DEPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVED OMB NO. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BOILDI				~	
435054			B. WING			C 04/15/2025		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			04/15/2025		
INAME OF FROMBER OR SUFFLIER					15 THIRD STREET EAST			
AVANTAR	A REDFIELD			REDFIELD, SD 57469				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE	
TAG			TAG		DEFICIENCY)			
F 000	INITIAL COMMENTS		FC	000				
	A complaint health s	urvey for compliance with 42						
	CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/14/25				<ol> <li>There is no corrective action to be made to missing food temperatures on the Food Temperature Chart.</li> <li>The Dietary Manager provided re education to all cooks on the Food Temperatures Policy on 4/16/25.</li> <li>The Dietary Manager or designee will</li> </ol>			
	through 4/15/25. Areas surveyed included							
	resident neglect, and dietary services. Avantara							
	Redfield was found not in compliance with the							
	following requirement	llowing requirement: F812.						
F 812				812				
SS=E								
	§483.60(i) Food safety requirements. The facility must -							
	\$482.60(i)(1) Produce food from courses							
	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by fe				audit 5 random meal services for food			
	state or local authoriti				temperature completion weekly x 4 and monthly x 3 to ensure adherence to the Food Temperatures Policy. Results of			
		ood items obtained directly						
	from local producers, subject to applicable State and local laws or regulations.				the audits will be presented by the Dietary Manager or designee at the			
		This provision does not prohibit or prevent			monthly QAPI meeting for discussion of effectiveness and recommendations.			
	facilities from using produce grown in facility				enectiveness and recommendations.		4. 5/12/25	
		ompliance with applicable						
	safe growing and food							
		es not preclude residents						
	from consuming lood	s not procured by the facility.						
	§483.60(i)(2) - Store, prepare, distribute and							
		ince with professional						
	standards for food se							
		is not met as evidenced						
	by:							
		n, interview, record review,						
		e provider failed to follow						
		pratices to ensure resident						
		ere monitored and recorded						
		ider's policy for all meals in one of one kitchen.						
LABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATURE	1		TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

4/23/2025

PRINTED: 04/22/2025

Diane Forgey, Administrator

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.

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/22/2025 MAPPROVED ). 0938-0391
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		435054	B. WING		-	C 04/15/2025		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
AVANTARA REDFIELD				1015 THIRD STREET EAST REDFIELD, SD 57469				
					-	PLAN OF CORRECTION		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	ETIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page 1 Findings include:		F	812				
	1 0							

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Facility ID: 0035

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/22/2025 MAPPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED	
435054		435054	B. WING			C 04/15/2025		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE	E, ZIP CODE		
AVANTAR	A REDFIELD				015 THIRD STREET EAST EDFIELD, SD 57469			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 812	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	312				

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