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 _____	09/28/2023

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 9/26/23 through 9/28/23. Avantara Watertown was found not in compliance with the following requirement: F761.	F 000		
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 §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 record	F 761	1. Resident number 11 EMAR was updated to include precautions when handling medication. Resident number 12 EMAR was updated to include precautions when handling medication. Resident number13 EMAR was updated to include precautions when handling medication. Resident number15 EMAR was updated to include precautions when handling medication. Resident number 36 EMAR was updated to include precautions when handling medication. 2. An audit of all residents to determine if they are on finasteride, paroxetine, and methotrexate was conducted and precautions added to EMAR. 3. Education provided to all nurses on the hazard label, the NIOSH hazard list, the procedure for handling hazardous medications, the required PPE for handling hazardous medications and where to find hazardous medication table by 11/6/2023 4. Audits of medication pass 3 times weekly to ensure proper PPE is used when handling hazardous medications times 4 weeks, then two times weekly for 4 weeks then weekly until sustained compliance achieved. Results of audits reported to QAPI.	11/6/23

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

TITLE: Administrator

(X6) DATE: 10/17/23

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F 761	Continued From page 1 review the provider failed to ensure their pharmacy services were consistent in labeling identification information and appropriate handling information for cytotoxic agents (a toxic agent that has the ability to kill dividing cells such as cancer treatment or substance in some types of venom) for five of five sampled residents (11, 12, 13, 15, and 36) receiving such agents. Findings include: 1. Observation and interview on 9/27/23 at 4:07 p.m. with registered nurse (RN) D regarding the medication bubble packs that had red hazardous labels attached to them located in the medication room revealed: *Finasteride 5 mg bubble pack was labeled as hazardous, but there were no instructions for the nursing staff regarding proper administration of that medication. *Paroxetine 20 mg bubble pack was labeled as hazardous, but there were no instructions for the nursing staff regarding proper administration of that medication. *RN D was not sure why the above medications had a red hazardous label attached to them. -She was not aware that finasteride was a cytotoxic medication. 2. Review of resident 11's electronic medical record (EMR) revealed: *There was a physician's order to administer finasteride 5 milligrams (mg) daily orally. *There was no black box warning (proper handling, administration, and the destruction of medication) on the medication. 3. Review of resident 12's EMR revealed: *There was a physician's order to administer finasteride 5 mg daily orally.	F 761		

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F 761	Continued From page 2 *There was no black box warning (proper handling, administration, and destruction of the medication) on the medication. 4. Review of resident 13's EMR revealed: *There was a physician's order to administer finasteride 5 mg daily orally. *There was no black box warning on the medication. 5. Review of resident 15's EMR revealed: *There was a physician's order to administer finasteride 5 mg daily orally. *Medication was to have been crushed and administered with applesauce. *There was no black box warning on the medication. 6. Review of resident 36's EMR revealed: *There was a physician's order to administer finasteride 5 mg daily orally. *The medication was to have been dissolved in 15 to 30 milliliters (ml) of warm water. *There was no black box warning on the medication. Interview on 9/28/23 at 8:30 a.m. with RN D regarding the black box warnings on the medication administration record (MAR) revealed: *She agreed that the finasteride had no black box warning information for staff administering the medications. *There was a warning tab on the methotrexate that the medication was cytotoxic. Interview on 9/28/23 at 8:55 a.m. with unit manager RN C regarding the hazardous labeling of the above medication revealed: *She noticed the hazardous labels on those	F 761		

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F 761	Continued From page 3 medications. *She agreed that there was no further information regarding the handling or administration of those medications labeled as hazardous. *The previous pharmacy that was used labeled medication with safe handling and administration instructions for the hazardous medication. Interview by phone on 9/28/23 at 12:24 p.m. with consultant licensed pharmacist E regarding the labeling of hazardous medication revealed: *The pharmacy had only placed red hazardous labels on those medications. *She felt the responsibility to know what the medication hazard was the facility's responsibility. *Staff that were pregnant should not have been handling those medications without wearing gloves. Request on 9/28/23 at 12:30 p.m. to RN C had been made to prior to survey exit for a policy on hazardous medication administration.	F 761		

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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 from 9/26/23 through 9/28/23. Avantara Watertown was found in compliance.	E 000		

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

TITLE: Administrator

(X6) DATE: 10/20/23

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South Dakota Department of Health

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	10704	A. BUILDING: _____ B. WING _____	09/28/2023

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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 9/26/23 through 9/28/23. 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 9/26/23 through 9/28/23. Avantara Watertown was found in compliance.	S 000		

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STATE FORM VDK611 If continuation sheet 1 of 1

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	435068	A. BUILDING **01 - BUILDING 01,02,03** B. WING _____	**09/26/2023**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/26/23. Avantara Watertown was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K131 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 131 SS=D	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of	K 131		

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K 131	Continued From page 1 patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the fire-resistive design of one randomly observed building separation wall (between the nursing home and the former hospital at the tunnel). Findings include: 1. Observation on 9/26/23 at 11:47 a.m. revealed the 90-minute rated fire door in the two-hour fire-rated separation wall between the nursing home and the former hospital at the tunnel did not latch into the door frame. That door was required to latch to maintain its fire-resistive rating. Interview with the maintenance director at the time of the observation confirmed that finding. He stated he was unaware of the requirement for that door, he further stated that door had not latched into the frame for as long as he had been the maintenance director. He then added it appeared someone had previously removed all of the latching hardware.	K 131	1. All residents, staff and visitors were identified for correction. No negative outcomes noted. 2. Facility Maintenance Director contacted Brian's Glass Door, on 9/27/23. Parts were ordered to repair latching mechanism on 9/27/23. Parts arrived on 10/14/23, Brian's Glass door is schedule to install latching mechanism on 10/25/23 to ensure door is meets the requirement to maintain its fire-resistive rating. 3. Maintenance Director or Designe e conducted an inspection of all fire doors to ensure latching mechanisms were working in accordance with NFPA 101 Multiple Occupancies and maintaining their fire-resistive rating. Administrator or Designee will audit weekly testing for 4 weeks to ensure compliance with NFPA 101, Egress Doors. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce 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 compliance as determined by committee. 4. Completion Date 10/25/23	10/25/23
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible	K 712		

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K 712	Continued From page 2 alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills). Findings include: 1. Record review on 9/26/23 at 2:15 p.m. revealed there was no documentation of third shift fire drills for quarter one (January, February, March) of 2023. Interview with the maintenance director at the time of the record review confirmed those findings. He stated he was unaware the minimum number of fire drills per the required frequency had not been met for each shift in 2023. He further stated quarter two of 2023 predated his employment at the facility. The deficiency had the potential to affect 100% of the occupants of the building.	K 712	1. All residents, staff, and visitors were identified for correction. Facility is unable to go back and correct the missing fire drill. No negative outcomes were noted. 2. Administrator educated Maintenance Director regarding NFPA 101 Fire Drills, and the facilities processes to hold fire drills at expected and unexpected times under varying conditions, at least quarterly on each shift. Maintenance Director or Designee will conduct fire drills in accordance with NFPA 101, Fire Drills. Maintenance Director or Designee will utilize Direct Supply TELS, a Building maintenance software to complete and the completion of the facilities Fire drills. 3. Administrator or Designee will audit for 3 months to ensure compliance with NFPA, Fire Drills. 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: 10/17/23	10/17/23