Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

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	12/05/2024

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. 50915 Based on observation and interview, the provider failed to preserve the dignity of three of three sampled residents (13), (145), and (146) by not ensuring urinary catheter bags (collects drained urine) were covered while residents were in the common areas. Findings include: 1. Observation on 12/3/24 of resident 13 revealed: *His catheter bag was hanging under his wheelchair with visible urine in it. *At 11:37 a.m., the resident was observed wheeling himself in the hallway with his urinary catheter bag uncovered with visible urine in it. *At 12:08 p.m., the resident was seated in the dining area with his urinary catheter bag uncovered with visible urine. 2. Observation on 12/3/24 of resident 145 revealed: *At 12:25 p.m. during lunch, she was sitting in the dining room with her urinary catheter bag uncovered. -There were three other residents sitting at her table. -The catheter bag contained visible urine and was in clear view of the other residents. *At 3:00 p.m. and again at 3:55 p.m., she was observed in the dining area playing bingo and later watching TV with her urinary catheter bag not covered and with visible urine. 3. Observation on 12/4/24 at 8:25 a.m. of resident 146 revealed he was sitting in the dining area with his urinary catheter bag uncovered and in view of other residents, staff, and visitors. 4. Interview on 12/4/24 at 10:30 a.m. with licensed practical nurse (LPN) D revealed: *She was not unaware of any policy that required urinary catheter bags to be covered. (continued on next page)

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	12/05/2024

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	*She reported that she had worked at a different facility that required urinary catheter bag covers to be utilized to preserve resident dignity. 5. Interview on 12/4/24 at 10:35 a.m. with registered nurse (RN) F revealed: *She was not sure if the facility had urinary catheter bag covers. *She was not aware of any policy that required urinary catheter bags to be covered when the resident was not in their room. 6. Follow-up interview on 12/4/24 at 12:30 p.m. with RN F revealed: *She showed this surveyor a packaged urinary catheter privacy cover. *She stated, we do have catheter covers. *When asked if there was a reason they were not used on the previous day, she replied she was not sure, but we fixed it. 7. Interview on 12/5/24 at 1:00 p.m. with director of nursing (DON) B revealed it was her expectation that resident's urinary catheter drainage bags would be covered while residents were out of their rooms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024

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 - Some

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

45383

Based on the South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI), interview, record review, and policy review, the provider failed to ensure teh accountability of fentanyl patches (a controlled topical pain medication) by not monitoring and documenting the placement of the patches for three of five sampled residents (8, 30, and 144) who were administered fentanyl patches. Findings include:

1. Review of the provider's submitted SD DOH FRI revealed:

*On 5/7/24 at 8:00 a.m., registered nurse (RN) G reported to assistant director of nursing (ADON) C that on 5/6/24, she was unable to locate resident 144's fentanyl patch that had been placed on resident 144 on 5/3/24.

*ADON C reviewed resident 144's-controlled substance/narcotic record and discovered that nursing staff had been unable to locate his fentanyl patch on four other occasions.

*Resident 144 and his spouse were interviewed by administrator A on 5/7/24 and they were not able to determine what may have happened to the missing fentanyl patch.

-Administrator A reported that resident 144's spouse was confused at this time.

*Housekeeper H was interviewed by administrator A, she was unable to recall seeing any patches or bandages on the floor while cleaning the resident's room.

*A pain assessment was completed, and resident rated his pain 0 on a zero to ten scale (0=no pain, 10=the worst pain).

*On 5/8/24 at 4:00 a.m., the fentanyl patch placed on 5/6/24 was found on the floor.

*The resident's primary care physician was notified of the missing fentanyl patches.

-Fentanyl patches were discontinued for the resident.

-Resident 144 was started on oral medication for his pain control.

*Controlled substance/narcotic record for all other residents who utilized fentanyl patches were reviewed with no other patches found missing.

*Education was provided to all nursing staff that any missing narcotic must be reported to the DON and administrator immediately when identified.

*Monitoring was added to the medication administration record (MAR) to check placement of fentanyl patches at the beginning and the end of each shift, with the location of the patch being documented in the resident's MAR.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Avantara Watertown		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	2. Interview on 12/4/24 at 3:15 p.m. with RN F revealed: *The placement of fentanyl patches should be checked each shift. *The checking of patch placement each shift has been considered standard practice since the start of her employment at the facility. *If she was unable to locate a fentanyl patch on a resident, she would search the resident's room (floor, linen, clothing), and if still unable to find the patch, she would report it to her DON. *When asked how to waste or discard controlled substances, she reported there needs to be two nurses to verify and document the waste or discard. 3. Interview on 12/4/24 at 3:18 p.m. with licensed practical nurse (LPN) D revealed: *Fentanyl patch placement should be verified each shift and documented. *Checking patch placement has been considered standard practice since the start of her employment at the facility. *She reported if she were unable to locate a fentanyl patch on a resident, she would first search the resident's room, and if she still could not locate the patch, she would report it to her DON. 4. Interview on 12/5/24 at 9:15 a.m. with administrator A revealed: *When asked who monitors the controlled substance/narcotic record, he reported it was the responsibility of the DON to review the logs. *Referring to the prompt placed in the MAR to check the fentanyl patch placement each shift, he reported it would be the responsibility of the nurse admitting the resident to ensure that was entered into the MAR. *It was his expectation that staff would report a missing fentanyl patch immediately to the DON. 5. Interview on 12/5/24 at 10:00 a.m. with DON B, ADON C, and regional nurse consultant (RNC) I revealed: *Referring to new resident admissions, DON B reported that admissions are a team effort. -The floor nurse would perform and document the resident assessment. -The DON or ADON would usually put in the physician orders. *Referring to the prompt placed in the MAR to check the fentanyl patch placement, DON B reported it would be the responsibility of the person putting in the admission orders to recognize the resident uses a fentanyl patch and to enter the verification of the patch placement each shift prompt into that resident's MAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Avantara Watertown		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	-The fentanyl patch placement verification did not automatically accompany the order for the fentanyl patch. *Regional nurse consultant (RNC) I reported the facility was in the process of changing pharmacies and the new pharmacy planned to automatically include the placement verification of the fentanyl patches each shift when a resident utilized a fentanyl patch. *It was the expectation of DON B and ADON C that a resident missing their fentanyl patch would be reported immediately. 6. Review of resident 144's-controlled substance/narcotic record revealed: *On 3/16/24, 3/22/24, 4/18/24, 4/30/24, and 5/3/24, the record was signed by only one nurse and it was documented that the patches were patch missing, or not found. *He had been discharged from the facility. 7. Review of resident 144's MAR revealed: *On 4/21/24, LPN J noted, Patch not on left rear shoulder. Not found on res clothes, bed, floor, table. Two nurse check was done. Not found at this time -It was not noted on the resident's-controlled substance/narcotic record that the fentanyl patch was missing. 8. Review of the provider's list of residents utilizing fentanyl patches printed on 12/4/24 at 2:31 p.m. revealed there were four current residents receiving fentanyl patches (2, 8, 29, and 30). 9. Record review of residents 8 and 30 revealed: *Resident 30's fentanyl patch was ordered on 11/13/24. -The placement verification of the fentanyl patch each shift was not entered into the resident's MAR until 12/4/24 at 2:30 p.m. *Resident 8's fentanyl patch was ordered on 9/10/24. -The placement verification of the fentanyl patch each shift was not entered into the resident's MAR until 12/4/24 at 2:30 p.m. 10. Review of the provider's 11/19/24 Drug Diversion Prevention policy revealed: *Administration of controlled substances section B: Administration of transdermal controlled substances should follow the steps above for documentation of administration, as well as: -i. Placement of patches will be checked and documented on the MAR every shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024

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 - Some	-ii. Removal and destruction of controlled substance transdermal patches requires two nurses with appropriate documentation on the specific inventory sheet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Avantara Watertown		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50915 Based on observation, interview, and policy review, the provider failed to ensure expired medications were removed from one of one medication storage room. Findings include: 1. Observation on 12/5/24 at 10:55 a.m. in the provider's medication storage room with assistant director of nursing (ADON) C revealed: *In the locked refrigerator, 23 of 23 Hepatitis B vaccines were expired on 6/2/24. *In the locked refrigerator, three 5 milliliters (ml) multi-dose vials of influenza (Flu) vaccine were expired on 6/20/24. 2. Interview with director of nursing (DON) B revealed: *The medication room was checked for outdated medications and supplies each month. *The task was to be completed on night shifts, there was no documented verification that task was completed. *It was her expectation that expired medications would be removed and properly disposed of. 3. Review of the provider's January 2018 Medication Storage in the Facility policy revealed: *Expiration Dating, section G. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner.