STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435068	A. BUILDING _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA WATERTOWN	415 FOURTH AVE NE WATERTOWN, SD 57201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/3/24 through 12/5/24. Avantara Watertown was found not in compliance with the following requirements: F550, F755, F761. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/3/24 through 12/5/24. Areas surveyed included nursing services and an allegation of resident neglect. Avantara Watertown was found not in compliance with the following requirement: F755.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	1/6/25

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.

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to preserve the dignity of three of three sampled residents (13), (145), and (146) by not ensuring urinary catheter bags (collects drained urine) were covered while residents were in the common areas. Findings include: 1. Observation on 12/3/24 of resident 13 revealed: *His catheter bag was hanging under his wheelchair with visible urine in it. *At 11:37 a.m., the resident was observed wheeling himself in the hallway with his urinary catheter bag uncovered with visible urine in it. *At 12:08 p.m., the resident was seated in the dining area with his urinary catheter bag uncovered with visible urine.	F 550	1. Indwelling Foley Catheter (IFC) drainage bag was placed in a Privacy Bag for Resident 13 to provide dignity while in common areas on 12/5/24. Indwelling Foley Catheter (IFC) drainage bag was placed in a Privacy Bag for Resident 145 to provide dignity while in common areas on 12/5/24. Indwelling Foley Catheter (IFC) drainage bag was placed in a Privacy Bag for Resident 146 to provide dignity while in common areas on 12/5/24. 2. Audit was completed on all residents with catheters to ensure dignity cover was in place. 3. Education initiated 12/5/24 and ongoing to nursing and activities staff by DON/designee of Catheter Care Dignity Cover policy, addressing significance of use for residents with IFCs. A new duty task has been created in PCC for Certified Nurse Assistants (CNAs) to check for placement of Privacy Bags every shift for residents with IFCs. All education will be completed no later than 1/06/2025. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked.	1/6/25

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F 550	Continued From page 2 2. Observation on 12/3/24 of resident 145 revealed: *At 12:25 p.m. during lunch, she was sitting in the dining room with her urinary catheter bag uncovered. -There were three other residents sitting at her table. -The catheter bag contained visible urine and was in clear view of the other residents. *At 3:00 p.m. and again at 3:55 p.m., she was observed in the dining area playing bingo and later watching TV with her urinary catheter bag not covered and with visible urine. 3. Observation on 12/4/24 at 8:25 a.m. of resident 146 revealed he was sitting in the dining area with his urinary catheter bag uncovered and in view of other residents, staff, and visitors. 4. Interview on 12/4/24 at 10:30 a.m. with licensed practical nurse (LPN) D revealed: *She was not unaware of any policy that required urinary catheter bags to be covered. *She reported that she had worked at a different facility that required urinary catheter bag covers to be utilized to preserve resident dignity. 5. Interview on 12/4/24 at 10:35 a.m. with registered nurse (RN) F revealed: *She was not sure if the facility had urinary catheter bag covers. *She was not aware of any policy that required urinary catheter bags to be covered when the resident was not in their room. 6. Follow-up interview on 12/4/24 at 12:30 p.m. with RN F revealed: *She showed this surveyor a packaged urinary catheter privacy cover.	F 550	4. DON/designee will perform audits of Privacy bag to ensure resident dignity is maintained. Audits will be weekly for 4 weeks, bi-weekly for 2 months, and monthly for 2 months. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	

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F 550	Continued From page 3 *She stated, "we do have catheter covers." *When asked if there was a reason they were not used on the previous day, she replied she was not sure, "but we fixed it." 7. Interview on 12/5/24 at 1:00 p.m. with director of nursing (DON) B revealed it was her expectation that resident's urinary catheter drainage bags would be covered while residents were out of their rooms.	F 550		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		

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F 755	Continued From page 4 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on the South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI), interview, record review, and policy review, the provider failed to ensure teh accountability of fentanyl patches (a controlled topical pain medication) by not monitoring and documenting the placement of the patches for three of five sampled residents (8, 30, and 144) who were administered fentanyl patches. Findings include: 1. Review of the provider's submitted SD DOH FRI revealed: *On 5/7/24 at 8:00 a.m., registered nurse (RN) G reported to assistant director of nursing (ADON) C that on 5/6/24, she was unable to locate resident 144's fentanyl patch that had been placed on resident 144 on 5/3/24. *ADON C reviewed resident 144's-controlled substance/narcotic record and discovered that nursing staff had been unable to locate his fentanyl patch on four other occasions. *Resident 144 and his spouse were interviewed by administrator A on 5/7/24 and they were not able to determine what may have happened to the missing fentanyl patch. -Administrator A reported that resident 144's spouse was confused at this time. *Housekeeper H was interviewed by administrator A, she was unable to recall seeing any patches or bandages on the floor while cleaning the resident's room.	F 755		

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F 755	Continued From page 5 *A pain assessment was completed, and resident rated his pain 0 on a zero to ten scale (0=no pain, 10=the worst pain). *On 5/8/24 at 4:00 a.m., the fentanyl patch placed on 5/6/24 was found on the floor. *The resident's primary care physician was notified of the missing fentanyl patches. -Fentanyl patches were discontinued for the resident. -Resident 144 was started on oral medication for his pain control. *Controlled substance/narcotic record for all other residents who utilized fentanyl patches were reviewed with no other patches found missing. *Education was provided to all nursing staff that any missing narcotic must be reported to the DON and administrator immediately when identified. *Monitoring was added to the medication administration record (MAR) to check placement of fentanyl patches at the beginning and the end of each shift, with the location of the patch being documented in the resident's MAR. 2. Interview on 12/4/24 at 3:15 p.m. with RN F revealed: *The placement of fentanyl patches should be checked each shift. *The checking of patch placement each shift has been considered standard practice since the start of her employment at the facility. *If she was unable to locate a fentanyl patch on a resident, she would search the resident's room (floor, linen, clothing), and if still unable to find the patch, she would report it to her DON. *When asked how to waste or discard controlled substances, she reported there needs to be two nurses to verify and document the waste or discard.	F 755		

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F 755	Continued From page 6 3. Interview on 12/4/24 at 3:18 p.m. with licensed practical nurse (LPN) D revealed: *Fentanyl patch placement should be verified each shift and documented. *Checking patch placement has been considered standard practice since the start of her employment at the facility. *She reported if she were unable to locate a fentanyl patch on a resident, she would first search the resident's room, and if she still could not locate the patch, she would report it to her DON. 4. Interview on 12/5/24 at 9:15 a.m. with administrator A revealed: *When asked who monitors the controlled substance/narcotic record, he reported it was the responsibility of the DON to review the logs. *Referring to the prompt placed in the MAR to check the fentanyl patch placement each shift, he reported it would be the responsibility of the nurse admitting the resident to ensure that was entered into the MAR. *It was his expectation that staff would report a missing fentanyl patch immediately to the DON. 5. Interview on 12/5/24 at 10:00 a.m. with DON B, ADON C, and regional nurse consultant (RNC) I revealed: *Referring to new resident admissions, DON B reported that "admissions are a team effort." -The floor nurse would perform and document the resident assessment. -The DON or ADON would usually put in the physician orders. *Referring to the prompt placed in the MAR to check the fentanyl patch placement, DON B reported it would be the responsibility of the	F 755	1. Resident 144 was discharged on June 6, 2024 and is no longer a resident in the facility. Resident 2 order to check Fentanyl Patch placement verified and continues to be active. Resident 29 order to check Fentanyl Patch placement every shift verified and continues to be active. Resident 8 order to check Fentanyl Patch placement every shift entered on 12/4/24 and continues to be active. Resident 30 order to check Fentanyl Patch placement every shift entered on 12/4/24 and continues to be active. 2. All residents (current, new admissions, and readmissions) with orders for Fentanyl Transdermal Patch use were audited. 3. Education initiated on 12/5/24 and ongoing to Licensed Nurses and Direct Care Staff of Drug Diversion Prevention policy with emphasis to administration of transdermal controlled substances documentation and monitoring of verification of patch placement every shift in MAR. Education initiated and ongoing to Housekeeping and Activities staff by DON/designee on controlled substances, with emphasis to controlled substance transdermal patches, what they look like, what to do and who to notify in the event they are found in areas other than the appropriate placement on resident. All education will be completed no later than 1/06/2025. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked.	1/6/25

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F 755	Continued From page 7 person putting in the admission orders to recognize the resident uses a fentanyl patch and to enter the verification of the patch placement each shift prompt into that resident's MAR. -The fentanyl patch placement verification did not automatically accompany the order for the fentanyl patch. *Regional nurse consultant (RNC) I reported the facility was in the process of changing pharmacies and the new pharmacy planned to automatically include the placement verification of the fentanyl patches each shift when a resident utilized a fentanyl patch. *It was the expectation of DON B and ADON C that a resident missing their fentanyl patch would be reported immediately. 6. Review of resident 144's-controlled substance/narcotic record revealed: *On 3/16/24, 3/22/24, 4/18/24, 4/30/24, and 5/3/24, the record was signed by only one nurse and it was documented that the patches were "patch missing", or "not found." *He had been discharged from the facility. 7. Review of resident 144's MAR revealed: *On 4/21/24, LPN J noted, "Patch not on left rear shoulder. Not found on res clothes, bed, floor, table. Two nurse check was done. Not found at this time" -It was not noted on the resident's-controlled substance/narcotic record that the fentanyl patch was missing. 8. Review of the provider's list of residents utilizing fentanyl patches printed on 12/4/24 at 2:31 p.m. revealed there were four current residents receiving fentanyl patches (2, 8, 29, and 30).	F 755	4. DON/designee will perform audits of residents with orders for Duragesic patch use to check for Licensed Nurse documentation in MAR of placement every shift, and to check if order is paired with order for verification of placement every shift in MAR. Audits will be weekly for 4 weeks, bi-weekly for 2 months, and monthly for 2 months. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	

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F 755	Continued From page 8 9. Record review of residents 8 and 30 revealed: *Resident 30's fentanyl patch was ordered on 11/13/24. -The placement verification of the fentanyl patch each shift was not entered into the resident's MAR until 12/4/24 at 2:30 p.m. *Resident 8's fentanyl patch was ordered on 9/10/24. -The placement verification of the fentanyl patch each shift was not entered into the resident's MAR until 12/4/24 at 2:30 p.m. 10. Review of the provider's 11/19/24 Drug Diversion Prevention policy revealed: *Administration of controlled substances section B: "Administration of transdermal controlled substances should follow the steps above for documentation of administration, as well as:" -i. Placement of patches will be checked and documented on the MAR every shift. -ii. Removal and destruction of controlled substance transdermal patches requires two nurses with appropriate documentation on the specific inventory sheet.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		

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F 761	Continued From page 9 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure expired medications were removed from one of one medication storage room. Findings include: 1. Observation on 12/5/24 at 10:55 a.m. in the provider's medication storage room with assistant director of nursing (ADON) C revealed: *In the locked refrigerator, 23 of 23 Hepatitis B vaccines were expired on 6/2/24. *In the locked refrigerator, three 5 milliliters (ml) multi-dose vials of influenza (Flu) vaccine were expired on 6/20/24. 2. Interview with director of nursing (DON) B revealed: *The medication room was checked for outdated medications and supplies each month. *The task was to be completed on night shifts, there was no documented verification that task was completed. *It was her expectation that expired medications	F 761	1. 23 of 23 Hepatitis B vaccines noted with expiration date of 6/2/24 were removed from active supply medication area and were discarded and destroyed in the usual manner per Pharmacy policy on 12/5/24. Three 5 millimeter (ml) multi-dose vials of influenza (Flu) vaccines noted with expiration date of 6/20/24 removed from active supply medication area and were discarded and destroyed in the usual manner per Pharmacy policy on 12/5/24. 2. The facility has determined that all resident medications and supplies stored in active supply areas (Nurse Medication Carts, Treatment Cart, Medication Room, etc.) have the potential to be affected. Audits were completed to ensure no expired medications, treatments, or supplies were in the med room, medication carts, or treatment carts. 3. In-service and Education initiated on 12/6/24 and ongoing to Licensed Nurses by DON/designee on Pharmacy Policies with emphasis to Medication Storage in the Facility and Disposal on Medications and Medication-Related Supplies. All education will be completed no later than January 6, 2025. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked.	1/6/25

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F 761	Continued From page 10 would be removed and properly disposed of. 3. Review of the provider's January 2018 Medication Storage in the Facility policy revealed: *Expiration Dating, section G. "All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner."	F 761	Current "Medication Cart and Med Room Cleaning Schedule" reviewed And revised on 12/20/24 to include area for Licensed Nurse to sign off upon completion of task for documentation, and column/row added for DON/designee to verify completion. Updated Med Cart and Medication Room Check schedule implemented and in place effective December 22, 2024. 4. DON/designee will complete audits to ensure there are no expired medications or treatments in the medication room or medication carts. Audits will be weekly for 4 weeks, bi-weekly for 2 months, and monthly for 2 months. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/ revision of audits based on findings.	

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K 000	INITIAL COMMENTS A recertification survey was conducted on 12/4/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Watertown was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K211 and K754 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to provide operable egress doors as required at one randomly observed exit door location (north wing north exit door). Findings include: 1. Observation on 12/4/24 at 8:45 a.m. revealed the exit door adjacent to the sunroom was unable to be opened without entering a code. Testing of the door by applying greater than fifty pounds of force in the direction of the path of egress revealed it would not open.	K 211	1. Facility contacted Automatic Door Doctor on 12/4/24, On 12/5/24, Automatic Door Doctor was able to repair the north wing, north exit door's 15 second egress release. Mag lock was adjusted to release with less the 50 pounds of force. 2. Maintenance Director or Designee conducted an inspection of all means of egress are continuously maintained and free of all obstructions to full use in case of emergency and are working in accordance with NFPA 101 Means of Egress- General, Aisles, passageways, corridors and access. Administrator or designee will educate Maintenance Director on ensuring that all means of egress are operable no later than 1/6/2025. 3. Administrator or Designee will audit weekly testing for 4 weeks to ensure compliance with NFPA 101, Means of Egress Doors. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to monthly for at least 2 months. Monitoring results will be reported by administrator or a designee to the QAPI committee and continued until the demonstrates sustained compliance as determined by committee. 4. Completion Date 1/6/25	1/6/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	12/26/24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435068	A. BUILDING **01 - BUILDING 01,02,03** B. WING _____	**12/04/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA WATERTOWN	**415 FOURTH AVE NE** **WATERTOWN, SD 57201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 1 Interview at the time of the observation with the administrator confirmed those conditions. He stated he was unaware that door was not able to be opened. Failure to provide working egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.1, 7.2.1.4.5.1(2)	K 211		
K 754 SS=E	Soiled Linen and Trash Containers CFR(s): NFPA 101 Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This REQUIREMENT is not met as evidenced by:	K 754		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435068	A. BUILDING **01 - BUILDING 01,02,03** B. WING _____	**12/04/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA WATERTOWN	**415 FOURTH AVE NE WATERTOWN, SD 57201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 754	Continued From page 2 Based on observation and interview, the provider failed to maintain proper storage of soiled linen and trash receptacles in two locations (repurposed housekeeping closets adjacent to resident rooms 7 and 11). Findings include: 1. Observation on 12/4/24 at 8:45 a.m. revealed a closet adjacent to resident room 7 held two 40 gallon plastic tub containers, one labeled soiled linen, and one labeled trash. The room was under 50 square feet in area with an out-swinging door. The door was not equipped with a closer or positive latching device. Interview with the administrator at the time of the observation confirmed the finding. 2. Observation on 12/4/24 at 9:20 a.m. revealed a closet adjacent to resident room 11 held two 40 gallon plastic tub containers, one labeled soiled linen, and one labeled trash. The room was under 50 square feet in area with an out-swinging door. The door was not equipped with a closer or positive latching device. Interview with the administrator at the time of the observation confirmed the finding. The deficiency had the potential to affect 100% of the occupants of the smoke compartments.	K 754	1. Facility contacted Automatic Door Doctor on 12/4/24 to request door closing mechanism installed on closet doors adjacent to room 7 and room 11. On 12/5/24, Automatic Door Doctor attached door closing mechanisms on both closets. 2. Maintenance Director or Designee conducted an inspection of all storage of soiled linen and trash containers in the facility were in compliance with NFPA 101, Soiled linen and Trash container, shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Administrator or designee will educate Maintenance Director on proper storage of soiled linen and trash receptacle storage requirements no later than 1/6/2025. 3. Maintenance Director will audit monthly for 3 months to ensure compliance with NFPA, Soiled linen and trash containers. After 3 months, monitoring may reduce to quarterly. Monitoring results will be reported by the administrator or designee to the QAPI committee and continued until the facility demonstrates sustained compliance determined by the committee. 4. Completion Date 1/6/25	1/6/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435068	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA WATERTOWN	415 FOURTH AVE NE WATERTOWN, SD 57201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness requirements for Long Term Care Facilities, was conducted on 12/04/24. Avantara Watertown was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 1/6/25

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.

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10704	A. BUILDING: _____ B. WING _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA WATERTOWN	415 4TH AVE NE WATERTOWN, SD 57201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/3/24 through 12/5/24. Avantara Watertown was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 12/3/24 through 12/5/24. Avantara Watertown was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 1/6/25