PRINTED: 10/18/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	X3) DATE COMP	SURVEY LETED
		405000	D. MANIC				
		435009	B. WING_			10/	08/2024
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
A\/ANTAR	A MILBANK		1103 SOUTH SECOND STREET				
AVAIVIAIS	AMEDANIA			N	IILBANK, SD 57252		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	_	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		
F 000	INITIAL COMMENTS		FO	000			
	Part 483, Subpart B, Care facilities was co through 10/8/24. Area care/treatment. Avant	as included quality of tara Milbank was found not e following requirements:					
F 609			F	309	1. Resident number 1 discharged on		11/02/2024
SS=G			' '	500	9/30/2024. Identified concerns wer		11/02/2024
00-0	01 11(3). 400. 12(0)(0)	(1)(1)(1)(1)(1)(1)			reported to SDDOH on 10/08/2024		
	8483 12(c) In respons	se to allegations of abuse,			residents have the potential for be		
		or mistreatment, the facility			affected. All residents were review		
	must:	or modecations, the lacinty			and any resident able to participate	e in	
	illust.				interviews were interviewed by		
	\$493 12/a\(1) Enguro	that all alleged violations			managerial staff regarding whethe	r they	
	involving abuse, negl				had personally been abused or		
		•			neglected or if they had witnessed		
		ng injuries of unknown			abuse or neglect of any other resid		
		priation of resident property,			whether by staff or other residents		
		tely, but not later than 2			further allegations or concerns ide	ntified	
		tion is made, if the events			during these interviews.		
		ion involve abuse or result in			O Administrator DON and		
		or not later than 24 hours if			2. Administrator, DON, and	ion	
		the allegation do not involve			interdisciplinary team in collaborat		
		ult in serious bodily injury, to			with the medical director reviewed current Abuse and Neglect policy of		
		ne facility and to other					
		the State Survey Agency and			10/29/2024 No changes were mad staff were educated on: The Abuse		
		ces where state law provides			Neglect Policy; See something, sa		
	for jurisdiction in long	-term care facilities) in			something; their role and responsi	•	
	accordance with State	e law through established			to ensure residents are free from a		
	procedures.				neglect, and exploitation; and repo	,	
					injuries of unknown origin. Educati		
	§483.12(c)(4) Report				and training provided by Regional		
		administrator or his or her			consultant to all team members		
		ative and to other officials in			responsible for investigating,		
		e law, including to the State			documenting, and reporting instan	ces of	
	Survey Agency, within	n 5 working days of the			potential abuse, neglect, and		
	incident, and if the all	eged violation is verified			exploitation.		
ABORATORY	DIRECTOR'S OR PROMINERS	SUPPLIER REPRESENTATIVE'S SIGNATURI			TITLE		(X6) DATE
R. Pul		The second secon	-		Administrator		10/25/2024
15 MUL	al				, territoria de la constanta d		

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		435009	B. WING			08/2024
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1103 SOUTH SECOND STREET MILBANK, SD 57252			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	ULD BE	(X5) COMPLETION DATE
F 609	appropriate corrective This REQUIREMENT by: Based on a 10/7/24 review, interview, recreview. The provider investigation was corand neglect occurred resident (1) who had unknown origin on the penis and to report the Dakota Department of the 10/7 Department of Health revealed: * On 8/21/24, staff not 1 had fallen in the batear. * On 9/22/24, staff not 1's knee is swollen, a happened. * On 9/29/24, staff was resident 1's right wrisunaware of the swelling may have be during a transfer. It were sident 1 had a small resident 1 fell a few using his right hand. I right hand and wrist in department [ED]". * Resident one was defined to the swelling hand and wrist in department [ED]".	e action must be taken. T is not met as evidenced complaint intake report ford review, and policy failed to ensure a thorough inpleted to rule out if abuse for one of one sampled bruising and swelling of e left knee, right wrist, and he incidents to the South of Health. Findings include. If 24 South Dakota In (SD DOH) complaint intake In third the family that resident throom and had a small skin In third the family that resident as notified by family that the was swollen. Nursing was and, assessed the wrist, and and. The staff thought the there caused by the sling as also reported that all bruise on his penis. It is 9/30/24 hospitalization aled: In oted "Additionally he weeks ago and hasn't been Nobody has evaluated his In the clinic or emergency	F 609	Additional education to be provide Administrator and DON on report investigation of allegations Educated occur no later than November 2, those staff not in attendance at expessions due to vacation, sick lease work status will be educated prior shift worked. 3. The Administrator or designee walking rounds with resident inter random residents weekly for 4 westen 10 random residents monthly months. The Administrator or dealso complete interviews with 5 ratemployees weekly for 1 month ar random employees weekly for 2 review employee's knowledge of and neglect policies, reporting injunknown origin and whether employees weekly for 1 month and the remployees weekly for 2 review employee's knowledge of and neglect policies, reporting injunknown origin and whether employees weekly for 1 month and the remployees weekly for 2 review employee's knowledge of and neglect policies, reporting injunknown origin and whether employees weekly for 1 month and the remployees weekly for 1 month and the previous day (on Monday through Sunday notes) to ensure any injury of unknown origin that been reported to the DOH and into the previous day (monday t	ing and ation will 2024, and ducation will 2024, and ducation ave, or PRN to their first will conduct views on 10 eeks and y for 2 signee will andom and then 3 months to the abuse uries of aloyees have ey would The DON or see each day for Friday there is not exestigated. In the weekly audits will do the exercise the	

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AVANTARA MILBANK STREET ADDRESS, CITY, STATE, ZIP CODE 1103 SOUTH SECOND STREET MILBANK, SD 57252 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED 10/08/2024	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER AVANTARA MILBANK (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 2 the scaphoid and lunate bones in the wrist and most common cause is a fall on the wrist). * The assessment and plan on 10/1/24 indicated a right scapholunate ligament tear that required a splint. The resident was not a candidate for			435009	B. WNG			C 0/08/2024
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PROBLEM F 609 Continued From page 2 the scaphoid and lunate bones in the wrist and most common cause is a fall on the wrist). * The assessment and plan on 10/1/24 indicated a right scapholunate ligament tear that required a splint. The resident was not a candidate for					1103 SOUTH SECOND STREET		0/00/2024
the scaphoid and lunate bones in the wrist and most common cause is a fall on the wrist). * The assessment and plan on 10/1/24 indicated a right scapholunate ligament tear that required a splint. The resident was not a candidate for	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
2. Interview on 10/8/24 at 11:30 a.m. with certified nurse aide (CNA) H revealed: * On or around 9/27/24 she reported to the nursing staff an incident of possible abuse regarding two other CNAs. She reported that the CNA came out of resident 1's room and had stated, "that motherfucker". When CNA H had asked the other CNA what had happened, the CNA stated that resident 1 had started fighting with them during a transfer so instead of using a total body mechanical lift as it was care planned, they decided to use a two-assist (two staff) transfer to get him on the toilet. CNA H reported the incident to an unidentified nurse. She was unsure if it was investigated. * On 9/29/24, she reported to the nursing staff a sore on resident 1's scrotum and a bruise on his penis. CNA H felt that the bruising may have been caused by the two-assist transfer a few days prior. * She was not sure if the bruising was investigated. No one had followed up with her regarding the incident. 3. Record review of nursing progress notes for resident 1 revealed: *A 9/15/24 nursing progress note indicated that the resident was complaining of left knee pain. Evaluation of the knee indicated that the left knee appeared swollen and tender to the touch. The resident had denied any injury that the could	F 609	the scaphoid and lur most common cause * The assessment are a right scapholunate splint. The resident visurgery. 2. Interview on 10/8/nurse aide (CNA) H * On or around 9/27/nursing staff an incide regarding two other of CNA came out of resistated, "that motherf asked the other CNA CNA stated that reside with them during a treation to the incident to an ununsure if it was invested to an ununsure if it was invested to an investigated. No one regarding the incident of the two-aprior. * She was not sure it investigated. No one regarding the incident of the incident of the incident of the kneapeared swollen are surely	nate bones in the wrist and e is a fall on the wrist). Ind plan on 10/1/24 indicated a ligament tear that required a was not a candidate for was not a fall was not a candidate for was not a fall	F 60			

Facility ID: 0052

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		435009	B. WNG		10	C 0/08/2024
	ROVIDER OR SUPPLIER		11	REET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH SECOND STREET ILBANK, SD 57252		510012024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 609	was noted that his le elevated, and ice wa would be considered. * A 9/29/24 nursing president 1's family whad brought to the arresident 1's right wrist that there were no recause of the swelling was notified, and state to the area and to mecondition had worset been considered. 4. Interview on 10/8//1:00 p.m. with CNA I (DON) B revealed: *If CNA K had witnes neglect, she would read to the area and to mecondition had worset been considered. Interview on 10/8//1:00 p.m. with CNA I (DON) B revealed: *If CNA K had witnes neglect, she would read that regarding abuse and taken very seriously have been notified in Interview on 10/8/24 administrator A reveated that it will be stated that it will localized swelling in the stated that it will be callized swelling in the stated that it will be	tent was difficult that day. It ft knee was wrapped, s applied. An appointment for evaluation the next day. Progress note indicated that as visiting during supper and attention of the staff that set was swollen. It was noted apports of falls that day and the gray was unclear. The physician ff were instructed to apply ice pointor overnight. If the med, an x-ray would have a seed an incident of abuse or apport it to the nurse on duty, all reports to the nurses neglect would have been and the administrator would namediately. at 1:15 p.m. with aled: notified of the allegations of dent 1. It is provide documentation of rule out abuse and neglect of or unknown origin related to and right wrist. as determined that the resident 1's left knee and of the resident 1's disease	F 609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	435009	B. WNG		C 10/08/2024	
NAME OF PROVIDER OR SUPPLIER AVANTARA MILBANK		1	TREET ADDRESS, CITY, STATE, ZIP CODE 103 SOUTH SECOND STREET MILBANK, SD 57252		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
family that resident 1 I 8/21/24. * No report was made swollen left knee and undetermined on 9/22 * No report was made of resident 1's swollen noted to be unclear. * No report was made resident 1's penis that 6. Review of the provice reporting policy reveal * The provider would resident outcome of the disease reported. * An incident that does will not be reported. * The policy defined the include skin tear or brown to stopped by a band that involves more that with subsequent finding to be reported. Review of the provide neglect policy reveale * Injury of unknown or all three criteria accordoperations Manual]: - The source of injury person.	regarding staff reporting to had fallen on or around regarding the resident's the cause was 724. regarding the report to staff a wrist and the cause was regarding the bruise on was identified on 9/29/24. der's 7/31/24 Incident led: report any serious injury on that was not an expected se process would have been as not result in serious injury that "physical harm" did not uise or something that a band-aid. But that d a fracture or blood flow d- aid or hospital treatment an diagnostic evaluation only ag of no injury do not need	F 609			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		3) DATE SURVEY COMPLETED	
		435009	B. WNG_		1	C 10/08/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1103 SOUTH SECOND STREET MILBANK, SD 57252		0/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 609	- The injury was su of the injury or the was in an area not trauma) or the numpoint in time or the * Examples of possmay fall under the unknown origin inc - Unobserved/unex dislocations Unobserved/unex found in suspicious neck, upper chest, - Unobserved/unex linked to a medical - Unobserved/unex injuries in the genit breasts Unobserved/unex transfer to the hosp treatment Any injury that wabe a result of abuse * If abuse was susphave: - Took immediate s of the residents Notified the approor or organization Conducted a care centering on facts, from the alleged vic - Notified authoritie of a crime Report investigatid department.	spicious because of the extent location of the injury (the injury generally vulnerable to ber of injuries at one particular incident of injuries over time. Sible reportable injuries that definition of injuries of uded: plained fractures, sprains, or plained scratches or bruises. Iocations such as the head, and back. plained swelling that was not condition. plained bruising or other all area, inner thighs, or plained injury requiring sital for examination and/or sexplained and appeared to be must be reported. Pected the provider would be teps to assure the protection priate/designated authorities ful and deliberate investigation observations, and statements at tim and witnesses. In the abuse was also a case on findings to the state health	F 6				
F 610 SS=G		/Correct Alleged Violation 2)-(4)	F6	10			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETE						
		435009	B. WING		C	
NAME OF B	DOMOED OD CLIDDLIED	435009		TREET ARRESS OF STATE ZID CORE	10/0	08/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AVANTAR	A MILBANK			103 SOUTH SECOND STREET		
			N	MILBANK, SD 57252		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	§483.12(c) In responsing neglect, exploitation, must: §483.12(c)(2) Have eviolations are thoroug §483.12(c)(3) Preven neglect, exploitation, investigation is in programmed investigation is in programmed investigations to the adesignated represent accordance with State Survey Agency, within incident, and if the alliappropriate corrective This REQUIREMENT by: Based on a 10/7/24 or review, interview, recordence with state of the provider of the investigation was contained in the provider of the penis and to report the Dakota Department of Health revealed: * On 8/21/24, staff no 1 had fallen in the battear. * On 9/22/24, staff no 1 had fallen in the battear.	se to allegations of abuse, or mistreatment, the facility vidence that all alleged withly investigated. It further potential abuse, or mistreatment while the gress. It e results of all administrator or his or her ative and to other officials in a law, including to the State of 5 working days of the eged violation is verified a action must be taken. It is not met as evidenced complaint intake report ord review, and policy failed to ensure a thorough appleted to rule out if abuse for one of one sampled bruising and swelling of the left knee, right wrist, and the incidents to the South of Health. Findings include.	F 610	 Resident #1 no longer resides at Identified concerns were reported DOH on 10/8/24 with subsequent investigation. All Residents have potential to be affected. All reside were reviewed and any resident participate in interviews were interviewed by managerial staff regarding whether they had persident whether by staff or other residents. No further allegations concerns identified during these interviews. Administrator, DON, and interdisciplinary team in collaboration with the medical director reviewed current Abuse and Neglect policy 10/29/2024 No changes were mastaff were educated on: The Abus Neglect Policy; See something, something; their role and respons to ensure residents are free from neglect and exploitation; and repinjuries of unknown origin. Education and training provided by Regional consultant to all team members responsible for investigating, documenting, and reporting instate potential abuse, neglect and exploitation. Additional education provided to the Administrator and on reporting and investigation of allegations. Education will occulater than November 2, 2024, and staff not in attendance at education sessions due to vacation, sick le PRN work status will be educate to their first shift worked. 	d to the it te the ents able to onally ney had ny other ror or ation add. All isse and say sibility a abuse, porting ation all Nurse ances of in to be d DON ir no d those ion ave, or	11/02/2024

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		407000			С
		435009	B. WING_		10/08/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AVANTAR	A MILBANK			1103 SOUTH SECOND STREET	
AVAIVIAIV	AIIICDANN			MILBANK, SD 57252	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 610	resident 1's right wrist unaware of the swellin notified the physician. swelling may have be during a transfer. It was resident 1 had a small Review of resident 1's medical records reveated and I feel a few using his right hand. It right hand and wrist in department [ED]". * Resident one was discapholunate ligament the scapholunate ligament aright scapholunate ligament the scapholunate ligament the scapholunate ligament aright scapholunate ligament the scapholunate ligament aright scapholunate ligament	as notified by family that it was swollen. Nursing was and, assessed the wrist, and The staff thought the en caused by the sling as also reported that I bruise on his penis. 8 9/30/24 hospitalization aled: noted "Additionally he weeks ago and hasn't been blobody has evaluated his in the clinic or emergency agnosed with a right at tear (tissue that connects ate bones in the wrist and is a fall on the wrist). If plan on 10/1/24 indicated agament tear that required a as not a candidate for 4 at 11:30 a.m. with certified evealed: 4 she reported to the ent of possible abuse NAs. She reported that the dent 1's room and had cker". When CNA H had what had happened, the ent 1 had started fighting insfer so instead of using a I lift as it was care planned,	F6	3. The Administrator or designee will walking rounds with resident interview random residents weekly for 4 weeks then 10 random residents monthly for months. The Administrator or designeralso complete interviews with 5 randomemployees weekly for 1 month and the random employees weekly for 2 montreview employee's knowledge of the and neglect policies, reporting injuries unknown origin and whether employed witnessed or heard of anything they were consider to be abuse or neglect. The designee will review progress notes enday for the previous day (on Monday in Friday through Sunday notes) to ensure there is not any injury of unknown originals not been reported to the DOH and investigated. This audit will be daily (in through Friday) for 1 month and then weekly for two months. Results of the audits will be discussed by the IDT teather Medical Director at the monthly Quimeeting to determine if additional audit must be completed or revised.	vs on 10 and 2 ee will en en 3 chs to abuse s of es have vould DON or each for ure gin that d Monday 1 time se am and API

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE C AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			NSTRUCTION		LETED		
		435009	B. WING_			10/	08/2024
	ROVIDER OR SUPPLIER			1103	ET ADDRESS, CITY, STATE, ZIP CODE SOUTH SECOND STREET BANK, SD 57252		
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F 610	unsure if it was invest * On 9/29/24, she rep sore on resident 1's si penis. CNA H felt that caused by the two-asi prior. * She was not sure if i investigated. No one is regarding the incident 3. Record review of ni resident 1 revealed: *A 9/15/24 nursing pro the resident was comp Evaluation of the knee appeared swollen and resident had denied a remember. A CNA har transferring the reside was noted that his left elevated, and ice was would be considered if *A 9/29/24 nursing pr resident 1's family wa had brought to the att resident 1's right wrist that there were no rep cause of the swelling was notified, and staff to the area and to mo condition had worsend been considered. 4. Interview on 10/8/2 1:00 p.m. with CNA K (DON) B revealed: *If CNA K had witness neglect, she would re	igated. orted to the nursing staff a crotum and a bruise on his the bruising may have been sist transfer a few days the bruising was had followed up with her or	F	610			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		435009	B. WNG			C 10/08/2024	
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 103 SOUTH SECOND STREET MILBANK, SD 57252		00/2027
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F 610	regarding abuse and taken very seriously a have been notified im Interview on 10/8/24 a administrator A reveal * She had not been no abuse regarding reside * She was not able to any investigations to regarding the injuries resident 1's left knee a * She stated that it was localized swelling in regist wrist was due to process. 5. Review of the SD E reporting database re * No report was made family that resident 1 8/21/24. * No report was made swollen left knee and undetermined on 9/22 * No report was made of resident 1's swoller noted to be unclear. * No report was made resident 1's penis that 6. Review of the proving policy revea * The provider would sustained by a resident outcome of the diseas reported.	neglect would have been and the administrator would mediately. at 1:15 p.m. with led: otified of the allegations of lent 1. provide documentation of rule out abuse and neglect of unknown origin related to and right wrist. as determined that the esident 1's left knee and the resident 1's disease OOH facility incident vealed: a regarding staff reporting to had fallen on or around a regarding the resident's the cause was eregarding the report to staff in wrist and the cause was a regarding the bruise on the was identified on 9/29/24. der's 7/31/24 Incident	F	610			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SU COMPLE	
		435009	B. WING			C 10/08	/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 1103 SOUTH SECOND STREET MILBANK, SD 57252		10/00	72024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD BE D TO THE APPROPRIA ICIENCY)	- 1	(X5) COMPLETION DATE
F 610	include skin tear or br could be covered with physical harm include not stopped by a band that involves more that with subsequent finding to be reported. Review of the provide neglect policy revealer Injury of unknown or all three criteria accordoperations Manual]: The source of injury person. The source of injury the resident. The injury was susp of the injury or the locustion of the injury of injury of the i	nat "physical harm" did not use or something that a band-aid. But that da fracture or blood flow d-aid or hospital treatment an diagnostic evaluation onlying of no injury do not need or's 7/12/24 abuse and did: irigin were injuries that met ding to the SOM [State was not observed by any could not be explained by icious because of the extent ation of the injury (the injury nerally vulnerable to or of injuries at one particular cident of injuries over time. The reportable injuries that finition of injuries of led: ained fractures, sprains, or sained scratches or bruises cations such as the head, do back, ained swelling that was not undition. ained bruising or other area, inner thighs, or	F6				
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: 1M9V1		Facility ID: 0052	If continu	iation sheet P	age 11 of 18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		435009	B. WING		C 10/08/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1103 SOUTH SECOND STREET MILBANK, SD 57252		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 610	- Any injury that was obe a result of abuse in * If abuse was suspect have: - Took immediate step of the residents Notified the approprior or organization Conducted a careful centering on facts, ob from the alleged victir Notified authorities in of a crime Report investigation department. Nutrition/Hydration St CFR(s): 483.25(g)(1)- §483.25(g) Assisted in (Includes naso-gastric both percutaneous endoscenteral fluids). Based comprehensive assessensure that a resident \$483.25(g)(1) Maintait of nutritional status, so desirable body weight balance, unless the redemonstrates that this preferences indicate of \$483.25(g)(2) Is offered in the status of the statu	explained and appeared to nust be reported. Sted the provider would be to assure the protection ate/designated authorities and deliberate investigation servations, and statements in and witnesses. If the abuse was also a case findings to the state health atus Maintenance (3) Sutrition and hydration. It is and gastrostomy tubes, doscopic gastrostomy and on a resident's sment, the facility must be such as usual body weight or a range and electrolyte is ident's clinical condition is is not possible or resident otherwise;	F 69		ction could 5, and 6 desident 3 in room staff to e at risk for anager, in director policy on ere made. vide esponsible following: d hydration cur no later nose staff sessions PRN work	11/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		435009	B. WING			II.	; 08/2024		
NAME OF PROVIDER OR SUPPLIER AVANTARA MILBANK				STREET ADDRESS, CITY, STATE, ZIP CODE 1103 SOUTH SECOND STREET MILBANK, SD 57252					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 692	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F6	592	3. The DON or designee will conduct of 10 random resident rooms 3 days week at various times to ensure their has water and water pitcher is within resident's reach. Audits will be week weeks and then monthly for 2 months Additionally, the DON or designee wiresident charts to ensure fluid intake documented. Audits will be weekly for weeks and then monthly for 2 months Results of these audits will be discust the IDT team and the Medical Direct monthly QAPI meeting to determine additional audits must be completed revised.	per esident ly for 4 s. Il audit 5 is r 4 s. sed by or at the f			

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		435009	B. WING_				C 08/2024
NAME OF PROVIDER OR SUPPLIER AVANTARA MILBANK				1	TREET ADDRESS, CITY, STATE, ZIP CODE 103 SOUTH SECOND STREET IILBANK, SD 57252		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	day of admission to the * Discharge plan on 9 and weakness. * Laboratory findings - Potassium was low at BUN (blood urea nither - Albumin was low at poor nutrition. 2. Observation on 10//* Resident 2's water particular * Resident 3 did not heavily a straight of the st	three liters of fluid on the be hospital. /30/24 reported dehydration included: at 3.4. rogen) was high at 27. 3.2 and is an indicator of 7/24 at 11:21 a.m. revealed: itcher was out of reach. ave a water pitcher. oth had a full water pitcher ands. The pitchers were not ovisible ice in the water. 4 at 1:15 p.m. with dietary at the resident's fluid intake ntake form and enter it into ic Medical Record (EMR). Forms would have been tion. at 1:30 p.m. with certified evealed: ave had a water pitcher and ared water between meals to have their liquids offered is. at 1:00 p.m. byed with the provider for 45	Fé	592			

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NAME OF PROVIDER OR SUPPLIER AVANTARA MILBANK MANAMY STATEMENT OF DEFICIENCIES TAG REGULATION VALUE OF PROVIDER OR SUPPLIES TAG F 692 COntinued From page 14 residents with mickened liquids would sometimes not have water available at their bedside. 1 There was no thickened liquid in the fridge where ONA E stated it would be. 2 Nesident 3 would need assistance to drink and could not communicate her needs to staff. Interview on 10/7/24 at 3:30 p.m. with Administrator A revealed: 1 Resident's was not in his romal procedure to encourage residents to drink water between meals. Interview on 10/7/24 at 3:30 p.m. with Administrator A revealed: 2 Nesident's water provide Resident 1 with 950 mt. per day. 3 Numing staff were to provide Resident 1 with 1040 mt. per day. 3 Nesident's fluid intake should have been documented in two places in the resident's EMR. 4 Administrator A revealed: 4 Nesident's fluid intake should have been documented in two places in the resident's EMR. 5 Administrator A revealed: 5 Nesident's fluid intake should have been documented in two places in the resident's EMR. 6 Administrator A revealed that Resident's TS EMR. 7 Administrator A revealed that Resident's and accurate account of the resident's a not a fluid restriction, the CNAs. 8 Interview on 10/7/24 at 4:00 p.m. with registered nurse (RN) G revealed: 9 The resident's a not a fluid restriction, the CNAs.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
MANE OF PROVIDER OR SUPPLIER AVANTARA MILBANK WILBANK, SD 57252 MILBANK, SD 57252 PROVIDER'S FLAN OF CORRECTION WEST CONTINUED TO PROVIDER SHAN OF CORRECTION PRESENT TAG F 692 Continued From page 14 residents with thickened liquids would sometimes not have water available at their bedside. There would have been thickened liquid in the fridge where CNA E stated it would be. She thought resident 3 should have had water or liquids offered to her during resident checks and when providing her care. Resident 3 would need assistance to drink and could not communicate her needs to staff. Interview on 10/7/24 at 2:10 p.m. with CNA F revealed: There was not increased to encourage residents to drink water picture was not a 2000 milliliter (mL) a day fluid restriction related to heart failure. The resident is would be resident 1 with 960 mt. per day. Nursing staff were to provide Resident 1 with 1040 mt. per day. Nursing staff were to provide Resident 1 with 1040 mt. per day. Resident 1 fluid intake should have been documented in two places in the resident's EMR. Administrator A resident 1 set that Resident's EMR. Administrator A resident 1 set that Resident's EMR. Administrator A resident's fluid intake. There was no process in place to accurately document resident's fluid intakes. Interview on 10/7/24 at 4:00 p.m. with registered nurse (RN) G revealed:	435009		B. WNG.	B. WNG				
AVANTARA MILBANK 103 SOUTH SECOND STREET MILBANK, SD 57252				1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	10/	00/2024
MILEARK, SO \$7232 SUMMARY STATEMENT OF DEFICIENCIES FREEDED BY FULL TAG					1	103 SOUTH SECOND STREET		
PREPIX TAG GEACH DEFICIENCY MIST BE PRECEDED BY FULL TAG CONTINUED FROM THE PROPRENT BY TAG TO SHEEP REPORT BY THE PROPRENT BY TAG TO SHEEP REPORT BY THE APPROPRIATE OF THE PROPRENT BY THE	AVANTAR	A MILBANK			N	MILBANK, SD 57252		
residents with thickened liquids would sometimes not have water available at their bedside. *There would have been thickened liquids in the fridge to offer resident 3. *There was no thickened liquid in the fridge where CNAE stated it would be. *She thought resident 3 should have had water or liquids offered to her during resident checks and when providing her care. *Resident 3 would need assistance to drink and could not communicate her needs to staff. Interview on 10/7/24 at 2:10 p.m. with CNAF revealed: *The resident's water pitchers were filled with water and ice twice during the day shift. *It was not in her normal procedure to encourage residents to drink water between meals. Interview on 10/7/24 at 3:30 p.m. with Administrator A revealed: *Resident 1 was on a 2000 milliliter (mL) a day fluid restriction related to heart failure. *Dietary staff were to provide Resident 1 with 990 mL per day. *Nursing staff were to provide Resident 1 with 1040 mL per day. *Resident 1's fluid intake should have been documented in two places in the resident's EMR. *Administrator A stated that Resident 1's EMR fluid intake report was not an accurate account of the resident's actual fluid intake. *There was no process in place to accurately document resident's fluid intake. Interview on 10/7/24 at 4:00 p.m. with registered nurse (RN) G revealed:	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFE	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
would have given him the fluid intake report at the	F 692	residents with thicken not have water availal * There would have be fridge to offer resident * There was no thicke where CNA E stated if * She thought resident or liquids offered to he and when providing he * Resident 3 would ne could not communical Interview on 10/7/24 a revealed: * The resident's water water and ice twice du * It was not in her non residents to drink water and ice twice du * It was not in her non residents to drink water Administrator A reveal * Resident 1 was on a fluid restriction related * Dietary staff were to 960 mL per day. * Nursing staff were to 1040 mL per day. * Resident 1's fluid int documented in two pla * Administrator A state fluid intake report was the resident's actual fl * There was no proceed document resident's fl Interview on 10/7/24 a nurse (RN) G revealed * If a resident was on	ed liquids would sometimes ble at their bedside. een thickened liquids in the it 3. ned liquid in the fridge it would be. It 3 should have had water er during resident checks er care. It ded assistance to drink and ite her needs to staff. In pitchers were filled with ruring the day shift. In all procedure to encourage er between meals. In 2000 milliliter (mL) a day if to heart failure. In provide Resident 1 with each should have been eaces in the resident's EMR. It is not an accurate account of fuid intake. In all process in place to accurately luid intakes. In all 100 p.m. with registered dice a fluid restriction, the CNAs	F	692			

Facility ID: 0052

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7,351.5110			С		
		435009	B. WNG				10/08/2024	
NAME OF PROVIDER OR SUPPLIER AVANTARA MILBANK			•	1103	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH SECOND STREET BANK, SD 57252			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO) TAG CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY)		ULD BE	(X5) COMPLETION DATE	
F 692	end of the shift. He left in the resident' documented in the record (TAR). Interview on 10/8/2 J revealed: * She would docur on the daily nutritic the resident's EMF * If she noticed a refluids all day, she shall be she is not part of the she is not	e would have noted the amount is water pitcher and then a treatment administration. 24 at 9:00 a.m. with dietary aide ment the resident's fluid intake on intake form and enter it into R. resident had not drunk any would only record this in the rit it to the nursing staff because he medical staff. at 9:44 a.m. with director of and (DON) D revealed: dent 5 had not consumed any t, lunch, or supper. dent 6 had not consumed any t, lunch, or supper. corded fluid intakes from the reform that would have been MR would have not alerted resident was not drinking fluids. ents 1's 7/17/24 care plan skin integrity.	F	592				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	COMPLETED			
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F 692	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 6	92				

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						С	
435009			B. WING			10/	08/2024
NAME OF PROVIDER OR SUPPLIER AVANTARA MILBANK				11	REET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH SECOND STREET ILBANK, SD 57252		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 692	retention). * Interventions include -Staff were to assess -Staff were to encoun hydration in order to -Staff were to monito of fluid deficit. Review of the provide revealed: * The purpose of the residents are adequated: * Staff were to encounce of the residents are adequated: * Staff were to ensured the residents have fluids * Staff were to ensured asks for it. * Staff were to ensured the residents and pour the pitchers *Those residents with intake and output (1.8)	x related to edema (fluid ded: s for signs of dehydration. rage good nutrition and promote healthier skin. or for any sign and symptoms er's 7/30/24 Hydration policy policy was to ensure that ately hydrated. urage fluid intake unless e that during meals,	F	692			