAP machine, mask, and reservoir was not scheduled on the TAR to be completed. *Replacement of the mask and tubing was not scheduled on the TAR to be completed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Interview on 9/10/25 at 1:37 p.m. with certified medication aide (CMA) O revealed: *CPAP machines, masks, and tubing were to be scheduled to be cleaned weekly for residents who wore CPAPs. *The CPAP mask and tubing were to be disassembled, washed with soap and water, and then hung to dry. *Cleaning of the CPAP machines, masks, and tubing was to be documented on the resident’s TAR. *Nasal cannulas were to be replaced weekly on the night shift. *Nasal cannulas were to be stored rolled up in a bag when it was not in use. *The filters in the oxygen concentrators were to be checked weekly and replaced as needed. *CMA O observed resident 58’s oxygen concentrator and filter, and stated he would not have considered the oxygen concentrator or the filter clean and verified there was dust and white flakes on the concentrator and dust on the filter and in the filter compartment. 7. Interview on 9/11/25 at 9:58 a.m. with licensed practical nurse (LPN) K revealed: *There were to be orders for the residents’ nasal cannula to be replaced weekly by the nurse and documented in the resident’s’ TAR. *The nasal cannulas were to be stored coiled up and placed on the oxygen concentrator, off the floor, when not in use. *Nursing staff did not clean the filters in the oxygen concentrators, she thought the maintenance staff was responsible for cleaning the filters. *CPAP masks were to be cleaned or replaced weekly by the nurse and documented in the resident’s TAR. 8. Interview on 9/11/25 at 4:28 p.m. with the infection preventionist (IP)/wound care nurse C revealed: *Nasal cannulas were to be replaced weekly, and the replacement was to be documented on the resident’s TAR. *Nasal cannulas were to be stored in a bag off the floor when they were not being used. The bags were to be replaced weekly when the nasal cannula was replaced. *IP/wound nurse C expected the oxygen concentrators to be wiped down if they were visibly soiled. *She thought the oxygen concentrator filters were cleaned and replaced by the provider’s contracted oxygen company. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She was not aware that some residents had the cleaning of the oxygen concentrator filters scheduled on their TAR and others did not. *She verified if there was no schedule for cleaning of the oxygen concentrator filter on the TAR there was no place to document the cleaning was completed and therefore, the cleaning could not be verified as having been completed. *She expected the residents’ CPAP masks to be separated from the tubing and washed daily. *The CPAP tubing was to be washed with soap and water weekly and hung to dry. *The cleaning of the CPAP mask and tubing was to be documented on the residents’ TAR. *She verified if there was no schedule for cleaning of the CPAP machine and mask on the TAR there was no place to document the cleaning and therefore the cleaning would not be able to be verified as having been completed. 9. Interview on 9/11/25 at 4:46 p.m. with director of nursing (DON) B revealed: *Nasal cannulas were to be replaced weekly by the nurse and documented on the residents’ TARs. *The cleaning of the oxygen concentrators and the filters for the oxygen concentrators were completed weekly by the previous medical records staff member. *She expected the nasal cannulas to be stored in a bag, off the floor when they were not in use. *Cleaning of the CPAP machines, mask, and tubing should be completed according to the manufacturer’s instructions. *She stated she reviewed the different CPAP machines that were used in the facility and the manufacturers’ instructions indicated the tubing should be soaked weekly and changed monthly. *She verified that there was no documentation for the cleaning of the oxygen concentrator and CPAP supplies, or the replacement of the nasal cannulas weekly, she could not verify it had been completed. 10. Review of the provider’s 3/31/25 CPAP and BiPAP Cleaning policy revealed: *Procedures -“After each use, the mask/reservoir will be wiped with warm soapy water per manufacturer’s instructions, rinsed, and placed upside down to dry on a paper towel.” -“The tubing will be replaced at the time interval recommended by the individual machine’s manufacturer.” (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-“The machine should be wiped/cleaned with a disinfectant on at least a weekly basis and as needed. ” Review of the provider’s 11/19/24 Oxygen Administration policy revealed: *”Oxygen masks and tubing will be changed weekly and as needed. Change of tubing and mask should be documented in the medical record. When not in use, the mask should be stored in a plastic bag. ” *“The nasal cannula and tubing will be changed weekly and as needed. Change of tubing and cannula should be documented in the medical record. When not in use, the nasal cannula should be stored in a plastic bag.” *“Oxygen concentrators will have exterior wiped down when soiled and at least weekly. If equipped with a filter, [the] filter will be cleaned at least weekly by rinsing with water and allowing to dry…Weekly cleaning of the concentrator and filter should be documented in the medical record.”

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F 0697 Level of Harm - 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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure pain management interventions were implemented and effective for one of one sampled resident (6).Findings include:1. Observation and interview on 9/9/25 at 9:53 a.m. in resident 6's room revealed he was lying on his back in bed wearing a hospital gown. He had a U-shaped pillow around the back of his neck. The resident had a grim expression on his face, and he strained to answer simple questions. He complained of being cold. Observation on 9/9/25 at 12:00 noon outside of resident 6's room revealed he was overheard telling an unidentified caregiver, I wish that nurse would come. I need that oxy [oxycodone, pain medication that is a controlled medication meaning at risk for abuse and addiction].Observation on 9/9/25 at 12:03 p.m. revealed licensed practical nurse (LPN) E entered resident 6's room. She explained to him that he had a physician's order for Tylenol, but there was no order for him to have oxycodone. LPN E stated she would have to call the resident's physician to discuss his request for oxycodone. She adjusted the resident's U-shaped neck pillow. Without first asking the resident what his pain level was or where his pain was, she administered two Tylenol tablets to resident 6. Observation and interview on 9/9/25 at 12:05 p.m. with resident 6 revealed he was lying on his back in bed, rubbing his forehead back and forth repeatedly and moaning, uh, uh. He stated on a scale of one to ten, with ten being the worst possible pain, that his pain was a ten. He identified his left ankle as the source of his pain. He described his pain as hot and stabbing and nearly constant. His eyes watered as he described his pain. Review of resident 6's electronic medical record (EMR) revealed he was admitted to the facility on [DATE]. His diagnoses included multiple sclerosis (MS), metastatic malignant neoplasm (cancer), depression, peripheral vascular disease (circulation disease), a history of left lower leg pain, and a history of cellulitis (bacterial infection of the skin) of his left lower limb. His 6/18/25 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated he had moderate cognitive impairment. Review of resident 6's September 2025 medication administration record (MAR) revealed a 6/12/25 physician's order for acetaminophen (generic Tylenol), 325 milligrams (mg), two tablets every eight hours for pain rated one to seven on a pain scale from zero to ten. There was a 6/12/25 physician's order for oxycodone HCl (hydrochloride), one tablet every eight hours as needed for pain rated eight to ten on a pain scale from zero to ten. Review of resident 6's September 2025 MAR and interview on 9/9/25 at 2:00 p.m. with LPN E revealed it's [the oxycodone order] right below the Tylenol. She had not known that resident 6 had an order for oxycodone; otherwise, she would have administered the oxycodone instead of the Tylenol as the resident had requested.When asked why resident 6 had pain, she stated, I'm not honestly sure the cause of his pain. It may be related to an accident. She thought he had pain in his leg or his neck. She was not sure how often or if resident 6 had gotten out of bed. She had not reassessed resident 6's pain level after she administered the two Tylenol tablets two hours earlier.LPN E administered resident 6's oxycodone after she was made aware of his physician's order for oxycodone.Review of resident 6's September 2025 MAR revealed LPN E had reassessed the resident's pain after she administered the above oxycodone. That administration was documented as having been an effective response to his pain.Interview on 9/10/25 at 2:40 p.m. with director of nursing (DON) B revealed LPN E had not administered resident 6's pain medication per his physician's order. That had potentially caused resident 6 unnecessary pain. DON B had expected LPN E to have thoroughly reviewed resident 6's MAR for all physician-ordered pain medication options and to have administered the most appropriate pain medication to him based on his level of pain. LPN E should have assessed and documented resident 6's pain level before administering any pain medication. That assessment should have identified whether his pain was new, acute, chronic, or related to an injury and what medication to administer for effective pain relief. Observation and interview on 9/10/25 at 1:30 p.m. with resident 6 revealed he was lying in his bed on his back in a hospital gown. He was watching television. He stated his MS had worsened, and caused a decline in his physical abilities. He thought his MS was also partially to blame for his near-constant pain. Observation on 9/11/25 at 8:30 a.m. of resident 6 revealed he was lying in his bed on his back in a hospital gown. His television was on, and his eyes were closed. Interview on 9/11/25 at 2:15 p.m. with resident 6 revealed he had no significant pain and stated, in a minute or so the pain will start back up at a ten.Review of resident 6's EMR revealed:On 7/26/25, he was transferred to the local emergency room due to left lower leg pain. No pain medication changes were made, and the resident was referred to his primary care physician for follow-up His 9/9/25 Monthly Nursing Summary

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to implement specific care approaches that addressed the mental and psychosocial needs of two of two sampled residents (8 and 31) with diagnosed post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event) (PTSD) history of trauma exposure to mitigate triggers and prevent re-traumatization. Findings include: 1. Observation and interview on 9/10/25 at 9:01 a.m. with resident 31 in her room revealed: *The room was dark with the only light source coming from the outside window. *She had multiple items situated around her on her over-the-bed tables. *She did not move her legs when she attempted to reposition herself in bed with the used of her side rails (bars attached to the bed). *She stated she used the side rails to reposition herself, but her legs sometimes got “tangled up”. *Resident 31 stated she was a veteran of the armed forces. *Since her admission to the facility, she had not spoken to a staff member about her past traumas or experiences that have been difficult for her. *She felt like she was “talked around” instead of being spoke to. *She did not remember being offered counseling services since her admission, but stated she may have been offered, and she did not remember. *Resident 31 stated she had been in counseling through the VA (Veterans Affairs) but did not have a good experience. 2. Review of resident 31’s electronic medical record (EMR) revealed: *She was admitted on [DATE]. *She had a 7/24/25 Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated her cognition was intact. *Resident 31’s diagnoses included, adjustment disorder (a mental health reaction to stressful life events or changes that are considered a maladaptive response to a psychosocial stressor), borderline personality disorder (a mental disorder characterized by unstable moods, behavior, and relationships), major depressive disorder, chronic post-traumatic stress disorder(a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event) (PTSD), nightmare disorder, and anxiety disorder. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She was a veteran of the armed forces. *She was involved in a motor vehicle crash which resulted in paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs). *She had a physician’s orders for, “Bupropion HCL ER (XL) Tablet Extended Release 24 Hour [and anti-depressant medication]150 MG [milligrams] Give 1 tablet by mouth one time a day for depression”, and “DULoxetine HCL Capsule Delayed Release Particles [an anti-depressant medication] 30 MG Give 3 capsules by mouth at bedtime for depression”. *An 8/31/25 Summary of Episode Note by qualified mental health practitioner (QMHP) stated, “In addition to addressing the patient’s medical needs, behavioral health concerns were identified, including moderately severe depression symptoms and severe anxiety symptoms. Conducted a brief behavioral health assessment to further evaluate the patient’s needs. Provided brief interventions and counseling to address immediate concerns and promote coping strategies.” *A 9/5/25 progress note stated, Resident 31, “expressed experiencing hallucinations since readmission [from the hospital]. Per resident and POA [power of attorney]. Physician notified.” *Resident 31’s 9/10/25 care plan had a focus area of “I am at risk for experiencing Hallucinations [to see, hear, smell, taste or touch something that is not there]”, and “I receive Psychoactive medications [drugs that affect brain activities associated with mental processes and behavior] d/t [due to] Adjustment disorder, Personality Disorder, Depression, PTSD, [and] Nightmare disorder”. 3. Review of resident 31’s 11/5/24 Social Services assessment revealed: *The assessment was completed by social service designee (SSD) D. *The first four questions of the assessment were labeled “Trauma Screening” *To question number four in the trauma screening, “Per family information and medical record information, is the resident a victim of trauma including violence (example: torture, assault), war (example: Holocaust survivor), natural disaster, man-made disaster (example: fire), terrorism, and catastrophic accident?”, SSD D answered “No”. *At the end of the trauma screening portion stated, “If there is a YES for questions #1 to #4, a trauma-informed care plan is required and information derived from questions #5 to #7 should be included in the care plan and care of the resident.” Questions five through seven had not been completed due to the answering of “No” to question four. *In section III (three) “Screen to Determine Abuse/Neglect SSD D documented “No” to the questions, “Does the resident have a psychiatric history and/or present mental health diagnosis?”, and “Does the resident have a diagnosis of depression and/or a history of depressive illness and/or present with signs/symptoms of depression/mood distress; low self esteem, isolation and withdrawn behavior; complaints of chronic pain, illness, fatigue, and/or persistent anger, fear and/or anxiety?” (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*In section IV (four) “Screening for Evaluating Self-Harm” SSD D “No” was documented to the questions, “History of psychiatric problems and/or a personality disorder diagnosis” and “Individual with a history/diagnosis of Post Traumatic Stress Disorder (PTSD), especially a veteran of the armed forces”. 4. Observation and interview on 9/10/25 at 11:38 a.m. with resident 8 in his room revealed he: *Resided in a private room. He was sitting in his bed with his laptop on the table in front of him. He was wearing a hospital gown. *Does not usually go to the facility’s activities and preferred to stay in his room. *Was a veteran of the Unites States armed forces in the 1970’s. *Had worked in underground [NAME] part-time while he was going to college. He would have to climb up and down a height of 150 feet on ladders. He sometimes had to carry dynamite up and down that ladder. *Said, “I didn’t know they [the facility] knew about that” when he was asked about his diagnosis of PTSD. *Had a hard time knowing what would trigger him. *Had not been offered any services for his PTSD that he can remember since being in the facility. 5. Review of resident 8’s electronic medical record (EMR) revealed: *He was admitted to the facility on [DATE]. *He had a Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated his cognition was intact. *Resident 8’s diagnoses included: insomnia (trouble falling and staying asleep), alcohol abuse, major depressive disorder, anxiety disorder, post-traumatic stress disorder, depression, adjustment disorder (a mental health reaction to stressful life events or changes that are considered a maladaptive response to a psychosocial stressor), and hallucinations. 6. Review of resident 8’s care plan revealed: *He had a focus area of “I am at risk for altered thought process due to history of alcohol abuse, PTSD, depression, and anxiety”. -The Interventions listed for this focus area included “Call provider for any changes in cognitive functioning and/or any changes in behavior. Give medications as ordered. Keep the environment uncluttered. Make sure the resident wears eyeglasses and hearing aids, if applicable. Offer cues, direction, and redirection as needed”. -The interventions did not include what would potentially trigger resident 8’s PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The interventions did not tell staff what kind of behaviors they would need to monitor him for. -The care plan interventions for resident 8 were not specific to what staff would need to do when he would have that altered thought process. 7. Interview with social services designee (SSD) D on 9/10/25 at 1:52 p.m. revealed: *She assessed new residents for trauma when they were admitted to the facility. -If the resident did not verbalize a history of trauma, that is what she would document on the trauma assessment. *She agreed that a resident might not want to share off of their historical trauma upon admission to the facility. 8. Interview and review of resident 8’s and 31’s care plans with director of nursing (DON) B on 9/11/25 at 4:46 p.m. revealed: *She verified trauma-informed care (a compassionate approach to healing that addresses the root cause of mental health struggles) was not addressed within those residents’ care plans. *She stated the information gathered during the trauma-informed care process should be included in the care plan because it could affect how and what cares needed to be provided for the resident to prevent things that may trigger emotions or behaviors or re-traumatize the resident. *DON B stated the triggers, behaviors, and interventions would vary between residents who have experienced trauma because their past traumas may have been different. 9. Review of the provider’s 9/30/24 Mental Health Adjustment Difficulties Related to Trauma, PTSD or Other Mental Health issues policy revealed: *“To ensure appropriate treatment and services are provided to all residents with adjustment difficulties to achieve the highest practicable mental and psychosocial well-being. ‘Appropriate’ means based upon assessment and care plan, should be person-centered, and the facility must make attempts to provide the services or assist residents with accessing such services.” *“Adjustment Difficulties: -…Are characterized by distress that is out of proportion to the severity or intensity of the stressor, taking into account external context and cultural factors, and/or a significant impairment in social, occupational, or other important areas of functioning. -May be related to a single event or involve multiple stressors and may be recurrent or continuous. -May cause a depressed mood, anxiety, and/or aggression.” *“History of Trauma: (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Involves psychological distress, following a traumatic or stressful event, that is often variable. -May be connected to feelings of anxiety and/or fear. -Often involves expressions of anger or aggressiveness. -Some individuals who experience trauma will develop PTSD.” *“PTSD: -Involves the development of symptoms following exposure to one or more traumatic, life-threatening events. -…Symptoms may include, but are not limited to, the re-experiencing or re-living of the stressful event (e.g. flashbacks or disturbing dreams), emotional and behavioral expressions of distress (e.g. outbursts of anger, irritability, or hostility), extreme discontentment or inability to experience pleasure, as well as dissociation (e.g. detachment from reality, avoidance, or social withdrawal), hyperarousal (e.g. increased startle response or difficulty sleeping).” *“Moving from the community into a long-term care facility can be a very difficult transition and cause worsening or reemergence of symptoms for an individual with a history of trauma or PTSD.” *“Assess the resident to determine if services are needed.” *“[The resident’s] Care Plan should address the individualized emotional and psychosocial needs of the resident.” *“Staff must consistently implement the care approaches identified in the Care Plan. [The resident’s] Care Plan must be reviewed and revised if interventions are not effective or [the] resident has had a change in condition.”

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

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

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F 0745 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 observation, interview, record review, and job description review, the provider failed to provide medically-related social services for one of one sampled resident (6) at risk for a decline in his psychosocial well-being. Findings include:1. Observation and interview on [DATE] at 9:53 a.m. in resident 6's room revealed he was lying on his back in bed wearing a hospital gown. He had a U-shaped pillow around the back of his neck. The resident had a grim expression on his face, and he strained to answer simple questions. He complained of being cold. Observation on [DATE] at 12:00 noon outside of resident 6's room revealed he was overheard telling an unidentified caregiver, I wish that nurse would come. I need that oxy [oxycodone-a narcotic pain medication].Observation and interview on [DATE] at 12:05 p.m. with resident 6 revealed he was lying on his back in bed, rubbing his forehead back and forth repeatedly and moaning, uh, uh. He stated on a scale of 1 to 10, with 10 being the worst possible pain, that his pain was a 10. His eyes watered as he described his pain. Interview on [DATE] at 2:00 p.m. with licensed practical nurse (LPN) E regarding the cause of resident 6's pain revealed she stated, I'm not honestly sure the cause of his pain. It may be related to an accident. She thought he had pain in his leg or his neck. She was not sure how often or if resident 6 had ever gotten out of bed. He only had physician orders for as needed and not scheduled pain medication. Interview on [DATE] at 3:45 p.m. with resident 6 revealed that he missed his dog, which had died. He had a friend who visited him a few times a month, but his immediate family members lived far away from him. He had a recliner at his home that he often sat in. There was no recliner in his current room. He reported frequently not being able to sleep at night. He questioned if he was better off no longer alive, but he still wanted to live. He was willing to speak with a counselor about his depression if one was available. Interview on [DATE] at 4:00 p.m. with guest services aide (GSA) F and certified nurse aide (CNA) H regarding resident 6 revealed GSA F had worked at the facility for about two months and had not seen resident 6 out of his bed. She thought that was due to his pain. CNA H stated that resident 6 was supposed to be transferred to his wheelchair to eat his meals, but that had not been occurring.Review of resident 6's electronic medical record (EMR) revealed he was admitted to the facility on [DATE]. His diagnoses included multiple sclerosis (MS), metastatic malignant neoplasm (cancer), depression, peripheral vascular disease (circulatory disease), and a history of left lower leg pain. His [DATE] Brief Interview for Mental Status assessment score was 10, which indicated he was moderately cognitively impaired. His [DATE] PHQ-9 (depression scale) score was 11, which indicated he had mild to moderate depression. There were three documented progress notes completed by social services designee (SSD) D. On [DATE], she called the resident's family to discuss discharge planning. On [DATE], she had offered the resident counseling services, and he declined. On [DATE], she called the resident's family to set up a care conference time. Review of resident 6's care plan revealed no social services-related goals or interventions.Observation and interview on [DATE] at 1:30 p.m. with resident 6 revealed he was lying in his bed on his back in a hospital gown. He was watching television. He stated his MS had worsened, and caused a decline in his physical abilities. He thought that was also to blame for his near-constant pain. He had lived in his own home with the support of caregivers before he came to the facility, but he was not certain he would be able to return there. He had been a professional musician. He had written songs, but his hands were no longer able to hold a pen to compose. He wondered if there was some type of voice-activated device that would allow him to pursue that passion. He had a recliner at his home that he had liked to sit in. There was no recliner in his current room. He reported not being able to sleep at night frequently. He questioned if he was better off no longer living, but he still wanted to live. He was willing to speak with a counselor about his depression if it was available.Observation on [DATE] at 8:30 a.m. of resident 6 revealed he was lying in his bed on his back in a hospital gown. His television was on, and his eyes were closed.Interview on [DATE] at 2:15 p.m. with resident 6 revealed he had no significant pain and stated, in a minute or so the pain will start back up at a ten. Interview on [DATE] at 9:30 a.m. with social services designee (SSD) D regarding resident 6 revealed he still had a home, but it was not likely he would be able to return there. He had two roommates since he was admitted , who no longer reside at the facility. One of those roommates had become a good friend to resident 6. SSD D had not followed up with resident 6 to determine how resident 6 was dealing with those losses. SSD had not followed up with resident 6 about counseling services since she had first spoken with him about it on [DATE], but she should have SSD D had known music was very important to resident 6. She

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, policy review, and manufacturer's recommendations review, the provider failed to ensure a medication error rate of less than 5 percent related to:*A topical pain medication was not applied according to the manufacturer's recommendations for one of one sampled resident (11) by one of one observed licensed practical nurse (LPN) (K).*An extended release medication was crushed and administered to one of one sampled resident who required their medications to be crushed (12) by one of one observed LPN (K).Those observed medication errors resulted in a medication error rate of 6.9%.Findings include:1. Observation and interview on 9/11/25 at 8:00 a.m. of LPN K during medication administration revealed:*She dispensed an unknown amount of diclofenac sodium external gel 1% (for arthritis pain and inflammation) into a medicine cup and administered the gel to resident 11's left upper back/shoulder.-The order on resident 11's medication administration record (MAR) indicated he was to receive two grams of the gel.*When asked how she knew she was administering the correct dose, she stated, I guess I don't.*She was unaware that there was a measuring device included in the box that was to be used to determine the dose of the gel to be administered. Three-fourths of that tube of diclofenac sodium 1% gel had been used.-That measuring device was still secured to the diclofenac sodium 1% gel box.-She removed the measuring device from the box and stated, Oh. So, you just lay it on there?*She crushed resident 12's oral medications, mixed them with applesauce, and administered them to her.-There was no indication on the MAR that those medications should be crushed. *Omeprazole [used to treat and prevent conditions caused by excessive stomach acid] 20mg [milligram] Delayed Release Oral Tablet was included in those medications that were crushed.*She did not think the omeprazole was a delayed-release tablet.*She reviewed the label on the bottle and stated, Oh, it is delayed release. I shouldn't have crushed that. 2. Interview on 9/11/25 at 1:36 p.m. with DON B about the above medication administration observations and errors revealed she agreed that a delayed-release medication should not have been crushed.*She stated, I think we'll do some follow-up and education. 3. Review of the manufacturers' 2023 recommendations for the diclofenac sodium 1% gel revealed:*Read the label and use the enclosed dosing card.*Dosage-Using the dosing card, apply the following amounts:--Upper body areas (hand, wrist, elbow): 2.25 inches 4. Review of the provider's 9/18 Medication Administration Guidelines revealed:* Policy-Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication.* Procedures-Medication Preparation:--If safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines and with a specific order from prescriber.---The need for crushing medications is indicated on the residents' orders and the MAR so that all personnel administering medications are aware of this need and the consultant pharmacist can advise on safety and alternatives, if appropriate, during Medication Regimen Reviews.---Long-acting, extended release, or enteric-coated dosage forms should generally not be crushed; an alternative should be sought.- Medication Administration:--Medications are administered in accordance with written orders of the prescriber.-- Verify medication is correct three (3) times before administering the medication.a. When pulling medication package from med [medication] cartb. When dose is preparedc. Before dose is administered

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and policy review, the provider failed to follow standard food safety practices to ensure:*Handwashing was completed be three of five observed kitchen staff (cook N, dietary aide Z, and dietary aide AA) according to the provider's policy. *Food observed in one of one dining room refrigerator belonging to three sampled residents (4, 5, and 44) was stored according to the provider's policy. *One of one kitchen where resident's food was prepared stored, and served was maintained in a clean condition. Findings include:1. Observation on 9/9/25 at 10:10 a.m. in the kitchen revealed:*A power cord was hung from the ceiling and draped down to the floor by the middle of the food prep countertops.-The power cord was covered in dust.-The cord was above clean bowls and plates on a shelf.-The hot food steamer used for serving residents' food was under the cord and the shelf storing clean dishware.*Serving utensils were stored in clear plastic containers under the food preparation counter. They were not covered.-The filter to the ventilation system was under the sanitizing sink was covered with dust and black in color.*Air vents next to the sanitization sink and in the dishwashing room were covered in dust.*A thick tan substance was built up in the filter next to the dishwasher.*Cook N, dietary aide Z, and dietary aide AA washed their hands in the designated handwashing sink and failed to use a paper towel to turn off the sink faucet. They repeated that same process for six of the nine handwashing observations during the food preparation for the lunch meal service.-The sign above the handwashing sink had instructions to:--a.Wet your hands with warm running water. Lather with soap and scrub between your fingers, on the backs of your hands, and under nails. Wash for at least 20 seconds, or as long as it takes to sing Happy Birthday to yourself twice. Dry hands. Use single-use paper towels. Use a paper towel when you turn off the tap.2. Interview with dietary manager Y on 9/10/25 at 9:27 a.m. revealed:*The provider's handwashing policy and procedures was to use a paper towel to turn the faucet off after handwashing.*She would expect all kitchen staff to follow the correct procedure as directed in the policy.*She agreed that turning off the sink with bare hands would potentially contaminate those hands.3. Interview with infection preventionist/wound care nurse C on 9/11/25 at 4:28 p. m. revealed:*Her expectation for performing hand hygiene is to wash with soap and water when hands are visibly soiled or use alcohol-based hand rub following all times in the facility's policy.*She would expect a single use paper towel to be used to turn off the faucet after every hand washing in the sink.4. Review of the provider's 5/15/25 Hand Hygiene policy revealed:*Employees must wash hands using soap and water before and after eating or handling food.*Washing hands:-Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least twenty seconds under a moderate stream of running water, at a comfortably temperature.-Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to the inside of the sink.-Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel.5. Observation on 9/10/25 at 8:39 a.m. of the refrigerator in the dining room revealed:*Both the refrigerator and freezer compartments were locked. The keys were kept on top of the fridge.*Inside the refrigerator was:-A Styrofoam container with a dry baked potato. It was labeled with resident 5's name but no date was written on the container.-A plastic container labeled with resident 44's name and no date. There was meat, vegetables, and a type of dumpling in the container. There was a foul odor when the container was opened.-A plastic grocery bag filled with a green vegetable. It was sitting in liquid, and mold could be seen throughout the bag. The bag was labeled with resident 4's name. No date was written on it.6. Interview with activities director (AD) V on 9/11/25 at 9:20 a.m. revealed:*She and activity aide W were responsible for managing the refrigerator in the dining room.*She was to check the refrigerator temperature daily and record it in a log.*It is deep cleaned weekly or sooner if needed. The deep clean included:-Making sure every food item has a label with the resident's name and the date it was put in the refrigerator.*The cleaning log showed the last clean of that refrigerator was 9/2/25.*She agreed that the food without a date on it should have been thrown away with the last cleaning on 9/2/25. *Food was to be thrown away after three to five days.7. Review of the provider's 11/19/24 Food Brought in by Outside Sources policy revealed:*All food brought by visitors and family members from the outside of the facility will be labeled with the date it was brought to the facility'.*If refrigeration is required, the food items will be placed inside the refrigerator.*After three to five days, these food items will be discarded'.*All undated food items will be discarded to ensure safety of the residents".

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 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 record review, interview, and policy review, the provider failed to ensure preadmission screening and resident review (PASRR) assessment level II (level two, in-depth evaluation of a resident's needs, recommended services, and determination of what type of setting was appropriate for her care) had been uploaded and/or available within the record when conducting the Minimum Data Set (MDS) assessment (a tool used to evaluation a resident's health status and to develop an individualized care plan to manage the resident's care needs) for one of two sampled residents (31) with a chronic post-traumatic stress disorder (PTSD) (a disorder in which a person has lasting difficulty recovering after exposure to a traumatic event). Findings include:1. Review of resident 31's electronic medical record (EMR) revealed:*She was admitted on [DATE].*She had a 7/24/25 Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated her cognition was intact.*Resident 31's diagnoses included adjustment disorder (a mental health reaction to stressful life events or changes that are considered a maladaptive response to a psychosocial stressor), borderline personality disorder (a mental disorder characterized by unstable moods, behavior, and relationships), major depressive disorder, PTSD, nightmare disorder (repeated intense nightmares), and anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability).*She had a 9/2/25 physician's orders for, Bupropion HCL ER (XL) Tablet Extended Release 24 Hour [and anti-depressant medication]150 MG [milligrams] Give 1 tablet by mouth one time a day for depression, and a 9/2/25 physician's order for DULoxetine HCL Capsule Delayed Release Particles [an anti-depressant medication] 30 MG Give 3 capsules by mouth at bedtime for depression.*Her 9/10/25 care plan had focus areas of I am at risk for experiencing Hallucinations [to see, hear, smell, taste or touch something that is not there], I am at risk for altered thought process r/t [related to] new environment, adjustment disorder, [and] PTSD, and I receive Psychoactive medications [drugs that affect brain activities associated with mental processes and behavior] d/t [due to] Adjustment disorder, Personality Disorder, Depression, PTSD, [and] Nightmare disorder.*Resident 31's 10/29/24 PASRR screening form stated, resident 31 is suspected as having a PASRR condition due to a diagnosis of MDD [major depressive disorder] and will likely need a [PASRR] Level II unless categorical applies. Do you know if this individual will need less than a 100 day stay in the NF/SB [nursing facility/swing bed]? If so, you can have your doctor write an order that states they will need less than 100 days in the NF/SB and send that to us, and we can give the Convalescent Categorical [refers to a person who is recovering from an illness or operation], where they will be approved for 100 days. If they stay past 100 days a new referral would need [be needed] in order to have a Level II completed at that time.*Resident 31 did not have a PASRR level II in her EMR.2. Interview on 9/10/25 at 1:52 p.m. with social services designee (SSD) D revealed:*A PASRR screening needed to be completed prior to the admission of a resident.*There were two different levels of a PASRR, I (one) and II.*If a resident was issued a 100-day PASSR, meaning they were not expected to remain in the facility for more than 100 days, and remained in the facility longer than 100 days she would refile a PASRR screening to determine if the resident qualified for a PASRR II.*Resident 31 had a 100-day PASRR and remained in the facility longer than 100 days.*SSD D was unable to locate a PASRR after resident 31's 100 days in the facility at that time.*She stated she would have to look through her files to determine if one had been submitted.*On 9/11/25 SSD D provided resident 31's 2/25/25 Level II PASRR.3. Interview on 9/11/25 at 1:00 p.m. with administrator A revealed:*The provider did not have a MDS coordinator who worked onsite at the facility, and the resident's MDS assessments were completed by an off-site corporate MDS coordinator.*The provider did not have an MDS policy, they referred to the Resident Assessment Instrument (RAI) manual.4. Interview on 9/11/25 at 1:58 p.m. with SSD D and corporate MDS coordinator P revealed:*Since corporate MDS coordinator P was not on-site she completed the residents' MDS assessments according to the documents found in the residents' EMR.*The PASRR II received on 2/25/25 had not been uploaded into resident 31's EMR, therefore corporate MDS coordinator P was not able to locate in resident 31's EMR that a PASRR II had been received so she completed resident 31's MDS assessment to reflect the information that was in resident 31's EMR, which was a PASRR I screen.*SSD D verified she had not uploaded the PASRR II into resident 31's EMR so corporate MDS coordinator P would not have known a PASRR II had been received for resident 31.*SSD D and corporate MDS coordinator verified resident 31's comprehensive MDS assessments submitted on 4/2/25, 5/29/25, 6/16/25, and 7/25/25

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, policy review, and review of the manufacturer's Important Safety Precautions, including instructions on how to clean and disinfect the glucometer, the provider failed to ensure:One of one observed guest service aide (F) who did not wear personal protective equipment while in two of two sampled residents' (5 and 8) rooms. One of one observed certified nurse aide (CNA) (T) who did not wash her hands after removing unclean gloves after assisting sampled resident (39) with personal care and dressing.One of one observed licensed practical nurse (LPN) (E) who did not wash her hands and placed a drinking straw inside one sampled resident's (6) lidded water cup with her bare, unwashed hands. *One of one observed LPN (K) who did not follow the manufacturer's recommendations for disinfection of a shared blood glucose monitor (glucometer) that was used to test multiple residents.Findings include:1. Observation and interview with guest services aide F outside of resident 5’s room on 9/9/25 at 2:29 p. m. revealed: *She was passing out fresh ice water to the residents. She did not perform hand hygiene before entering resident 5’s room and was wearing a face mask. That room had a sign that read “Enhanced Droplet Precautions” next to the door. She exited the room and performed hand hygiene. She then entered resident 8's room, which had the same sign next to the door. She did not change her face mask between those two residents' rooms. She performed hand hygiene when she left. *She explained the sign on those doors meant that personal protective equipment (PPE) was expected to be worn in the room. Guest services aide F stated “I would definitely wear a gown.” *The sign indicated a surgical mask or N95 mask, gown, gloves, and eye protection [goggles or glasses] were to be worn while in those rooms. 2.Interview with infection preventionist/wound care nurse C on 9/11/25 at 4:28 p.m. revealed: *She would expect all staff members to wear the correct PPE per policy. Interview with director of nursing B on 9/11/25 at 4:46 p.m. revealed: *She expected all staff to perform hand hygiene following the facility’s policy. *She would expect staff to always wear the correct PPE per facility policy. 3. Observation and interview on 9/9/25 at 8:54 a.m. with CNA T in resident 39's room revealed she performed hand hygiene, and put on a clean pair of gloves. After changing the resident's incontinence brief, she removed her gloves and, without washing her hands, put on a clean pair of gloves. She then assisted resident 39 with dressing. CNA T confirmed that she should have performed hand hygiene after removing her unclean gloves and before putting on clean gloves. 4. Observation on 9/9/25 at 11:59 a.m. of LPN E inside of resident 6's room revealed she used her bare hand to place a straw inside the resident's lidded plastic cup. The resident then used the straw to drink water from the cup to swallow his medication. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 9/9/25 at 12:01 p.m. with LPN E regarding the above observation revealed she stated she should have applied gloves or washed her hands before she handled the straw and gave it to the resident. 5. Observation and interview on 9/11/25 at 8:57 a.m. with LPN K revealed: *There was an unlabeled glucometer on top of the medication (med) cart. *She was observed taking the glucometer to check other residents’ blood sugar that day. *LPN K took that glucometer into resident 58’s room, performed hand hygiene, put on gloves, checked his blood sugar, disposed of the lancet (a small, pointed instrument used to prick the skin and obtain a blood sample for testing) and test strip, removed her gloves, and performed hand hygiene. *She then administered resident 58’s medications and put the glucometer back on top of the med cart. *She stated the glucometer was used to check blood sugars for all of the residents with orders for blood sugar checks. *She said, “I’ll clean it with a wipe before I go see my next resident.” *There were no cleaning wipes on the med cart, and she stated, “I’ll go track one down.” *She left and returned with a container of bleach wipes, wiped the glucometer with one bleach wipe, and set the container of bleach wipes on top of the med cart. *She said she used a bleach wipe since the glucometer could be contaminated with blood. 6. Interview on 9/11/25 at 1:36 p.m. with DON B about shared glucometer use revealed: *She stated, “Our policy says they should all have individual glucometers that are stored in their room or in the med cart.” *She agreed the provider’s policy had not been followed. Review of the provider's 5/15/25 Hand Hygiene policy revealed hand hygiene was expected to have been performed Before moving from a contaminated body site to a clean body site during resident care. Gloves should be removed, hand hygiene performed and [a] new pair of gloves applied. Review of the manufacturer’s Important Safety Precautions and instructions to clean and disinfect the glucometer revealed: (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 - Some	*“Users need to adhere to Standard Precautions [a set of infection control practices designed to prevent the transmission of infectious diseases] when handling or using this device. All parts of the glucose monitoring system should be considered potentially infectious and are capable of transmitting blood-borne pathogens between patients and healthcare professionals.” *“The meter should be disinfected after use on each patient. This Blood Glucose Monitoring System may only be used for testing multiple patients when Standard Precautions and the manufacturer’s disinfection procedures are followed.” *“When to clean and disinfect the meter -All surface of meter if visibly soiled must be physically cleaned to remove gross soil. Disinfect the meter between each patient to prevent infection.” *“How to clean and disinfect the meter -The meter must be cleaned prior to the disinfection. Use one disinfecting wipe to clean exposed surfaces of the meter thoroughly and remove any visible dirt, blood, or any other body fluid with the wipe. Use a second wipe to disinfect the meter by following the disinfecting procedure below. We recommend for meter cleaning and disinfection you should use the disinfecting wipe/towelette: --Micro-Kill Plus [disinfectant wipe].” *“Disinfecting Procedures” -“…Keep meter wet with disinfection solution for a minimum of 2 minutes for Micro-Kill Plus. ” “Each cleaning and disinfection cycle includes a pre-cleaning step with one wipe and a disinfection step with a second wipe.” Review of the provider’s 2/24/25 Blood Glucose Monitor Cleaning and Disinfection policy revealed: *“Policy: -Individual blood glucose monitors and strips will be issued to each resident requiring testing and the unit will be cleaned and control tested per policy. The monitor is to be used for a single resident only.” *“Procedure: -Monitors will be labeled with Resident’s name and stored in its case or plastic bag in the resident’s room, in medication room or in medication cart. -Perform blood glucose test according to manufacturer’s instructions and physician order.” (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*“Clean and disinfect the monitor weekly or when visible soiled per manufacturer’s instructions. Use an EPA approved disinfectant for contact time specified.” *“Upon discharge of resident, monitor can be sent home with resident or discarded.”