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	03/06/2025

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) complaint report review, record review, and interview, the provider failed to ensure one of one resident (1) had been free from a significant medication error and who suffered an acute kidney injury after she was administered the incorrect dose of medication for five consecutive days. Failure to administer that medication as ordered may have contributed to resident 1's health condition and acute kidney injury. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's 2/21/25 SD DOH FRI regarding resident 1 revealed: *Resident 1 had several changes in the frequency and dosage of furosemide (a diuretic medication that reduces extra body fluid) since her admission in response to weight gain and increased edema (fluid retention) in her extremities. *Upon receiving orders for medication changes, the facility faxed the pharmacy the new orders for review and entry into resident 1's medication administration record (MAR). *On 2/7/25 the physician ordered to increase resident 1's daily furosemide dose from 80 milligrams (mg) to 120 mg and she was referred to cardiology. *That physician's order was entered into the MAR by the pharmacy staff to administer an additional 40 mg of furosemide daily in addition to the current order of furosemide 80 mg for a total of 120 mg. *Resident 1 had cardiology appointments on 2/12/25, 2/13/25, and 2/14/25 and was given furosemide 80 mg intravenously (IV) at those appointments. -Written communication was provided by cardiology to the facility to hold resident 1's oral furosemide on those days. *On 2/14/25 resident 1 returned to the facility following her cardiology appointment with orders to restart oral furosemide 80 mg twice daily (a total of 160 mg) the following day (2/15/25). -That medication order was faxed to the pharmacy and was entered in her MAR by pharmacy staff as follows: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	--Furosemide 80 mg daily was discontinued, and furosemide 80 mg twice daily was entered to start on 2/15/25 as ordered. ---The previous additional furosemide 40 mg daily dose order was not discontinued *The resident was administered the additional dose of furosemide 40 mg daily for five days, from 2/15/25 through 2/19/25. -That medication error was discovered at her cardiology appointment on 2/19/25. *On 2/19/25 a review of her laboratory blood values indicated an increase in her Creatinine (waste product produced by muscle breakdown and is filtered by the kidneys and excreted in urine) level from 1.3 milligrams per deciliter (mg/dl) to 2.0 mg/dl (which may indicate impaired kidney function). *Resident 1 had a weight loss of 13 pounds in those five days. 2. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *She had diagnoses that included congestive heart failure, chronic kidney disease, localized edema, and hypertension. *She had a Brief Interview for Mental Status (BIMS) assessment score of 10 that indicated she had moderate cognitive impairment. *A 2/14/25 physician's order Restart oral Lasix tomorrow; 80 mg twice daily. *Her Creatinine level increased from 1.09 mg/dl on 2/5/25 to 2.57 mg/dl on 2/21/25. 3. Review of resident 1's medication administration record (MAR) revealed *She had been given furosemide 40 mg daily on 2/15/25, 2/16/25, 2/17/25, 2/18/25, and 2/19/25. *She had also been given furosemide 80 mg two times daily on those days. 4. Review of resident 1's 2/19/25 cardiology note revealed: *The cardiology provider had contacted the facility regarding resident 1's furosemide dose. -She should only be on 80 mg [of furosemide] twice daily *The care center [facility] did call back, and [resident 1] was given the wrong dose of Lasix [furosemide]. She had been getting a total of 120 mg in the morning with an additional 80 mg in the afternoon. This is likely the result of her acute kidney injury and hypotension. 5. Review of resident 1's 3/6/25 cardiology note revealed: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	*At her last appointment she was noted to be on the incorrect dose of Lasix and did suffer an acute kidney injury. 6. Review of resident 1's 2/27/25 medication error report revealed: *An additional dose of 40 mg of furosemide was given in the morning for five days. *It was indicated that was a transcription error/overlooked. *Discontinued Medication given, was not appropriately DCd [discontinued]. *The medication error type was marked as Significant. 7. Observation and interview on 3/6/25 at 9:01 a.m. with registered nurse D revealed: *She administered medications to two residents with no errors identified. *She had received education and training recently on the process to be followed when receiving medication orders, communicating with the pharmacy, and using a double-check when confirming those orders to minimize the risk of error. *A new system for processing physician's orders was implemented to ensure a double-check was completed when medication orders were changed in the EMR from pending to confirmed. -Two nurses verified that the order had been entered into the EMR correctly from the written physician's order. 8. Interview on 3/6/25 at 12:35 a.m. with administrator A and director of nursing (DON) B regarding resident 1's medication revealed: *The cardiology provider had notified the facility of the above potential medication error after resident 1's cardiology appointment on 2/19/25. *The facility investigated and confirmed the medication error had occurred. *The facility had faxed the physician's orders to the pharmacy and the pharmacy had entered those orders in the electronic system. The order then appeared as pending in the EMR. *DON B expected the nurse to verify that pending order by cross-checking it with the written physician's order. -That order would then have changed from pending to confirmed in the EMR before the medication was administered. *The furosemide order was changed from 80 mg from once a day to twice daily. *The furosemide 40 mg order had been overlooked and was not discontinued. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	*They felt the pharmacy staff should have discontinued the 40 mg dose of furosemide 40 mg order when the furosemide 80 mg dose was changed to twice daily. *The nurse should have caught the 40 mg dose needed to be discontinued when she confirmed that order. 9. Interview on 3/6/25 at 1:23 p.m. with registered pharmacist C regarding resident 1's furosemide orders revealed: *He was the manager at the pharmacy that received resident 1's furosemide order on 2/14/25. *He confirmed that before 2/14/25 resident 1 received an 80 mg dose of furosemide and an additional 40 mg dose of furosemide daily. *The facility staff faxed resident 1's 2/14/25 physician's order to Restart oral Lasix tomorrow; 80 mg twice daily, to the pharmacy, and the pharmacy staff entered that order into their EMR system. -They changed the previous 80 mg dose of furosemide from once daily to twice a day. -That pending order then required the facility nursing staff to confirm and verify that the order was correct before they administered that medication to resident 1. *The furosemide 40 mg dose had not been discontinued and had remained as an active order. -That dose should have been discontinued. *It was a manual process to review the EMR across all of the resident's existing medication orders and stated, We missed that one [discontinuing the furosemide 40 mg dose]. *The pharmacy was notified by the facility on 2/21/25 that a medication error had occurred when that furosemide 40 mg dose had not been discontinued and the resident continued to receive that medication for five days. *The pharmacy implemented education on their process to review the entire resident medication profile with all medication changes. -That education was completed on 2/27/25. *There was a daily audit completed to verify that the process was followed. 10. Interview on 3/6/25 at 3:06 p.m. with licensed practical nurse E who participated by phone revealed: *Resident 1 was confused at times and required assistance taking her medications. *On 2/15/25 she had confirmed resident 1's pending order for furosemide 80 mg twice daily. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-She had not been familiar with resident 1's medications and did not know that there was an additional order for furosemide 40 mg that needed to be discontinued. *She had been notified that an error had occurred when the 40 mg dose was not discontinued. -She received education on 2/27/25 regarding the facility's new process to have a second nurse verify that a new medication order was correct in the EMR before administering that medication. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 3/6/25 after record review revealed no other resident medication errors had been identified, system changes were implemented at the facility to create a double-check process when pending orders were confirmed, education was provided to all nursing care staff regarding medication order processing and pharmacy notification, interviews revealed staff understood the education provided regarding those topics, the facility had followed their quality assurance process and added accuracy of medication orders to their QAPI process for auditing and monitoring, and the pharmacy staff was re-educated on their responsibility when entering medication orders into the electronic system. Based on the above information, non-compliance at F760 occurred on 2/15/25, and based on the provider's implemented corrective action for the deficient practice confirmed on 3/6/25, the non-compliance is considered past non-compliance.