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	06/17/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, observation, record review, and policy review, the provider failed to ensure residents received care in accordance with their plan of care by two of two certified nursing assistants (CNAs) (N and Q) who did not change six of eight sampled residents' (1, 2, 3, 4, 5, and 6) incontinence (involuntary urine or bowel leakage) products during the night shift and did not reposition one of one sampled resident (4) who was found sideways in bed with urine-stained bedsheets, and by one of one contracted travel CNA (Z) who left one of one sampled resident (5) alone in the dining room for over three hours. Findings include: 1. Review of the provider's 6/16/26 at 1:00 p.m. SD DOH FRI revealed CNA M reported to the director of nursing (DON) B and regional nurse consultant (RNC), unidentified in report, that at the start of the day shift (6:30 a.m.), she found several residents who were heavily incontinent. She described resident 1 as being soaked through the incontinent brief and was incontinent of bowel. Resident 3 was wet/soaked from the shoulders down. Resident 2 was soaked with urine. Resident 4 was positioned sideways in bed and, upon repositioning, a urine stain was observed in the middle of the bed. Resident 5 stated that a CNA had placed a wet pillow underneath his side. CNA M reported that CNA R found resident 6 soaked from head to toe. The report indicated that residents were provided appropriate hygiene care, incontinent care, repositioning, and linen changes. Skin assessments are underway. It indicated that the physician and families were being notified, the care plans were being reviewed and updated as needed, and staff education would be completed. The investigation was ongoing. 2. Interview on 6/16/26 at 5:52 a.m. with CNA Q, conducted prior to review of the 6/16/26 FRI report, revealed that she was a new CNA and was still training on the night shift. She stated that standard practice was to complete resident rounds, which included repositioning residents and either helping them use the toilet or changing their incontinence briefs, every two to three hours. 3. Observation and interview on 6/16/26 at 6:00 a.m. of CNA M providing care to resident 3 in her room revealed that resident 3 was lying on her back, CNA M turned resident 3 onto her side, and resident 3's incontinence brief, the pad under her, her night gown, and the sheet under her were soiled. CNA M stated, She wasn't changed at all last night. Resident 3's room smelled of urine. CNA M stated that sometimes in the mornings when she came to work, residents were found lying in their beds soiled, and it depended on which CNA worked the night shift. Resident 3 could not tell anyone when she needed to be changed. When CNA M found residents incontinent in bed, she would tell the nurse, and the nurse would report it to DON B. Review of resident 3's EMR revealed she admitted to the facility on [DATE]. Her 3/22/26 Brief Interview for Mental Status (BIMS) assessment score was 3, which indicated her cognition was severely impaired. She had a diagnosis of Alzheimer's Disease (a progressive and irreversible brain (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder that affects memory, thinking, social abilities, and body functions), pain, difficulty in walking, and weakness. Her 6/9/26 Braden Scale (a tool used to assess the risk of developing pressure ulcers) assessment score was 12, which indicated that she was at high risk for developing a pressure sore (skin/and or underlying tissue injury from prolonged pressure), and that her skin was often moist. Resident 3's 4/11/26 care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) indicated she was dependent on the staff for assistance with completing her activities of daily living (ADLs), which included personal hygiene care. Her incontinence brief was to be checked and changed every few hours. The CNA task documentation in the computer system indicated resident 3 was incontinent of urine on 6/15/26 at 9:53 p.m., 6/16/26 at 12 a.m., and 2 a.m. She was dry at 4 a.m. and incontinent of urine at 6 a.m. The 6/16/26 night shift CNA sheet (a document that identifies residents' care needs and interventions) indicated resident 3 required staff to check and change her incontinence brief every two hours from 12 a.m. until 4 a.m. 4. Observation on 6/16/26 at 7:10 a.m. of CNA M providing care to resident 1 in her room revealed that resident 1's incontinence brief was soiled. CNA M said the pad under her was also soiled. CNA M assisted resident 1 onto the bedpan (a shallow tray used as a toilet by people who are confined to bed or unable to walk to the bathroom), and she had a continent void. Resident 1's had redness to her groin, maceration (damage to skin from being wet for too long) to her left and right inner buttocks, and superficial open areas across her sacrum (the base of the spine, sitting directly between the hip bones). Review of resident 1's electronic medical record (EMR) revealed she admitted to the facility on [DATE]. Her 3/17/26 BIMS assessment score was 15, which indicated her cognition was intact. She had a diagnosis of generalized anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), non-surgical impingement syndrome (a condition where tissues like tendons and cushioning sacs get painfully pinched inside a joint every time the arm is lifted) of both shoulders, lumbar radiculopathy (pinched or irritated nerve in the low back), and chronic pain. Her 5/24/26 Braden Scale assessment score was 17, which indicated she was at high risk for developing a pressure ulcer, and that her skin was occasionally moist. Resident 1's 6/1/26 care plan indicated she was dependent on the staff for toilet hygiene, dressing her lower body, and transfers. She required substantial assistance to move in bed and to dress her upper body. She required the use of the sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) for all transfers. She used the bedpan at night, and the staff was to change her incontinent brief as needed. The CNA task documentation indicated resident 1 was continent of urine on 6/15/26 at 9:40 p.m. and incontinent of urine on 6/16/26 at 6:29 a.m. She was not scheduled in the tasks to be checked and changed at 4 a.m. The 6/16/26 night shift CNA sheets indicated staff was to assist resident 1 with the bedpan when (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she requested. It indicated she usually rings at midnight and that she required to be checked and changed at 4 a.m. Resident 1's 6/13/26 Skin Evaluation assessment indicated that she had redness to her groin, and she had maceration to her inner buttocks. Her 6/16/26 Skin Evaluation assessment indicated that she did not have any changes since her previous skin assessment. Resident 1's 6/17/26 Skin Evaluation assessment indicated she had maceration to her left and right buttocks and to her sacrum. 5. Interview on 6/16/26 at 7:30 a.m. with resident 1 revealed that staff usually help her to the bathroom during the night, but they did not last night. She did not let the staff know she was wet because she did not know she had to urinate. 6. Interview on 6/16/26 at 7:32 a.m. with CNA M revealed that resident 1 usually rang her call light during the day shift when she needed to use the bathroom. 7. Interview on 6/17/26 at 6:30 a.m. with registered nurse (RN) K revealed she worked on the night shift. She thought CNA Q was doing well. RN K monitored that residents were being checked and changed at night by listening to the CNA discussions that came across the radios, and she offered assistance to the CNAs. She was not sure if resident 1 used her call light at night to alert staff when she needed to use the bathroom. 8. Interview and EMR review on 6/17/26 at 10:26 a.m. with licensed practical nurse (LPN) V revealed that resident 1 had superficial open areas to her sacrum and not just her inner buttocks. She would not state if it was a change from resident 1's previous skin assessment, which indicated the maceration was to her inner buttocks, because she had not seen resident 1's skin before that day. 9. Interview on 6/17/26 at 10:35 a.m. with DON B revealed that she had not looked at resident 1's wounds on wound rounds. 10. Observation on 6/17/26 at 10:48 a.m. revealed that DON B completed a wound assessment on resident 1 and measured her wounds. DON B stated that she would now monitor resident 1's skin during wound rounds so she could monitor it weekly and notify the physician to receive different treatment orders. 11. Interview on 6/17/26 at 2:18 p.m. with DON B revealed that resident 1 had experienced a recent decline, and the staff were to check in with resident 1 every two hours to offer her bathroom assistance and to see if she was incontinent. She verified that with resident 1's decline, the staff should have been proactive in updating her plan of care. 12. Interview on 6/17/26 at 3:20 p.m. with DON B and RNC Y revealed that they could not verify that resident 1's skin was worse than the previously documented skin assessments that indicated that resident 1 had maceration to her inner left and right buttocks, and now had open areas on her sacrum since they had not seen her wound before and without a diagram of where the maceration areas were previously at. 13. Observation on 6/16/26 at 7:35 a.m. of CNA M providing care to resident 2 in her room revealed that resident 2 was lying on her back. CNA M turned resident 2 onto her side, and her incontinence brief was soiled. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident 2's EMR revealed she admitted to the facility on [DATE]. Her 4/18/26 BIMS assessment score was 6, which indicated her cognition was severely impaired. She had a diagnosis of need for assistance with personal care, cognitive communication deficit, muscle wasting (muscles shrinking, thinning, and losing strength), and abnormalities of gait (walking) and mobility. Her 6/12/26 Braden Scale assessment score was 16, which indicated she was at high risk for developing a pressure ulcer. It indicated her skin was rarely moist. Resident 2's 6/8/26 care plan indicated she was dependent on the staff for toileting hygiene, personal hygiene, and dressing her lower body. She required a substantial amount of staff assistance for dressing her upper body, repositioning in bed, and transferring. The staff were to offer and assist her as needed with using the bathroom. The staff were to reposition her every two to three hours. Resident 2's CNA task documentation indicated she did not indicate that the CNAs were to check and change her every two hours. The CNAs documented that she was incontinent of urine on 6/15/26 at 9:30 p.m. and on 6/16/26 at 6:29 a.m. There was no documentation to support if she had been checked or changed between 9:30 p.m. and 6:29 a.m. The 6/16/26 night shift CNA sheets indicated that resident 2 was to be checked and changed at 12 a.m., 2 a.m., and 4 a.m. 14. Interview and EMR review on 6/17/26 at 2:18 p.m. with DON B revealed that resident 2's CNA task documentation should have indicated that she needed to be checked and changed every two hours. DON B was responsible for adding that to the resident's EMR. 15. Interview and observation on 6/17/26 at 7:34 a.m. with housekeeper U revealed that resident 4 was sleeping in his bed. His room did not smell of urine. Housekeeper U said she cleaned resident 4's bathroom several times each day because he often missed the toilet while urinating throughout the night. Review of resident 4's EMR revealed that he admitted to the facility on [DATE]. His 4/10/26 BIMS assessment score was 11, which indicated his cognition was moderately impaired. He had a diagnosis of chronic kidney disease and other specified disorders of the bladder, left-sided hemiparesis (muscular weakness) and hemiplegia (paralysis on one side of the body), contracture (tightened or shortened connective tissue, tendons or skin) of the left hand, muscle wasting and atrophy (shrinking or progressive decline) due to a cerebrovascular accident (when blood flow to the brain is interrupted, commonly referred to as a stroke), and a history of bladder retention and urinary tract infections (UTIs). Resident 4's 4/10/26 Minimum Data Set (MDS) assessment revealed that he was occasionally incontinent of bowel and bladder. His 6/16/26 care plan indicated that he wished to maintain independence with toileting and incontinence care and frequently declined assistance. He was to be checked for incontinence and offered assistance or supervised with changing his brief every two to three hours and as needed. His 6/7/26 Braden Scale assessment score was 17, which indicated that he was at high risk for developing a pressure sore and that his skin was often very moist. The CNA task documentation indicated resident 4 was incontinent of urine every day except on 6/11/26. He refused staff assistance on 6/15/26 at 9:57 p.m. The 6/16/26 night shift CNA sheet indicated resident 4 was incontinent of bowel and bladder, wore (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	all nursing staff. 28. Review of the provider's 5/14/25 Nursing Care Standards policy revealed that Incontinent residents shall be checked according to their individualized assessment and should have partial baths and clean linens promptly each time the bed or clothing is soiled. Peri-care is provided after each incontinence episode. Residents who use the toilet and need assistance should be offered/assisted to use the toilet at least every two to three hours or per their individualized plan of care. 29. Review of the provider's 5/14/25 Skin and Pressure Injury Prevention Program revealed that residents who have the risk factor for pressure injury related to incontinence were to be routinely checked for incontinence and have their skin cleaned when soiled. 30. Review of the provider's 5/13/26 South Dakota Department of Health (SD DOH) facility reported incident (FRI) revealed that on 5/10/26, resident 5 was left unaccompanied in the dining room for several hours following the evening meal. The report revealed that camera footage showed resident 5 eating from 6:51 p.m. until 7:21 p.m. He remained in the dining room until contracted travel CNA Z wheeled him out at 10:17 p.m. The incident was brought to DON B's attention by resident 5's family member, who was told by another resident's family member that she saw resident 5 alone in the dining room late that evening. 31. Review of resident 5's EMR revealed he needed assistance to go to and from meals and eat his meals, and that he had a BIMS assessment score of 11, which indicated his cognition was moderately impaired. His care plan indicated he was at risk for skin impairment due to limited mobility and incontinence, and that he was dependent upon the staff to complete all activities of daily living including bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting. His care plan included an intervention from 10/25/25 that read, Please remove me from the dining room promptly after meals and assist me in laying down to rest and relieve pressure from sitting. Resident 5's care plan was updated on 5/13/26 to include a new intervention that read, I will be laid down immediately after meals. The updated care plan was highlighted and placed in a binder at the nurse's station for all staff to read at the start of their scheduled shift. As of 6/16/26, nine of the provider's 64 staff members had signed the in-service sheet acknowledging that they had read resident 5's updated care plan. 32. Interview on 6/16/26 at 9:02 a.m. with DON B and RNC Y revealed that resident 5 frequently complained that his family member wanted the staff to have him lie down after meals, so the staff sometimes let him stay in the dining room for a while before going to his room. DON B said resident 5 was usually in the dining room a half hour before mealtime and could take several hours to finish a meal. 33. Review of audits conducted by RNC Y and administrator A from 5/14/26 to 6/5/26 revealed that resident 5 remained in the dining room for more than two hours after supper had concluded on 5/27/26 (left the dining room at 7:49 p.m.), 5/28/26 (left the dining room at 7:55 p.m.), and 6/1/26 (left the dining room at 7:43 p.m.). 34. Observation in the dining room on 6/16/26 revealed that at 11:30 a.m., staff brought resident 5 to a table with other residents who received mealtime assistance. After he finished eating, staff took resident 5 back to his room at 1:54 p.m. Observation in the dining room on 6/17/26 revealed that staff brought resident 5 to the same table for breakfast at 7:30 a.m. He finished eating and staff helped him (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	06/17/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	leave the dining room at 9:45 a.m. 35. Interview with resident 5's family member on 6/16/26 at 3:52 p.m. revealed that she recalled two other times, both in early May, when friends reported seeing resident 5 in the dining room late at night: once at 8:30 p.m. with other residents, and another time at 7:30 p.m. with the dining room lights turned off. She believed the facility was short staffed and that RNC Y and DON B were monitoring the dining room to ensure that resident 5 was not left alone again. 36. Interview on 6/17/26 at 11:03 a.m. with contracted travel CNA Z revealed that the staff assisted many residents back to their rooms during the two hours following mealtimes. She stated, Call lights are going off after supper because residents want to get to bed right away,. It's a very busy time. CNA Z recalled that after supper on 5/10/26, she had glanced into the dining room and thought all the residents had returned to their rooms. The CNAs were assigned to one of two hallways during their scheduled shift, and it was their responsibility to assist all residents in that hallway. She expected another staff member to let her know if one of her residents needed to be assisted after mealtime. 37. Review of the All-staff meeting in-service sheets from 5/13/26 to 5/15/26 to educate the staff on abuse and neglect revealed the meeting handouts referenced resident 5's incident on 5/10/26 as resident isolation: intentionally ignoring residents or limiting social interaction without clinical reason. Forty-five of the provider's 64 staff members had signed the all-staff meeting in-service sheets acknowledging that they had received education on abuse, neglect, and resident 5's incident on 5/10/26. 38. Review of the provider's 5/14/25 Care Plans policy revealed that care plans were maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence.