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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, interview, record review, and policy review, the provider failed to ensure that staff protected three of four sampled resident's (3, 22, 37) right to a sense of dignity, respect, and self-determination regarding bathing preferences. Findings include: 1. Review of the provider's 1/6/25 SD DOH FRI revealed that resident 22 informed director of nursing (DON) B that on his bath days, certified nurse aide (CNA) U had undressed him in his room, covered him with a blanket, then transported him to the shower room. Resident 22 stated he was uncomfortable going through the hallway covered with only a blanket and that he preferred to get undressed in the shower room. According to the FRI, CNA U had been made aware of the concern and was educated to respect the resident's preference. 2. Interview on 4/21/26 at 2:15 p.m. with resident 22 revealed that CNA U continued to undress him in his room, cover him with a blanket, and transport him to the shower room. He said it made him uncomfortable and that it happens all the time. 3. Interview on 4/27/26 at 2:16 p.m. with CNA U revealed that she was aware of resident 22's preference to undress in the shower room rather than his room. She stated that all residents were undressed in the shower room. 4. Interview on 4/28/26 at 10:30 a.m. with CNA M revealed that residents with limited mobility use a medical device called a mechanical lift to transfer between beds, wheelchairs, toilets, and shower chairs. She stated that residents typically get undressed in their room, especially if they're a lift [require a lift to transfer them to the shower chair], then they get undressed in their room and we cover them with a blanket to take them to the shower room. 5. Interview on 4/28/26 at 4:15 p.m. with resident 3 revealed that he had seen resident 22 transported to the shower room with a blanket over his body [which] means he's undressed. Resident 3 stated that CNA U did not ask resident 3 where he preferred to undress for his baths; instead, she just comes in and says, ?It's time for your bath,' and starts getting me undressed. Resident 3 said that CNA U can be a little picky, so he does what she tells him to do. 6. Interview on 4/28/26 at 4:20 p.m. with resident 37 revealed that he undressed in his room. He stated, [CNA U] just takes me out of the bed and puts me into the chair to transport, then covers me with a white sheet and takes me to the tub room, without asking him his preferences. He stated that he had also seen other residents transported to the shower room covered by a white sheet. 7. Interview on 4/29/26 at 8:19 a.m. with DON B revealed that the bathing protocol was to follow the resident's preference to undress in their room or the shower room. She stated that she had educated CNA U that resident 22 preferred to undress in the shower room and said, Sometimes it might be easier to undress the resident in their room, but [the staff] should follow what the resident wants. 8. Review of resident 22's 10/25/25 care plan revealed that he required partial assistance with upper body dressing and full assistance with lower body dressing. His care plan did not indicate any bathing preferences other than frequency. 9. Review of the provider's 11/18/25 Resident Dignity & Privacy Policy revealed that, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity. The policy indicated that staff were to groom and dress residents according to their preference and to maintain resident privacy when providing care.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, record review, and policy review, the provider failed to implement procedures to ensure allegations of abuse were reported to the required entities for two separate allegations of abuse:*A sexual abuse allegation made by one of one sampled residentˆ(21) to registered nurse (RN)ˆF and RNˆD involving certified nursing assistant (CNA)ˆE and an unidentified staff member.*A possible financial abuse allegation made by one of one sampled resident's (40) family member to social services designee (SSD)ˆJ.Findings include: 1. Observation on 4/21/26 at 9:17 a.m. of resident 21 in the hallway revealed he reported to RN D that contracted travel CNA E had touched him in a private area without his consent, which upset him (resident 21). RN D told the resident they had handled that situation. 2. Interview on 4/21/26 at 10:02 a.m. with resident 21 revealed that he was touched in a private area without his consent by one of one contracted travel certified nursing assistant (CNA) (E). At 6:00 a.m. on 4/21/26, he woke up with a quick startle when someone had their hands in my pants. I said, what the hell are you doing? He said that contracted travel CNA E replied, I am trying to see if you are wet. Resident 21 then stated to CNA E, I said you get the hell out of here, and per resident 21, CNA E left his room. The resident said that CNA E did not stop to explain anything to him. He stated that CNA E groped him with her hands down his pants and it made him feel cheap. He said he does not normally get checked for incontinence (involuntary urine or bowel leakage) at night. He was awake for an early morning blood sugar checks or blood lab draws, but not for going to the bathroom, because he used a urinal at night. 3. Interview on 4/21/26 at 11:18 a.m. with RN D revealed resident 21 had stopped her in the hallway and said that he was woken up at 6:00 a.m. that morning by a lady's hands down his pants. There was a contracted travel CNA working on the 4/20/26 night shift and RN D stated that we did speak with the traveler and normally he [resident 21] is able to take himself to the bathroom and put his call light on if he needs help to go to the bathroom. RN D knew resident 21 reported the allegation to RN F, who then had the conversation with the contracted travel CNA. RN D did not report this allegation to director of nursing (DON) B, but RN D was aware of the provider's process to inform the DON of the situation. The DON would then visit with the resident and contact the resident's family about the incident. RN D was aware that facilities had two hours to report allegations of abuse to the South Dakota Department of Health (SD DOH). The failure to report and investigate the allegation of abuse to the DON regarding the allegation, and provide safety to resident 21 and all the residents to prevent similar situations from occurring. 4. Interview on 4/21/26 at 11:47 a.m. with assistant director of nursing (ADON) G and DON B revealed they became aware of resident 21's abuse allegation at approximately 11:32 a.m. on 4/21/26 when RN D informed them. DON B confirmed that allegation should have been reported, and she expected RN D to have reported the allegation sooner. DON B said the allegation had not been investigated yet, but she attempted to call CNA E. 5. Interview on 4/21/26 at 11:58 a.m. with RN F revealed that she was in resident 21's room to check his blood sugar and administer his medications at around 7:00 a.m. that morning. She confirmed that resident 21 told her that someone came into his room at 6:00 a.m. and placed their hands down his pants to ensure he was dry. RN F did not think it was appropriate for a staff member to put their hands down a resident's pants to check their incontinent products, and she talked with CNA E about (continued on next page)

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the situation to educate her. RN F confirmed she did not report resident 21's allegations to anyone else after talking with CNA E. She explained that she was going to tell the DON but had not yet. RN F did not know the reporting time frame for abuse allegations. 6. Interview on 4/21/26 at 1:34 p.m. with administrator A revealed that RN D reported resident 21's allegations to her on 4/21/26 at 11:15 a.m. She would have expected staff to recognize that as an abuse allegation and that it should have been reported to the SD DOH within two hours of learning about the allegation. She explained that RN D should have reported resident 21's allegations to herself as the administrator or the nurse on call. She submitted a report to the SD DOH at 12:45 p.m. Administrator A did not contact the local law enforcement agency regarding the incident. She stated she would not report such allegations of abuse to law enforcement until their investigation determined if abuse occurred. She said, At this point we are going to interview the resident and staff and get part way through the investigation prior to getting them [law enforcement] involved. 7. Review of the provider's 4/21/26 SD DOH facility reported incident (FRI) report revealed that law enforcement and the ombudsman were not notified. 8. Interview on 4/28/26 at 11:19 a.m. with DON B revealed that if they received an allegation of abuse or neglect outside of business hours, she or administrator A would come to the facility to start the investigation process. They started by writing a reportable. Their investigation process included calling the staff for witness statements, reviewing the cameras, talking to family members, calling the police if it warrants, and sending a report to the SD DOH and the local ombudsman. She said that the time of the day doesn't matter when it came to reporting or investigating an allegation. 9. Review of resident 40's progress notes revealed that on 4/17/26 at 4:55 p.m., social service designee (SSD) J was made aware of concerns from resident 40's family member that there may be suspected financial abuse. SSD J provided the contact information for the states attorney's office for reporting suspected abuse along with how to file a report with [adult protective services]. 10. Interview on 4/29/26 at 9:00 a.m. with administrator A revealed that resident 40's family member had informed SSD J of a concern with financial abuse on 4/17/26. She said they did not get any details about the potential financial abuse that the resident's family member was worried about, so she did not think she needed to report the abuse allegation to SD DOH. She and SSD J provided resources to the resident's family member about where to report potential financial abuse. 11. Interview on 4/29/26 at 9:27 a.m. with SSD J revealed that on 4/17/26, she notified administrator A of resident 40's family members' concern regarding suspected financial abuse. 12. Review of the provider's 4/28/26 SD DOH FRI revealed that at approximately 1:00 p.m. on 4/28/26, [resident 40] reported concerns that her power of attorney (POA, someone designated on a legal document to act on behalf of a resident) may be misappropriating her funds. 13. Review of the provider's 5/14/25 Abuse and Neglect policy revealed the policy statement read, It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) (continued on next page)

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	federal components of prevention and investigation. The policy had five steps to take if abuse/neglect was suspected that included: 1. Take immediate steps to assure the protection of the resident(s). This may involve separation from the alleged abuser and/or provision of medical care. 2. Notify the appropriate/designated organization/authority that an investigation is being initiated immediately following intervention for the resident's safety. 3. Conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses. 4. Notify law enforcement authorities if indicated (i.e., a crime such as physical or sexual abuse, theft, etc.). 5. Report the investigation findings to all necessary state and/or local agencies and any other identified persons as required by law. The Steps in Abuse Prevention included Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting/Response. .IV. Identification: Have procedures to: Establish a written policy on how to assist staff in identifying abuse, neglect, exploitation, or misappropriation of property including the types of abuse. .V. Investigation: Have procedures to: Investigate all allegations of abuse, neglect, exploitation, and misappropriation of property. Identify [the] staff responsible for [the] investigation. All allegations will be investigated by the Administrator or Designee immediately. .VII. Reporting/Response.Have procedures to: All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee. All allegations of abuse will be reported to your state agency immediately (within 2 hours) after the initial allegation is received. A final investigation report will be submitted to your state agency within 5 working days. If the event that results in [an] allegation of abuse also causes the individual to suspect a crime, the facility will also report to the local law enforcement agency. Report to [the] State Nurse Registry and/or Department of Professional Regulations if the employer has knowledge of any action by the court of law against the licensed employee.

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the provider failed to ensure the resident's baseline care plan (personalized plan that addresses a resident's care needs, goals, and interventions) included the minimum healthcare information necessary to properly care for the resident, and that the care plan was completed within 48 hours of the resident's admission to the facility for six of 19 sampled residents (2, 4, 7, 33, 40, and 59), and was reviewed with, and a copy was offered to the resident or the resident's representative within 48 hours of the resident's admission to the facility for six of seven newly admitted sampled residents (2, 4, 7, 33, 40, and 59). Findings include:1. Review of resident 4's electronic medical record (EMR) revealed he was admitted to the facility on [DATE]. There was an uploaded signed paper copy of his baseline care plan. It was signed by resident 4's representative on 9/25/25 to indicate that they had received a copy and that it was reviewed with them. His 9/25/25 baseline care plan did not indicate the level of assistance he required for transfers, bed mobility, bathing, dressing, toileting, eating, or his physician's ordered diet. 2. Review of resident 59's closed EMR revealed she was admitted to the facility on [DATE]. There was a signed paper copy of her baseline care plan. It was signed by resident 59's resident representative to indicate that they had received a copy and that it was reviewed with them. It was not dated when it was signed. The last revisions made to the printed baseline care plan were made on 1/9/26. Resident 59's baseline care plan did not indicate the level of assistance she required for transfers, bed mobility, bathing, dressing, toileting, or eating. 3. Review of resident 7's EMR revealed he was admitted to the facility on [DATE] and he did not have a baseline care plan. 4. Review of resident 33's EMR revealed she was admitted to the facility on [DATE]. Her baseline care plan was signed by her representative. There was no date when it was signed. Her baseline care plan was uploaded into her EMR on 12/19/25. Her baseline care plan did not indicate how the resident transferred, walked, if assistive devices were required, or the amount of assistance resident 33 required for dressing or toileting. 5. Review of resident 2's EMR revealed she was admitted to the facility on [DATE]. There was no baseline care plan in her EMR. 6. Review of resident 40's EMR revealed she was admitted to the facility on [DATE]. Her 4/5/26 base line care plan did not indicate how she transferred from one surface to another, her diet, or the specific rehabilitation therapies that were ordered by her physician. 7. Interview on 4/27/26 at 4:20 p.m. with regional nurse consultant C revealed residents 2 and 7 did not have individualized baseline care plans completed. 8. Interview on 4/28/26 at 2:46 p.m. with licensed practical nurse (LPN) N revealed that the nurses initiated the baseline care plans for each resident during the admission process. All the nurses and (continued on next page)

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the leadership staff could make changes to the residents' care plans. The care plans should accurately reflect the current needs of each resident. 9. Interview on 4/28/26 at 2:09 p.m. with minimum data set/registered nurse (MDS/RN) H revealed that the staff probably really do not know how to provide care if the care plans were not resident-specific and completed. MDS/RN H revealed that she expected the baseline care plan to include information that direct caregivers needed to provide care to the resident. The baseline care plan was shared with the family and or the resident's representative when they had a care conference, and if they were unable to attend, they were to notify MDS/RN H, who would review it with them within 48 hours of the resident's admission. MDS/RN H expected the care plans to be accurate and to reflect the resident's current needs. She confirmed that resident 4 and resident 59's baseline care plans were reviewed with their representatives, but were not personalized to contain specific information on how to care for the residents. She expected that resident 4 and resident 59's baseline care plans would have been personalized to reflect their care needs before they were reviewed with the residents or their representatives. 10. Interview on 4/29/26 at 10:50 a.m. RNC C revealed that she did not think the facility had any signed baseline care plans to provide or documentation that a copy was provided to the resident or resident's representative. 11. Review of the provider's 5/14/25 Care Plans policy revealed: A Baseline Care plan is started by nursing staff on the first day of admission to provide guidance to direct caregivers as soon as possible after admission and completed no later than 48 hours after admission. Nursing, Dietary, Activities and Social Services staff complete formal assessments, interviews and observation and begin formulating the full care plan as soon after admission as possible (These departments do have areas that need to be completed by the 48-hour deadline). The areas that must be addressed in the baseline care plan include the minimum healthcare information necessary to properly care for the resident including, but not limited to: a) Initial goals based on admission orders. b) Physician orders. c) Dietary orders. d) Therapy services. e) Social Services. f) PASARR recommendations, if applicable.

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure the care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was reviewed and revised to reflect the current care needs for four of nineteen sampled residents (13, 33, 38, and 40).Findings include:1. Review of resident 40's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. Her 4/5/26 Brief Interview of Mental Status (BIMS) assessment score was a 9, which indicated his cognition was moderately impaired. Her diagnoses included Diabetes Mellitus (a condition involving disruptions in how the body regulates blood sugar), Parkinson's Disease (a brain disorder that makes it hard for a person to control their body movements), Alzheimer's Disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), Dementia (a group of symptoms affecting memory, thinking, and social abilities), Major Depressive Disorder, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and orthostatic hypotension (a sudden drop in blood pressure that happens when you stand up too quickly from sitting or lying down). Resident 40's 4/5/26 care plan revealed that it did not indicate how she transferred from one surface to another, her diet, and the specific rehabilitation therapies that were ordered by her physician. 2. Review of resident 33's EMR revealed she was admitted to the facility on [DATE]. Her 3/26/26 BIMS assessment score was 13, which indicated her cognition was intact. Her diagnoses included depression. She had a 3/29/26 physician's order for olanzapine (an antipsychotic medication) 5 milligrams (mg) daily to be administered at bedtime. There was no diagnosis identified on the physician's order that indicated why olanzapine was prescribed. The indication for use was behaviors and poor mood. She had a 12/4/25 physician's order for sertraline (an antidepressant medication) 100 mg every day to be administered at bedtime for depression. Review of resident 33's progress notes from 3/25/26 to 4/20/26 revealed a 3/25/26 progress note stated, Becomes very agitated and combative with attempts to assist resident. Grabs [the] staff, kicks, hits, scratches, and pinches. 'You just get out of here! I don't trust any of you!' Mimics sarcastically what [the] staff are asking/saying to her. A 3/28/26 progress note stated, Resident taking papers off nurse [nurses'] desk and ripping them apart. Yelling and name calling to [the] nurse and other staff. A 3/29/26 progress note stated Resident is name calling to [the] staff, arguing with [the] staff. Reaching out to pinch another resident. A 4/13/26 progress note stated, yelling at [the] staff to 'go to hell,' 'don't look at me.' 'you're all evil.' Unable to redirect [the resident]. Resident spit at [the] writer. Review of resident 33's 4/22/26 care plan revealed she had a focus area of Resident has potential for bruising, hemorrhage due to anticoagulant use, she had not taken an anticoagulant since 3/13/26. Her care plan did not indicate she was on an antipsychotic medication, that she had behaviors, or any nonpharmacological interventions that may be used when she had behaviors. The use of a psychotropic (antidepressant) medication was only identified in resident 33's care plan within the focus area related to her risk of falling. It did not indicate target symptoms for the use of her sertraline or non-pharmacological interventions. 3. Review of resident 13's EMR revealed she was admitted to the facility on [DATE]. Her current BIMS assessment score was 11, which indicated her cognition was moderately impaired. Her (continued on next page)

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Diagnoses included chronic diastolic heart failure (chronic progressive condition where the heart muscle is too weak to pump blood effectively), paroxysmal atrial fibrillation (irregular rapid heart rate). She had a 1/16/25 physician's order for Clopidogrel (an antiplatelet medication) 75 milligrams (mg) 1 tablet to be administered by mouth (PO) daily. She had a 8/8/25 physician's order for Aspirin (pain medication) 81mg enteric coated (EC) tablet to be administered PO once daily. Her 4/29/26 care plan included a focus area of potential for bruising, hemorrhage due to anticoagulant use initiated on 1/17/25, and revised on 9/30/25. 4. Review of resident 38's EMR revealed she was admitted to the facility on [DATE]. Her current BIMS assessment score was 9, which indicated her cognition was moderately impaired. Her diagnoses included atherosclerotic heart disease (a condition where plaque builds up in the heart arteries decreasing blood flow). She had a 4/1/26 physician's order for Aspirin (pain medication) 81 mg EC tablet to be administered PO once daily. She had no anticoagulant (blood thinner) medication ordered. Her current care plan included a focus area of: I have potential for bruising, hemorrhage due to anticoagulant use and self-propelling in w/c [wheelchair] initiated on 4/1/26 and revision on 4/8/26. 5. Interview on 4/21/26 at 1:36 p.m. with CNA O revealed she referred to the facility's pocket care plan and the Kardex (a report of the resident's care needs and interventions) to determine what care she needed to provide for each resident. She stated there have been times when the packet care plans were not up to date so she referenced the residents' Kardex and notified the nurse that the pocket care plan needed to be updated. 6. Interview on 4/22/26 at 3:22 p.m. with certified nursing assistant (CNA) S revealed she referenced the residents' care plans in their EMR or on the pocket care plans (a document that identifies residents' care needs and interventions) to know how to care for each resident. 7. Interview on 4/28/26 at 2:09 p.m. with minimum data set/registered nurse (MDS/RN) H revealed she started her position as the MDS/RN in September of 2025. She thought that the staff probably really do not know how to provide care if the care plans were not resident-specific and completed. She expected care plans to be updated to the resident's current care needs. Care plans were updated at least every three months. They also did a weekly care plan meeting where a set of residents who had upcoming care plan reviews or residents who had a change in status were reviewed to ensure that the focus areas in the care plan were specific to the residents. She was responsible for updating the nursing portion of resident care plans. If a resident was taking an antipsychotic medication, she expected that to be on their care plan as well as interventions to help alleviate their behaviors. Director of nursing (DON) B, assistant director of nursing (ADON) G, and she were responsible for updating the nursing portion of the resident care plans. She confirmed residents 13 and 38 were never on an anticoagulant medication and that their care plans needed to be updated. MDS/RN H updated resident care plans at least quarterly and as needed. She expected the resident care plan to be accurate and to reflect the residents' current needs. 8. Interview on 4/28/26 at 2:46 p.m. with licensed practical nurse (LPN) N revealed the nurses initiated the residents' care plans during the admission process. All the nurses and the leadership staff could update the residents' care plans. The care plans should be updated to accurately reflect the current needs of each resident. Resident 33 had intermittent behaviors such as being rude, abrupt, and blunt to the staff and other residents. LPN N thought the CNAs experienced resident 33's behaviors during her cares more than the nurses witnessed them. LPN N acknowledged that resident 33's behaviors as well as non-pharmacological interventions should be identified in her care plan. (continued on next page)

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Review of the provider's 4/28/25 Psychotropic Medications policy revealed, Psychotropic medications will be used only when it is necessary to treat a specific condition after non-pharmacological interventions have been attempted to assist with residents displaying mood, behavior, or sleep concerns. Resident's receiving psychotropic medication will have adverse side effects and target behaviors addressed in the care plan and will be monitored, recorded, and summarized each quarter. 10. Review of the provider's revised 5/14/25 Care Plans policy revealed Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team through the resident's stay to promote optimal quality of life while in residence. In doing so, the following considerations are made: 1. Each resident is an individual. The personal history, habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical/diagnosis-based care considerations. 2. Each resident has the right to be happy, continue their life-patters as able, and feel comfortable in their surroundings. 3. Care planning is constantly in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death. 4. Each resident is included in the care planning process and encouraged to achieve or maintain their highest practicable physical and mental abilities through the nursing home stay. 5. The physician's orders (including medications, treatments, labs, and diagnostics) in conjunction with the resident's plan constitute the total 'plan of care'. Physician orders are referenced in the resident's care plan, but not rewritten into that care plan.

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on observation, interview, record review, and policy review, the provider failed to ensure resident safety regarding the side rails/grab bars and mattresses on the resident's beds were assessed for entrapment (trapped between the rail, mattress, or bedframe spaces) risk for three of three sampled residents (23, 35, and 48) who had loose side rails/grab bars on their beds and three of three sampled residents (23, 32, and 35) who had an unsecured mattress on their bed. Those failures put the identified residents at risk for entrapment injury or harm. Findings include: 1. Observation and interview on 4/22/26 at 10:31 a.m. with resident 35 in his room revealed his bilateral side rails could move away from his bed one to two inches. He stated they had been like that since he admitted to the facility. 2. Observation on 4/22/26 at 3:27 p.m. of resident 35's bed revealed there was a gap of five inches between the top of his mattress and the headboard. The top opening of his bilateral side rails measured four and three-quarter inches in width by five and one-half inches in height. The bottom opening measured four and three-quarters inches in width by four and one-half inches in height. 3. Observation and interview on 4/22/26 at 10:16 a.m. with resident 48 in his room revealed he had bilateral side rails on his bed. He used the left side rail to get in and out of bed, but it was loose. He did not use the right-side rail because it was against the wall. He thought the side rails were on his bed because he had nightmares which made him move around in bed and he had fallen out of his bed due to the nightmares. His left side rail could move away from the mattress three inches when pulled. He denied that he had gotten a body part stuck in the either side rail. He had told a certified nursing assistant (CNA) and his daughter that his left side rail was loose but did not know when he told them. He thought it was a week or so. 4. Review of resident 48's electronic medical record (EMR) revealed he was admitted to the facility on [DATE]. He had a 3/13/26 Brief Interview of Mental Status (BIMS) assessment score of 15, which indicated his cognition was intact. His diagnoses included that he was legally blind. On 8/15/25 resident 48 had a dream and fell out of his bed. He was sent to the emergency room after this fall and was diagnosed with a brain bleed. 5. Observation and interview on 4/22/26 at 10:36 a.m. with resident 23 in her room revealed she used the bilateral side rails to roll over in bed. The right-side rail could move away from the bed two to three inches when pulled. Resident 23 did not know how long her side rail had been loose. The opening within the bilateral side rails measured three and one-half inches wide by 13 inches in height. The space between the foot of her mattress and the footboard was seven inches. 6. Observation and interview on 4/22/26 at 6:25 p.m. with licensed practical nurse (LPN) N in resident 32's room revealed resident 32 had a side rail on the right side of her bed. LPN N determined if a side rail or mattress was a risk for entrapment for a resident if there was a gap that a body part could be trapped in. LPN N measured the space at the top of the mattress to the side rail and the bottom of the mattress to the side rail when she assessed for an entrapment. She centered the mattress on the bed when she took the measurement even if the mattress could be slid over. Resident 32's mattress was able to slide to the wall leaving an eight-inch gap between the mattress and the side rail. (continued on next page)

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	7. Review of the maintenance logbook for side rail inspections for January 2026 through April 2026 revealed that in January the side rail audits indicated that zone 1 (the opening within the side rail) was the only entrapment zone assessed. The other six zones of entrapment were documented as not applicable. In February all seven zones of entrapment were documented as having passed the audit on every bed assessed. In March only zone 1 was documented as being assessed, all the other six zones were documented as not applicable. In April six side rail assessments were documented as passed for zone one with not applicable for the other 6 zones. Twenty-one side rail audits were documented as not applicable for all seven zones. Those residents documented as not applicable for all seven entrapment zones in April 2026 included residents 2, 3, 4, 12, 14, 16, 17, 22, 23, 31, 33, 35, 36, 37, 45, 47, and 48. Residents who were identified as having side rails that were not included on the April 2026 side rail audit included residents 8, 27, and 32. There were no entrapment assessments for zone 7 (the space between a mattress and headboard or footboard) from January 2026 through April 2026 documented for residents without a bed rail. 8. Interview on 4/22/26 at 6:06 p.m. with director of nursing (DON) B revealed she was unsure if the provider had a policy related to entrapment assessments. She thought maintenance did the entrapment assessments on the residents' beds. The side rail assessments were to be completed by the nurse on the resident's admission if the resident or the resident's representative wanted a side rail and quarterly by the Minimum Data Set (MDS) nurse. DON B completed the consent for side rails with the resident or the resident representative and that consent had the risks versus benefits of having a side rail on it. 9. Notice of immediate jeopardy (IJ) of F689 was given verbally and in writing on 4/22/26 at 7:00 p.m. to administrator A regarding the resident's side rails not being securely attached and the mattresses on residents' beds not being assessed for entrapment. Observations made throughout the survey and throughout the entire building on 4/22/26 revealed there were several safety concerns related to side rail installation, maintenance, and bed zone assessments. Residents 23, 35, and 48 had side rails that were not securely attached to their bed, which created a risk for resident entrapment and injury. Resident 23's side rail openings measured three and one-quarter inches in width by 13 inches in height, was loose and separated from the mattress with over two inches of a gap which created a risk for entrapment and injury. Resident 48's side rail opening measured three and one-quarter inches in width by 11 inches in height, was loose, and separated from the mattress with over two inches of a gap which created a risk for entrapment and injury. Resident 35 had a five-inch gap between the top of his mattress and his headboard which created a risk for entrapment and injury. The above concerns had the potential to cause serious harm, injury, impairment, or death for residents. A plan for removal of the immediacy was requested at that time. 10. On 4/23/26 at 10:14 a.m. the provider submitted the following IJ removal plan for review, Residents #23, #35, and #48 with identified safety concerns related to bed rail installations, (continued on next page)

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	maintenance, and bed zone assessments were addressed immediately. Bed rails for these residents were inspected and tightened to ensure secure installation. In addition, a 100% audit of all beds in the facility was completed on 4/23/2026 to specifically address gaps between side rails and mattresses and to confirm overall bed system safety. All residents with side rails or mobility bars had assessments and entrapment zone measurements completed to ensure compliance with regulatory requirements. During this process, mattress stabilizers were identified as removed from select beds, which contributed to potential gaps; these were corrected immediately by reinstalling hardware, adjusting components, or replacing beds as needed. All mattresses were evaluated to ensure proper fit with no gaps at the head, foot, or sides of the bed. At the conclusion of the audit, no residents were identified as having unsafe bed systems. The Regional Nurse Consultant provided education to Maintenance and Nursing staff on proper installation, inspection, and entrapment zone measurement requirements for bed rails, mobility bars, and mattresses. Education included all entrapment zones and emphasized the importance of completing measurements from a stabilized mattress position, including assessing for potential mattress shift during use to ensure accuracy. All staff were educated to immediately report any identified gaps between the mattress and bed frame or any loose mobility bars/side rails to the Maintenance Department for prompt correction. Nursing and Maintenance staff were additionally educated on the audit process and expectations for ongoing monitoring, including accurate completion of entrapment zone measurements. Education was conducted at the start of shift, and all staff present completed training, with plans in place to educate any staff not in attendance. The Maintenance Director or designee will conduct ongoing audits of 4 random residents with mobility bars/rails weekly for 4 weeks, followed by monthly audits for 2 additional months, including verification that all side rails and mobility bars are secure, all entrapment zone measurements meet regulatory requirements, and all mattresses fit appropriately without gaps and remain stabilized. Audits will also include confirmation that mattress stabilizers and related hardware remain in place. Results of these audits will be reviewed by the Administrator, Director of Nursing, or designee in collaboration with the Interdisciplinary Team (IDT) and Medical Director at monthly Quality Assurance Performance Improvement (QAPI) meetings. Findings will be analyzed for trends and used to determine the need for continuation, revision, or discontinuation of the audits based on findings. 11. The immediacy was removed on 4/23/26 at 3:40 p.m. after the survey team verified on site that the provider had implemented their removal plan through observation, document review, and staff interviews. After the removal of the IJ, the scope and severity of the noncompliance remained at an E. Current census was 45 residents. 12. Interview and review of the maintenance logbook for side rail inspections on 4/28/26 at 10:15 a.m. with regional maintenance II revealed when the maintenance staff completed the side rail audits they would first verify with the nurses that the residents still needed the side rail on their bed, and if they had left, right, or bilateral side rails. The maintenance staff would check the side rail to ensure it was tightly secured to the resident's bed and measured the entrapment zones to ensure they were less than four and three-quarter inches. He expected all seven entrapment zones to be checked but with the style of side rail that was in the facility only three of the zones applied. The side rail audits were to be completed by maintenance monthly. During the side rail audits the mattress was to be measured to be sure there was not a large gap between the mattress and the footboard or headboard. The measurements of the gaps between the mattress and head and footboard as well as the side rails were completed with a tape measure. (continued on next page)

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	He was not aware that in March 2026, only entrapment zone one was audited, and all the other zones were documented as not applicable or that in April 2026 the side rail audit indicated all seven zones were not applicable. He expected all entrapment zones to be checked monthly and documented as passed or not applicable. When the open area within the side rail was measured, the maintenance staff only measured one direction because the height of the upside-down U-shaped side rails was about 11 inches in height. He acknowledged that there were gaps between some residents' mattresses and their head or footboard which posed a risk for entrapment and there were loose side rails on the residents' beds which posed a risk for injury. 13. Interview on 4/29/26 at 9:30 a.m. with administrator A revealed that the maintenance staff was responsible for completing monthly audits of the residents' side rails to be sure nothing had changed or was modified since their original installation. The audits of the side rails were documented in the facility's online maintenance system. Administrator A reviewed that system to be sure the side rail audits were completed. If a resident was identified as needing a side rail installed that recommendation was communicated to the family and the resident's physician. The risks and benefits of the side rail, including entrapment, were reviewed with the resident or the resident's family and representative, and once those steps were completed the maintenance department would install the side rail. The maintenance staff were to ensure the entrapment zone measurements were in compliance with the recommendations from the food and drug administration (FDA). She stated the measurements within the opening of the side rails were to be less than four and three-quarter inches in width, and the FDA guidance did not address the measurements related to the height of the opening within the side rails. 14. Interview on 4/29/26 at 10:09 a.m. with DON B revealed the consent for side rails was in the resident's admission packet and all residents were offered side rails at the time of their admission. DON B stated she knew that alternate interventions should be attempted before side rails were put on a resident's bed, but she was following the resident's and the resident representative's wishes. The physical and occupational therapy staff also recommended side rails for some residents who received therapy to improve their mobility and independence. DON B acknowledged that there was missing documentation related to the side rail assessments, consents, and physician orders. She stated there were side rails on the residents' beds that were not documented when they were put on. She acknowledged that there was a risk for resident entrapment and injury when entrapment zone measurements and assessments were not completed on the side rails and mattresses, and when the side rails were loose. 15. Review of the provider's 11/18/25 Bed Rail policy revealed, These cbars [side rails] pose safety hazards and must be evaluated for appropriate placement for the sole purpose of transfer and bed mobility assistance for the resident. The Entrapment Zone Review Form (or electrical format in TELS) is completed upon placement of rails, quarterly and with a resident change of condition. Entrapment zones should be assessed with any changes of mattress. B. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), (continued on next page)

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	observation, interview, record review, and policy review, the provider failed to ensure the safety of: *One of one sampled resident (58) who fell from his bed that was left in an elevated position by CNA Z and required further evaluation in the emergency department (ED) due to a possible head injury. *One of one sampled resident (22) who was assisted by CNA NN with a sit to stand (a mechanical lift used to assist from a seated to a standing position) lift transfer done incorrectly which caused the resident to have pain. *One of one sampled resident (56) identified as at risk for elopement (leaving the facility without staff knowledge) who eloped through an unsecured door and was outside for approximately 15 minutes. *One of one sampled resident (59) who fell while transferring herself to the bathroom and hit her head which required an ED evaluation, when the provider failed to implement review and revise interventions to reduce the risk of falls when she fell 11 times in 30 days. Findings include: 1. Review of the provider's 1/8/26 SD DOH FRI revealed on 1/8/26 at 11:15 p.m. resident 58 fell out of his bed. When the staff responded to resident 58 they noted that his bed was not in its lowest position. Registered nurse (RN) OO thought resident 58 hit his head during the fall and due to him being on an anticoagulant (blood thinning) medication he was transported by ambulance to the ED for evaluation. He returned to the facility from the ED after a few hours with a diagnosis of a minor closed head injury and abrasions to his left forearm, wrist, and knee. Resident 58 was trying to take off his socks while he was in bed and due to his left-sided weakness from a prior stroke (blood supply to the brain is blocked or reduced), he fell sideways and out of bed. Resident 58's bed was left in an elevated waist high position by CNA Z at 9:30 p.m. 2. Review of CNA Z's 1/9/26 fall witness statement revealed she had assisted resident 58 to bed at approximately 9:30 p.m. She did not have a pocket care plan (a document that identifies residents' care needs and interventions) to reference because the system was not working so she left his bed at waist height. 3. Review of resident 58's EMR revealed he was admitted to the facility on [DATE] and passed away on 2/4/26. His diagnoses included a stroke with left sided weakness or paralysis. His care plan (personalized plan that addresses a resident's care needs, goals, and interventions) did not identify a specific height at which his bed was to be positioned before he fell from his bed on 1/9/26. After he fell out of bed on 1/9/26 his care plan indicated he had a high risk for falling, and his bed was to be left in the lowest position for his safety. 4. Interview on 4/29/26 at 9:10 a.m. with CNA HH revealed that if a resident was not care planned for a specific bed height the resident's bed was to be positioned at a height that when that resident sat up on the side of the bed their feet would rest flat on the floor. 5. Interview on 4/29/26 at 10:09 a.m. with DON B revealed she was notified when resident 58 fell out of bed. When she completed her investigation, she found out he was trying to remove his socks while he was in bed and due to his left-sided weakness because of his stroke he fell to the side and out of bed. His bed was not in the lowest position after the staff had assisted him to bed. She expected the (continued on next page)

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	staff to leave the residents' beds in the lowest position after they had completed cares for that resident. 6. Review of the 2025 CNA competency checklist that was used upon hire and annually revealed that the bed mobility competency required the resident's bed to be left in the low position after the staff assisted the resident. 7. Review of the provider's 4/25/26 SD DOH FRI revealed that resident 22 had sustained a back injury when contracted travel CNA NN transferred him using a sit-to-stand lift with a sling that was too small. Contracted travel CNA NN transferred the resident without another staff member's assistance when resident 22's care plan indicated he required two staff members to assist him to transfer. Resident 22 needed further outside medical evaluation for the injury. His care plan was updated to reflect that he should no longer receive care from contracted travel staff, only the provider's staff. 8. Interview on 4/22/26 at 10:06 a.m. with resident 22's family member revealed that although his care plan indicated he needed two staff members to assist him with transfers, she said, there's usually just one person transferring him. 9. Interview on 4/22/26 at 3:04 p.m. with social services designee (SSD) J revealed that updates to the resident's care plans were added to a communication book that the staff were to read each day before their next shift. 10. Interview on 4/27/26 at 2:16 p.m. with CNA U revealed that she determined how to transfer a resident by referencing the resident's care plan or Kardex (a report of the resident's care needs and interventions). 11. Interview on 4/27/26 at 3:53 p.m. with resident 22 revealed that he was aware that two staff members were supposed to help him transfer. He stated, Just one person comes to get me for my bath. I'm supposed to have two people [transfer me] at all times. He stated that he thought the contracted travel staff were not always aware that he was to be transferred by two staff members. He informed DON B when only one staff member transferred him. 12. Interview on 4/28/26 at 11:35 a.m. with resident 22's family member revealed that on 4/24/26, she had to show a contracted travel CNA how to use a mechanical lift in resident 22's room. Resident 22's family member stated, I asked her if she knew how to use the lift and she said, 'No, but I can look it up.' A nurse called [me] the next morning [to report the 4/25/26 incident], and she apologized and said a CNA transferred him [resident 22] by herself and he got hurt. 13. Interview on 4/28/26 at 12:15 p.m. with LPN KK revealed that as a contracted travel nurse, she was expected to arrive early on her first day at a facility to complete training on how to operate the mechanical lift equipment. She said the training only occurred the first time she was hired for a provider, and that the same models of lifts were used at most locations, so once you get the training, you don't need it again. She stated that she referenced the residents' care plan and Kardex to determine their required transfer assistance. 14. Interview on 4/28/26 at 2:09 p.m. with MDS RN H revealed that when resident care plans were updated, there was a binder at the nurse's station with updates of resident care needs and the staff were to review and sign the sheet to indicate that they were aware of the changes. She stated that the residents' transfer assistance needs were also documented on the resident Kardex and on report (continued on next page)

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	sheets that the CNAs referenced during each shift. The residents' care plans were reviewed and updated at least quarterly. She expected the care plans to be accurate and to reflect the residents' current needs. 15. Interview on 4/28/26 at 3:15 p.m. with DON B, regional nurse consultant (RNC) C, and administrator A revealed that the provider's staff completed regular competency assessments for using the lifts, and the contracted staff's employment agencies were expected to complete those evaluations with their contracted travel staff. DON B stated that the provider's CNAs were to reference a binder at the nurse's station that contained the manufacturer's instructions for each lift model to train the travel staff on how to operate the lifts. She indicated that resident 22 is competent enough that he'll tell me if only one person transferred him, and that the staff informed her when they saw others perform transfers incorrectly. If a resident's transfer status or care plan changed, DON B would print education for the staff, and the night shift [staff] would pass it on. 16. Interview on 4/29/26 at 8:19 a.m. with DON B revealed that the residents were evaluated by the therapy staff to determine the level of assistance they needed to transfer. She stated that CNAs have also recommended transfer assistance by two staff members for residents whose needs increased. Residents who used a full-body lift (a mechanical lift and sling used to lift a person's full body) were always to be transferred with the lift operated by two staff members. 17. Interview on 4/29/26 at 9:30 a.m. with administrator A revealed that she expected managers to communicate resident care plan updates to the staff. She indicated that there was a disconnect in communication due to having several new staff members. She stated that the resident's care plan was a living document (continuously updated and revised to reflect evolving needs) that anyone has the ability to change based on the residents' care needs identified during the staff meetings, care conferences, incident investigations, and grievance reports. She expected the charge nurses on duty to supervise the CNAs and to ensure that they followed the residents' care plans. 18. Review of resident 22's 10/25/25 care plan indicated that he required cares in pairs for transferring, repositioning in the shower chair, and to complete all activities of daily living (ADLs), and that two staff members were required to help him transfer using the sit-to-stand lift. 19. Review of resident 22's medical record revealed a 1/6/26 lift evaluation by nursing staff which specified he was Total dependent (full body lift). The evaluation was completed after resident 22 sustained a lower left leg hematoma when CNA U bumped his leg with the wheelchair pedals while transferring him to the shower chair. The evaluation read, Resident will use a total lift going forward for all transfers with two staff until his left leg heals. Once his leg heals, he may go back to using the standing lift for transfers to and from his chairs. He will use the total lift for all transfers to and from bed. A 1/7/26 progress note read, Resident [22's] care plan has been revised to reflect he is no longer using the sit-to-stand lift for transfers until the hematoma [from the 1/6/26 injury] is healed on the left leg. Staff will perform transfers using [a full body] lift with two staff assist. Another lift evaluation completed by nursing staff on 2/19/26 specified resident 22 was Total dependent (full body lift). A 4/14/26 progress note indicated that, Resident [22] may now use the [sit-to-stand lift] for all transfers utilizing two staff for all transfers. (continued on next page)

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A 4/25/26 progress note revealed, Resident [22].states that CNA [NN] hooked him up to [sit-to-stand lift] and used the wrong hook. States it was way too tight [and] he told the CNA that it was the wrong hook but she stated it would be ok. Also there [are] supposed to be two people at all times when caring for this resident. CNA [NN] was alone in the room with no assistance. 20. Review of resident 22's 4/23/26 physician orders revealed that his lower left leg hematoma from the 1/6/26 injury had not healed and required daily treatment and future evaluation at a local wound care clinic. 21. Review of the provider's 5/14/25 Care Plans policy revealed that, It is the responsibility of all direct care members to familiarize themselves with the care plans and review them routinely for changes, and that Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. 22. Review of the provider's 1/24/26 SD DOH FRI report regarding resident 56 revealed he followed another resident's family out of the south exit door on 1/24/26 at 2:25 p.m. and the temperature outside was three degrees. There was a sign on the exit door that informed the staff and visitors not to assist residents to exit. Resident 56 walked around the building independently and returned through the north door of the facility at 2:40 p.m. Resident 56 was wearing sweatpants, a long sleeve sweatshirt, a ball cap, socks, and sneakers. His Brief Interview for Mental Status (BIMS) assessment score was 2 which indicated his cognition was severely impaired. His vital signs (measurements of the body's function, such as temperature, blood pressure, pulse and respiration rate) were taken. Temperature was 96.9, blood pressure was 137/66, respirations were 20, and his pulse was 78. His oxygen saturation (percentage of oxygen in the blood) rate was 96%. A head-to-toe skin assessment indicated his skin was warm and dry with a pink color. Resident 56 was placed in a recliner, and given a warm blanket, and his feet were elevated. Resident 56's family and physician were notified of the incident and his physician ordered a wander guard (a wearable door alarm device) to wear on his right wrist. Resident 56's diagnoses included unspecified dementia (a group of symptoms affecting memory, thinking and social abilities), hypertension (elevated blood pressure), type two diabetes mellitus (a condition involving disruptions in how the body regulates blood sugar), COPD (a group of lung diseases that block airflow and make it difficult to breathe), depression, and anxiety (anticipation of future danger or misfortune with feelings of distress and /or sadness and symptoms such as restlessness or irritability) disorder. Elopement drills performed by the staff were last conducted on 1/19/26 and the exit door audits were completed on 1/12/26 and 1/19/26. The interdisciplinary team (IDT) conducted a quality assurance and performance improvement (QAPI) meeting and identified the root cause of resident 56's elopement incident was due to the staff deactivating the front door alarm during the facilities daytime hours to allow visitors to enter and exit the facility. This practice was discontinued, and the staff were educated to keep the door alarm activated. On 1/29/26 staff completed elopement education and repeated the monthly elopement drill to reinforce the importance of always knowing the location of assigned residents and promptly locating anyone whose whereabouts are unknown. Door audits are being performed regularly. 23. Review of resident 56's EMR revealed he was admitted to the facility on [DATE]. His 6/18/25 facility care plan indicated he had a potential for elopement and was revised on 1/9/26 and 1/26/26 addressing his history of elopement's. The 9/18/25 care plan interventions instructed the staff to ensure that the resident wore an identification bracelet, to have the resident follow a familiar routine, keep photographs of the resident's family and/or their significant other to help provide one to one (continued on next page)

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	care, maintain a calm environment, avoid stimulation by other physically aggressive residents, to place the resident on a therapeutic unit, provide the resident with his robotic dog, and to provide activities that resembled the residents prior lifestyle. On 1/25/26, a wander guard was added to the care plan and instructed staff to check the placement since the resident would remove it and place it on his ankle. The 1/26/26 initiated care plan interventions included the resident's family suggesting referrals be sent out to memory care locked units, the staff to check on the resident every 30 minutes, to maintain the elopement binder, and to have his family/friends sign the resident in and out of the facility. 24. Interview and record review on 4/29/26 at 11:45 a.m. with DON B revealed on 1/24/26, the door alarms were deactivated at the time of resident 56's elopement. The facility tried to redirect resident 56's wandering and agitation by having his significant other come and visit with him. Resident 56 would attend activities and would sit with management at times. He received a physician's order for a wander guard on 1/24/26 after his elopement. 25. Review of the provider's revised 5/14/25 Elopement policy revealed The facility must take steps to keep the resident safe and assess residents to identify those who are risk for elopement. Facility personnel must investigate all reports of missing residents. Elopement drills should be conducted monthly. 26. Review of the provider's 1/31/26 SD DOH FRI revealed on 1/31/26 at approximately 12:00 a.m., resident 59 was found sitting on the floor between her bed and the bathroom. RN QQ conducted a full body assessment. Resident 59 stated she hit the left side of her head and was transferred to the hospital for further evaluation because she was taking a blood t

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, and policy review, the provider failed to ensure accurate and complete documentation for the destruction of fentanyl patches (potent long-acting pain patch applied on the skin) for one of one sampled resident (9). Findings include:1. Review of the providers 4/2/26 SD DOH FRI revealed on 3/30/26 a fentanyl patch was ordered by hospice and resident 9 refused to have the fentanyl patch applied. On 3/31/26 licensed practical nurse (LPN) V placed the fentanyl patch on resident 9. On 4/2/26 LPN N went into resident 9's room to check the placement of her fentanyl patch and found the patch to be missing. Resident 9's family member stated he was present on 3/31/26 when LPN V placed the fentanyl patch on resident 9. The fentanyl patch was searched for by nursing and laundry staff but was not found. Resident 9 was interviewed about the missing fentanyl patch. She did not recall scratching the patch off.After that patch was not found, the plan was made to place the fentanyl patch on resident 9's back to prevent her from scratching the patch off. The medication administration record (MAR) was revised to include scheduled fentanyl patch placement checks every shift. Resident 9's care plan was updated to reflect the placement of the fentanyl patches on her back. 2. Review of the provider's 4/12/26 SD DOH FRI revealed that on 4/12/26 director of nursing (DON) B was notified by registered nurse (RN) T that she discovered resident 9's fentanyl patch to be missing when she was checking the patch's placement. On 4/10/26 the dose for resident 9's fentanyl patch had increased. LPN V entered the new order and did not include the additional instructions to place the fentanyl patch on resident 9's back. On 4/11/26 RN T placed the fentanyl patch on resident 9's right chest. On 4/12/26 at 1:20 p.m. RN AA documented the fentanyl patch was on resident 9's mid right upper back. On 4/12/26 at 7:00 p.m. RN T was unable to find the fentanyl patch. That patch was not found. After that patch was not found the placement monitoring was increased to every four hours. Other forms of pain management were discussed with hospice at that time. 3. Interview on 4/21/26 at 10:18 a.m. with resident 9's family member revealed he was in the room when the nurse put the fentanyl patch on resident 9 on 3/31/26. He had been notified two times that resident 9's fentanyl patch was missing. He stated that both times the fentanyl patch went missing the patch was placed on her chest. Resident 9 scratched frequently due to her liver disease, and he thought she probably scratched the fentanyl patches off. He stated she continued to use fentanyl patches for pain control and there had been no further lost patches. 4. Review of resident 9's EMR revealed she was admitted on [DATE] receiving hospice services. There was a 3/30/26 physician's order to start Fentanyl patch 12 microgram (mcg) per hour, change the patch every 72 hours. On 3/31/26 at 8:30 a.m. the fentanyl patch 12 mcg per hour was placed on resident 9. On 4/2/26 the fentanyl patch was missing. The patch was replaced on 4/2/26 at 12:45 p.m. On 4/3/26 the fentanyl patch dose was increased to 25 mcg per hour, with orders to change the patch every 72 hours. On 4/3/26 at 10:30 a.m. a 12 mcg fentanyl patch was placed on resident 9 and a second fentanyl patch was placed on her at 4:30 p.m. due to the physician's ordered fentanyl patch dose increase.On 4/10/26 the fentanyl patch increased to 37 mcg per hour, change the patch every 72 hours. On 4/11/26 at 7:00 p.m. a 12 mcg per hour patch and a 25 mcg per hour patch were applied to resident 9. On 4/12/26 at 7:00 p.m. resident 9's fentanyl patches were missing. On 4/13/26 at 10:00 a.m. a 12 mcg and 25 mcg per hour fentanyl patch were put on resident 9. On 4/13/26 there was a physician's order to place the fentanyl patches on resident 9's back only. On 4/22/26 there was a physician's order to increase resident 9's fentanyl patch dose to 50 mcg per hour, change every 72 hours. 5. Review of resident 9's April 2025 Transdermal Patch Controlled Drug Record revealed the fentanyl patch that was removed on 4/3/26 did not have a date or time when it was destroyed. The two 12 mcg fentanyl patches that were applied on 4/3/26 were not documented as being destroyed.On 4/6/26 at 4:30 p.m. the number five 25 (continued on next page)

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mcg fentanyl patch was signed out to be administered to resident 9. On 4/6/26 at 4:30 p.m. 25 mcg fentanyl patch five was documented as having been destroyed. On 4/9/26 at 4:30 p.m. the number four 25 mcg patch was administered at 4:30 p.m. and the number four 25mcg patch was documented as destroyed on 4/9/26 at 4:30 p.m. On 4/11/26 at 7:00 p.m. the number three 25 mcg fentanyl patch and the number one 12 mcg fentanyl patch were signed out to be administered and on 4/12/26 at 5:15 a.m. the number three 25 mcg fentanyl patch and the number one 12 mcg fentanyl patch were documented as having been destroyed. The 4/12/26 missing patch was not documented on the Transdermal Patch Controlled Drug Record as missing. On 4/13/26 at 10:00 a.m. the number two 25 mcg patch was signed out to be administeredOn 4/22/26 at 9:00 p.m. the number five fentanyl 50 mcg per hour patch was signed out to be administered and on 4/22/26 at 9:15 p.m. the number five 50 mcg fentanyl patch was documented as destroyed. On 4/25/26 at 9:00 p.m. the number four fentanyl 50 mcg patch was signed out to be administered and on 4/26/26 at 12:30 a.m. the number four 50 mcg fentanyl patch was documented as destroyed. The third 50 mcg fentanyl patch was documented as destroyed without a date or time. 6. Interview and review of resident 9's Transdermal Patch Controlled Drug Record on 4/29/26 at 9:12 a.m. with LPN V revealed she thought the Transdermal Patch Controlled Drug Record was difficult to understand. Resident 9's fentanyl patches were applied by the night nurses, unless a patch was found to be missing during a different shift. If there was not a second nurse available when the fentanyl patch was removed the nurse who removed the fentanyl patch would put the used patch in a medication cup and store it in the locked controlled medication drawer until the day shift nurse arrived and could witness the destruction.Two nurses were expected to witness the destruction of the fentanyl patch in the drug destruction bottle that was kept in the medication room. The date and time the fentanyl patch was destroyed would then be documented on the Transdermal Patch Controlled Drug Record. LPN V did not know how a fentanyl 50 mcg patch was documented as destroyed on the same day the first fentanyl 50 mcg patch was placed on resident 9. 7. Interview and review of resident 9's Transdermal Patch Controlled Drug Record on 4/29/26 at 10:09 a.m. with the director of nursing (DON) B revealed that resident 9 received her fentanyl patches from hospice. When controlled medications were provided by hospice, they were not accompanied by a controlled medication tracking form. Hospice gave them the Transdermal Patch Controlled Drug Record to track the removal of the fentanyl patch from the medication cart for application and the destruction of the fentanyl patch once it was removed from the resident.She expected the Transdermal Patch Controlled Drug Record to be completed accurately to include the date and time the patch was removed from the medication cart, and when it was destroyed. The fentanyl patches were to be destroyed by two licensed nurses as soon as they were removed. If the patch was removed after 11:00 p.m. there was only one nurse in the facility, so she expected that fentanyl patch to be stored in a plastic medication cup with the resident's initials on the cup. That cup was to be placed in the locked controlled medication drawer in the medication cart until the morning nurses arrived at the facility to witness the destruction of that fentanyl patch.DON B stated resident 9's fentanyl patch administration times changed when there was a change in the physician's order or when the patches were missing so a new patch could be placed immediately.There were two times resident 9's patches were reported to be missing on 4/2/26. The first time the patch was placed on her chest. Resident 9 scratched frequently due to her lever failure. DON B had looked for the patch and it was unable to be found. At that time, it was discovered that the order to check the fentanyl patches placement every shift had not been entered into the computer when the order for the fentanyl patch was entered, so the fentanyl patch placement had not been checked every shift.After that patch was unable to be found, an order to check for the fentanyl patches placement every shift was put into the computer. When the second fentanyl patch was missing on 4/13/26 the fentanyl patch placement checks were scheduled every four hours. She expected that the location of the patch be documented in the MAR when the patches were placed, and when the placement was checked.DON B acknowledged that the documentation on the Transdermal Patch Controlled Record indicated the (continued on next page)

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patch that was being destroyed was the same patch that had been removed from the medication cart for administration. She acknowledged the missing dates and times of the destruction of the fentanyl patches. 8. Review of the provider's 1/18/25 Drug Diversion Prevention policy revealed, Medications classified by the Drug Enforcement Administration (DEA) as controlled substances are subject to special handling, storage, disposal, and record keeping. Administration of transdermal controlled substances should follow the 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. During destruction of controlled substances, the inventory sheet of specific medications will be evaluated for signs of potential diversion, such as borrowing, consistent administration by one nurse, inappropriate documentation, etc.

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	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Watertown	415 Fourth Ave NE Watertown, SD 57201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure the facility was operated and administered by administrator A and director of nursing (DON) B in a manner that ensured quality of life and overall well-being for all 45 residents in the facility.Findings include:1. Observations, interviews, record reviews, and policy reviews throughout the survey on 4/21/26 through 4/23/26 and 4/27/26 through 4/29/26 revealed administrator A and DON B did not ensure the management, safety, quality of life, and overall well-being of all the residents who lived at the facility. Those were evidenced by a widespread system breakdown to ensure services provided met professional standards as it pertained to resident dignity, informed decision for psychotropic medications, resident self-administration of medications, resident meal choices/preferences, responses to resident concerns after resident council meetings, resident health information security, how to file a grievance, allegations of resident abuse, consent/diagnoses for psychotropic medications, reporting allegations timely, Ombudsman reports upon discharge, accurate Minimum Data Set (MDS) assessments (a federally mandated clinical assessment tool for nursing home residents, used to evaluate functional capabilities)/PASSR (Pre-admission Screening and Resident Review) (a federally mandated assessment required before admission to a Medicaid-certified nursing facility to ensure proper placement for individuals with serious mental illness or intellectual disabilities), PASSR refiling due to new resident diagnoses, resident specific baseline care plans within 48 hours of being admitted to the facility, updating resident care plans, notifying a physician of a resident's increased blood sugar levels, accident hazards related to bed side rails, nebulizer and nasal canula cleaning and storage, bed siderail assessments, orders and consent, call light wait times, controlled substance accountability, medication errors, and the storage of drugs and biologicals.2. Interview on 4/29/26 at 9:30 a.m. with administrator A revealed she had worked at this facility for approximately five years, left in 2021 to open a facility for another provider, and had returned to this facility in October of 2025. She confirmed she was responsible for the daily operations of the facility. She stated the siderail issue was frustrating because the company specifically bought new siderails to be compliant. 3. Review of the providers 4/23/25 updated administrator job description revealed, In keeping with our organization's goal of improving the lives of the residents we serve, the Administrator provides overall direction for all activities related to administration personnel, physical structure, information systems, office management and marketing of the entire facility. The Administrator works closely with all members of the management team and others to ensure their responsibilities are effectively and consistently discharged . The Administrator will ensure all facility operations are in compliance with federal, state and local regulations.4. Review of the providers 12/1/19 updated director of nursing job description revealed In keeping with our organization's goal of improving the lives of the Guests we serve, the Director of Nursing plays a critical role in providing superior customer service and nursing services to all Guests in the facility. The Director of Nursing is responsible for the planning, development and overall operation of the Nursing Department which ensures Guests receive quality care 24 hours a day.Refer to F550, F552, F554, F583, F585, F600, F605, F609, F628, F641, F644, F655, F657, F658, F689, F695, F700, F755, F759, F760, F761, and F806.