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 _____	01/29/2020

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 Surveyor: 29354 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 1/27/2020 through 1/29/2020. Avantara Watertown was found not in compliance with the following requirements: F693, F755, F760, and F880.	F 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set for in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal Law. Without waiving the foregoing statement, the facility states that: F693 Tube Feeding Mgmt/Restore Eating Skills 1. The facility Registered Dietician was contacted on 1/29/20 and completed an evaluation regarding the amount of free water being provided in addition to supplemental medication that the resident receives in relation to nutritional support provided by tube feedings on 1/30/20. The resident was seen by her Primary Care Physician on 1/30/20. The dietitian notes were reviewed at this visit with the discontinuation of vitamin D, folic acid, calcium with vitamin D, Tums and multivitamin. The water flushes were clearly written by the dietician to include: "Calculated daily fluid needs are approximately: 1600-2240cc's. Tube feeding+water flushes=2040cc. Recommend mixing the 1 scoop of protein powder with 60cc of water and then flush with 30cc before and after administration. Total water with the protein powder administration will =480cc's. Decrease the water flushes of 200cc three times a day to 100cc three times a day. On supplements of calcium plus vitamin d, vitamin d, multivitamin and folic acid. Tube feeding is supplemented with multivitamin and minerals. Recommend discontinuing the vitamin D, folic acid and calcium supplements. Labs on 1/16/20-Sodium was 131. Last albumin was 3.1. Monitor hydration status, weights, labs as new data is available." On 1/30/20, the orders for medication and water flushes were updated to include detail on flushes. Ongoing verbal education was provided to nursing staff by the DNS regarding the administration of water flushes and medication administration on 1/30/20. 2. An in-service and competency evaluations were completed on 2/19/20 by the DNS with licensed nursing staff to educate on the new enteral tube feeding policy, administration of medications, nutrition and enteral flushes per gastric tube. The DNS or designee will conduct random audits of licensed nursing staff to ensure proper administration of enteral feedings, medication and water 2x a week x4 weeks then weekly x4 weeks then biweekly x4 weeks to ensure compliance. The DNS or designee will present audit finding to QAPI monthly review and recommendations for at least 3 months.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Surveyor: 35237	F 693		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Lynna M. Speier | Administrator | 2/19/2020

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 693	Continued From page 1 Surveyor: 42477 Based on observation, interview, record review, professional reference review, and policy review, the provider failed to ensure physician's orders were followed for one of one sampled resident's (6) water flushes during medication (med) administration through her gastrostomy tube. Findings include: 1. Review of resident 6's medical record revealed: *She was admitted on 8/12/13. *She had low levels of sodium in her blood, according to laboratory (lab) tests. *Her diagnoses included: -Epilepsy. -Gastrostomy tube. -Hypertension. -Hyperlipidemia. -Aphasia. Review of resident 6's most recent 10/30/19 quarterly Minimum Data Set (MDS) assessment revealed: *She was unable to complete the cognitive assessment. *She was totally dependent on staff for moving, transferring, bathing, and toileting. *She had a gastrostomy feeding tube. *She received an average of 501 cubic centimeters (cc) of fluid per day. Review of resident 6's 1/5/17 physician's orders regarding to her gastrostomy tube revealed: *"Flush with 30 cc water before and after meds [medications]." *"If no meds given at times of scheduled feeding, flush with 30 cc before and after feeding." *"Dissolve meds in 5-10 cc of water."	F 693	3. Completion Date:	2/25/2020

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F 693	Continued From page 2 *"May mix meds together when administering per G-tube [Gastrostomy tube]." *"May flush G-tube with an extra 100 daily PRN [as needed] for concentrated or strong smelling urine." *"200 cc free [water] bolus three times daily per g-tube." Review of resident 6's January 2020 medication and treatment administration records revealed: *"MiraLax Powder give 0.5 scoop via PEG [percutaneous endoscopic gastrostomy] tube one time a day related to constipation, give 1/2 capful in 6 ounces of water daily." *There was no mention of how much water to mix with the protein powder. Review of resident 6's registered dietician (RD) E's notes from 8/7/19 through 1/9/20 revealed she should have received: *"200 cc water flush tid [three times a day], 30 cc water before and after meds, before and after tube feedings. Meds are dissolved in 5-10cc of water." Observation of licensed practical nurse (LPN) C on 1/28/20 at 10:01 a.m. performing med administration for resident 6 through her G-tube revealed: *She received multiple medications including 6 cc of liquid phenytoin. *She received Jevity 1.5 milliliter(ml) which was 8 ounces (oz) four times a day. *She crushed all the tablet style meds and placed them into a cup with an unmeasured amount of water. *She mixed the MiraLax powder in a cup with an unmeasured amount of water. *She mixed the protein powder in a cup with an	F 693		

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F 693	Continued From page 3 unmeasured amount of water. -Poured the protein mixture and the Jevity into the gravity feeding bag. *She used a triangular graduated container and measured out 200 cc of water. *She then used a 60 cc syringe and administered: -Crushed meds and unmeasured water. -MiraLax and unmeasured water. -Liquid phenytoin. *Used the 200 cc of water to flush the medications out of the cup and into the feeding tube. *Connected the gravity bag with the Jevity and the protein powder mixture. *She was unsure of how much water the cups held or how much water she had given all together. *That was her usual procedure. Interview on 1/28/20 at 2:12 p.m with registered nurse (RN) D regarding resident 6's med administration through the G-tube revealed: *They were using 5 oz cups when they completed medication administration through a G-tube. -They would fill the cups approximately three-fourths of the way to the top with water, but they did not measure it. *She confirmed they should have been measuring for appropriate fluid levels. *There was an as needed order for 100 cc of water, but that was if they noticed concentrated or strong odor of the urine. *They usually mixed the medications, MiraLax, and protein powder with unmeasured amounts of water. -She guessed it was about 3 to 4 ounces of fluid for each of the three mixtures. *She confirmed they had orders for certain parameters of water administration, but there was	F 693		

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F 693	Continued From page 4 no documentation on what was actually given. -She agreed not measuring the amounts of water could have affected the resident's lab values. Further interview on 1/28/20 at 2:20 p.m. with LPN C regarding resident 6 revealed: *She confirmed not measuring the amounts of water given could have affected lab values if they had given too much or too little water. *She did not remember having training or competency evaluations done regarding gastrostomy tubes and med administration. Interview and record review on 1/28/20 at 4:01 p.m. with RN B regarding medication administration for resident 6 revealed: *She gave 30 cc of water before and after medications. *She measured 200 cc of water in a triangular graduated container. -She took her 30 cc of water for medication administration from the 200 cc of water. -She wondered if the lack of measuring the water could have affected the resident's lab values. Interview on 1/29/20 at 7:49 a.m. with the director of nursing (DON) A regarding resident 6's tube feeding revealed: *She believed the nurses had annual competency evaluations done regarding feeding and medication administration through a G-tube. -They had all been trained on the above. *Water flushes should have been done according to the physician's orders. *Too much water or not enough water could have affected the resident's lab values. Phone interview on 1/29/20 at 8:23 a.m. with RD E related to resident 6's water flushes revealed:	F 693		

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F 693	Continued From page 5 *Nursing staff should have followed the physician's orders for the water flushes. *She based her assessments off the orders for the water flushes. *She agreed: -Additional water could have affected things such as lab values. -There should have been consistency with the water flush amounts and clear guidelines for the nurses. -There was quite a difference between 30 cc of water than the 3 to 4 oz that was being given. Interview on 1/29/20 at 9:39 a.m. with RN/ staff development director G regarding gastrostomy tubes and water flushes revealed: *She completed annual competency evaluations for the nurses but did not watch the amount of water given. *The annual competency evaluations included: -Medication administered at the correct time. -Medication record was signed after administration. -Medication per gastric tube was administered according to facility policy and procedure. Review of the provider's November 2017 Care and Treatment of Feeding Tubes policy revealed: *"Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush." *"The resident's plan of care will address the use of feeding tube, including strategies to prevent complications." *Regarding directions for staff on how feeding tube care will be provided: -"Frequency of and volume used for flushing,	F 693		

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F 693	Continued From page 6 including flushing for medication administration, and what to do when a prescriber's order does not specify." *"The facility will notify and involve the physician or designated practitioner of any complications, and in evaluating and managing care to address the complications and risk factors." Review of Lippincott Manual of Nursing Practice, 11th ed., 2019, pages 569 and 570 revealed: *Interventions listed to prevent tube obstruction: -"Flush tube every 4 hr[hour] with 30 mL of water and after administration of intermittent feeing and medication administration." *Interventions listed to prevent hyponatremia: *"Observe for signs and symptoms of hypervolemia (shortness of breath), rales, I & O[intake and output], daily weight, peripheral edema, elevated CVP[central venous pressure])." *"Observe for signs and symptoms of hyponatremia(lethargy, headaches, mental status change, nausea, vomiting, abdominal cramping)." *"Replace sodium, administer diuretics, or depending on the cause of hypernatremia, restrict fluids."	F 693		
F 755 SS=D	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(g). 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	F 755	F755 Pharmacy Services/Procedures/Pharmacist/ Records 1. A new consulting pharmacist was assigned effective 2/17/20 for monthly reviews. A comprehensive review of all resident records was completed with specific focus on drug interactions and high-risk medications by the new consulting pharmacist on 2/17/20. Expectations were reviewed and discussed with the consulting pharmacist with the DNs on 2/17/20 during the visit. An in-service was held on 2/19/20 by the DNS with licensed nursing staff to review alerts in Point Click Care that populate and follow-up to be completed for significant interactions including notation on medication bottles that may alert staff to interactions. The Consulting Pharmacist will continue to review resident records monthly with a summary of findings provided to the DNS.	

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F 755	Continued From page 7 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 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: Surveyor: 35237 Surveyor: 42477 Based on observation, interview, record review, and policy review, the provider failed to ensure pharmacy services had identified, evaluated, and documented their involvement for one of one sampled resident's (6) high risk seizure medication for potential negative interactions with her other medications and enteral (gastrostomy tube [g-tube]) feedings. Findings include: 1. Observation and interview on 1/28/2020 at 10:01 a.m. with licensed practical nurse (LPN) C during administration of resident 6's medications through her gastrotomy tube revealed concerns	F 755	The DNS will continue to review the findings with intervention as appropriate. Findings will be brought to QAPI for review and recommendations as warranted monthly by the DNS. 2. Completion Date:	2/25/2020

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F 755	Continued From page 8 regarding her phenytoin seizure medication. The medication had been administered at the same time as other medications with potential interactions and with her enteral feeding when it should not have been. Refer to F760, finding 1. Review of resident 6's medical record revealed: *She was admitted on 8/12/13. *Her diagnoses included: -Epilepsy. -Gastrostomy tube. -Aphasia. *Her phenytoin had been scheduled for the same time as her other medications and the G-tube feedings. *There were drug-to-drug interaction alerts for the phenytoin in the interdisciplinary notes that had not been followed up on. *There was no evidence the pharmacy had identified or evaluated the concerns with the phenytoin administration with other medications or the enteral feeding. Review of resident 6's medication administration record (MAR) revealed: *There was a notification regarding drug-to-drug interaction of "moderate" severity. -"Folic acid may decrease plasma concentrations and therapeutic effectiveness of phenytoin suspension 125 mg[milligrams]/5mL[milliliters]. Increased seizure frequency may occur." Review of Wolters Kluwer's Nursing 2020 Drug Handbook, 2020, regarding liquid phenytoin revealed: *Page 1282; "Shake suspension well before use." *Page 1284; Drug-food interactions listed:	F 755		

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F 755	Continued From page 9 -*"Enteral tube feedings; May interfere with absorption of oral drug. Stop enteral feedings for 2 hours before and 2 hours after drug use. Monitor serum drug level more frequently." -"...Folic acid...", "May decrease phenytoin activity. Monitor phenytoin level." Interview on 1/29/20 at 7:49 a.m. with director of nursing (DON) A regarding resident 6 revealed: *She confirmed the phenytoin had been started in August 2019 and had been scheduled for the same time as her other medications and the enteral feeding. *She expected drug interactions to have been followed-up on: -By nursing if there was an alert identified when inputting the orders. -By the pharmacist at the time the order was received and at the time of the monthly reviews. *She expected the pharmacy and pharmacy consultant to have assisted nursing in identifying those potential interactions and developing a plan to ensure the medication was given appropriately. Phone interview on 1/29/20 at 8:09 a.m. with consultant pharmacist F regarding resident 6's phenytoin administration revealed: *She confirmed the liquid phenytoin: -Should have been shaken prior to dispensing it to ensure an accurate dose was being administered. -Should not have been given at the same time as other medication such as the Tums due to interactions. -Should not have been given at the same time as the enteral feeding. *She was not aware the staff had not been following the manufacturer's instructions for the liquid phenytoin administration.	F 755		

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F 755	Continued From page 10 *She seemed hesitant and avoided direct response when asked about the pharmacy's involvement and what expectation for documentation would be for the above surveyor identified questions with the administration of the liquid phenytoin. *She stated if the pharmacist had identified any irregularities with residents' medications during the monthly reviews it should have been documented. Review of resident 6's monthly medication pharmacist regimen reviews from 8/14/19 through 1/21/20 revealed: *"No irregularities." *Those medication regimen reviews noted: -Acknowledgement of the liquid phenytoin order. -Lab values. -On 12/5/19 and 1/21/20 there were "no recommendations this review." *There was no indication the pharmacist had identified concerns with the timing and administration of the phenytoin or potential med interactions. Review of the provider's 2007 Medication Error Reporting and Adverse Drug Reaction Prevention and Detection policy revealed: *"The facility utilizes a system to assure that medication usage is evaluated on an ongoing basis. Medication errors and adverse drug reactions are assessed, documented, and reported as appropriate to the resident's attending physician and/or prescribers, the pharmaceutical services committee, the pharmacy, food and drug administration medwatch program or usp/ismp medication error reporting program." *Review of the guidelines and definitions: -"Medication error/variance shall be defined as	F 755		

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F 755	Continued From page 11 any preventable event that may cause or lead to inappropriate medication use or resident harm while the medication is in the control of the health care professional, resident or consumer." --That included "professional practice..., ...administration..., ...monitoring, and use." *"The interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis." *"When a resident received a new medication, the medication order is evaluated for the following: -The dose, route of administration, duration and monitoring are in agreement with current clinical practice, clinical guidelines, and/or manufacturer's specifications for use." -"The resident is not taking other medications, nutritional supplements, including herbal products, or foods that would be incompatible with the prescribed medication." *"Facility staff monitor the resident for possible medication-related adverse consequences, including mental status and level of consciousness, when the following conditions occur: -...Addition or discontinuation of medications and/or non-pharmacologic interventions." Review of the facility's 2007 Medication Administration policy revealed: *"Medications are administered in accordance with written orders of the prescriber. -"If necessary, the nurse contacts the prescriber for clarification. The interaction with the pharmacy and the resulting order clarification are documents in the nursing notes and elsewhere in the medical record as appropriate." *"Note any allergies or contraindications the	F 755		

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F 755	Continued From page 12 resident may have prior to medication administration."	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Surveyor: 42477 Based on observation, interview, record review, and policy review, the provider failed to ensure a high risk seizure medication (med) had been administered according to manufacturer's instructions for one of one sampled resident (6) who had a gastrostomy tube (G-tube) regarding a medication that: *Was not mixed or shaken before measured and then administered. *Should not have been given at the same time as her G-tube feeding. *Was not reviewed by professional staff to support it could have been given at the same time as medications that could have had potential reactions to it. Findings include: 1. Review of resident 6's medical record revealed: *She was admitted on 8/12/13. *She had low levels of sodium in her blood, according to laboratory tests. *Her diagnoses included: -Epilepsy. -Gastrostomy tube.	F 760	F760 Residents are free of significant Medication Errors 1. On 1/28/20, the Primary Care Physician (PCP) was updated via fax by the DNS regarding the administration of phenytoin with the enteral feedings and other medications which may cause decreased absorbency. The time of the administration of the phenytoin was changed by nursing on 1/28/20 based on these recommendations. An order was received to obtain a phenytoin level in 1 week. On 1/29/20, the Medical Director was contacted by the DNS via phone. A phenytoin level was ordered, obtained and recorded at 10.0 (Reference Range 10-20). The PCP reviewed the lab 1/29/20 with no new orders. 2. The PCP wrote at the visit on 1/30/20 at the living center, "I acknowledge recommendations of not administering Dilantin (phenytoin) with enteral feedings but has been receiving consistently and is therapeutic in preventing seizures. Recommend continuing current orders (with Dilantin (phenytoin))." A phenytoin level was ordered every 6 months during this visit to the living center. The MAR was updated to reflect the phenytoin administration with enteral feedings as ordered by the PCP. A phenytoin level was completed on 2/6/20 and was 7.3. On 2/7/20, the PCP ordered the phenytoin to by increased to 7ml twice a day and recheck level in 1 month. The resident continues to be free of any observed seizure activity. Review of the protocol labs with the Medical Director completed on 2/18/20 and protocol phenytoin level to be changed from annually to every 6 months. 3. An in-service and competency evaluations were completed on 2/19/20 by the DNS with licensed nursing staff, including RN B, to educate on the new enteral tube feeding policy, administration of medications, nutrition and enteral flushes per gastric tube. The DNS or designee will conduct random audits of licensed nursing staff to ensure proper administration of enteral feedings, medication and water 2x a week x4 weeks then weekly x4 weeks then biweekly x4 weeks to ensure compliance. The DNS or designee will present audit finding to QAPI monthly for review and recommendations for at least 3 months. 4. Completion Date:	2/25/2020

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F 760	Continued From page 13 -Hypertension. -Hyperlipidemia. -Aphasia. Review of resident 6's most recent 10/30/2019 quarterly Minimum Data Set (MDS) assessment revealed: *She was unable to complete the cognitive assessment. *She was totally dependent on staff for moving, transferring, bathing, and toileting. *She had a gastrostomy feeding tube. Observation and interview on 1/28/20 at 10:01 a.m. with licensed practical nurse (LPN) C during medication administration for resident 6 revealed: *The resident's medications were given through her G-tube and included: -A multivitamin. -Jevity 1.5 milliliters (mL) enteral nutrition, an eight ounce (oz) container. -Beneprotein, one scoop. -Aspirin, 81 milligram(mg). -Calcium/vitamin D tablet. -Folic acid. -Lisinopril. -MiraLax, 1/2 capful. -Phenytoin liquid,125 mg. -Tums. -Tylenol, 650 mg. -Vitamin D, 400 mg. -Zyrtec, 10 mg. *The liquid phenytoin was poured into a medication cup without first shaking it. *The other medications were crushed together and put in a cup. *Protein powder was mixed in a cup with an unmeasured amount of water. *All medications were administered and followed	F 760		

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F 760	Continued From page 14 immediately by the formula. *LPN C indicated the above was her usual procedure. Review of the manufacturer's instructions on the box the above liquid Phenytoin med was in revealed: *"Shake well before using." *"Do not take with antacids." Interview and label review on 1/28/20 at 2:12 p.m. with registered nurse (RN) D regarding resident 6's liquid phenytoin med revealed: *She confirmed: -The liquid phenytoin stated it should have been shaken well before administration. -The bottle stated it should not be taken with antacids, but that was what they had been doing. *The nurses administered her medications and Jevity at the same time according to the physician's orders. -She was not aware the phenytoin med should not have been given at the same time as the Jevity. Interview and record review on 1/28/20 at 2:12 p.m. with RN B regarding administering resident 6's liquid phenytoin med revealed: *She confirmed the resident 6 had been receiving Tums, liquid phenytoin, folic acid, and Jevity at the same time. -The phenytoin med had started on 8/9/19 when her other seizure medication had been discontinued. *She reviewed the 2020 Nursing Drug Handbook. -That was the reference the nurses had been using. *According to that drug handbook: -The liquid pheyntoin had reactions to	F 760		

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F 760	Continued From page 15 medications the resident was being given together at the same time that included the Tums and folic acid. -The liquid phenytoin should not have been given at the same time as the Jevity tube feeding. *She stated sometimes they received a moderate or severe drug interaction notification when inputting new orders into a resident's record. -If an alert happened the nurse would had to acknowledge it and call the pharmacy for further direction. --That information should have been documented in the resident's chart. *The pharmacy also should have notified nursing if there were any issues with giving the phenytoin with the Jevity or those medications with interactions. -A pharmacist reviewed all residents' medications monthly. *The only time the resident's phenytoin laboratory level had been check was on 8/15/19. -Her level had been below the therapeutic range, and the physician had ordered to continue at the same dose if no changes or seizures. *She was not aware of the resident having any seizure activity since prior to the phenytoin. Review of resident 6's 8/9/19 through 1/28/20 nursing notes revealed: *She was started on liquid phenytoin suspension on 8/9/19. -She was to have a basic metabolic panel and phenytoin level in one week. *The computer system had identified the following drug-to-drug interactions regarding liquid phenytoin: -Tums a mild interaction: "Interaction: Reduced pheyntoin plasma levels have been reported. Pharmacologic effects of phenytoin suspension	F 760		

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F 760	Continued From page 16 125mg [milligrams]/5ml [milliliters] might be decreased." -Folic acid a moderate interaction: "Interaction: Folic acid 1 mg tablet may decrease plasma concentration levels and therapeutic effectiveness of pheyntoin suspension 125mg/5ml. Increased seizure frequency may occur." *There were no comments or notes in the comment section of the drug-to-drug interaction note. *There was no documentation to: -Indicate the pharmacist or nursing staff had evaluated the timing of the phenytoin related to the medications or G-tube feedings. -Support increased monitoring of the resident for potential seizure activity, or an adverse reaction related to high risk medication change, or for potential medication interactions. Interview on 1/29/20 at 7:49 am with the director of nursing (DON) A regarding resident 6 revealed: *She confirmed the phenytoin had been started in August 2019 and had been scheduled for the same time as her other medications and enteral feeding. *She expected medication interactions to have been followed up on: -By nursing if there was an alert identified when inputting the orders. -By the pharmacist at the same time the order was received and at the time of the monthly reviews. *After the surveyors had identified and notified them of the potential negative effect/interactions: -They had moved the timing of the liquid phenytoin and Tums. -The folic acid interaction was not mentioned. *She confirmed the manufacturer's instructions	F 760		

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F 760	Continued From page 17 for the liquid phenytoin had not been followed and would have been considered a medication error. *She was not aware of the resident having any adverse outcome or seizure activity since before the phenytoin had been started. *She agreed phenytoin was a high risk medication and should have been given properly to avoid potential harm to the resident. Phone interview on 1/29/20 at 8:09 a.m. with consultant pharmacist F regarding resident 6's G-tube medication administration and the above concerns revealed: *She had been contacted by the facility staff the evening before about the resident's phenytoin after staff had been questioned about their administration procedure. *She confirmed the liquid phenytoin: -Should have been shaken prior to administering to ensure and accurate dose was being given. -Should not have been given at the same time as other medication with possible interactions such as Tums. -Should not have been given at the same time as enteral tube feeding. *She was not aware the staff had not been following the manufacturer's instructions for administering the liquid phenytoin. *She seemed hesitant and avoided direct response when asked about the pharmacy's involvement and what expectation for documentation would be for the above surveyor identified questions with the administration of the liquid phenytoin. *She stated if the pharmacist had identified any irregularities with a resident's medications during the monthly reviews it should have been documented. *Review of the monthly consultant pharmacist	F 760		

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F 760	Continued From page 18 reports from 8/14/19 through 1/21/20 revealed no irregularities or concerns with the liquid phenytoin had been identified. Refer to F755, finding 1. Review of the provider's November 2017 Care and Treatment of Feeding Tubes policy revealed: *"Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush." *"The resident's plan of care will address the use of feeding tube, including strategies to prevent complications." *Directions for staff on how feeding tube care would be provided revealed: -"Frequency of and volume used for flushing, including flushing for medication administration, and what to do when a prescriber's order does not specify." *"The facility will notify and involve the physician or designated practitioner of any complications, and in evaluating and managing care to address the complications and risk factors." Review of Wolters Kluwer's Nursing 2020 Drug Handbook, 2020, regarding liquid phenytoin revealed: *Page 1282; "Shake suspension well before use." *Page 1284; Drug-food interactions listed: -*"Enteral tube feedings; May interfere with absorption of oral drug. Stop enteral feedings for 2 hours before and 2 hours after drug use. Monitor serum drug level more frequently." -"...Folic acid...", "May decrease phenytoin activity. Monitor phenytoin level." Review of the provider's 2007 Medication Error	F 760		

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F 760	Continued From page 19 Reporting and Adverse Drug Reaction Prevention and Detection policy revealed: *"The facility utilizes a system to assure that medication usage is evaluated on an ongoing basis. Medication errors and adverse drug reactions are assessed, documented, and reported as appropriate to the resident's attending physician and/or prescribers, the pharmaceutical services committee, the pharmacy, food and drug administration medwatch program or usp/ismp medication error reporting program." *Review of the guidelines and definitions: -"Medication error/variance shall be defined as any preventable event that may cause or lead to inappropriate medication use or resident harm while the medication is in the control of the health care professional, resident or consumer." --That included "professional practice..., ...administration..., ...monitoring, and use." *"The interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis." *"When a resident received a new medication, the medication order is evaluated for the following: -The dose, route of administration, duration and monitoring are in agreement with current clinical practice, clinical guidelines, and/or manufacturer's specifications for use." -"The resident is not taking other medications, nutritional supplements, including herbal products, or foods that would be incompatible with the prescribed medication." *"Facility staff monitor the resident for possible medication-related adverse consequences, including mental status and level of consciousness, when the following conditions occur:	F 760		

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F 760	Continued From page 20 -...Addition or discontinuation of medications and/or non-pharmacologic interventions."	F 760		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880	F880 Infection Control 1. Residents who reside in the facility have the potential to be affected by this finding. 2. Past observed non-compliance regarding resident 150 cannot be corrected. All residents who reside in the facility have the potential to be affected by this finding. The policies for hand hygiene, catheter care and wound care were reviewed with no revisions. An in-service (including RN B) was held on 2/19/20 by the DNS, Unit Manager and Clinical Education with all staff regarding the hand hygiene policy and procedure, as well as demonstrated competencies completed. Hand hygiene will be reviewed, and competencies will be completed for all new hired staff and annually thereafter. The DNS or designee will conduct random hand hygiene audits of varied departmental staff 2x a week x4 weeks then weekly x4 weeks then biweekly x4 weeks to ensure proper technique. 3. An in-service was held on 2/19/20 by the DNS, Unit Manager and Clinical Education with certified and licensed nursing staff regarding catheter care and infection control techniques policies and procedures. The DNS or designee will conduct random catheter care audits of certified and licensed nursing staff 2x a week x4 weeks then weekly x4 weeks then biweekly x4 weeks to ensure proper technique. 4. An in-service will be held on 2/19/20 by the DNS, Unit Manager and Clinical Education with licensed nursing staff regarding policy and procedures for proper infection control techniques during dressing changes. Competencies will be completed at least annually by the Certified Wound Nurse or designee. The Certified Wound Nurse or designee will conduct random audits of licensed nursing staff to ensure proper dressing changes 2x a week x4 weeks then weekly x4 weeks then biweekly x4 weeks to ensure proper technique. The DNS or designee will present all the above audit findings to QAPI for review and recommendations as warranted for at least 3 months. 5. Completion Date:	2/25/2020

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F 880	Continued From page 21 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, and policy review, the provider failed to ensure infection control practice and technique was maintained for one of two sampled residents (150) by one of two registered nurses (RN) (B) during the resident's personal care and treatment. Findings include:	F 880		

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F 880	Continued From page 22 1. Observation on 1/28/20 at 9:54 a.m. with RN B while she performed a treatment on resident 150 revealed: *She entered the resident's room. *On the overbed table was a paper towel with a medication (med) cup of bacitracin and a med cup of zinc oxide and two Q-tips. *She put on gloves without performing hand hygiene and did the following: -Removed a wet wipe from a package, wiped his inner left leg crease, then put it in the garbage. -Removed another wet wipe and wiped his inner left leg crease. --That soiled wipe contained red drainage. -She took that soiled wet wipe and wiped the Foley catheter tubing approximately five inches from the base of the penis towards the end of the penis then discarded it. -She took another wet wipe from the package and cleaned around the base of the penis. -At that time she removed her gloves. *Without performing hand hygiene she picked up the syringe driver pain pump and administered additional medication to him. *Went to the bathroom, did not perform any hand hygiene, put on new gloves, and applied bacitracin with a Q-tip to the end of his penis. -At that time she removed her gloves. *Went to the bathroom, did not perform any hand hygiene, put on new gloves, and applied zinc oxide to both of his inner leg creases. -Removed her gloves and performed hand hygiene at that time. Interview on 1/29/20 at 9:16 a.m. with director of nursing A regarding the above observation of resident 150 revealed: *RN B should have:	F 880		

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F 880	Continued From page 23 -Removed her soiled gloves and performed hand hygiene. -Performed hand hygiene before touching the syringe driver. *Her expectations were to sanitize hands when moving from a soiled area to a clean area. Review of the provider's October 2019 Hand Hygiene policy revealed: *Policy: -"The facility considers hand hygiene the primary means to prevent the spread of infection." *Procedures: -"2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. -6. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-90% ethanol or isopropanol for all the following situations: --a. Before and after direct contact with residents. --b. When entering and leaving a Resident care area/room. --c. Before donning and after removing gloves. --e. Before preparing or handling medications. --g. Before moving from a contaminated body site to a clean body site during resident care. -8. The use of gloves does not replace handwashing/hand hygiene." Review of the provider's September 2019 Catheter Care policy revealed: *Policy: -"The purpose of this procedure is to prevent catheter-associated urinary tract infections." *Infection Control:	F 880		

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F 880	Continued From page 24 -"1. Use standard precautions when handling or manipulating the drainage system. -2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. --a. Routine hygiene (e.g., cleansing of the meatal surface with soap and water or with perineal wipes during daily cares) is appropriate and should be performed with AM and HS cares and with each episode of performing peri-care."	F 880		

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E 000	Initial Comments Surveyor: 29354 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 1/27/2020 through 1/29/2020. Avantara Watertown was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynna M. Speier — TITLE: Administrator — (X6) DATE: 2/19/2020

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	01/28/2020

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 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/28/20. Avantara Watertown was found not in compliance with 42 CFR 483.70 (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 deficiencies identified at K131 and K292 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	K 131	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set for in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal Law. Without waiving the foregoing statement, the facility states that: K 131 Multiple Occupancies 1. All residents, staff and visitors were identified for correction. No negative outcomes noted for residents. 2. Open pipes entering the care center were filled with Great Stuff ™ Fireblock Insulating Foam Sealant on 1/30/2020 by the Maintenance Director. 3. Maintenance Director or designee conducted inspections of all fire barriers on 1/30/2020 and documented all inspections and repairs according to the established procedures. Maintenance Director or designee will audit findings to monthly QAPI for review and recommendations as warranted for at least 3 months. 4. Completion Date:	2/25/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Lynna M. Speier Lynna Speier | Administrator | 2/19/2020

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 _____	01/28/2020

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AVANTARA WATERTOWN	415 FOURTH AVE NE WATERTOWN, SD 57201

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K 131	Continued From page 1 Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain the fire-resistive design of one of one building separation walls (between the nursing home and the adjacent apartment building). Findings include: 1. Observation on 1/28/20 at 12:30 p.m. revealed the two-hour fire-rated separation wall between the nursing home and the adjacent building corridor had three unsealed penetrations. The wall was penetrated by two 2-inch insulated steam pipes, and one 4-inch insulated steam pipe. The three pipes had been cut off 6-inches inside of the nursing home. The openings were not sealed or provided with any approved material to maintain the fire rating of the wall. Interview with the maintenance supervisor at the time of the observation confirmed that finding. The deficiency could affect 100% of the occupants of the smoke compartment.	K 131		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.	K 293	K 293 Exit Signage 1. All residents, staff and visitors were identified for correction. No negative outcomes noted for residents. 2. Two additional exit signs were installed on 2/18/2020 by the Maintenance Director. 3. Maintenance Director or designee will conduct inspections of evacuation route monthly with the regularly scheduled fire drill. Maintenance Director or designee will continue to document all inspections and	

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	435068	A. BUILDING 01 - BUILDING 01,02,03 B. WING _____	01/28/2020

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AVANTARA WATERTOWN	415 FOURTH AVE NE WATERTOWN, SD 57201

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K 293	Continued From page 2 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to install exit signs for two of two resident corridors (long corridor and short corridor). Findings include: 1. Observation on 1/28/20 at 1:30 p.m. revealed one exit sign located in the long corridor indicated egress to the exterior. The second required exit (through the cross-corridor smoke seperation doors to the nurses' station) was not identified with the exit signage. 2. Observation on 1/28/20 at 1:45 p.m. revealed one exit sign located in the short corridor indicated egress to the exterior. The second required exit (through the cross-corridor smoke seperation doors to the nurses' station) was not identified with the exit signage. Interview with the maintenance manager at the times of the above observations confirmed those findings. The deficiency affected two locations required to be provided with a marked and identifiable path of egress.	K 293	and repairs according to the established procedures. Maintenance Director or designee will audit findings to monthly QAPI for review and recommendations as warranted for at least 3 months. 4. Completion Date:	2/25/2020

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 _____	01/29/2020

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 Surveyor: 40506 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/27/2020 through 1/29/2020. Avantara Watertown was found not in compliance with the following requirement: S157.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain exhaust ventilation in four randomly observed rooms (two corridor soiled laundry storage rooms, the toilet room of resident room 18, and the dirty laundry room). Findings include: 1.a. Observation on 1/28/20 at 10:00 a.m. revealed the soiled laundry storage room on the long corridor did not have working exhaust ventilation. Interview with the maintenance manager at the time of the observation confirmed that finding. b. Observation on 1/28/20 at 10:20 a.m. revealed the toilet room for resident room 18 did not have working exhaust ventilation. Interview with the maintenance manager at the time of the observation confirmed that finding.	S 157	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set for in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal Law. Without waiving the foregoing statement, the facility states S 157 44:73:02:13 Ventilation 1. All residents, staff and visitors were identified for correction. No negative outcomes noted for residents. 2. Active Heating, Inc performed all full inspection and completed immediately repairs of all electrically powered exhaust fan in the identified areas on 2/17/2020. a. Soiled laundry storage room exhaust ventilation in the long corridor is served by roof vent #6. The fan belt was retightened, bearings re-greased and fan motor amps were found to be at maximum. Exhaust air flow was measured again and passes monthly maintenance checks air flow. This fan is original to 1966 construction is scheduled for replacement. b. Resident room 18 exhaust fan is served by roof vent #7. Building blueprints show required ventilation in that room is to be 60cfm. Exhaust air flow was measured at 64cfm. The exhaust fan passed monthly maintenance checks. No further actions are required this ventilation meets all known requirements c. Soiled laundry storage room exhaust ventilation in the short corridor is served by roof vent #8. Building blueprints show required ventilation in that room is to be 40cfm. Exhaust air flow was measured at 51cfm. The exhaust fan passed monthly maintenance checks. No further actions are required this ventilation meets all known requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynna M. Speier — TITLE: Administrator — (X6) DATE: 2/19/2020

STATE FORM 6899 80EI11 if continuation sheet 1 of 2

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 _____	01/29/2020

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S 157	Continued From page 1 c. Observation on 1/28/20 at 11:00 a.m. revealed the soiled laundry storage room on the short corridor did not have working exhaust ventilation. Interview with the maintenance manager at the time of the observation confirmed that finding. d. Observationon 1/28/20 at 11:15 a.m. revealed the soiled laundry holding room adjacent to the laundry room did not have working exhaust ventilation. Interview with the maintenance manager at the time of the observation confirmed that finding. e. The maintenance manager stated he did not have exhaust ventilation checks as a required part of his preventative maintenance plan.	S 157	d. Soiled laundry holding room exhaust ventilation is served by roof vent #2. Building blueprints show required ventilation in that room is to be 360cfm. Exhaust air flow was measured at 80cfm. The fan belt was retightened, bearings re-greased and fan motor was rewired after finding it wired backwards causing the fan to spin backwards. Exhaust air flow was measured again and found to be 375cfm. All corrective and repair actions are complete on this exhaust fan. 3. Maintenance Director or designee will conduct monthly inspections of facility equipment for operability and make necessary repairs. Designee will continue to document all inspections and repairs according to the established procedures. Maintenance Director or designee will audit findings to monthly QAPI for review and recommendations as warranted for at least 3 months. 4. Completion Date:	2/25/2020
S 000	Compliance/Noncompliance Statement Surveyor: 29354 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 1/27/2020 through 1/29/2020. Avantara Watertown was found in compliance.	S 000		