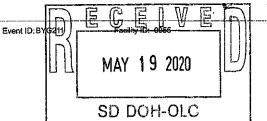
DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2020 FORM APPROVED OMB NO. 0938-0391

ATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
	435068					05/05/2020
NAME OF PROVIDER OR SUPPLIER AVANTARA WATERTOWN				STREET ADDRESS, CITY, STATE, ZIP 6 415 FOURTH AVE NE WATERTOWN, SD 57201		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETA DATE
F 000	was conducted by the of Health Licensure 5/5/20. Avantara Was compliance with 42 control regulation: F	ed Infection Control Survey ne South Dakota Department & Certification Office on atertown was found in CFR Part 483.80 infection	FO			
		R/SUPPLIER REPRESENTA/PIVE:9/SIGNATU		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a defigiency 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 clied, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolate



If continuation sheet Page 1 of 1